Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 20, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 18, 2025, we notified you a remedy was imposed.

On May 7, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 1, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 3, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 18, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 3, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 1, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
May 20, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: Reinspection Results
Event ID: CJEE12

Dear Administrator:

On May 7, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 3, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 18, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 3, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 3, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 3, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 3, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 3, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mayo Clinic Health System - Lake City will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 3, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 3, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate

formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/2/25 and 4/3/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52182462C (MN111886 and MN111993) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and document reviews, the facility did not assess or analyze trends in falls to	F 689	Preparation, submission and implementation of this Plan of Correction	5/1/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 determine causal factors or root causes and implemented individualized interventions aimed at preventing or reducing the risk of falls with major injuries for one of three residents (R1) who experienced falls. This resulted in actual harm when R1 suffered two thoracic spinal fractures and hospitalization after he was left unsupervised on the commode and fell. Findings include: R1's After Visit Summary (AVS) dated 2/1/25 to 2/20/25, identified R1 had a newly diagnosed stroke with left sided hemianopsia (loss of vision in half of visual field) hemiparesis (weakness on one side of body), left sided neglect, and right gaze deviation (condition where the right eye deviates to one side and there's difficulty looking to the opposite side). Further identified R1 had safety considerations due to R1's cognition identified he had poor safety awareness, poor attention/concentration and poor judgement. R1's Fall Risk Assessment dated 2/20/25, identified a score of 8 indicating R1 was at moderate risk of falls. R1's AVS dated 2/27/25 to 3/7/25, identified R1's admitting diagnosis was sepsis due to cholecystitis (gall bladder inflammation), presumed prostate cancer with bone metastasis (occurs when cancer cells from a primary tumor elsewhere in the body spread to and establish secondary tumors within the bones), and stercoral colitis (an inflammatory condition of the colon caused by prolonged constipation and fecal impaction). Further identified R1 had safety considerations due to R1's cognition identified he was impulsive, had poor judgement, and poor	F 689	does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facilitys allegation of compliance. 1. Corrective Action: Resident (R1) discharged from facility and did not return. 2. Corrective Action as it applies to other residents: The Fall Risk – Post Fall policy was reviewed and remains current. Staff will be re-educated regarding the Fall Risk – Post Fall policy to ensure each fall incident has proper post fall investigation, root cause analysis, follow up and care. Staff were also re-educated on the Falling Star policy to promote resident safety and prevent/reduce falls. Nurses were re-educated regarding our Risk Management Falls Program. 3. Reviewed residents with falls within the last 90 days to ensure a comprehensive fall analysis and corresponding assessment were in place with appropriate interventions. Care plan reviewed and revised as appropriate. 4. Date of Completion: 5/1/2025 5. Reoccurrence will be prevented by: Audits of fall incidents will be conducted three times a week for two months to ensure root cause analysis is completed and appropriate interventions are in place	

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F 689	Continued From page 2 safety awareness. R1's fall care plan revised 3/13/25, R1 was at risk for falls due to impulsivity related to stroke, cognitive impairment, dependence on staff for transfers and all cares. was reviewed and identified R1 was impulsive, had cognitive impairment and required extensive assist with activities of daily living (ADL's). Interventions dated 3/6/25, included: -R1 needed prompt response to all requests for assist -Anticipate and meet needs. -Be sure call light was in reach -Encourage use for assistance as needed, needed prompt response to all requests for assist -physical therapy (PT) to evaluate and treat as ordered. Care plan was revised on 3/7/25 directed to make sure R1 was centered in bed and ensure bed is in lowest position when cares not being performed. R1's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 3/7/25, identified the reason for therapy was the recommended level of skilled therapy services required due to age, complicated medical history, concomitant cognitive deficits, impairment to multiple areas of the body, impairments to multiple systems, interaction of conditions, multiple diagnoses, need for multiple therapies and patient with dementia requiring repetition of structured task to facilitate new learning. R1's progress note dated 3/8/25, identified R1 was found on the floor in front of his wheelchair at 12:45 p.m., had removed grippy socks and slid out of the wheelchair. When asked what he was doing he replied, "my socks aren't very good." R1	F 689	to prevent falls. Results of the audits will be reviewed at QAPI for follow-up and recommendations to ensure ongoing compliance and those solutions are sustained. 6. The Correction will be monitored by: Director of Nursing or designee.	

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F 689	Continued From page 3 had been needing more assist since readmission with confusion. R1 had been sitting in wheelchair but declined to eat lunch. R1 had been more restless since admission wanting staff or someone with him all the time. R1 was last toileted at 12:20 p.m. At 12:40 p.m. nurse offered R1 lunch and R1 declined. Root cause was R1 slid from his wheelchair, new intervention identified blue grippy in wheelchair, R1 not to be left unattended in room when in wheelchair and dining room for meals if family is not present. R1's Fall Incident report dated 3/8/25 at 12:45 p.m., included the aforementioned description of the fall. The incident report also included: Immediate action taken was vital signs were performed, range of motion (ROM) performed with no concerns. Neuros initiated due to an unwitnessed fall. R1 oriented to person with impaired memory. R1's corresponding Fall Scene Investigation Report (FSI) dated 3/8/25, was requested and not received. In review of R1's fall record dated 3/8/25, there was no indication the care plan had been revised with the interventions identified in the progress note. Although the report identified the intervention that directed staff not to leave R1 alone in his room in his wheelchair, the record did not include and assessment that would identify if R1 could be left alone in his room sitting on other surfaces such as commode/toilet or other type of chair. Further, the record did not identify an assessment that determined R1's overall level of supervision to prevent/negate falls related to R1's impulsivity as identified on hospital AVS dated 2/27/25. R1's admission Minimum Data Set (MDS) dated	F 689		

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F 689	Continued From page 4 3/12/25, identified R1 had moderate cognitive impairment and diagnoses of stroke with left sided hemiplegia, cognitive impairment and long-term use of anticoagulants. R1 had behavioral symptoms not directed at others occurring 1-3 days, impairment in ROM to upper and lower side of body, was extensive assist of two staff with bed mobility, toileting and transfers and was frequently incontinent of bowel and bladder. In addition, R1 had one fall with no injury. R1's Care Area Assessment (CAA) dated 3/13/25, identified R1 had fall risk factors due to being newly diagnosed with a stroke, anticoagulation use, assistance needed for all cares. R1 had a fall when he slid out of his wheelchair (3/8/25) due to two cushions being in place. Cushion was removed and a slip resistant material placed in wheelchair. R1 was not to be up in wheelchair in his room alone. Internal risk factors included diagnoses of stroke with hemiplegia, incontinence, loss of arm or leg movement, cognitive impairment and agitation behavior. R1's Fall Incident report dated 3/13/25 at 6:05 a.m., indicated R1 had an unwitnessed fall and when nursing assistant (NA) entered room R1 was found on the floor; R1's legs were in bed, and he was lying on his back. R1 stated he was trying to get in wheelchair. Immediate action taken was ROM was within normal limits (WNL) for R1. Vital Signs (VS) and neuros started per policy. R1 stated his back hurt when he landed on floor but now it's his pride that hurts. No injuries noted. R1 returned to bed with assist of 2 and lift. Aides changed brief and did ADL's. Mental status identified R1 was cognitively impaired and	F 689		

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F 689	Continued From page 5 oriented to person. Predisposing physiological factors that were identified was confused, incontinent, impaired memory and impaired safety judgement. R1's corresponding FSI included the following additional information: R1 was last seen at 4:30 a.m., when staff were taking tube feeding off and flushing his G-tube. Section 5 of the form identifying, "last time toileted," was left blank. Interventions included offer fluids when restless, must be supervised and mats next to the bed. R1's progress note dated 3/13/25 at 8:03 a.m., identified R1 had a fall trying to get from his bed to his wheelchair. R1 stated he wasn't hurt and had no injury; he was just trying to get up. Activity level identified R1 had minimal activity and was restless. New intervention to place fall mats on each side of his bed. R1's Occupational Therapy (OT) notes dated 3/13/25, identified spoke with nursing who reported R1 had a fall close to 6:00 a.m., trying to get out of bed. Discussed with nursing strategies to reduce restlessness such as scheduled times to offer him ice chips due to frequently feeling thirsty, typically had not wanted to spend a lot of time outside of his bed. R1's care plan interventions dated 3/13/25, included blue floor mats to be placed on both sides of bed every time R1 was in bed, offer fluids when restless, fluids or ice chips on last rounds, oral care to be done first, scheduled assist with ice chips/free water protocol with staff only in between meals, and wear appropriate footwear; grippy socks or shoes with transfers.	F 689		

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F 689	Continued From page 6 Review of R1's fall record dated 3/13/25, identified although the facility determined the predisposing physiological causal factors included incontinence, R1's record did not include an assessment and/or individualized interventions that would prevent or mitigate the risk for falls that would be related to incontinence. R1's Fall Risk Assessment dated 3/16/25, identified a score of 8 indicating R1 was at moderate risk of falls. R1's progress note dated 3/16/25 at 9:30 a.m., identified aide walked past R1's room and noted him to be lying on the floor, nurse was alerted. Note indicated prior to the fall, R1 was lying in his bed slightly positioned on his left side with head of bed elevated 45 degrees. All four mats were on the floor two on each side of the bed. R1's call light was in his hand and on. R1 was transferred back to bed with the Hoyer lift and ensured R1 was positioned more in the center of the bed with the head of the bed not elevated more than 45 degrees. R1's Fall Incident Report dated 3/16/25 at 9:30 a.m., included the aforementioned fall description. Additional information included: R1 had been asking for drinks of water all morning, does not like ice chips, "educated on reason why", R1 was upset about not being able to drink water. R1's FSI report dated 3/16/25 was requested and not received. R1's fall record dated 3/16/25 did not include a comprehensive analysis that identified causal factors/root cause nor identify individualized interventions that prevent and/or negate risk for re-current falls. R1's OT notes dated 3/26/25, identified R1's	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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F 689	Continued From page 7 precautions were decreased vision to left side, left sided hemiplegia and decreased coordination, feeding tube-pureed diet with no liquids, biliary drain, safety/cognition/impulsivity, fall risk and history of 2 assist with Hoyer. R1's cognition was assessed for discharge, results identified a cognitive performance test (CPT) was completed with a score of 4.1 identifying moderate cognitive deficits, requiring 24-hour supervision, up to 1:1 cognitive assist with ADL's and assist with ADL's. All tasks were modified for left visual cut and vision deficits. During a phone interview on 4/3/25 at 2:13 p.m., Occupational Therapist (OT)-A stated R1's cognition was assessed and he required 24-hour supervision and 1:1 with ADL's which therapy educated the aides on. Therapy never saw R1 try to self-transfer, we know he had tried to get out of bed in the past, we did try to come up with a plan to reduce his restlessness. OT-A further stated R1 was impulsive when it came to toileting and drinking. Therapy educated the nurses on R1's impulsiveness quite a bit. OT-A was unable to articulate when a resident who had cognitive deficits with impulsivity and required assistance would be assessed for the level of supervision during toileting tasks. During an interview on 4/3/25 at 11:28 a.m., physical therapist (PT)-A indicated the last day she assessed R1 was on 3/27/25, where R1 had improved since his last hospitalization on 3/7/25. PT-A stated R1's balance was better, required supervision and stand by assist with adl's. R1 could ambulate up to 100 feet with minimal assist and a two wheeled walker. R1 was very willing to work in therapy, however, could not tolerate sitting long because it hurt him, so he spent a lot	F 689		

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F 689	Continued From page 8 of time in bed. R1's cognition was poor, and he was very impulsive. Therapy performed several cognitive tests with results that identified significant impairment indicating a level of dementia. PT-A stated she did not assess R1 to see if he required supervision with toileting and could not find anything in the therapy notes that indicated R1 was ever assessed for supervision with toileting. R1's Fall Incident report dated 3/29/25 at 9:25 a.m., indicated R1 had an unwitnessed fall in his room. R1 was found on the floor in between commode and foot of bed lying on his back. R1 complained of level 4 out of 10 low back pain, prn (as needed) Tylenol administered. NA had informed nurse they had placed R1 on the commode as requested. R1 explained he was on the commode and thought he could walk back to bed. R1 stated, "I knew I shouldn't have, and I should have tucked and rolled." Immediate Action Taken: writer assessed R1 for physical injury, R1 transferred to bed using a Hoyer. Predisposing factors were gait imbalance, confused, weakness, impaired safety judgement, self-transfer and ambulating without assist. Staff statement identified co-worker, and myself went to toilet R1 on the commode using a gait belt. We sat him down gave him his call light and told him to turn on his call light when he was done. She was checking on other residents when his call light go on. When she went to his room, she saw him lying on the floor. R1's corresponding FSI report dated 3/29/25, was requested and not received. R1's progress notes dated 3/29/25, included the aforementioned fall description. At 4:20 p.m. R1's family wanted R1 sent to the emergency	F 689		

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F 689	Continued From page 9	F 689		

department (ED). R1 was reporting pain 10 out of 10 in his low back. On-call provider gave order to transfer R1 to ED. R1 was transferred to the ED at 4:30 p.m.

R1's progress note dated 3/30/25 at 11:37 a.m., identified R1 was admitted to the hospital for fracture in T11 and T12. R1 was discharged from facility because no bed hold was signed.

R1's physician visits on 3/10/25, 3/17/25, 3/24/25 and 3/26/25 did not address R1's falls.

During a phone interview on 4/3/25 at 2:29 p.m., family member (FM)-A stated R1 fell on 3/29/25, because staff left him on the commode by himself. Nursing staff should not have done that because R1 was very impulsive and did not always remember to ask for help. FM-A stated R1 ended up in the hospital from that fall and suffered two fractures in his spine- T11 and T12. The injuries had "really set [R1] back" and will be transferring to another facility from the hospital today (4/3/25).

During an interview on 4/3/25 at 1:21 p.m., nursing assistant (NA)-A stated on 3/29/25 around 9:00 a.m., R1 had put his call light on and had asked to go to the bathroom. NA-A was not familiar with R1's care and was not aware he had previous falls, so she checked R1's care plan before transferring him. NA-A and another staff member used a gait belt and two wheeled walker and walked R1 from his bed approximately 13 feet to his commode. NA-A placed R1's walker in front of him and tied his call light to it. NA-A instructed R1 to push his button when he was done. NA-A explained she then left the room to answer a call light a couple of rooms away. NA-A

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F 689	Continued From page 10 noticed call light was on then heard a "thud", when she got to R1's room, she found R 1 lying on the floor partially on his right side and back. R1 had made it three steps from the commode. NA-A stayed with R1 and radioed for help. R1 had reported pain and pointed to his middle back. After the nurse assessed him, R1 was transferred back to bed using a hoyer. NA-A did not remember R1 being on the "Falling Star Program" and would have seen the star on R1's door. During an interview on 4/3/25 at 10:07 a.m., nurse manager (NM)-A stated with a fall, the floor nurse would assess the resident and provide any needed care. Floor nurse would then fill out a fall huddle form, make an incident report, and put in a fall progress note. After each fall nursing staff should try to determine the root cause of the fall and update the care plan with an appropriate intervention. NM-A stated R1's incident reports for the falls on 3/8/25, 3/13/25 and 3/18/25 did not identify if R1's basic needs were met. For example, the incident reports did not identify if R1 had been incontinent at the time of the fall and the last time he was toileted. Because of the lack of information it was not possible to appropriately root cause each fall. NM-A stated she did not see root cause for R1's 3/16/25 fall and did not see that R1's care plan was updated with any new interventions. The root cause of R1's fall on 3/29/25 was due to staff leaving R1 unattended on his commode where he fell and was hospitalized with two thoracic fractures. During an interview on 4/3/25 at 11:01 a.m., director of nursing (DON) verified R1 had 4 falls since 3/8/25 to 3/29/25. DON explained the facility used a fall huddle form that the floor nurse was supposed to fill out at the time of the fall to	F 689		

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F 689	Continued From page 11 help determine a root cause of the resident's fall. During "morning meeting" interdisciplinary team (IDT) discuss the resident falls to ensure prevention interventions are put in place. DON reviewed R1's falls and verified the nurse did not fill out a fall huddle form for 3/8/25, 3/16/25, and 3/29/25. The fall investigations did not always identify or include in the analysis if R1's needs were met such as toileting, pain and thirst. R1's fall on 3/16/25 did not include a comprehensive analysis due to the lack of investigation. Further the care plan had not been updated to include any new fall prevention interventions. DON stated R1 was left on the commode on 3/29/25 unsupervised when he fell and was sent to the hospital that resulted in two thoracic fractures. DON was unaware of how long R1 was left on the commode and verified his cognition was impaired, was impulsive and required extensive assist with toileting. DON further stated we usually have therapy assess a resident for safety with supervision of ADL's if they are dependent on staff for care and have impaired cognition. Facility Policy entitled, "Fall Risk, Post Fall Investigation, Follow Up and Care," effective dates of 7/2021, 10/21 and 12/23, identified purpose-to define Nursing's role in the management of patients at risk for falls and post fall investigation, follow up and care. 2. Universal fall precautions are used for all patients based on individual patient needs. Interventions should be selected based on individual patient needs. Document interventions in the medical record. Falls risk and interventions should be noted on the plan of care. POST FALL INVESTI AT ON, FOLLOW UP AND CARE-1. Evaluate patient's pain range of motion and level of consciousness or change in cognitive level before moving or	F 689		

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F 689	Continued From page 12 helping patient to a safer position/chair/bed. Document Post Fall Huddle completed. Document Care Plan reviewed and revised as indicated. Document and complete UDA's that were triggered if applicable. 3. Any changes in interventions will be noted, on the resident's Care Plan and Kardex. The IDT (interdisciplinary team) will meet each weekday to review fall(s) and determine if further investigation of incident is needed; and assign who will assist with assessing further intervention(s). Risk Management Reports and statistics of the falls that have occurred to be maintained and reported to the QAPI committee for interpretation of patterns and quality improvement interventions. Nursing staff actions-information gathering ...assess for basic needs-hunger, pain, toileting ...bowel and bladder training programs in place and effective ...review care plan to ensure fall prevention strategies are included ...increase patient observation ...Mandatory high-risk interventions, but not limited to: o Place a yellow wristband on wheelchair, walker, o Place "Falling Star" symbol on doorframe outside patient's room. and o Ensure that the falling star is removed upon discharge from falling star program.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 18, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: State Nursing Home Licensing Orders
Event ID: CJEE11

Dear Administrator:

The above facility was surveyed on April 2, 2025 through April 3, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

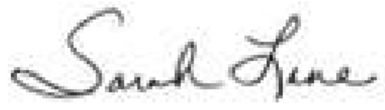
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: _____ B. WING _____	C 04/03/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/2/25 and 4/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52182462C (MN111886 and MN111993) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interviews and document reviews, the facility did not assess or analyze trends in falls to determine causal factors or root causes and implemented individualized interventions aimed at preventing or reducing the risk of falls with major injuries for one of three residents (R1) who experienced falls. This resulted in actual harm when R1 suffered two thoracic spinal fractures and hospitalization after he was left unsupervised on the commode and fell.	2 830	CORRECTED	5/1/25

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2 830	Continued From page 3 Findings include: R1's After Visit Summary (AVS) dated 2/1/25 to 2/20/25, identified R1 had a newly diagnosed stroke with left sided hemianopsia (loss of vision in half of visual field) hemiparesis (weakness on one side of body), left sided neglect, and right gaze deviation (condition where the right eye deviates to one side and there's difficulty looking to the opposite side). Further identified R1 had safety considerations due to R1's cognition identified he had poor safety awareness, poor attention/concentration and poor judgement. R1's Fall Risk Assessment dated 2/20/25, identified a score of 8 indicating R1 was at moderate risk of falls. R1's AVS dated 2/27/25 to 3/7/25, identified R1's admitting diagnosis was sepsis due to cholecystitis (gall bladder inflammation), presumed prostate cancer with bone metastasis (occurs when cancer cells from a primary tumor elsewhere in the body spread to and establish secondary tumors within the bones), and stercoral colitis (an inflammatory condition of the colon caused by prolonged constipation and fecal impaction). Further identified R1 had safety considerations due to R1's cognition identified he was impulsive, had poor judgement, and poor safety awareness. R1's fall care plan revised 3/13/25, R1 was at risk for falls due to impulsivity related to stroke, cognitive impairment, dependence on staff for transfers and all cares. was reviewed and identified R1 was impulsive, had cognitive impairment and required extensive assist with activities of daily living (ADL's). Interventions dated 3/6/25, included:	2 830		

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2 830	Continued From page 4 -R1 needed prompt response to all requests for assist -Anticipate and meet needs. -Be sure call light was in reach -Encourage use for assistance as needed, needed prompt response to all requests for assist -physical therapy (PT) to evaluate and treat as ordered. Care plan was revised on 3/7/25 directed to make sure R1 was centered in bed and ensure bed is in lowest position when cares not being performed. R1's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 3/7/25, identified the reason for therapy was the recommended level of skilled therapy services required due to age, complicated medical history, concomitant cognitive deficits, impairment to multiple areas of the body, impairments to multiple systems, interaction of conditions, multiple diagnoses, need for multiple therapies and patient with dementia requiring repetition of structured task to facilitate new learning. R1's progress note dated 3/8/25, identified R1 was found on the floor in front of his wheelchair at 12:45 p.m., had removed grippy socks and slid out of the wheelchair. When asked what he was doing he replied, "my socks aren't very good." R1 had been needing more assist since readmission with confusion. R1 had been sitting in wheelchair but declined to eat lunch. R1 had been more restless since admission wanting staff or someone with him all the time. R1 was last toileted at 12:20 p.m. At 12:40 p.m. nurse offered R1 lunch and R1 declined. Root cause was R1 slid from his wheelchair, new intervention identified blue grippy in wheelchair, R1 not to be left unattended in room when in wheelchair and dining room for meals if family is not present.	2 830		

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2 830	Continued From page 5 R1's Fall Incident report dated 3/8/25 at 12:45 p.m., included the aforementioned description of the fall. The incident report also included: Immediate action taken was vital signs were performed, range of motion (ROM) performed with no concerns. Neuros initiated due to an unwitnessed fall. R1 oriented to person with impaired memory. R1's corresponding Fall Scene Investigation Report (FSI) dated 3/8/25, was requested and not received. In review of R1's fall record dated 3/8/25, there was no indication the care plan had been revised with the interventions identified in the progress note. Although the report identified the intervention that directed staff not to leave R1 alone in his room in his wheelchair, the record did not include and assessment that would identify if R1 could be left alone in his room sitting on other surfaces such as commode/toilet or other type of chair. Further, the record did not identify an assessment that determined R1's overall level of supervision to prevent/negate falls related to R1's impulsivity as identified on hospital AVS dated 2/27/25. R1's admission Minimum Data Set (MDS) dated 3/12/25, identified R1 had moderate cognitive impairment and diagnoses of stroke with left sided hemiplegia, cognitive impairment and long-term use of anticoagulants. R1 had behavioral symptoms not directed at others occurring 1-3 days, impairment in ROM to upper and lower side of body, was extensive assist of two staff with bed mobility, toileting and transfers and was frequently incontinent of bowel and bladder. In addition, R1 had one fall with no injury.	2 830		

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2 830	Continued From page 6 R1's Care Area Assessment (CAA) dated 3/13/25, identified R1 had fall risk factors due to being newly diagnosed with a stroke, anticoagulation use, assistance needed for all cares. R1 had a fall when he slid out of his wheelchair (3/8/25) due to two cushions being in place. Cushion was removed and a slip resistant material placed in wheelchair. R1 was not to be up in wheelchair in his room alone. Internal risk factors included diagnoses of stroke with hemiplegia, incontinence, loss of arm or leg movement, cognitive impairment and agitation behavior. R1's Fall Incident report dated 3/13/25 at 6:05 a.m., indicated R1 had an unwitnessed fall and when nursing assistant (NA) entered room R1 was found on the floor; R1's legs were in bed, and he was lying on his back. R1 stated he was trying to get in wheelchair. Immediate action taken was ROM was within normal limits (WNL) for R1. Vital Signs (VS) and neuros started per policy. R1 stated his back hurt when he landed on floor but now it's his pride that hurts. No injuries noted. R1 returned to bed with assist of 2 and lift. Aides changed brief and did ADL's. Mental status identified R1 was cognitively impaired and oriented to person. Predisposing physiological factors that were identified was confused, incontinent, impaired memory and impaired safety judgement. R1's corresponding FSI included the following additional information: R1 was last seen at 4:30 a.m., when staff were taking tube feeding off and flushing his G-tube. Section 5 of the form identifying, "last time toileted," was left blank. Interventions included offer fluids when restless, must be supervised and mats next to the bed. R1's progress note dated 3/13/25 at 8:03 a.m.,	2 830		

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2 830	Continued From page 7 identified R1 had a fall trying to get from his bed to his wheelchair. R1 stated he wasn't hurt and had no injury; he was just trying to get up. Activity level identified R1 had minimal activity and was restless. New intervention to place fall mats on each side of his bed. R1's Occupational Therapy (OT) notes dated 3/13/25, identified spoke with nursing who reported R1 had a fall close to 6:00 a.m., trying to get out of bed. Discussed with nursing strategies to reduce restlessness such as scheduled times to offer him ice chips due to frequently feeling thirsty, typically had not wanted to spend a lot of time outside of his bed. R1's care plan interventions dated 3/13/25, included blue floor mats to be placed on both sides of bed every time R1 was in bed, offer fluids when restless, fluids or ice chips on last rounds, oral care to be done first, scheduled assist with ice chips/free water protocol with staff only in between meals, and wear appropriate footwear; grippy socks or shoes with transfers. Review of R1's fall record dated 3/13/25, identified although the facility determined the predisposing physiological causal factors included incontinence, R1's record did not include an assessment and/or individualized interventions that would prevent or mitigate the risk for falls that would be related to incontinence. R1's Fall Risk Assessment dated 3/16/25, identified a score of 8 indicating R1 was at moderate risk of falls. R1's progress note dated 3/16/25 at 9:30 a.m., identified aide walked past R1's room and noted	2 830		

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2 830	Continued From page 8 him to be lying on the floor, nurse was alerted. Note indicated prior to the fall, R1 was lying in his bed slightly positioned on his left side with head of bed elevated 45 degrees. All four mats were on the floor two on each side of the bed. R1's call light was in his hand and on. R1 was transferred back to bed with the Hoyer lift and ensured R1 was positioned more in the center of the bed with the head of the bed not elevated more than 45 degrees. R1's Fall Incident Report dated 3/16/25 at 9:30 a.m., included the aforementioned fall description. Additional information included: R1 had been asking for drinks of water all morning, does not like ice chips, "educated on reason why", R1 was upset about not being able to drink water. R1's FSI report dated 3/16/25 was requested and not received. R1's fall record dated 3/16/25 did not include a comprehensive analysis that identified causal factors/root cause nor identify individualized interventions that prevent and/or negate risk for re-current falls. R1's OT notes dated 3/26/25, identified R1's precautions were decreased vision to left side, left sided hemiplegia and decreased coordination, feeding tube-pureed diet with no liquids, biliary drain, safety/cognition/impulsivity, fall risk and history of 2 assist with Hoyer. R1's cognition was assessed for discharge, results identified a cognitive performance test (CPT) was completed with a score of 4.1 identifying moderate cognitive deficits, requiring 24-hour supervision, up to 1:1 cognitive assist with ADL's and assist with ADL's. All tasks were modified for left visual cut and vision deficits. During a phone interview on 4/3/25 at 2:13 p.m., Occupational Therapist (OT)-A stated R1's	2 830		

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2 830	Continued From page 9 cognition was assessed and he required 24-hour supervision and 1:1 with ADL's which therapy educated the aides on. Therapy never saw R1 try to self-transfer, we know he had tried to get out of bed in the past, we did try to come up with a plan to reduce his restlessness. OT-A further stated R1 was impulsive when it came to toileting and drinking. Therapy educated the nurses on R1's impulsiveness quite a bit. OT-A was unable to articulate when a resident who had cognitive deficits with impulsivity and required assistance would be assessed for the level of supervision during toileting tasks. During an interview on 4/3/25 at 11:28 a.m., physical therapist (PT)-A indicated the last day she assessed R1 was on 3/27/25, where R1 had improved since his last hospitalization on 3/7/25. PT-A stated R1's balance was better, required supervision and stand by assist with adl's. R1 could ambulate up to 100 feet with minimal assist and a two wheeled walker. R1 was very willing to work in therapy, however, could not tolerate sitting long because it hurt him, so he spent a lot of time in bed. R1's cognition was poor, and he was very impulsive. Therapy performed several cognitive tests with results that identified significant impairment indicating a level of dementia. PT-A stated she did not assess R1 to see if he required supervision with toileting and could not find anything in the therapy notes that indicated R1 was ever assessed for supervision with toileting. R1's Fall Incident report dated 3/29/25 at 9:25 a.m., indicated R1 had an unwitnessed fall in his room. R1 was found on the floor in between commode and foot of bed lying on his back. R1 complained of level 4 out of 10 low back pain, prn (as needed) Tylenol administered. NA had	2 830		

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2 830	Continued From page 10 informed nurse they had placed R1 on the commode as requested. R1 explained he was on the commode and thought he could walk back to bed. R1 stated, "I knew I shouldn't have, and I should have tucked and rolled." Immediate Action Taken: writer assessed R1 for physical injury, R1 transferred to bed using a Hoyer. Predisposing factors were gait imbalance, confused, weakness, impaired safety judgement, self-transfer and ambulating without assist. Staff statement identified co-worker, and myself went to toilet R1 on the commode using a gait belt. We sat him down gave him his call light and told him to turn on his call light when he was done. She was checking on other residents when his call light go on. When she went to his room, she saw him lying on the floor. R1's corresponding FSI report dated 3/29/25, was requested and not received. R1's progress notes dated 3/29/25, included the aforementioned fall description. At 4:20 p.m. R1's family wanted R1 sent to the emergency department (ED). R1 was reporting pain 10 out of 10 in his low back. On-call provider gave order to transfer R1 to ED. R1 was transferred to the ED at 4:30 p.m. R1's progress note dated 3/30/25 at 11:37 a.m., identified R1 was admitted to the hospital for fracture in T11 and T12. R1 was discharged from facility because no bed hold was signed. R1's physician visits on 3/10/25, 3/17/25, 3/24/25 and 3/26/25 did not address R1's falls. During a phone interview on 4/3/25 at 2:29 p.m., family member (FM)-A stated R1 fell on 3/29/25, because staff left him on the commode by himself. Nursing staff should not have done that	2 830		

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2 830	Continued From page 11 because R1 was very impulsive and did not always remember to ask for help. FM-A stated R1 ended up in the hospital from that fall and suffered two fractures in his spine- T11 and T12. The injuries had "really set [R1] back" and will be transferring to another facility from the hospital today (4/3/25). During an interview on 4/3/25 at 1:21 p.m., nursing assistant (NA)-A stated on 3/29/25 around 9:00 a.m., R1 had put his call light on and had asked to go to the bathroom. NA-A was not familiar with R1's care and was not aware he had previous falls, so she checked R1's care plan before transferring him. NA-A and another staff member used a gait belt and two wheeled walker and walked R1 from his bed approximately 13 feet to his commode. NA-A placed R1's walker in front of him and tied his call light to it. NA-A instructed R1 to push his button when he was done. NA-A explained she then left the room to answer a call light a couple of rooms away. NA-A noticed call light was on then heard a "thud", when she got to R1's room, she found R 1 lying on the floor partially on his right side and back. R1 had made it three steps from the commode. NA-A stayed with R1 and radioed for help. R1 had reported pain and pointed to his middle back. After the nurse assessed him, R1 was transferred back to bed using a hoyer. NA-A did not remember R1 being on the "Falling Star Program" and would have seen the star on R1's door. During an interview on 4/3/25 at 10:07 a.m., nurse manager (NM)-A stated with a fall, the floor nurse would assess the resident and provide any needed care. Floor nurse would then fill out a fall huddle form, make an incident report, and put in a fall progress note. After each fall nursing staff should try to determine the root cause of the fall	2 830		

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2 830	Continued From page 12 and update the care plan with an appropriate intervention. NM-A stated R1's incident reports for the falls on 3/8/25, 3/13/25 and 3/18/25 did not identify if R1's basic needs were met. For example, the incident reports did not identify if R1 had been incontinent at the time of the fall and the last time he was toileted. Because of the lack of information it was not possible to appropriately root cause each fall. NM-A stated she did not see root cause for R1's 3/16/25 fall and did not see that R1's care plan was updated with any new interventions. The root cause of R1's fall on 3/29/25 was due to staff leaving R1 unattended on his commode where he fell and was hospitalized with two thoracic fractures. During an interview on 4/3/25 at 11:01 a.m., director of nursing (DON) verified R1 had 4 falls since 3/8/25 to 3/29/25. DON explained the facility used a fall huddle form that the floor nurse was supposed to fill out at the time of the fall to help determine a root cause of the resident's fall. During "morning meeting" interdisciplinary team (IDT) discuss the resident falls to ensure prevention interventions are put in place. DON reviewed R1's falls and verified the nurse did not fill out a fall huddle form for 3/8/25, 3/16/25, and 3/29/25. The fall investigations did not always identify or include in the analysis if R1's needs were met such as toileting, pain and thirst. R1's fall on 3/16/25 did not include a comprehensive analysis due to the lack of investigation. Further the care plan had not been updated to include any new fall prevention interventions. DON stated R1 was left on the commode on 3/29/25 unsupervised when he fell and was sent to the hospital that resulted in two thoracic fractures. DON was unaware of how long R1 was left on the commode and verified his cognition was impaired, was impulsive and required extensive	2 830		

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2 830	Continued From page 13 assist with toileting. DON further stated we usually have therapy assess a resident for safety with supervision of ADL's if they are dependent on staff for care and have impaired cognition. Facility Policy entitled, "Fall Risk, Post Fall Investigation, Follow Up and Care," effective dates of 7/2021, 10/21 and 12/23, identified purpose-to define Nursing's role in the management of patients at risk for falls and post fall investigation, follow up and care. 2. Universal fall precautions are used for all patients based on individual patient needs. Interventions should be selected based on individual patient needs. Document interventions in the medical record. Falls risk and interventions should be noted on the plan of care. POST FALL INVESTI AT ON, FOLLOW UP AND CARE-1. Evaluate patient's pain range of motion and level of consciousness or change in cognitive level before moving or helping patient to a safer position/chair/bed. Document Post Fall Huddle completed. Document Care Plan reviewed and revised as indicated. Document and complete UDA's that were triggered if applicable. 3. Any changes in interventions will be noted, on the resident's Care Plan and Kardex. The IDT (interdisciplinary team) will meet each weekday to review fall(s) and determine if further investigation of incident is needed; and assign who will assist with assessing further intervention(s). Risk Management Reports and statistics of the falls that have occurred to be maintained and reported to the QAPI committee for interpretation of patterns and quality improvement interventions. Nursing staff actions-information gathering ...assess for basic needs-hunger, pain, toileting ...bowel and bladder training programs in place and effective ...review care plan to ensure fall prevention strategies are included ...increase patient observation	2 830		

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2 830	Continued From page 14 ...Mandatory high-risk interventions, but not limited to: o Place a yellow wristband on wheelchair, walker, o Place "Falling Star" symbol on doorframe outside patient's room. and o Ensure that the falling star is removed upon discharge from falling star program. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analaysis of falls occurs for fall prevention. The director of nursing or designee, should conduct measurable audits of fall to ensure analysis of the root cause if completed and identify if appropriate interventions are in place to prevent falls. The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		