Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 31, 2023

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

RE: CCN: 245231
Cycle Start Date: June 23, 2023

Dear Administrator:

On August 24, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 31, 2023

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

Re: Reinspection Results
Event ID: CQ8B12

Dear Administrator:

On August 24, 2023 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 June 23, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 12, 2023

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

RE: CCN: 245231
Cycle Start Date: June 23, 2023

Dear Administrator:

On June 23, 2023, a survey was completed at your facility by the Minnesota Department 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, 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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 approved 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 23, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 23, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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

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Electronically delivered
July 12, 2023

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

Re: State Nursing Home Licensing Orders
Event ID: CQ8B11

Dear Administrator:

The above facility was surveyed on June 22, 2023 through June 23, 2023 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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

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
	245231	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLETON AREA HEALTH	30 S BEHL ST APPLETON, MN 56208

(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 6/22/23 and 6/23/23, 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 complaints were reviewed: H52313122C (MN00093704). The following complaints were reviewed: H52312948C (MN00094519) with a deficiency issued 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=D	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	F 689		8/4/23

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

Electronically Signed | 07/21/2023

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 by: Based on interview and document review the facility failed to ensure comprehensive fall assessments, identification of casual factors and probable root cause, and development and implementation of interventions that would prevent/or mitigate the risk or re-current falls and injury for 2 out of 3 (R2 and R3) residents evaluated for falls. Finding include: EZ lift = (Hoyer) full body mechanical lift. EZ stand=mechanical lift that residents are able to bear weight and assist to stand with R2's quarterly Minimum Data Set (MDS) dated 6/7/23, identified R2's diagnoses included heart failure, diabetes, and seizure disorder. R2 had moderate cognitive impairment. R2 required extensive assist of 2 staff for bed mobility, transfers, and toileting. R2 required human assistance with balancing while moving from a seated to standing position, walking, moving on and off the toilet and surface-to-surface transfers. R2 used a wheelchair and a walker for mobility. R2 had two falls without injury since the last MDS. R2's fall care plan dated 12/21/22, identified R2 was at risk for falls related to multiple health problems including weakness evidence by low tolerance to activity. Interventions included: -gripper strips on floor in front of bed to prevent slipping, start date 5/4/23, -Assist of two staff, walker, and gait belt, to walk a few steps in room, revised date 6/22/23, -R2 Required wheelchair and assist of one staff with locomotion outside of room, revised date	F 689	F689 1.It is the policy of this facility to abide by state and federal regulations within 24 hours of a fall, begin to try to identify possible or causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. To ensure that resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to ensure comprehensive falls assessments, identification of casual factors and probable root cause, and development and implementation of interventions that would prevent/mitigate the risk or re-current falls and injury for 2 out of 3 (R2 and R3) residents evaluated for falls. Each fall was and is currently being tracked and discussed at the morning stand up meeting with IDT which occurs every morning M-F and then discussed further at the Risk Management meeting with IDT which occurs every Thursday. R2 and R3 have graduated from hospice since focused survey. The care plan goal for both R2 and R3 is to have no major injuries with falls as residents have the potential to fall, it is our responsibility to ensure they are unharmed from any fall that may occur. R2 was started on Keppra for seizure activity this has been added to care plan. R2 has allowed staff to weigh on a larger scale outside of room. Gripper socks in care plan and on care sheet, R2 has history of refusing gripper socks. R2	

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F 689	Continued From page 2 6/22/23, -R2 required assist of two staff with transfer to and from commode next to the bed for bowel movements, one staff to wipe after bowel movements and adjust and change brief. R2 used call light to request assist, start date 6/22/23, -the resident is able to come to standing potion from bed by raising bed height before standing and with staff assist, gait belt and walker, revised date 6/22/23 R2's safety risk assessment dated 6/7/23, indicated a risk for falls secondary to multiple comorbidities and generalized weakness. R2 was non-compliant with most treatments and orders. R2 had been educated on risk for falls with independent transfers and ambulation but desired to be left alone despite the risk for injury or death. R2's care sheet (abbreviated care plan used by direct care staff), dated 6/22/23, did not identify R2 as a fall risk and did not list any fall interventions. R2's fall records were reviewed between 2/21/23 thru 6/22/23, the record identified R2 had six unwitnessed falls and one witnessed fall. Although R2's record identified predisposing risk factors, the record consistently lacked a comprehensive fall assessment to determine root cause for appropriate interventions or failed to include appropriate interventions when the root cause was identified. Fall 1 R2's progress note dated 2/21/23, indicated R2 had a witnessed fall, R2 lost his balance while stepping off the portable scale and nursing	F 689	has been more complaint with using call light for assistance and has had no more falls since starting of Keppra. R3 falls reviewed, noted multiple falls from bed. Has high Low bed and mat on floor, TAB alarm, concave mattress (implemented 7/5/2023), and motion sensor (implemented 7/11/23). R3 was visualized unclipping TAB alarm, pad alarm not appropriate. R3 is not able to bear own weight. R3 is on a toileting schedule that was implemented after review of falls and trend. Reviewed falls since admission found decreased number of falls for two years. Reviewed medication during those years found the R3 was on a higher dose of Fentanyl. Decrease in Fentanyl Patch December of 2022, noted an increase in falls since decrease in Fentanyl. RCA identified R3 may not be able to express increased pain, reviewed with provider, and received order for Tylenol Extended Release 650mg TID. R3 has been less anxious since the start of Tylenol. Interventions are currently effective for both R2 and R3. 2.All current residents who experience a fall may have the potential to be affected by the cited deficiency. Each resident fall will be reviewed for the Post Fall Root Cause Analysis Form, verify that care plan is up to date with current interventions, and the daily care sheet will be reviewed for accuracy and interventions and updated as warranted. 3.To enhance the Care Center falls process and under the direction of the	

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F 689	Continued From page 3 assistant (NA) lowered R2 to the floor. R2 was sitting on his bottom with legs/feet folded to the left side of his body. No injuries denied pain. R2 was not wearing any footwear or stocking per his preference. Assisted off the floor after assessment and vital signs (VS) obtained. Oxygen saturations were low at 84%, (normal is above 90%) on room air, oxygen reapplied as R2 removed the oxygen for his transfer. Corresponding incident report identified the fall occurred at 9:20 a.m. with predisposing factors included gait imbalance during transfer. R2's post fall interdisciplinary team (IDT) notes dated 2/23/23, identified R2 refused to allow staff to place gait belt or provide contact guarded assist (CGA) or allow assistance for all transfers. R2 removed his oxygen prior to being weighed and saturations dropped to 84%. R2 refused physician required rounding visit on 2/22/23. Encouraged staff to be more aware during collection of weight, R2 refuses multiple staff in room at once. R2's follow up IDT note for 3/2/23, indicated no injury from fall. NA stated that R2 had already stepped off the scale and was standing with walker when he lost his balance. Portable scale used as R2 refused to leave room. Will initiate standby by assist (SBA) of one staff when resident weighed to minimize risk of falls. R2's care plan did not reflect revisions. Fall 2 R2's progress note dated 4/15/23, indicated R2 had an unwitnessed fall with no injuries. Corresponding incident report identified the fall occurred at 3:00 p.m. R2 stated that his bathroom was too small and slipped. Denied injuries and	F 689	Director of Nursing, the interdisciplinary team upon review of our post fall process, found areas where improvement could be made. The Post Fall Root Cause Analysis Forms were not being completed as expected; immediately updated form and posted for staff in their form□s binder. Falls were being reviewed by IDT but new interventions were not being added to the care plan or care sheets after reviewing and implementing. In addition to the following: a.A review of the Post-Fall Root Cause Analysis Form was completed and updated to include; When were last medications given? Is resident on any mood-altering medications? When was the last mood-altering medication given? Updated 6/28/2023 and copies were provided to staff, staff informed of where to find and that they need to be completed. b.Assigned the RN Supervisor to ensure Post-Fall Analysis forms are being completed after every fall. If not completed the RN Supervisor will attempt to have them completed by staff and provide education to the present charge nurses at time of incident. c.A review of the policy and procedure was completed. Will update as necessary. d.Fall Risk Tracking Excel file created to track falls and patterns of residents that have repeated falls. Created and implemented 6/28/2023. Information from the Post-Fall RCA will be entered here to track patterns in repeated falls and review effectiveness. e.IDT was educated on 6/23/2023 post	

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F 689	Continued From page 4 denied hitting his head but neuros were started due to unwitnessed fall. Immediate action was noted to be VS obtained and neuros started, transferred from floor to bed via Hoyer lift assisted by three staff. Predisposing factors listed wet floor, R2 was incontinent, ambulating without proper footwear, ambulating without assist and using walker. R2 was offered gripper socks but refused. R2 post fall IDT notes dated 4/20/23 Reviewed. Offered gripper socks, resident refused. R2's follow up IDT was not completed until 4/27/23; that note indicated R2 had a status change and was no longer using bathroom without help and was using his call light for assistance now. Although, R2's fall record identified potential causal factors, the record lacked full comprehensive analysis to determine probable root cause and was not evident immediate interventions were developed and implemented to mitigate modifiable risk factors to prevent recurrent falls or the risk. Fall 3 R2's progress notes dated 4/19/23, indicated R2 had an unwitnessed fall. R2 was noted to by lying on his right side. R2 was not able to say what he was doing prior to fall. Denies injuries. Walker noted near foot of bed, R2 was barefoot. Assisted off floor with two staff and EZ-Lift into bed. Seizure like activity noted for about 20 seconds during assessment and occurred two more times at 7:30 a.m. and 7:45 a.m. After episode R2 was able to answer questions and was alert, pupils no longer fixed. Corresponding incident report	F 689	state survey the need to review and update care plans and care sheets to include interventions. f.Each fall will be reviewed the following day for Post-Fall Root Cause Analysis completion, an intervention initiated appropriate to the root cause analysis, and the care plan and care guide updated. g.Each week all falls in the past week will be reviewed to note if interventions remain effective and appropriate or if changes need to be made. h.Education provided to the licensed staff on the changes to the policy and procedures as necessary, review of root cause analysis, updating of the care plan along with competency determined through a post-test with 80% correct by 8/4/2023. 4.Audits will be completed monthly x 3 months to ensure interventions were initiated, care plans, and care sheets for nursing assistance have been updated for each fall. Audits to be completed by Director of Nursing or designee. Findings will be brought to the quarterly QAPI committee for review and action, as appropriate. Next QAPI meeting is October 17th, 2023. The QAPI committee will determine the need for further audits and/or action plan.	

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F 689	Continued From page 5 identified the fall happened at 7:15 a.m. Immediate interventions were to start neurological checks and vital signs (VS) as R2 allowed, and housekeeping to mop floor. Predisposing factors included decrease in ornamentation over the past week, confusion, incontinent, wet floor-floor sticky with jello particles, gait imbalance, recent change in medications/new- increase Ativan (anti-anxiety medication) over weekend, recent change in condition and weakness/fainted. R2's post fall IDT notes dated 4/27/23, referred to IDT note second fall for 4/19/23. Which was R2 had a status change and was no longer using bathroom without help and was using his call light for assistance now. Although R2's record identified a new medication was started, the record did not address interventions to prevent and/or mitigate R2's risk for falls related to seizure activity. Fall 4 R2's progress note dated 4/19/23, indicated R2 has an unwitnessed fall. R2 was found with right leg bent under him and left leg out in front of him. R2's back was against the bed. R2 was able to move right leg and denied pain. Assisted off of floor with EZ-Lift and assist of four staff. Video monitoring initiated with family consent. Corresponding incident report identified the fall occurred at 3:22 p.m., predisposing factors included second fall of the day, weakness, confusion, recent illness. Resident able to say that he slipped off the bed. Recent history seizure like activity of freezing and holding unusual body positions. Immediate actions were to assist off of floor. IDT determined best action would be for	F 689		

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APPLETON AREA HEALTH	30 S BEHL ST APPLETON, MN 56208

(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 689	Continued From page 6 video monitoring as a alarm would irritate R2. Hospice requested increasing pain medication. R2's post fall IDT note dated 4/20/23, indicated seizure activity, start Keppra and video monitoring. R2 was medicated as needed. R2's care plan did not include video monitoring as an intervention. Fall 5 R2's progress notes dated 4/21/23, indicated R2 had an unwitnessed fall. R2 was heard calling out for help and was found on floor next to bed, feet tucked under bottom and head and left shoulder resting on walker near foot of bed. Bedding and gown noted to be on floor saturated with urine, water, or soup from meal. Resident denied pain. R2 refused to allow staff to do proper assessment but did allow them to assist him with the EZ-Lift . Once in bed noted to be having visual hallucinations. Staff provided one on one and R2 seemed to have seizure like activity, lasting approximately 30 seconds. R2 was alert after episode but continued to refuse neuro's and VS. Corresponding incident report indicated the fall happened at 12:15 p.m. and R2 received a bruise to his right hip measuring 3-centimeters (cm) x 3 cm. Predisposing factors included wet floor, furniture, confusion, R2 was incontinent, recent change in condition, and recent medication change/new- started Keppra, increase Morphine. R2's post fall IDT note dated 4/27/23 stated to see "risk notes." (Asked for and not received). Although, R2's fall record identified potential causal factors, the record lacked full comprehensive analysis to determine probable	F 689		

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F 689	Continued From page 7	F 689		

root cause and was not evident immediate interventions were developed and implemented to mitigate modifiable risk factors to prevent recurrent falls or the risk.

Fall 6
R2's progress note dated 4/23/23, indicated R2 was found on floor calling for help by hospital staff. R2 was lying on floor mat with food noted on floor, bowel movement was on floor, underwear and on bedding. R2 refused VS and assessment but did allow staff to assist off the floor with Hoyer lift and two staff. Hematoma noted on R2's right bottom, skin tear on back of right hand, R2 refused measurements of but did allow staff to apply dressing. Corresponding incident report dated 4/22/23, indicted an unwitnessed fall at 6:40 p.m. Predisposing factors include confusion, gait imbalance, impaired memory, ambulating without assist.

R2's post fall IDT note dated R2 could have been having seizures and refusing Keppra. R2 was restless and having hallucination, was medicated with Morphine (narcotic pain medication) and Haldol (antipsychotic medication). Mat attempted on floor beside bed but bed table not able to be by beside which upset R2. Gripper strips were applied to floor on 4/27/23. R2 now taking Keppra with no seizure activity, improved mood, and less confusion. R2 using call light for assist. R2's follow up IDT note dated 5/11/23, started on Keppra, more alert, no recent seizure activity and more cooperative.

R2's record identified R2's grip strips were not implemented until 5 days after fall on 4/22/23.

Fall 7

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F 689	Continued From page 8 R2's progress note dated 4/23/23, noted that on 4/22/23 at 7:30 p.m. R2 was found lying on floor mat with bowel movement noted on floor, food on floor. R2 stated he was looking for his remote. R2 was transferred from floor to bed and refused VS and neuro checks. R2 was medicated with lorazepam (anti-anxiety medication) by mouth. There was no corresponding incident report. R2's fall record lacked a comprehensive analysis that identified root cause and was not evident immediate interventions were developed and implemented to prevent and/or mitigate risk of recurrent falls. R3 R3's quarterly MDS dated 4/18/23, identified R2's diagnoses included Alzheimer's disease, dementia, anxiety, psychotic disorder other than schizophrenia, visual and auditory hallucinations. R3 had severe cognitive impairment. R3 was totally dependent on two staff for transfers, locomotion on and off unit. R3 had range of motion impairment to one side upper and lower extremities. R3 had no fall since previous significant change MDS dated 1/17/23, which R3 had one fall. R3's revised care plan, dated 5/2/23, indicated R3 had limited physical mobility related to history of cardiovascular accident (CVA), with right sided weakness, syncopal episodes. Physically unable to bear weight, walk or stand without assist of EZ-Stand. R3 was at high risk for falls related to history of and falls since admit to facility. R3 did not remember her limitations. Interventions included -Ensure R3 is wearing proper footwear; gripper socks or her slip-on tennis shoes when	F 689		

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F 689	Continued From page 9 transferring with mechanical stand (revised date 9/5/19.) -Anticipate and meet R3 needs. If restless or agitated, assess for sign and symptoms of pain, or need to use bathroom. Staff assist R3 as soon as possible if she is awake, be aware R3 attempts self-transfers, does not wait for assist (revised date 10/04/19.) -Place books of interest with large print in resident's room to enable staff to offer to resident (revised date 11/7/19.) -IDT to review R3's falls, discuss causal factors, relationship to agitation and/or pain (revised date 12/16/19.) -R3 uses TABS chair/bed alarms. Ensure device is in place and functioning with every care contact and nurse to follow up with nursing assistants, document in treatment record (revised date 12/18/20.) -Be sure call light within reach and encourage use during periods of alertness. R3 needs prompt response to all requests for assistance and to TABs alarm sounding. Use mat on floor during night and day especially when agitated to decrease risk of injury with falls (revised date 4/4/20.) -When R3 is attempting to go into her room, she wants to lay down. Assist R3 into bed at these times. Start date 10/29/21. -When restless or agitated, attempting to self-transfer, may try warm blankets or weighted blanket. Sleeps/rests better with lights off and door only slightly open allowing visual checks (revised date 12/21/21.) -Needs a safe environment with even floors free from spills and/or clutter; adequate glare-free lighting; a working and reachable call light, the bed in lowest position at night; grab bar as ordered, personal items within reach. Revised	F 689		

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F 689	Continued From page 10 date 12/22/22. -Has grab rails on bed to allow resident to assist if able if/when her status allows. Bed in low position with mat on floor, noodle under outside mattress edge (revised date 12/22/22.) -Allow resident to rest in recliner if desires, use EZ-Lift and assist of 3 staff for transfers. Staff to run the lift chair and lift chair control to be kept out of resident's reach (revised date 5/2/23) R3's current care sheet indicated fall risk with the fall interventions of low bed, floor mat, alarms in bed and while in broda chair. Keep recliner unplugged and to monitor frequently (monitoring frequency was not identified). R3's safety risk assessment dated 6/8/23, indicated at risk for falls, continue current care plan with high low bed in lowest position when in bed, mat on floor by bed when in bed, TABs alarms on bed and wheelchair, and staff assist resident to lay in bed when tired. Fall 1 R3's progress note dated 4/20/23, indicated R3 had an unwitnessed fall. R3 was noted to be hollering out and was found on floor mat next to bed and attempting to get back into bed. R3 was assisted with two staff to get back into bed. VS obtained. R3 was anxious and restless most of the shift and required one-on-one. Did receive as needed Ativan, had multiple snacks, fluids, repositioning, wheeled in wheelchair up and down the halls. Air mattress overlay was placed earlier; staff thought the mattress caused the fall and encouraged night shift to remove if R3 seemed uncomfortable during the night. Corresponding incident report indicated fall happened at 6:25 p.m. Immediate interventions taken was to assist	F 689		

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F 689	Continued From page 11 R3 off the floor via two staff as R3 was partially on the bed. No injuries noted. Predisposing factors included fall alarm, impaired memory, recent change in condition, recent medication change/new. Resident noted to be more anxious and received PRN Ativan and nonpharmacological interventions used with minimal effect noted. R3's post fall IDT note dated 4/27/23, new air mattress overlay thought to be the reason along with increased confusion that day. Evaluated the use of toilet as resident gets restless when needs to have a BM. Attempt to toilet the resident when stating need. R3's fall record did not mention if the TAB alarm had been functioning at the time of the fall. R3's record did not identify when/if mattress was removed and/or revision to the care plan. Fall 2 R3's progress note dated 6/19/23, indicated an unwitnessed fall at 4:15 p.m. R3 stated pain when asked but not able to tell where pain was located. R3 also stated that she did not feel well. VS taken and R3 had an elevated diastolic blood pressure (blood pressure not identified). Recheck of blood pressure 15 minutes later was 127/86. Corresponding incident report indicated the R3 slid out of bed and was found on her mat with TABS alarm going off. R3 had no injuries. Immediate interventions were R3 was assessed for injuries; no injuries were identified, however, R3 reported pain, and stated "I don't feel well." Predisposing factors included confusion, memory impairment. Although R3's fall record identified potential causal factors, it was not evident a	F 689		

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F 689	Continued From page 12 comprehensive analysis was completed that identified root cause and not evident interventions were developed and implemented to prevent and/or mitigate risk for recurrent falls. During an interview on 6/22/23 at 3:33 p.m., nursing assistant (NA)-L indicated that R2 had been waxing and waning with his level of care and his cognition since his admission. R2 went through a period where R2 he was falling a lot but NA-L could not remember if the falls resulted in injury. NA-L stated staff had to anticipate R3's needs, NA-L was not aware if R3 had any falls. NA-L would refer to the current care sheet to look for residents at fall risk for falls and what their fall interventions were. During an interview on 6/22/23 at 3:47 p.m., NA-A indicated R2 was assist of two staff with transfers and could not remember any recent falls for R2 . R2 wore a TABs alarm at all times and had a fall mat beside her bed. NA-A stated R3 was a hoyer lift with assist of two staff. NA-A indicated R3 liked to crawl out of bed at times. NA-A was able to articulate the steps involved when there was a fall per facility protocol. make sure resident is safe, call for nurse and stay with resident until nurse comes to assess resident, and then help get resident off the floor. During an interview on 6/23/23 at 8:27 a.m., NA-N indicated R2 was a two person pivot transfer from bed to commode and back again, and was able to turn self in bed. R2 had a history of falls, could not remember how long ago R2 last fell, and was not sure of his fall interventions however would check the care sheet. NA-N stated R3 was a EZ-Lift with assist of 2 for most transfers, EZ-Stand for transfers to and from	F 689		

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F 689	Continued From page 13 commode only after breakfast. NA-A could not remember R3' s last fall. NA-N was able to articulate the steps involved with falls per facility protocol. During an interview on 6/22/23 at 2:10 p.m., director of nursing (DON) indicated when there was a fall the NAs would contact the nurse to come and do assessment and then staff would assist resident off the floor with the EZ-Lift The nurse would document the incident, note any injuries, and who they contacted. Every Thursday the IDT risk management meeting was held. IDT reviews the incidents from the previous week; notes were made on the incident report during the meetings. On 6/23/23 at 12:00 p.m., DON explained nurses were supposed to complete the Post Fall RCA (root cause analysis) questionnaire with each fall. DON reviewed R2 and R3's fall records; stated she was unable to completed RCA's for R2 and R3's falls. DON stated nurses were supposed to follow and complete the Fall Checklist. DON stated expectation nursing staff followed the facility's fall program policies. Review of revised facility's policies Fall-Clinical Protocol and Assessing Falls and Their Causes, both dated 6/22/23, indicated identifying causes of a fall within 24 hours. Currently IDT meets weekly to discuss falls. Performing post fall evaluation 4) ...complete of falls risk assessment and put in appropriate interventions taken to prevent future falls.	F 689		

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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 6/22/23 and 6/23/23, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H52313122C (MN00093704). The following complaints were reviewed: H52312948C (MN00094519) 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	2 000		

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2 000	Continued From page 2 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 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 interview and document review the facility failed to ensure comprehensive fall assessments, identification of casual factors and probable root cause, and development and implementation of interventions that would prevent/or mitigate the risk or re-current falls and injury for 2 out of 3 (R2 and R3) residents evaluated for falls.	2 830	Corrected	7/21/23

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2 830	Continued From page 3 Finding include: EZ lift = (Hoyer) full body mechanical lift. EZ stand=mechanical lift that residents are able to bear weight and assist to stand with R2's quarterly Minimum Data Set (MDS) dated 6/7/23, identified R2's diagnoses included heart failure, diabetes, and seizure disorder. R2 had moderate cognitive impairment. R2 required extensive assist of 2 staff for bed mobility, transfers, and toileting. R2 required human assistance with balancing while moving from a seated to standing position, walking, moving on and off the toilet and surface-to-surface transfers. R2 used a wheelchair and a walker for mobility. R2 had two falls without injury since the last MDS. R2's fall care plan dated 12/21/22, identified R2 was at risk for falls related to multiple health problems including weakness evidence by low tolerance to activity. Interventions included: -gripper strips on floor in front of bed to prevent slipping, start date 5/4/23, -Assist of two staff, walker, and gait belt, to walk a few steps in room, revised date 6/22/23, -R2 Required wheelchair and assist of one staff with locomotion outside of room, revised date 6/22/23, -R2 required assist of two staff with transfer to and from commode next to the bed for bowel movements, one staff to wipe after bowel movements and adjust and change brief. R2 used call light to request assist, start date 6/22/23, -the resident is able to come to standing potion from bed by raising bed height before standing and with staff assist, gait belt and walker, revised	2 830		

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2 830	Continued From page 4 date 6/22/23 R2's safety risk assessment dated 6/7/23, indicated a risk for falls secondary to multiple comorbidities and generalized weakness. R2 was non-compliant with most treatments and orders. R2 had been educated on risk for falls with independent transfers and ambulation but desired to be left alone despite the risk for injury or death. R2's care sheet (abbreviated care plan used by direct care staff), dated 6/22/23, did not identify R2 as a fall risk and did not list any fall interventions. R2's fall records were reviewed between 2/21/23 thru 6/22/23, the record identified R2 had six unwitnessed falls and one witnessed fall. Although R2's record identified predisposing risk factors, the record consistently lacked a comprehensive fall assessment to determine root cause for appropriate interventions or failed to include appropriate interventions when the root cause was identified. Fall 1 R2's progress note dated 2/21/23, indicated R2 had a witnessed fall, R2 lost his balance while stepping off the portable scale and nursing assistant (NA) lowered R2 to the floor. R2 was sitting on his bottom with legs/feet folded to the left side of his body. No injuries denied pain. R2 was not wearing any footwear or stocking per his preference. Assisted off the floor after assessment and vital signs (VS) obtained. Oxygen saturations were low at 84%, (normal is above 90%) on room air, oxygen reapplied as R2 removed the oxygen for his transfer. Corresponding incident report identified the fall occurred at 9:20 a.m. with predisposing factors	2 830		

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2 830	Continued From page 5 included gait imbalance during transfer. R2's post fall interdisciplinary team (IDT) notes dated 2/23/23, identified R2 refused to allow staff to place gait belt or provide contact guarded assist (CGA) or allow assistance for all transfers. R2 removed his oxygen prior to being weighed and saturations dropped to 84%. R2 refused physician required rounding visit on 2/22/23. Encouraged staff to be more aware during collection of weight, R2 refuses multiple staff in room at once. R2's follow up IDT note for 3/2/23, indicated no injury from fall. NA stated that R2 had already stepped off the scale and was standing with walker when he lost his balance. Portable scale used as R2 refused to leave room. Will initiate standby by assist (SBA) of one staff when resident weighed to minimize risk of falls. R2's care plan did not reflect revisions. Fall 2 R2's progress note dated 4/15/23, indicated R2 had an unwitnessed fall with no injuries. Corresponding incident report identified the fall occurred at 3:00 p.m. R2 stated that his bathroom was too small and slipped. Denied injuries and denied hitting his head but neuros were started due to unwitnessed fall. Immediate action was noted to be VS obtained and neuros started, transferred from floor to bed via Hoyer lift assisted by three staff. Predisposing factors listed wet floor, R2 was incontinent, ambulating without proper footwear, ambulating without assist and using walker. R2 was offered gripper socks but refused. R2 post fall IDT notes dated 4/20/23 Reviewed. Offered gripper socks, resident refused.	2 830		

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2 830	Continued From page 6 R2's follow up IDT was not completed until 4/27/23; that note indicated R2 had a status change and was no longer using bathroom without help and was using his call light for assistance now. Although, R2's fall record identified potential causal factors, the record lacked full comprehensive analysis to determine probable root cause and was not evident immediate interventions were developed and implemented to mitigate modifiable risk factors to prevent recurrent falls or the risk. Fall 3 R2's progress notes dated 4/19/23, indicated R2 had an unwitnessed fall. R2 was noted to by lying on his right side. R2 was not able to say what he was doing prior to fall. Denies injuries. Walker noted near foot of bed, R2 was barefoot. Assisted off floor with two staff and EZ-Lift into bed. Seizure like activity noted for about 20 seconds during assessment and occurred two more times at 7:30 a.m. and 7:45 a.m. After episode R2 was able to answer questions and was alert, pupils no longer fixed. Corresponding incident report identified the fall happened at 7:15 a.m. Immediate interventions were to start neurological checks and vital signs (VS) as R2 allowed, and housekeeping to mop floor. Predisposing factors included decrease in ornamentation over the past week, confusion, incontinent, wet floor-floor sticky with jello particles, gait imbalance, recent change in medications/new- increase Ativan (anti-anxiety medication) over weekend, recent change in condition and weakness/fainted. R2's post fall IDT notes dated 4/27/23, referred to IDT note second fall for 4/19/23. Which was R2	2 830		

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2 830	Continued From page 7 had a status change and was no longer using bathroom without help and was using his call light for assistance now. Although R2's record identified a new medication was started, the record did not address interventions to prevent and/or mitigate R2's risk for falls related to seizure activity. Fall 4 R2's progress note dated 4/19/23, indicated R2 has an unwitnessed fall. R2 was found with right leg bent under him and left leg out in front of him. R2's back was against the bed. R2 was able to move right leg and denied pain. Assisted off of floor with EZ-Lift and assist of four staff. Video monitoring initiated with family consent. Corresponding incident report identified the fall occurred at 3:22 p.m., predisposing factors included second fall of the day, weakness, confusion, recent illness. Resident able to say that he slipped off the bed. Recent history seizure like activity of freezing and holding unusual body positions. Immediate actions were to assist off of floor. IDT determined best action would be for video monitoring as a alarm would irritate R2. Hospice requested increasing pain medication. R2's post fall IDT note dated 4/20/23, indicated seizure activity, start Keppra and video monitoring. R2 was medicated as needed. R2's care plan did not include video monitoring as an intervention. Fall 5 R2's progress notes dated 4/21/23, indicated R2 had an unwitnessed fall. R2 was heard calling out for help and was found on floor next to bed, feet	2 830		

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2 830	Continued From page 8 tucked under bottom and head and left shoulder resting on walker near foot of bed. Bedding and gown noted to be on floor saturated with urine, water, or soup from meal. Resident denied pain. R2 refused to allow staff to do proper assessment but did allow them to assist him with the EZ-Lift . Once in bed noted to be having visual hallucinations. Staff provided one on one and R2 seemed to have seizure like activity, lasting approximately 30 seconds. R2 was alert after episode but continued to refuse neuro's and VS. Corresponding incident report indicated the fall happened at 12:15 p.m. and R2 received a bruise to his right hip measuring 3-centimeters (cm) x 3 cm. Predisposing factors included wet floor, furniture, confusion, R2 was incontinent, recent change in condition, and recent medication change/new- started Keppra, increase Morphine. R2's post fall IDT note dated 4/27/23 stated to see "risk notes." (Asked for and not received). Although, R2's fall record identified potential causal factors, the record lacked full comprehensive analysis to determine probable root cause and was not evident immediate interventions were developed and implemented to mitigate modifiable risk factors to prevent recurrent falls or the risk. Fall 6 R2's progress note dated 4/23/23, indicated R2 was found on floor calling for help by hospital staff. R2 was lying on floor mat with food noted on floor, bowel movement was on floor, underwear and on bedding. R2 refused VS and assessment but did allow staff to assist off the floor with Hoyer lift and two staff. Hematoma noted on R2's right bottom, skin tear on back of right hand, R2 refused measurements of but did	2 830		

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2 830	Continued From page 9 allow staff to apply dressing. Corresponding incident report dated 4/22/23, indicted an unwitnessed fall at 6:40 p.m. Predisposing factors include confusion, gait imbalance, impaired memory, ambulating without assist. R2's post fall IDT note dated R2 could have been having seizures and refusing Keppra. R2 was restless and having hallucination, was medicated with Morphine (narcotic pain medication) and Haldol (antipsychotic medication). Mat attempted on floor beside bed but bed table not able to be by beside which upset R2. Gripper strips were applied to floor on 4/27/23. R2 now taking Keppra with no seizure activity, improved mood, and less confusion. R2 using call light for assist. R2's follow up IDT note dated 5/11/23, started on Keppra, more alert, no recent seizure activity and more cooperative. R2's record identified R2's grip strips were not implemented until 5 days after fall on 4/22/23. Fall 7 R2's progress note dated 4/23/23, noted that on 4/22/23 at 7:30 p.m. R2 was found lying on floor mat with bowel movement noted on floor, food on floor. R2 stated he was looking for his remote. R2 was transferred from floor to bed and refused VS and neuro checks. R2 was medicated with lorazepam (anti-anxiety medication) by mouth. There was no corresponding incident report. R2's fall record lacked a comprehensive analysis that identified root cause and was not evident immediate interventions were developed and implemented to prevent and/or mitigate risk of recurrent falls. R3	2 830		

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2 830	Continued From page 10 R3's quarterly MDS dated 4/18/23, identified R2's diagnoses included Alzheimer's disease, dementia, anxiety, psychotic disorder other than schizophrenia, visual and auditory hallucinations. R3 had severe cognitive impairment. R3 was totally dependent on two staff for transfers, locomotion on and off unit. R3 had range of motion impairment to one side upper and lower extremities. R3 had no fall since previous significant change MDS dated 1/17/23, which R3 had one fall. R3's revised care plan, dated 5/2/23, indicated R3 had limited physical mobility related to history of cardiovascular accident (CVA), with right sided weakness, syncopal episodes. Physically unable to bear weight, walk or stand without assist of EZ-Stand. R3 was at high risk for falls related to history of and falls since admit to facility. R3 did not remember her limitations. Interventions included -Ensure R3 is wearing proper footwear; gripper socks or her slip-on tennis shoes when transferring with mechanical stand (revised date 9/5/19.) -Anticipate and meet R3 needs. If restless or agitated, assess for sign and symptoms of pain, or need to use bathroom. Staff assist R3 as soon as possible if she is awake, be aware R3 attempts self-transfers, does not wait for assist (revised date 10/04/19.) -Place books of interest with large print in resident's room to enable staff to offer to resident (revised date 11/7/19.) -IDT to review R3's falls, discuss causal factors, relationship to agitation and/or pain (revised date 12/16/19.) -R3 uses TABS chair/bed alarms. Ensure device is in place and functioning with every care contact and nurse to follow up with nursing assistants,	2 830		

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2 830	Continued From page 11 document in treatment record (revised date 12/18/20.) -Be sure call light within reach and encourage use during periods of alertness. R3 needs prompt response to all requests for assistance and to TABs alarm sounding. Use mat on floor during night and day especially when agitated to decrease risk of injury with falls (revised date 4/4/20.) -When R3 is attempting to go into her room, she wants to lay down. Assist R3 into bed at these times. Start date 10/29/21. -When restless or agitated, attempting to self-transfer, may try warm blankets or weighted blanket. Sleeps/rests better with lights off and door only slightly open allowing visual checks (revised date 12/21/21.) -Needs a safe environment with even floors free from spills and/or clutter; adequate glare-free lighting; a working and reachable call light, the bed in lowest position at night; grab bar as ordered, personal items within reach. Revised date 12/22/22. -Has grab rails on bed to allow resident to assist if able if/when her status allows. Bed in low position with mat on floor, noodle under outside mattress edge (revised date 12/22/22.) -Allow resident to rest in recliner if desires, use EZ-Lift and assist of 3 staff for transfers. Staff to run the lift chair and lift chair control to be kept out of resident's reach (revised date 5/2/23) R3's current care sheet indicated fall risk with the fall interventions of low bed, floor mat, alarms in bed and while in broda chair. Keep recliner unplugged and to monitor frequently (monitoring frequency was not identified). R3's safety risk assessment dated 6/8/23, indicated at risk for falls, continue current care	2 830		

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2 830	Continued From page 12 plan with high low bed in lowest position when in bed, mat on floor by bed when in bed, TABs alarms on bed and wheelchair, and staff assist resident to lay in bed when tired. Fall 1 R3's progress note dated 4/20/23, indicated R3 had an unwitnessed fall. R3 was noted to be hollering out and was found on floor mat next to bed and attempting to get back into bed. R3 was assisted with two staff to get back into bed. VS obtained. R3 was anxious and restless most of the shift and required one-on-one. Did receive as needed Ativan, had multiple snacks, fluids, repositioning, wheeled in wheelchair up and down the halls. Air mattress overlay was placed earlier; staff thought the mattress caused the fall and encouraged night shift to remove if R3 seemed uncomfortable during the night. Corresponding incident report indicated fall happened at 6:25 p.m. Immediate interventions taken was to assist R3 off the floor via two staff as R3 was partially on the bed. No injuries noted. Predisposing factors included fall alarm, impaired memory, recent change in condition, recent medication change/new. Resident noted to be more anxious and received PRN Ativan and nonpharmacological interventions used with minimal effect noted. R3's post fall IDT note dated 4/27/23, new air mattress overlay thought to be the reason along with increased confusion that day. Evaluated the use of toilet as resident gets restless when needs to have a BM. Attempt to toilet the resident when stating need. R3's fall record did not mention if the TAB alarm had been functioning at the time of the fall. R3's record did not identify when/if mattress was removed and/or revision to the care plan.	2 830		

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2 830	Continued From page 13 Fall 2 R3's progress note dated 6/19/23, indicated an unwitnessed fall at 4:15 p.m. R3 stated pain when asked but not able to tell where pain was located. R3 also stated that she did not feel well. VS taken and R3 had an elevated diastolic blood pressure (blood pressure not identified). Recheck of blood pressure 15 minutes later was 127/86. Corresponding incident report indicated the R3 slid out of bed and was found on her mat with TABS alarm going off. R3 had no injuries. Immediate interventions were R3 was assessed for injuries; no injuries were identified, however, R3 reported pain, and stated "I don't feel well." Predisposing factors included confusion, memory impairment. Although R3's fall record identified potential causal factors, it was not evident a comprehensive analysis was completed that identified root cause and not evident interventions were developed and implemented to prevent and/or mitigate risk for recurrent falls. During an interview on 6/22/23 at 3:33 p.m., nursing assistant (NA)-L indicated that R2 had been waxing and waning with his level of care and his cognition since his admission. R2 went through a period where R2 he was falling a lot but NA-L could not remember if the falls resulted in injury. NA-L stated staff had to anticipate R3's needs, NA-L was not aware if R3 had any falls. NA-L would refer to the current care sheet to look for residents at fall risk for falls and what their fall interventions were. During an interview on 6/22/23 at 3:47 p.m., NA-A indicated R2 was assist of two staff with transfers and could not remember any recent falls for R2 .	2 830		

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2 830	Continued From page 14 R2 wore a TABs alarm at all times and had a fall mat beside her bed. NA-A stated R3 was a hoyer lift with assist of two staff. NA-A indicated R3 liked to crawl out of bed at times. NA-A was able to articulate the steps involved when there was a fall per facility protocol. make sure resident is safe, call for nurse and stay with resident until nurse comes to assess resident, and then help get resident off the floor. During an interview on 6/23/23 at 8:27 a.m., NA-N indicated R2 was a two person pivot transfer from bed to commode and back again, and was able to turn self in bed. R2 had a history of falls, could not remember how long ago R2 last fell, and was not sure of his fall interventions however would check the care sheet. NA-N stated R3 was a EZ-Lift with assist of 2 for most transfers, EZ-Stand for transfers to and from commode only after breakfast. NA-A could not remember R3' s last fall. NA-N was able to articulate the steps involved with falls per facility protocol. During an interview on 6/22/23 at 2:10 p.m., director of nursing (DON) indicated when there was a fall the NAs would contact the nurse to come and do assessment and then staff would assist resident off the floor with the EZ-Lift The nurse would document the incident, note any injuries, and who they contacted. Every Thursday the IDT risk management meeting was held. IDT reviews the incidents from the previous week; notes were made on the incident report during the meetings. On 6/23/23 at 12:00 p.m., DON explained nurses were supposed to complete the Post Fall RCA (root cause analysis) questionnaire with each fall. DON reviewed R2 and R3's fall records; stated she was unable to completed RCA's for R2 and R3's falls. DON stated nurses	2 830		

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2 830	Continued From page 15 were supposed to follow and complete the Fall Checklist. DON stated expectation nursing staff followed the facility's fall program policies. Review of revised facility's policies Fall-Clinical Protocol and Assessing Falls and Their Causes, both dated 6/22/23, indicated identifying causes of a fall within 24 hours. Currently IDT meets weekly to discuss falls. Performing post fall evaluation 4) ...complete of falls risk assessment and put in appropriate interventions taken to prevent future falls. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occurring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		