Electronically delivered
April 27, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: April 12, 2022

Dear Administrator:

On April 12, 2022, 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 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 Region V Office for imposition. The CMS Region V Office 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 12, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 12, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 12, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,292; 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 12, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mahnomen Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2022. 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)

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 12, 2022 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	C 04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

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F 000	INITIAL COMMENTS On 4/6/22 through 4/12/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5238036C (MN81998), H5238037C (MN81070), H5238038C (MN81197), H5238039C (MN81591) with a deficiency cited at F689. AND The following complaint was found to be UNSUBSTANTIATED: H5238040C (MN82361). As a result of the investigation, additional deficiencies were cited at F609, F697, F760, and F777. 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 609	Reporting of Alleged Violations	F 609		5/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2022

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 609 SS=D	Continued From page 1 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of potential abuse and events with serious bodily injury to the State Agency (SA) immediately (within 2 hours) for 3 of 4 residents (R2, R3, R4) reviewed for allegations of abuse and falls with serious bodily injury.	F 609	05/04/2022-DON educated staff at monthly staff meeting: • Education on reporting within 2 hours of any suspicion of any type of abuse. • Review of Statute • Review of scenarios that require OHFC reporting	

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F 609	Continued From page 2 Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/25/22, indicated R2 was cognitively intact, was able to understand others and others understood her. The MDS indicated R2 required extensive physical assist for cares. In addition, the MDS indicated R2's diagnoses included cerebrovascular accident (CVA, a stroke) with weakness on her left side and difficulty with walking and mobility. The MDS indicated R2 fell two or more times with no injuries since her prior MDS assessment. R2's discharge MDS dated 3/25/22, indicated R2 discharged back to the community on 3/25/22. R3's quarterly MDS dated 2/1/22, indicated R3 was severely cognitively impaired, was able to sometimes understand others and others understood her, and she required extensive physical assist for cares. The MDS indicated R3's diagnoses included dementia and arthritis. The MDS indicated R3 fell once with minor injury since her prior MDS assessment. R3's discharge MDS dated 3/13/22, indicated R3 expired in the facility on 3/13/22. R4's quarterly MDS dated 2/22/22, indicated R4 was cognitively intact, was able to understand others and others understood her, had minimal hearing difficulty, and she required extensive physical assist for cares. The MDS indicated R4's diagnoses included anxiety and arthritis, with functional limitations to upper and lower extremities.	F 609	• Review of reporting Process • The Vulnerable Adult policy, protocol and procedure Those unable to attend will schedule a face to face or phone conference with DON or designee by 05/12/2022 QAPI: Weekly audits regarding OHFC questions and scenarios will be performed by the CARE PLAN TEAM and those delegated by the CARE PLAN TEAM to ensure staff are competent with what to report, how to report and when to report. These audits will be monitored by the CARE PLAN TEAM and reported monthly through QAPI CARE PLAN TEAM: RN/MDS Unit Coordinators, DON, Social Services case manager. QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction.	

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F 609	Continued From page 3 On 2/15/22, at 4:05 p.m. the facility submitted an initial report to the SA. The report identified R3 fell on 2/13/22, in her bathroom. On 2/15/22, at 1:30 p.m. she was diagnosed with a thoracic (vertebrae) fracture. The initial report was submitted two hours and 35 minutes after the fracture was diagnosed. On 2/19/22, at 4:00 p.m. the facility submitted an initial report to the SA. The report identified R2 fell on 2/19/22, at 12:00 a.m. in the nursing home day room. R2 sustained a laceration (deep cut) to the back of her head and received seven staples to the area. The initial report was submitted 16 hours after the fall. On 4/4/22, at 7:45 a.m. the facility submitted an initial report to the SA. The report identified on 4/2/22, at 4:00 a.m. R4 was transferred with a standing mechanical lift. R4 complained to the nurse, who controlled the lift during the transfer, she was being lifted too high. The report indicated the nurse responded by yelling at R4, R4 ""needs to be patient, everyone around this damn place needs to be patient." The initial report was submitted more than two days after the incident. When interviewed on 4/11/22, at 12:20 p.m. the director of nursing (DON) stated abuse allegations were to be reported [to the SA] "immediately" or "within 24 hours." The DON stated these time frames depends "if there is harm. If there is [harm] it [reporting] is within two hours. If there is not, it's within 24 hours." The DON explained abuse education for staff was a "standing item" in her [staff] meeting minutes; however, stated, "The problem is they [staff] do not want to get people in trouble or they do not think it's abuse and they do not want to report it."	F 609		

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F 609	Continued From page 4 During interview on 4/12/22, at 10:41 a.m. social worker (SW)-A stated abuse allegations were to be reported "right away" or at least within two hours of the event. SW-A stated facility staff were educated "all the time" on the expectation of reporting abuse within two hours "especially with injury." SW-A stated she had experienced episodes where she arrived to work on a Monday morning and found incidents from the weekend which lacked expected SA reporting. SW-A stated, "That needs to change." SW-A stated staff received education on reporting in their "huddle" meetings, when reporting issues were identified, and with required yearly education. SW-A stated staff were allowed access to the facility's electronic system which included policies and procedures. SW-A stated it was a huge concern when staff failed to report to the SA, as "the residents could be mistreated when the staff are not fulfilling their roles," and, "that is not acceptable." When interviewed on 4/12/22, at 10: 57 a.m. registered nurse (RN)-B stated abuse allegations were to be reported "immediately," which she explained meant "right after it happens within a two hour limit." The facility policy Reporting of Maltreatment of Vulnerable Adult dated 7/21, directed under the heading "Reporting/Response: Reporting of Abuse and/or Neglect Required. Follow the OHFC (Office of Health Facility Complaints) Investigation Process Policy ... All employees of the facility are mandated reporters and must report all incidents of actual or suspected maltreatment." The policy defined verbal abuse as any oral, written or gestured language that	F 609		

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F 609	Continued From page 5 willfully included disparaging and derogatory terms, along with malicious language, to the resident or within their hearing. Further, the policy defined serious bodily harm as "an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of bodily member, organ or mental faculty; or requiring medical intervention such as surgery, hospitalization or physical rehabilitation. In addition, the policy defined immediately as "No later than 2 hours after forming the suspicion, if events that cause the suspicion involve abuse or result in serious bodily injury, or not later than 24 hours if events that cause the suspicion do not involve abuse and do not result in serious bodily injury. The facility policy OHFC Investigation Process Policy dated 7/21, directed the purpose of the policy was to document resident incidents, to conduct an investigation of each incident, and to identify root causes for future prevention. The scope of the policy identified all Mahnomen Health Center staff and directed under the policy procedure the incident was to be "Reported to OHFC (Immediately or within 2 hours of initial report if abuse or bodily harm or no later than 24 hours if no bodily harm!!!)."	F 609		
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	F 689		5/13/22

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F 689	Continued From page 6 accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure interventions were developed and implemented to prevent falls for 3 of 3 residents (R1, R2, R3) who had a history of falls. This resulted in actual harm to R1 who sustained a fractured hip following a fall, actual harm to R2 who required 7 staples in her head following a fall, and actual harm to R3 who sustained a compression fracture following a fall. Findings include: R1 R1's admission Minimal Data Set (MDS) dated 3/8/22, indicated R1 was cognitively intact with a diagnosis of stroke. The MDS indicated R1 required extensive assist of two staff for bed mobility, transfers, ambulation in room, and toileting. In addition, the MDS indicated R1 had two or more falls since admission. R1's Face Sheet printed 4/12/22, indicated R1 was discharged 4/3/22. R1's care plan dated 3/23/22, indicated R1 was at risk for falls due to the use of diuretics and antipsychotics, as well as poor communication skills due to tracheostomy (curved tube that is inserted into a tracheostomy stoma, the hole made in the neck and windpipe) diagnosis of paralysis of vocal cords, stroke affecting left side of the body and a broken left shoulder. R1's care plan identified R1 had a fall that occurred on 3/20/22, which resulted in a broken hip. In addition, R1's care plan identified fall	F 689	04/08/2022 DON created the RN Fall Protocol to: " Reduce the risk of harm from resident falls " Provide guidelines for fall risk identification and fall prevention " Establish a uniform plan and define responsibilities related to a resident fall. " Determine appropriate interventions have been put into place and are working. This protocol includes the following expectations: " A Falls Event, falls risk assessment, and a safety event report online are completed after every fall. " A pain assessment performed after the fall and in 7-10 days. " An intervention was put into place, deemed appropriate and documented in the medical record " The fall and intervention updated in the care plan with every fall. " A root cause analysis is to be completed upon each fall. " A daily summary sheet to communicate the fall and intervention to staff completed by a member of the CARE PLAN TEAM. 04/08/2022 Education was provided by DON on RN Fall Protocol to Nurses and TMA□s via in person and zoom. Those unable to attend have access to the zoom meeting while on duty and all nursing staff be in compliance by 05/12/2022 04/28/2022 Post Fall Huddle Form was	

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F 689	Continued From page 7 interventions which included of the use of a fall mat on the floor and the bed lowered to the ground when R1 was in bed implemented 3/23/22, call light on both recliner and bed implemented 3/15/22, and increased supervision with intensity or agitation episodes implemented on 3/15/22, for R1's fall interventions. Review of R1's falls indicated: On 3/8/22, 5:07 p.m. a Post Fall Huddle Form indicated R1 had an unwitnessed fall in room related to a self-transfer from bed. R1 stated he didn't want to stay in bed any longer due to his legs hurting. At the time of the incident, R1 reported pain to the right elbow and left knee, and appeared to have a small hematoma (bruising happens when blood collects under skin) on knee. Immediate intervention implemented following the fall was another call light by chair. On 3/11/22, 6:00 p.m. Post Fall Huddle Forms indicated R1 had an unwitnessed fall in room. R1 was found on the floor at the side of the bed, and was unable to state what happened. Immediate intervention implemented following the fall was to provide frequent checks. On 3/20/22, 5:15 p.m. Post Fall Huddle Forms indicated R1 had an unwitnessed fall in his room while attempting to self-transfer from the recliner to his bed. R1 reported pain in his left shoulder, and he obtained a skin tear to the left elbow area. Immediate intervention implemented following the fall was to add a low bed. R1's progress notes dated 3/21/22, indicated R1 was noted to have increased complaints of pain in his left hip. R1 would not allow nursing staff to	F 689	updated to include a checklist for RN□s to remember to complete all the components needed for follow up after a fall as stated on the RN Fall Protocol. All staff educated 05/04/2022 at the staff meeting via in person or zoom. Those unable to attend meeting will schedule a face to face or phone conference with DON by 05/12/2022 to receive the education. 04/08/2022 CARE PLAN TEAM morning huddle agenda was updated to include: " Falls and follow up (pain assessment, interventions, and care plan) " What intervention has been put into place " Falls root cause analysis " Pain /Comfort discussion including a section to note if the provider was informed. 04/08/2022 DON developed the Daily Summary Sheet to include all falls and interventions put into place as well as any medication or condition changes. This form is fill out by the CARE PLAN TEAM after morning huddles to provide pertinent information to all staff regarding falls and interventions. This was implemented 04/08/2022 and is put in the daily communication book. 05/03/2022 DON updated the Bed and Chair alarm policy to include criteria for implementing chair/bed alarms, monitoring of alarms and discontinuing bed/chair alarms. Staff educated on the policy 05/04/2022 during the staff meeting via zoom or in person. All those unable to	

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F 689	Continued From page 8 assess, and even lightly touching his left leg would cause R1 to yell. R1 was transferred to the emergency department (ED). On 3/21/22, R1 returned from the ED where x-rays revealed a left hip fracture. R1's electronic medical record lacked evidence of Safety Events-Fall event, which is the facility's process of completing the form as an interdisciplinary team (IDT) to determine casuative factors and review of interventions, was completed for R1's three falls that occurred on 3/8/22, 3/11/22 and 3/20/22. On 4/7/22, at 12:04 p.m. registered nurse (RN)-A stated R1 was a "huge" fall risk when he was displaying delusions and hallucination episodes. RN-A indicated R1 had a fall on 3/8/22, related to self-transferring from bed due to pain in legs with an intervention added for a call light by recliner. RN-A stated R1 had another fall that occurred on 3/11/22, with an intervention implemented for frequent checks; however, did not clarify how often frequent checks were and "can't find much in the chart other than that." RN-A stated on 3/20/22, R1 had another fall self-transferring from recliner to bed and intervention added was a low bed. RN-A stated "I have no clue why that was implemented and I am getting so frustrated." R2 R2's quarterly MDS dated 1/25/22, indicated R2 had a diagnosis of stroke and was cognitively intact. R2 required extensive assist of one staff for bed mobility, transfers, ambulation, and toileting. The MDS indicated R2 had two or more falls with no injury since the previous assessment.	F 689	attend will schedule a face to face or phone conference with DON or designee by 05/12/2022 05/03/2022 Bed and Chair alarm review was added to the care conference agenda to review with families at care conferences. It was also added to the CARE PLAN TEAM morning huddle agenda. 05/04/2022 Education provided by DON to staff regarding frequent checks for a fall intervention. Staff were educated if this intervention is put into place, a time frame needs to be indicated and documentation to back it up. 04/28/22 the Post Fall Huddle Form was updated to reflect this information as well. 04/18/2022 The orientation process is being restructured to ensure all these details are reviewed with the appropriate staff. This will be completed by 05/12/2022 to ensure oncoming staff know what their expectations are. 04/22/2022 The nurse in the MDS/ Clinical role at the time frame this survey focused on, was placed in a role so that she could have just one area of focus. She is now working the RN Clinical nurse role. The MDS role is now being done by another RN. The intent for this&is so that each RN can focus in their one area and ensure follow through is complete. DON will be doing the MDS training to assist with both the MDS and clinical	

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F 689	Continued From page 9 R2's Face Sheet printed 4/12/22, indicated R2 discharged on 3/25/22. R2's care plan revised 3/15/22, indicated R2 was at risk for falls related to impaired mobility resulting from stroke, hemiparesis (inability to move on one side of the body) and lack of motivation. R2's care plan indicated R2 had falls on 10/30/21, 11/1/21, 11/2/21, 11/5/21, 1/10/22, 2/12/22, 2/19/22, 3/7/22, and 3/13/22. R2's fall interventions included encourage gripper socks if she is not wearing shoes implemented 3/15/22; place bell at table for use in commons area implemented on 3/7/22; chair and bed alarms to alert staff to assist with needs implemented 2/17/22; redirect R2 with snack, activity or phone call to family when ambulance arrives at the hospital implemented 12/24/21; have R2's clothes ready the night before implemented 9/10/21; staff will dress R2 at 5:00 a.m. implemented 8/30/21; remind R2 to call and wait for assistance implemented 8/2/21; gripper socks on while in bed implemented 7/18/21; "call don't fall" sign in room and bathroom implemented on 7/6/21; limited assist of one with front wheeled walker, be aware veers left, guide walker as needed, non-skid shoes implemented 7/1/21; be aware gets dizzy when ambulating with glasses on ensure they are removed before transferring/ambulating implemented on 7/1/21; bed alarm on bed to alert staff of attempts to get up unassisted implemented on 7/1/21; and fall assessment quarterly and as needed, assess falls and implement interventions as appropriate implemented on 7/1/21. Review of R2's falls per facility fall report log :	F 689	aspects of the job. Currently the DON does not have MDS training. QAPI CARE PLAN TEAM will perform weekly audits until goals are met, then move to audits every two weeks until goals met and monthly thereafter to ensure falls documentation has been done with all the components required per policy and will be monitored through monthly QAPI meetings. QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction. The residents investigated at the time of the survey who had falls with injury had either discharged or passed away. All other residents' care plans will be reviewed and updated by May 13th. Fall risk assessments completed on all residents by May 13th. Root cause analysis will be completed on all residents who have had a fall within the last 3 months by May 13th. Pain observations completed on all residents by May 13th. Any residents who have complained of pain will have interventions put into place and a pain observation done weekly until the pain has resolved or is being managed with current interventions. RN's were assigned a care plan education course through the American Association	

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F 689	Continued From page 10 Facilitiy's fall report log printed 4/6/22, indicated R2 had fall which occured on 10/31/21, 11/1/21, 11/2/21, 11/5/21 which lacked evidence a Post Fall Huddle Form was completed per facility Fall policy. On 12/19/21, at 2:00 p.m. Post Fall Huddle Form indicated R2 had an unwitnessed fall in the commons area while attempting to stand up from the chair. R2 transferred to the ED for further evaluation due to hitting her head. The form lacked evidence an immediate intervention was implemented. On 1/10/22, at 6:30 p.m. Post Fall Huddle Form indicated R2 had an unwitnessed fall in room while self-transferring to get ready for bed. R2 reported pain in her coccyx following the fall. R2 was provided "up to date education" to call for assistance. The form lacked evidence of additional interventions being implemented following the incident. On 2/12/22, at 12:00 p.m. Post Fall Huddle Form indicated R2 had an unwitnessed fall in room while self-transferring attempting to change the television channel. R2 sustained a laceration to a finger on her right hand and struck her head on the dresser. Immediate intervention implemented at the time of the fall included education to nursing assistant to not leave R2 alone in room unless R2 is in bed with bed alarm. On 2/19/22, lacked evidence a Post Fall Huddle Form was completed per facility policy. On 3/6/22, at 4:30 p.m. Post Fall Huddle Form R2 had a witnessed fall in commons area while self-transferring attempting to return to room.	F 689	of Post-acute Care Nursing (AAPACN) called “A Post-Fall Review-Is Your Medical Record Complete” and will be completed by May 26th. All other staff will be educated on care planning at the skills Fair scheduled May 26th and May 31st.	

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Nursing staff was guiding resident back to her seat in the commons area, staff was adjusting the chair alarm on the seat while holding onto R2 by the gait belt. R2 stated she was going to fall, and staff was unable to catch her. R2's head was noted to "bounce off the floor," and R2 reported a headache following the incident. R2 was noted to have a "bulge" on the back of her head where she had staples from a previous fall. R2 was transferred to the ED for further evaluation. The form lacked evidence of immediate intervention implemented following the incident.

On 3/13/22, at 3:45 p.m. Post Fall Huddle Form R2 had an unwitnessed fall in her room while attempting to self-transfer to the bathroom. At the time of the fall, R2's shoes were off and non-skid footwear was implemented at time of incident.

Review of R2's Safety Events-Falls event report, which is the facility's process of completing the form as an interdisciplinary team (IDT) to determine casuative factors and review of interventions, was completed for R2's falls that occurred 10/21/21, 11/1/21, 11/2/21, and 12/19/21.

-11/5/21,at 2:17 p.m.Safety Event-Fall indicated R2 was witnessed walking with her walker in hallway and "fell onto the blunt edge" on the end table and hit the right side of head and shoulder. Event lacked evidence of intervention implemented following incident

-2/19/22, at 2:46 p.m. Safety Event- Fall indicated R2 had a fall in commons area while attempting to self-transfer and fell backwards hitting head and sustained a laceration to the back of her head. R2 was sent to the emergency

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room and received 7 staples in the posterior of head. Event lacked evidence of intervention implemented following the incident.

R2's Nursing Home Fall Risk assessment dated 3/11/22, indicated R2 had "total disregard" for level of functioning and her comprehension and retention of information was "poor to nonexistent." R2 required constant cues by staff to call for assistance to transfer or ambulate. The director of nursing (DON), registered nurse (RN)-A, RN-B, and social worker (SW)-A met to discuss R2's falls from January through March of 2022, and determined staff had attempted every intervention possible and nursing continued to come up with new interventions following R2's fall; however, R2 was impulsive, which caused difficulty for staff to try to prevent falls. Further, R2's fall risk assessment indicated nursing would continue to try to find interventions to prevent major injury falls, and family had been updated on R2's falls with no additional input on interventions for staff to attempt.

On 4/7/22, at 12:04 p.m. RN-A stated R2 was at "extremely" high risk for falls related to impaired gait and previous stroke. RN-A stated a post fall huddle form was not completed for R2's fall on 10/11/21, and confirmed there were no additional interventions added to care plan for this time. RN-A stated R2 had a fall on 11/1/21, and intervention was added for staff to encourage R2 to sit in commons area, however the intervention was not added to R2's care plan. RN-A stated R2 had another fall on 11/2/21, while attempting to self-transfer in room and intervention added directing staff to place R2 in commons area with no additional interventions added to R2's care plan. RN-A stated R2 had a fall on 11/5/21, while

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self-transferring in the hallway with no additional interventions added following the fall. RN-A stated R2 had a fall on 1/10/22, while attempting to self-transfer to room and confirmed no additional interventions implemented following team review. R2 had a fall on 2/12/22, attempting to change TV channel in room and intervention included nursing education provided R2 was not to be in room alone unless in bed with no care plan updates initiated after team review. R2 had a fall on 2/19/22, and RN-A stated a post fall form was not completed following the incident, however progress notes revealed R2 had a fall which resulted in 7 staples to the back of her head. RN-A was unsure the root cause of the fall and was unsure of an intervention added following the incident. RN-A stated R2 had a fall on 3/6/22, while self-transferring and while nursing staff assisted R2 to a chair, staff was unable to catch R2 from falling. R2 was sent to the emergency room for evaluation and sustained a hematoma (bruising when blood collects under the skin) to the back of R2's head where staples from previous fall were located and RN-A stated immediate intervention was call bell placed in commons area. Further RN-A stated R2 was "emotionally afraid" of the alarms and she didn't like the loud noise and due to dignity concern the alarms were removed from R2 for a while before bringing them back. RN-A indicated the bed and chair alarms are not monitored and staff are not expected to chart on the alarms to identify any trends or patterns they are solely used for staff purpose to know when a resident is attempting to get up without assistance

R3's quarterly MDS dated 2/1/22, indicated R3 had a diagnosis of dementia and had severe cognitive impairment. R3 required extensive

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assist of two staff for bed mobility, transfers, and toileting. The MDS indicated R2 had one fall with injury since the previous assessment.

R3's Face Sheet printed 4/12/22, indicated R4 discharged on 3/13/22.

R3's care plan revised 2/17/22, indicated R2 was at risk for falls related to dementia diagnosis and arthritis in knees. The care plan indicated R3 had falls that occurred on 10/21/21, 11/6/21, 12/14/21, and 2/13/21. R3'a fall interventions included chair and bed alarms implemented on 2/17/22, provide toileting assistance in early morning -resident to be one of the first ones up implemented on 12/16/21, and provide proper non-slip footwear implemented on 5/31/21.

Review of R3's falls:

On 10/21/21, at 8:30 a.m. Post Fall Huddle Form indicated R3 had an witnessed fall in room while attempting to straighten bed linens and no injury was noted. Immediate intervention implemented was frequently checks.

On 11/6/21, R3's medical record lacked evidence a Post Fall Huddle Form was completed for this incident per facility policy.

On 12/14/21, at 8:10 a.m. Post Fall Huddle Form indicated R3 had an unwitnessed fall in room while attempting to self-transfer to bathroom or get dressed. No injury was noted. Immediate intervention implemented to wake R3 up by 7:00 a.m. and assist with cares.

On 2/13/22, at 3:00 a.m. Post Fall Huddle Form indicated R3 had an unwitnessed fall in room

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while attempting to self-transfer to the bathroom. R3 was noted to report worsening back pain and had bruising on right hand. Immediate intervention implemented was encourage resident not to self-transfer.

Review of R3's x-ray results dated 2/15/22, revealed slight compression of the superior end plate of T12 noted of indeterminate age.

Review of R3's Safety Event-Fall reports, which is the facility's process of completing the form as an interdisciplinary team (IDT) to determine casuative factors and review of interventions, was not completed following R3's falls which occurred 10/21/21, and 11/6/21.

On 4/6/22, at 3:07 p.m. licensed practical nurse (LPN)-A was interviewed and stated R1 was a "huge" fall risk and R1's fall interventions included low bed, fall mat, frequent checks, and re-education to use his call light for assistance. LPN-A stated R2 was a high fall risk and interventions included bed and chair alarms, and constant reminders to call for assistance. LPN-A stated R3 had a couple falls but was unsure what interventions were in place to prevent falls for R3.

On 4/6/22, at 3:37 p.m. LPN-B stated R2 was at risk for falls and interventions included bed and chair alarms; however, at times the alarms would "malfunction." Further, LPN-B stated the licensed nurses were expected to complete a progress note and a fall sheet after a fall incident and notify family, doctor and DON as well as implementing an immediate intervention. In addition, LPN-B stated the supervising RN will investigate the root cause of the fall and implementing a different intervention to prevent another fall if needed.

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F 689	Continued From page 16 On 4/7/22, at 9:25 a.m. nursing assistant (NA)-A stated R1 was at risk for falls and interventions included low bed and fall mat on floor while in bed, frequent checks making sure he was "good", promptly answering call light and a chair alarm. NA-A stated R2 was also a high fall risk and interventions included bed and chair alarm, toileting program, and offering activities. Further, NA-A stated R2 disliked the bed and chair alarms and R2 would attempt to shut off the alarms and silence the box so staff would not hear R2 attempting to self transfer. NA-A stated staff were not monitoring the alarms or charting when the alarm was going off but stated it was to alert staff if R2 was attempting to self-transfer. On 4/7/22, at 12:04 p.m. RN-A stated R3 was noted to self-transfer, which put her at risk for falls. RN-A stated R3 had a fall that occurred on 10/21/21, with an intervention of check on R3 frequently however was not sure what "frequently" meant and confirmed no additional interventions were added to R3's care plan following the fall. RN-A stated R3 had another fall on 11/8/21, but was unsure what the root cause of the fall was or what interventions were put in place as electronic medical record lacked evidence. When asked about the facility's fall procedure, RN-A stated the nurse on duty when the fall occurs were expected to complete the top portion of the Post Fall Huddle Form and implement an immediate intervention determined on cause and the completed form would be forwarded to the RN supervisors, which included RN-A, RN-B, and DON, who review the form as a team and determine a root cause for the fall to determine an appropriate intervention and update the care	F 689		

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plan. Further, RN-A stated she should be completing the bottom of the Post Fall Huddle forms and confirmed "these things I need to work on obviously". In addition, RN-A stated with recent staffing changes clarification was needed on who was supposed to complete what following a fall.

On 4/7/22, at 3:19 p.m. the DON was interviewed and stated when a resident falls, the licensed nurse on duty when the fall occurred should complete an assessment and report the fall to the DON, administrator, family and provider. The nurse is expected to complete the Post Fall Huddle form and a head-to-toe assessment and implement an immediate intervention. Further, DON stated the team meets every morning and will determine a root cause for the fall and determine an intervention for "long term" to keep them the safest when they fall. At this time, the resident's care plan is updated to reflect the new intervention and put a note in the communication log for staff to be educated. In addition, DON stated R2 disliked the chair and bed alarms due to the noise, so they were discontinued, however R2 continued to self-transfer so staff re-established the alarms. DON stated alarms are initiated as "a last resort intervention" since they don't prevent falls. When asked how staff are monitoring the alarms, DON stated staff are expected to monitor if the alarm was functioning appropriately other than that there was no additional monitoring for alarms and the alarms are used for staff purpose to respond quickly.

The facility policy Bed and Chair alarms dated 2022, directed residents with confusion and dementia who may get out of bed or chair without assistance, demonstrate potential for falling, history of falling are guidelines for staff for the use

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F 689	Continued From page 18 of bed or chair alarms. Further, policy indicates bed and chair alarms will be used in accordance to manufacturers instructions however, policy lacks criteria for when a resident would begin the use of alarms, monitoring alarms for trends and patterns or criteria for alarms being removed. The facility policy Falls revised 01/22, directed nursing home procedure included after resident is determined safe immediately complete a post fall huddle and put an appropriate intervention into place, notify the DON immediately, notify the provider or on-call medical provider, notify family, and report fall to on-coming personnel. Further, facility's documentation procedure post fall included immediately complete the post fall huddle and investigation tool in its entirety, give the form to the RN unit coordinator or DON, the form will be reviewed at the interdisciplinary team meetings, the form will be handed to the falls prevention coordinator and discussed at the next fall prevention meeting. In addition, the RN staff will enter the event into the electronic incident reporting tool and update the care plan accordingly.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure complaints of	F 697	04/25/2022 started utilizing the RN task list in Matrix EMAR to put orders in for	5/13/22

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F 697	Continued From page 19 worsening low back pain were comprehensively assessed and treated in a timely manner to provide comfort and reduce risk of complications for 1 of 1 residents (R3) who voiced concerns about pain management. This resulted in actual harm when staff failed to follow physician ordered lumbar xrays, collaborate with other health professionals and address ongoing severe pain for several weeks which resulted in a decline in R3's activities of daily living (ADLs). Findings include: R3's significant change Minimal Data Set (MDS) dated 11/9/21, indicated R3 had diagnosis of dementia and severe cognitive impairment. R3 required extensive assist of one staff for ADLs such as bed mobility, transfers, dressing and hygiene. Further review of MDS indicated R3 was independent with ambulation in room and required supervision while ambulating out of room and with toileting. R3 reported occasional pain during assessment period. R3's quarterly MDS dated 2/1/22, indicated R3 required extensive assist of two staff for ADLs such as bed mobility, transfers and toileting. Further review of MDS indicated R3 required extensive assist of one staff for ambulation in room and through out the facility. R3 reported almost constant pain during assessment period R3's care plan dated 2/15/22, indicated R3 suffers from painful knees related to arthritis. R3 recently had injections which seemed to help very little. R3 was needing increased assistance ambulating long distances and was not able to at times. R3 was needing to use wheelchair due to increased pain. R3 recently started yelling and	F 697	pain assessments and follow up assessments with new pain, change in pain or assessments after a fall. This is prompted by the CARE PLAN TEAM morning huddles discussion. This item has been added to the agenda. If pain is indicated on a resident, the order will be entered into the RN Task list on the EMAR for RN staff to complete. This also allows us to put in future orders for follow up. 05/04/2022 Education at the staff meeting to nursing staff on the pain management policy in regards to notifying the provider with any new or change in pain. When to perform pain assessments and follow through with pain assessments. Those unable to attend the staff meeting will make a face to face meeting or phone conference with DON by 05/14/2022. 04/08/2022 The RN FALLS PROTOCOL was reviewed with all nursing staff to ensure that pain assessments were performed appropriately after all falls. 05/03/2022 The pain management policy was updated with this information as well. These policies were reviewed at the 05/04/2022 staff meeting. Those unable to attend the staff meeting will make a face to face meeting or phone conference with DON by 05/14/2022. 05/03/2022 The CARE PLAN TEAM morning huddle agenda was added a pain discussion to include notifying the medical provider and who is responsible to notify. It also includes the type of pain, new onset or worsening of pain and plan of care. These items are carried over to the	

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F 697	Continued From page 20 shouting out when staff try to transfer. Further review of care plan indicated R3's goal for pain included adequate pain control and continue to walk with interventions that included encourage R3 to take small rest breaks when ambulating or increase pain occurs, scheduled pain medications, repositioning, warm/cold packs, stretching, and therapy. R3's progress notes were reviewed and R3 reported increased pain often. R3's progress notes lacked evidence a physician was updated on increased low back pain and change in condition. R3's progress notes also lacked evidence a comprehensive pain assessment was completed to determine root cause of pain. R3's progress notes include: -12/20/21 The following medication changes were made due to emergency room visit this weekend Tramadol was increased to 100 milligrams (mg) three times daily, Ibuprofen 400 mg every six hours as needed, Voltaren gel every four hours for pain. Follow up with primary physician on 12/20/21. -12/21/21 Medical doctor (MD) decreased Tramadol back down to 50 mg three times daily and ordered lumbar x-rays, -12/23/21 R3 complained of low back pain and used the wheelchair for locomotion and required assistance with transfers -12/24/21 R3 complained of pain upon transfer and Ibuprofen was given. -12/25/21 R3 complained of back pain with assistance of morning ADLs and Ibuprofen was given. -12/27/21 R3 complained of back pain when assisted to sit up in bed. R3 was able to walk to the bathroom with walker and assist of one and	F 697	next day□s discussion until the situation has resolved. 04/22/2022 The nurse in the MDS/ Clinical role at the time frame this survey focused on, was placed in a role so that she could have just one area of focus. She is now working the RN Clinical nurse role. The MDS role is now being done by another RN. The intent for this&is so that each RN can focus in their one area and ensure follow through is complete. DON will be doing the MDS training to assist with both the MDS and clinical aspects of the job. Currently the DON does not have MDS training. QAPI CARE PLAN TEAM will perform weekly audits until goals are met, then move to audits every two weeks until goals met and monthly thereafter. This will be brought to monthly QAPI for monitoring. QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction. The residents investigated at the time of the survey who had falls with injury had either discharged or passed away. All other residents' care plans will be reviewed and updated by May 13th. Fall risk assessments completed on all residents by May 13th. Root cause analysis will be completed on all residents who have had a fall within the last 3 months by May 13th.	

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F 697	Continued From page 21 complained of low back pain. R3 required cues several times to stand up straight and to stay close to walker as she was leaning over and unsafe. -12/29/21 R3 refused rehabilitation due to back hurting. -1/1/22 R3 complained of lower back pain, Biofreeze was applied, and scheduled medications given. -1/3/22 R3 complained of lower back pain, Biofreeze and scheduled medications given which were somewhat effective. -1/4/22 R3 reported more pain today. -1/6/22 R3 complained of low back pain. -1/14/22 R3 ambulated slowly into the dining room in the morning and had complaints of pain in back. -1/17/22 R3's gait noted to be slow, shuffling and slightly stooped over while ambulating. -1/26/22 R3 complained of back pain in the am. R3 was independent to assist of one with locomotion depending on back pain -1/27/22 R3 had complaints of back pain in the morning with Biofreeze was applied and small amount of relief. R3 yelled out "ouch" during transfers. -1/28/22 R3 required the use of the mechanical sit to stand lift and was not able to tolerate walking or sitting up in bed without assist. R3 required total care with dressing staff must thread arms into shirt and pull arm over head and body, thread legs into pants and pull them up over body. R3 refused restorative therapy due to back pain. Later in the day on 1/28/22, R3 required the use of a full body mechanical lift and assistance of two staff to transfer due to back pain. R3 had also been noted to have been using the wheelchair. -1/29/22 R3 required assist with all ADLs. R3	F 697	Pain observations completed on all residents by May 13th. Any residents who have complained of pain will have interventions put into place and a pain observation done weekly until the pain has resolved or is being managed with current interventions. RN's were assigned a care plan education course through the American Association of Post-acute Care Nursing (AAPACN) called "A Post-Fall Review-Is Your Medical Record Complete" and will be completed by May 26th. All other staff will be educated on care planning at the skills Fair scheduled May 26th and May 31st.	

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F 697	Continued From page 22	F 697		

required the use of mechanical sit to stand lift for transfers. R3 was noted to yell out during transfers. R3 was observed shifting her weight on and off her buttocks while trying to eat. R3 refused restorative therapy due to back pain. R3 was also noted to require total assist with dressing, transfers with lift and two staff and transports in wheelchair with the assistance of one staff.
-1/30/22 R3 continued to complain of increased pain. R3 had been requiring total care due to increased back pain. R3 required assistance of two staff using the mechanical lift for transfers and was unable to ambulate and is utilizing the wheelchair currently. R3 refused restorative therapy due to back pain.
-1/31/22 R3 had been transferring using full mechanical lift and assistance of two staff for transfers from bed due to back pain. R3 had been using a wheelchair with assistance of one staff.
-2/1/22 R3 complained of back pain and transferred using lift due to back pain. R3 had lower back pain which she had scheduled and as needed pain medication.
-2/2/22 R3 had back pain throughout the day. R3 would yelp in pain with first movement and then gets better. Certified nurse practitioner (CNP) assessed R3 and R3 winced some when CNP pressed on lower back, not her spine but her muscle. CNP indicated it was more muscle pain than spine and suggested continuing with heat and Biofreeze and may use the Voltaren gel.
-2/3/22 R3 screamed out in pain while being transferred with assist of two staff. Pain noted in the back and worse upon getting up in the morning. R3 noted to have difficulty transferring to a standing position and would scream out in pain. R3 will continue with current goals of ambulation with rest breaks and being able to

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push up from sitting position in restorative therapy due to residents set back with back pain.
-2/7/22 R3 yelled out in pain upon getting out of bed. R3's sister was worried and crying saying why can't she have a back brace, writer explained that she had been seen by a doctor.
-2/8/22 R3 could be heard screaming from her room while transferring with staff due to lower back pain. R3 was noted to be walking with severe flexion over her walker in a very poor stance and unable to get R3 to stand up straight. R3 was provided Motrin for pain management.
-2/11/22 R3 yelled out in pain while transferred.
-2/12/22 R3 kept repeating "my back is so bad" and R3 was educated to keep walking and moving so pain doesn't get bad.
-2/13/22 R3 had an unwitnessed fall in bathroom. R3 was found in bathroom on the floor sitting on her bottom with her legs out in front of her and back against the wall. R3 was noted to have pain in midback with raising arms up over head and a red area to midback was noted. On call provider ordered Motrin, ice packs and muscle rub for the back pain if pain continues and treatments are not effective send to the emergency room.
-2/14/22 R3 was noted to scream out in pain in back reporting extreme pain 9/10.
-2/15/22 R3 was seen by MD for increased pain. MD ordered x-rays for back. X-rays revealed compression fracture of T12 noted. MD increased R3's Tramadol to 100 mg three times daily.

Review of progress note from nursing home visit dated 2/2/22, indicated R3 was seen by CNP for a routine nursing home follow-up. R3 reported to CNP she had a fall on 12/14/21, and has been having some residual back pain since then. R3 had been getting scheduled Tramadol and Tylenol three times daily and Ibuprofen as

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needed. CNP indicated no new orders and encouraged Diclofenac gel and heat to low back as needed.

Review of spine lumbar x-ray results dated 2/15/22, indicated R3 had a slight compression of the superior endplate of T12 noted of indeterminate age.

On 4/11/22, at 3:35 p.m. MD indicated lumbar x-rays were ordered on 12/21/22, due to R3 reporting increased pain in her back which were not completed as ordered. MD indicated depending on what those x-rays would have shown would have determined R3's pain management plan. MD indicated the facility staff did not report R3 had consistent pain and appeared to be more behavioral. Further, MD indicated R3 had a fall which occurred on 2/13/22, which she became more tender on her midline and MD was then worried about a fracture.

On 4/6/22, at 3:07 p.m. licensed practical nurse (LPN)-A indicated R3 had a change in condition following her fall on 12/14/21. LPN-A indicated R3 required limited to extensive assist of one staff for ADLs and after the fall due to pain and weakness required total care with ADLs.

On 4/6/22, at 3:57 p.m. registered nurse (RN)-C indicated R3 had a few falls and due to increased pain in her back, R3 was no longer independent with ADLs and required more assistance from staff for ADLs depending on her pain level.

On 4/7/22, at 8:54 a.m. RN-D indicated R3 had increased weakness before she passed and had sustained a fracture to her lower spine which

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caused increased pain and made it difficult for R3 to ambulate. Further, RN-D indicated R3's pain management consisted of scheduled Tramadol and Tylenol "around the clock". RN-D indicated R3 had a change in condition related to increased pain in lower back and prior R3 was independent with ambulation. In addition, RN-D indicated R3 was noted to sustain a compression fracture in her back and received a back brace that helped alleviate the pain to that area.

On 4/7/22, at 9:25 a.m. nursing assistant (NA)-A indicated when she first started working as a traveling assistant for the facility R3 required minimal assistance for ADLs and R3 became weaker and had increased pain which then she required assistance of two staff for ADLs. In addition, NA-A indicated change in condition and increased pain noted is reported to the nurse on shift immediately.

On 4/7/22, at 12:04 p.m. RN-A indicated R3 was needing increased amount of assistance. R3 was noted to scream out in pain during transfers and MD was following her for pain management. Further, RN-A indicated R3's back pain started approximately in November of 2021 and MD ordered a lumbar x-ray for increased back pain. RN-A confirmed the x-ray was not completed as ordered on 12/21/21, and was unsure why.

On 4/8/22, at 10:57 a.m. NA-B indicated R3 required minimal assistance with ADLs and then began to require extensive to total assistance with all ADLs. RN-B indicated R3 had a fall on 12/14/21, and slowly started to decline with ADL ability and requiring more staff assistance. RN-B indicated R3 had "excruciating pain" that began "a couple of months ago" and R3 would scream

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F 697	Continued From page 26 in pain in her lower back during cares. Further RN-B indicated nursing would apply heat or cold to her back as needed for pain management. On 4/8/22, at 12:20 p.m. director of nursing (DON) indicated R3 was confirmed to have a compression fracture in her back and family did not want to pursue further treatment just wanted to keep R3 comfortable. Further, DON indicated R3 received a back brace for the compression fracture which "helped a lot". DON stated R3's pain was being treated "the best we could" and "sometimes residents just have pain after a call doing the x-ray earlier would not have changed anything but adding a brace". On 4/12/22, at 12:14 p.m. RN-A indicated R3 was being followed by MD for pain management. RN-A indicated R3's pain management consisted of scheduled Tylenol three times a day for arthritis pain and added Tramadol 100 mg three times daily for lumbar pain, as well as Biofreeze, and hot/cold packs applied to back. Further, RN-A stated R3 had a decline in ADLs due to pain and there was a "big change" noticed following R3's fall in December. In addition, RN-A indicated a comprehensive pain assessment was expected to be completed annually, quarterly, and as needed. RN-A indicated as needed pain assessment should be completed when a resident has a significant change and confirmed a pain assessment should have been complete following R3's fall on 12/13/21, when increased back pain was noted. On 4/12/22, at 1:47 p.m. RN-A confirmed there was no evidence MD was updated from 12/21/22 through 2/2/22, related to R3's increased back pain and increased need for assistance with	F 697		

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F 697	Continued From page 27 ADLs due to back pain. On 2/2/22, R3 was seen by CNP related to back pain. In addition, RN-A confirmed there was not a comprehensive pain assessment completed related to significant change in R3's condition. RN-A indicated licensed nurses are expected to update the MD with change in each resident's condition, however there is no evidence MD was updated. RN-A also confirmed a pain assessment was completed on 1/31/22, for R3's quarterly assessment but no other pain assessments were completed when increased pain and significant change was noted. On 4/12/22, at 2:03 p.m. administrator indicated nursing assistants are expected to notify the floor nurse if a resident reports pain and the nurse should complete a comprehensive assessment and licensed nursing staff are expected to communicate with the clinic provider or the emergency room provider to determine next steps related to the pain. Further, administrator indicated staff are expected to complete an x-ray order timely. In addition, administrator indicated completing a comprehensive pain assessment is important and it is an expectation that it is completed especially if there has been a fall to help the resident get healthy as quickly as possible. Review of facility policy titled Pain Management revised 11/7/18, indicated the purpose of the policy is to ensure that resident's will receive pain management that allows them to maintain the highest degree of functioning and wellbeing, enhance resident comfort and satisfaction, and ensure pain relief defined by a mutually determined goal by patient, family and staff is provided for each resident according to their individual needs. Further review of policy	F 697		

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F 697	Continued From page 28 indicated an initial pain assessment tool shall be completed on every resident upon admission and with the MDS schedule and may also be used with new onset or pain or increased pain. In addition, the policy also indicated reassess after each intervention and with each new complaint of pain in a timely manner and evaluation of resident's who receive scheduled pain medications shall be ongoing with adjustments in dosage or changes in medication made as needed after consultation with the resident and primary physician.	F 697		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication to prevent blood clotting was held in accordance with physician orders for 1 of 1 residents (R2) reviewed who fell and sustained a hematoma (solid swelling from localized area of bleeding) to the back of the head. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/25/22, indicated R2 was cognitively intact, was able to understand others and others understood her, and required extensive physical assist for cares. The MDS indicated R2's diagnoses included cerebrovascular accident (CVA, a stroke) with weakness on her left side and difficulty with walking and mobility. The MDS	F 760	05/04/2022 Staff meeting: Reviewed the Medication and Treatment Orders policy, the Medication and Treatment Administration policy, the Medication Error reporting policy. It was re-inforced: • All orders need a 2 person nurse verification to ensure transcription accuracy. • All orders will go the RN MDS/Unit Coordinator office when completed for review by DON or designee to ensure accuracy and orders are scanned in. • Documentation requirements with new orders • Process for ALL medication errors…who to notify, what to document, where to document and definition of a med error.	5/9/22

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F 760	Continued From page 29 indicated R2 fell two or more times with no injuries since her prior MDS assessment. R2's discharge MDS dated 3/25/22, identified R2 discharged back to the community on 3/25/22. On 3/6/22, at 10:21 p.m. a Mahnomen Health Center Plan of Care report identified an instruction order for R2 which read, "STOP ASPIRIN For 4 weeks." In addition, the reason for the visit indicated "Fall" with diagnosis of "Intraparenchymal hemorrhage (bleeding from ruptured vessels) of brain," along with closed head injury, hematoma of scalp, contusion (bruising) of left shoulder, and arterial ischemic stroke. The report lacked documented information which indicated R2's order was processed by facility staff on 3/6/22. On 3/6/22, at 10:48 p.m. a R2's progress note indicated the following: Instructions from the ER (emergency room) recommend stopping Aspirin for 4 weeks, and R2 did sustain a hematoma to the back left occipital area of her head, visible bruising and slight swelling visible. The note continued to indicate, "Will report to RN (registered nurse) on call and call resident's daughter too to give her updates." A progress note dated 3/6/22, at 11:15 p.m. recorded the following: "Called and updated resident's daughter about her current state, no concerns." Progress notes from 3/6/22 - 3/7/22 lacked documentation RN on call was notified of R2's aspirin hold order. A progress note dated 3/7/22, at 2:50 p.m.	F 760	• Reviewed how to enter an order to ensure that it shows up on the MAR…if it is put into the wrong flowsheet it will not show up. All nursing staff were educated on this to prevent orders from being missed. 04/22/2022 The nurse in the MDS/ Clinical role at the time frame this survey focused on, was placed in a role so that she could have just one area of focus. She is now working the RN Clinical nurse role. The MDS role is now being done by another RN. The intent for this…is so that each RN can focus in their one area and ensure follow through is complete. DON will be doing the MDS training to assist with both the MDS and clinical aspects of the job. Currently the DON does not have MDS training. QAPI DON or designee will perform daily audits as orders are reviewed to ensure accuracy until goals are met. This will be monitored monthly through QAPI. QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	C 04/12/2022

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F 760	Continued From page 30 identified a post fall follow up note in which R2 continued to self-transfer that shift and "[R2] does appear more dazed or glossed over in look. Resident's face appears more swollen." The note lacked documented information which pertained to R2's aspirin hold orders. R2's Medications Administration History record (MAR), dated 3/6/22 to 3/22/22, identified R2 was provided aspirin 81 mg (milligrams) once a day on 3/7/22, 3/8/22, 3/9/22, 3/10/22, 3/11/22, 3/12, 22, 3/13/22, 3/14/22, 3/15/22, 3/16/22, 3/17/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, and 3/22/22. The start date of the order listed a date of 1/13/22 and an end date of "Open Ended." No further doses of aspirin were provided to R2 according to the MAR. R2's Sanford-Pharmacist Drug Regimen Review Observation, dated 3/11/22, identified the following: "1. Nursing - Per 3/6/2022 orders from ER visit, provider ordered Aspirin to be stopped for a duration of 4 weeks. However, per eMAR, resident continues to receive Aspirin daily. Please clarify why Aspirin is not currently being held per 3/2022 provider order." Further, the review identified on 3/22/22, at 8:01 a.m. a staff nurse reviewed the observation documentation and commented "Pharm review noted, will update provider." On 4/7/22, at 12:04 p.m. registered nurse (RN)-A indicated on 3/6/22, R2 had a fall which resulted in R2 being transferred to the emergency room for further evaluation following a head strike. R2 sustained a hematoma to the back of the occipital area of the head, had visible bruising and swelling and may have had a possible cranial internal	F 760		

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F 760	Continued From page 31 bleeding per emergency room report. Further, RN-A indicated R2 returned from the emergency room with orders to "stop" aspirin for four weeks and monitor closely however, her aspirin was not stopped "right away" until 3/22/22. RN-A was not sure what happened related to this incident but confirmed she found this medication error on 3/22/22, and was unsure if this medication was reported to the director of nursing (DON). RN-A indicated the importance of holding aspirin following a head strike was because R2 could have had a brain bleed and had major injuries. On 4/7/22, at 3:19 p.m. DON indicated she was not aware the medication error for R2 pertaining to holding the aspirin following a head strike and stated, "I am assuming RN-A and RN-B took car of that". Further DON indicated holding aspirin following a head strike would be important due to the possibility of R2 having a brain bleed. On 4/8/22, at 12:20 p.m. DON indicated staff were expected to follow facility policy of one nurse enters the order into the computer and the second nurse will verify the order was transcribed correctly. Further, DON indicated R2's order to hold aspirin "was not signed off it was missed." Further, DON indicated the emergency department was expected to give facility nurse an "Interagency Transfer Form" and if the resident does not return with one the facility staff was expected to request it from the emergency department. DON indicated with the change in staff this process does not seem to get communicated and RN-D who was the nurse on shift was from the travel agency which "he wouldn't know to even ask for that form". In addition, DON indicated the mediation error was	F 760		

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F 760	Continued From page 32	F 760		

identified on 3/22/22, by the pharmacy consultant and RN-A was aware. DON confirmed a medication error form was not completed for this incident, as staff are expected, and DON was not made aware of the error to follow up on for the investigation, corrective actions, or education that may be needed.

On 4/11/22, at 8:44 a.m. RN-D indicated he was the nurse on shift on 3/6/22, when R2 returned to the facility from the emergency room. RN-A indicated R2 returned to the facility with "bleeding precautions" and RN-A recalled seeing an order to hold aspirin as part of the precautions. Further, RN-D indicated R2 did not require medications on his shift, so he reported these precautions to the on-coming nurse and added the order to the report sheet. RN-A indicated if a resident returns with new order on the over-night shift and "if it doesn't have to be done that night" the over night staff leave the order and report the new order to the oncoming morning shift to add into the resident's medical record. In addition, RN-A indicated the importance of holding aspirin following a head strike was due to the increased risk of bleeding.

On 4/11/22, at 3:35 p.m. medical doctor (MD) indicated he was made aware of R2's medication error on 3/22/22, when the facility identified the error from the pharmacy consultant. MD indicated there was not an adverse outcome for R2 due to the medication error. In addition, MD indicated holding the aspirin following the fall with head strike would be important since R2 "had a little intracranial bleed" and don't want it to continue or keep bleeding.

A policy Medication and Treatment Orders, dated

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F 760	Continued From page 33 11/2020, directed "Orders must be received by a licensed nurse...any orders needing clarification must be communicated with the prescribing provider." "A nurse's note should be made in the Residents chart regarding the new order... Licensed nurse changes or adds the order on physician orders in electronic record. New orders will be verified and signed off by two licensed nurses to ensure transcription accuracy. The order is faxed to the resident's preferred pharmacy." Review of facility policy titled Medication Error and Reporting Policy revised 2022, indicated when a medication error occurs, the person noting the error will complete a safety event in out electronic safety reporting system and a Medication Error Report form filled out,notify the medical director and DON. In addition, licensed nursing personnel will be responsible for monitoring for any potential side effects or adverse reactions related to medication error.	F 760		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.	F 777		5/9/22

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F 777	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain x-rays for nearly two months for 1 of 1 residents (R3), which resulted in delayed treatment for increased low back pain. Findings include: R3's quarterly Minimal Data Set (MDS) dated 2/1/22, indicated R3 had severe cognitive impairment and reported almost constant pain. On 12/21/21, a progress note indicated medical doctor (MD)-A did not see R3 today, as he did assess last week, and has been following her closely since fall noted on 12/14/21. MD-A decreased R3's Tramadol (pain medication) is to 50 milligrams (mg) three times daily, and gave an order for a lumbar x-ray. Further review of R1's progress notes lacked evidence the lumbar x-ray was obtained. The facility document Mahnomen Health Center Medication Review dated 12/20/21, indicated nursing assessments included R3 had a fall last week and staff wanted to obtain an x-ray due to increased pain noted over the week. MD-A responded with a telephone order for lumbar x-rays. R3's lumbar x-ray results dated 2/15/22, indicated R3 had a slight compression fracture of the superior endplate of T12 noted of indeterminate age, and degenerative osteophytes seen at L1-L5. On 4/7/22, at 12:04 p.m. registered nurse (RN)-A was interviewed and stated MD-A ordered lumbar	F 777	05/04/2022 Staff meeting: Reviewed the Medication and Treatment Orders policy, the Medication and Treatment Administration policy, the Medication Error reporting policy. It was re-inforced: • All orders need a 2 person nurse verification to ensure transcription accuracy. • All orders will go the RN MDS/Unit Coordinator office when completed for review by DON or designee to ensure accuracy and orders are scanned in. • Documentation requirements with new orders • Process for ALL medication errors…who to notify, what to document, where to document and definition of a med error. • Reviewed how to enter an order to ensure that it shows up on the MAR…if it is put into the wrong flowsheet it will not show up. All nursing staff were educated on this to prevent orders from being missed. 04/22/2022 The nurse in the MDS/ Clinical role at the time frame this survey focused on, was placed in a role so that she could have just one area of focus. She is now working the RN Clinical nurse role. The MDS role is now being done by another RN. The intent for this…is so that each RN can focus in their one area and ensure follow through is complete. DON will be doing the MDS training to assist with both the MDS and clinical	

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F 777	Continued From page 35 x-rays on 12/21/21, related to R3 reporting increased pain. RN-A confirmed the x-ray was not obtained until 2/15/22, and was unsure why the x-ray was not completed as ordered on 12/21/22. RN-A confirmed both she and RN-B double-signed on the order verifying it was entered into R3's chart. RN-A stated there was a barrier between the computer systems of MD-A and the facility. RN-A stated staff were expected to call the radiology department once an x-ray order was received to schedule the appointment. RN-A stated she could not recall if the order was called to radiology at that time. On 4/7/22, at 3:19 p.m. the director of nursing (DON) was interviewed and confirmed R3's lumbar x-ray was not obtained on 12/21/21, as ordered, stating it was missed and "it was human error." The DON stated she was made aware by MD-A when he asked why the x-ray was not completed a few months later. The DON stated staff were expected to follow facility process for transcribing orders, which required a two person check on all orders, and stated "maybe that is not being done, I don't know." In addition, the DON stated she educated staff on following orders; however, was not able to provide evidence any education was completed. The facility policy Medication and Treatment Orders revised 11/20, directed once a verbal/telephone or written order is received, a nurse's note should be made in the resident's chart regarding the new order, licensed nurse changes or adds the order on physician orders in electronic record, and new orders will be verified and signed off by two licensed nurses to ensure transcription accuracy.	F 777	aspects of the job. Currently the DON does not have MDS training. QAPI DON or designee will perform daily audits as orders are reviewed to ensure accuracy until goals are met. This will be monitored monthly through QAPI. QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 27, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, MN 56557

Re: State Nursing Home Licensing Orders
Event ID: EDO211

Dear Administrator:

The above facility was surveyed on April 6, 2022 through April 12, 2022 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00353	A. BUILDING: _____ B. WING _____	04/12/2022

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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 4/6/22 through 4/12/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5238036C (MN81998), H5238037C (MN81070) H5238038C (MN81197), H5238039C (MN81591), with a licensing order issued at 0830. AND The following complaint was found to be UNSUBSTANTIATED: H5238040C (MN82361). As a result of the investigation, additional licensing order was issued at 1545. 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	2 000		

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2 000	Continued From page 2 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 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	2 830		5/9/22

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2 830	Continued From page 3 by: Based on interview and document review, the facility failed to ensure interventions were developed and implemented to prevent falls for 3 of 3 residents (R1, R2, R3) who had a history of falls. This resulted in actual harm to R1 who sustained a fractured hip following a fall, actual harm to R2 who required 7 staples in her head following a fall, and actual harm to R3 who sustained a compression fracture following a fall. Findings include: R1 R1's admission Minimal Data Set (MDS) dated 3/8/22, indicated R1 was cognitively intact with a diagnosis of stroke. The MDS indicated R1 required extensive assist of two staff for bed mobility, transfers, ambulation in room, and toileting. In addition, the MDS indicated R1 had two or more falls since admission. R1's Face Sheet printed 4/12/22, indicated R1 was discharged 4/3/22. R1's care plan dated 3/23/22, indicated R1 was at risk for falls due to the use of diuretics and antipsychotics, as well as poor communication skills due to tracheostomy (curved tube that is inserted into a tracheostomy stoma, the hole made in the neck and windpipe) diagnosis of paralysis of vocal cords, stroke affecting left side of the body and a broken left shoulder. R1's care plan identified R1 had a fall that occurred on 3/20/22, which resulted in a broken hip. In addition, R1's care plan identified fall interventions which included of the use of a fall mat on the floor and the bed lowered to the ground when R1 was in bed implemented	2 830	04/28/2022 Post Fall Huddle Form was updated to include a checklist for RN's to remember to complete all the components needed for follow up after a fall as stated on the RN Fall Protocol. All staff educated 05/04/2022 at the staff meeting via in person or zoom. Those unable to attend meeting will schedule a face to face or phone conference with DON by 05/12/2022 to receive the education. 04/08/2022 CARE PLAN TEAM morning huddle agenda was updated to include: • Falls and follow up (pain assessment, interventions, and care plan) • What intervention has been put into place • Falls root cause analysis • Pain /Comfort discussion including a section to note if the provider was informed. 04/08/2022 DON developed the Daily Summary Sheet to include all falls and interventions put into place as well as any medication or condition changes. This form is fill out by the CARE PLAN TEAM after morning huddles to provide pertinent information to all staff regarding falls and interventions. This was implemented 04/08/2022 and is put in the daily communication book. 05/03/2022 DON updated the Bed and Chair alarm policy to include criteria for implementing chair/bed alarms, monitoring of alarms and discontinuing bed/chair alarms. Staff educated on the policy 05/04/2022 during the staff meeting via	

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2 830	Continued From page 4 3/23/22, call light on both recliner and bed implemented 3/15/22, and increased supervision with intensity or agitation episodes implemented on 3/15/22, for R1's fall interventions. Review of R1's falls indicated: On 3/8/22, 5:07 p.m. a Post Fall Huddle Form indicated R1 had an unwitnessed fall in room related to a self-transfer from bed. R1 stated he didn't want to stay in bed any longer due to his legs hurting. At the time of the incident, R1 reported pain to the right elbow and left knee, and appeared to have a small hematoma (bruising happens when blood collects under skin) on knee. Immediate intervention implemented following the fall was another call light by chair. On 3/11/22, 6:00 p.m. Post Fall Huddle Forms indicated R1 had an unwitnessed fall in room. R1 was found on the floor at the side of the bed, and was unable to state what happened. Immediate intervention implemented following the fall was to provide frequent checks. On 3/20/22, 5:15 p.m. Post Fall Huddle Forms indicated R1 had an unwitnessed fall in his room while attempting to self-transfer from the recliner to his bed. R1 reported pain in his left shoulder, and he obtained a skin tear to the left elbow area. Immediate intervention implemented following the fall was to add a low bed. R1's progress notes dated 3/21/22, indicated R1 was noted to have increased complaints of pain in his left hip. R1 would not allow nursing staff to assess, and even lightly touching his left leg would cause R1 to yell. R1 was transferred to the emergency department (ED). On 3/21/22, R1 returned from the ED where x-rays revealed a left	2 830	zoom or in person. All those unable to attend will schedule a face to face or phone conference with DON or designee by 05/12/2022 05/03/2022 Bed and Chair alarm review was added to the care conference agenda to review with families at care conferences. It was also added to the CARE PLAN TEAM morning huddle agenda. 05/04/2022 Education provided by DON to staff regarding “frequent checks” for a fall intervention. Staff were educated if this intervention is put into place, a time frame needs to be indicated and documentation to back it up. 04/28/22 the Post Fall Huddle Form was updated to reflect this information as well. 04/18/2022 The orientation process is being restructured to ensure all these details are reviewed with the appropriate staff. This will be completed by 05/12/2022 to ensure oncoming staff know what their expectations are. CARE PLAN TEAM will perform weekly audits until goals are met, then move to audits every two weeks until goals met and monthly thereafter to ensure falls documentation has been done with all the components required per policy and will be monitored through monthly QAPI meetings. CARE PLAN TEAM will perform weekly audits until goals are met, then move to audits every two weeks until goals met	

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2 830	Continued From page 5 hip fracture. R1's electronic medical record lacked evidence of Safety Events-Fall event, which is the facility's process of completing the form as an interdisciplinary team (IDT) to determine casuative factors and review of interventions, was completed for R1's three falls that occurred on 3/8/22, 3/11/22 and 3/20/22. On 4/7/22, at 12:04 p.m. registered nurse (RN)-A stated R1 was a "huge" fall risk when he was displaying delusions and hallucination episodes. RN-A indicated R1 had a fall on 3/8/22, related to self-transferring from bed due to pain in legs with an intervention added for a call light by recliner. RN-A stated R1 had another fall that occurred on 3/11/22, with an intervention implemented for frequent checks; however, did not clarify how often frequent checks were and "can't find much in the chart other than that." RN-A stated on 3/20/22, R1 had another fall self-transferring from recliner to bed and intervention added was a low bed. RN-A stated "I have no clue why that was implemented and I am getting so frustrated." R2 R2's quarterly MDS dated 1/25/22, indicated R2 had a diagnosis of stroke and was cognitively intact. R2 required extensive assist of one staff for bed mobility, transfers, ambulation, and toileting. The MDS indicated R2 had two or more falls with no injury since the previous assessment. R2's Face Sheet printed 4/12/22, indicated R2 discharged on 3/25/22. R2's care plan revised 3/15/22, indicated R2 was	2 830	and monthly thereafter. This will be brought to monthly QAPI for monitoring. 04/22/2022 The nurse in the MDS/ Clinical role at the time frame this survey focused on, was placed in a role so that she could have just one area of focus. She is now working the RN Clinical nurse role. The MDS role is now being done by another RN. The intent for this…is so that each RN can focus in their one area and ensure follow through is complete. DON will be doing the MDS training to assist with both the MDS and clinical aspects of the job. Currently the DON does not have MDS training. 05/04/2022 Staff meeting: Reviewed the Medication and Treatment Orders policy, the Medication and Treatment Administration policy, the Medication Error reporting policy. It was re-inforced: • All orders need a 2 person nurse verification to ensure transcription accuracy. • All orders will go the RN MDS/Unit Coordinator office when completed for review by DON or designee to ensure accuracy and orders are scanned in. • Documentation requirements with new orders • Process for ALL medication errors…who to notify, what to document, where to document and definition of a med error. • Reviewed how to enter an order to ensure that it shows up on the MAR…if it is put into the wrong flowsheet it will not show up. All nursing staff were educated	

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2 830	Continued From page 6 at risk for falls related to impaired mobility resulting from stroke, hemiparesis (inability to move on one side of the body) and lack of motivation. R2's care plan indicated R2 had falls on 10/30/21, 11/1/21, 11/2/21, 11/5/21, 1/10/22, 2/12/22, 2/19/22, 3/7/22, and 3/13/22. R2's fall interventions included encourage gripper socks if she is not wearing shoes implemented 3/15/22; place bell at table for use in commons area implemented on 3/7/22; chair and bed alarms to alert staff to assist with needs implemented 2/17/22; redirect R2 with snack, activity or phone call to family when ambulance arrives at the hospital implemented 12/24/21; have R2's clothes ready the night before implemented 9/10/21; staff will dress R2 at 5:00 a.m. implemented 8/30/21; remind R2 to call and wait for assistance implemented 8/2/21; gripper socks on while in bed implemented 7/18/21; "call don't fall" sign in room and bathroom implemented on 7/6/21; limited assist of one with front wheeled walker, be aware veers left, guide walker as needed, non-skid shoes implemented 7/1/21; be aware gets dizzy when ambulating with glasses on ensure they are removed before transferring/ambulating implemented on 7/1/21; bed alarm on bed to alert staff of attempts to get up unassisted implemented on 7/1/21; and fall assessment quarterly and as needed, assess falls and implement interventions as appropriate implemented on 7/1/21. Review of R2's falls per facility fall report log : Facilitiy's fall report log printed 4/6/22, indicated R2 had fall which occured on 10/31/21, 11/1/21, 11/2/21, 11/5/21 which lacked evidence a Post Fall Huddle Form was completed per facility Fall policy.	2 830	on this to prevent orders from being missed. DON or designee will perform daily audits as orders are reviewed to ensure accuracy until goals are met. This will be monitored monthly through QAPI QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction.	

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2 830	Continued From page 7 On 12/19/21, at 2:00 p.m. Post Fall Huddle Form indicated R2 had an unwitnessed fall in the commons area while attempting to stand up from the chair. R2 transferred to the ED for further evaluation due to hitting her head. The form lacked evidence an immediate intervention was implemented. On 1/10/22, at 6:30 p.m. Post Fall Huddle Form indicated R2 had an unwitnessed fall in room while self-transferring to get ready for bed. R2 reported pain in her coccyx following the fall. R2 was provided "up to date education" to call for assistance. The form lacked evidence of additional interventions being implemented following the incident. On 2/12/22, at 12:00 p.m. Post Fall Huddle Form indicated R2 had an unwitnessed fall in room while self-transferring attempting to change the television channel. R2 sustained a laceration to a finger on her right hand and struck her head on the dresser. Immediate intervention implemented at the time of the fall included education to nursing assistant to not leave R2 alone in room unless R2 is in bed with bed alarm. On 2/19/22, lacked evidence a Post Fall Huddle Form was completed per facility policy. On 3/6/22, at 4:30 p.m. Post Fall Huddle Form R2 had a witnessed fall in commons area while self-transferring attempting to return to room. Nursing staff was guiding resident back to her seat in the commons area, staff was adjusting the chair alarm on the seat while holding onto R2 by the gait belt. R2 stated she was going to fall, and staff was unable to catch her. R2's head was noted to "bounce off the floor," and R2 reported a headache following the incident. R2 was noted to	2 830		

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2 830	Continued From page 8 have a "bulge" on the back of her head where she had staples from a previous fall. R2 was transferred to the ED for further evaluation. The form lacked evidence of immediate intervention implemented following the incident. On 3/13/22, at 3:45 p.m. Post Fall Huddle Form R2 had an unwitnessed fall in her room while attempting to self-transfer to the bathroom. At the time of the fall, R2's shoes were off and non-skid footwear was implemented at time of incident. Review of R2's Safety Events-Falls event report, which is the facility's process of completing the form as an interdisciplinary team (IDT) to determine casuative factors and review of interventions, was completed for R2's falls that occurred 10/21/21, 11/1/21, 11/2/21, and 12/19/21. -11/5/21,at 2:17 p.m.Safety Event-Fall indicated R2 was witnessed walking with her walker in hallway and "fell onto the blunt edge" on the end table and hit the right side of head and shoulder. Event lacked evidence of intervention implemented following incident -2/19/22, at 2:46 p.m. Safety Event- Fall indicated R2 had a fall in commons area while attempting to self-transfer and fell backwards hitting head and sustained a laceration to the back of her head. R2 was sent to the emergency room and received 7 staples in the posterior of head. Event lacked evidence of intervention implemented following the incident. R2's Nursing Home Fall Risk assessment dated 3/11/22, indicated R2 had "total disregard" for level of functioning and her comprehension and retention of information was "poor to nonexistent."	2 830		

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2 830	Continued From page 9 R2 required constant cues by staff to call for assistance to transfer or ambulate. The director of nursing (DON), registered nurse (RN)-A, RN-B, and social worker (SW)-A met to discuss R2's falls from January through March of 2022, and determined staff had attempted every intervention possible and nursing continued to come up with new interventions following R2's fall; however, R2 was impulsive, which caused difficulty for staff to try to prevent falls. Further, R2's fall risk assessment indicated nursing would continue to try to find interventions to prevent major injury falls, and family had been updated on R2's falls with no additional input on interventions for staff to attempt. On 4/7/22, at 12:04 p.m. RN-A stated R2 was at "extremely" high risk for falls related to impaired gait and previous stroke. RN-A stated a post fall huddle form was not completed for R2's fall on 10/11/21, and confirmed there were no additional interventions added to care plan for this time. RN-A stated R2 had a fall on 11/1/21, and intervention was added for staff to encourage R2 to sit in commons area, however the intervention was not added to R2's care plan. RN-A stated R2 had another fall on 11/2/21, while attempting to self-transfer in room and intervention added directing staff to place R2 in commons area with no additional interventions added to R2's care plan. RN-A stated R2 had a fall on 11/5/21, while self-transferring in the hallway with no additional interventions added following the fall. RN-A stated R2 had a fall on 1/10/22, while attempting to self-transfer to room and confirmed no additional interventions implemented following team review. R2 had a fall on 2/12/22, attempting to change TV channel in room and intervention included nursing education provided R2 was not to be in room alone unless in bed with no care	2 830		

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2 830	Continued From page 10	2 830		

plan updates initiated after team review. R2 had a fall on 2/19/22, and RN-A stated a post fall form was not completed following the incident, however progress notes revealed R2 had a fall which resulted in 7 staples to the back of her head. RN-A was unsure the root cause of the fall and was unsure of an intervention added following the incident. RN-A stated R2 had a fall on 3/6/22, while self-transferring and while nursing staff assisted R2 to a chair, staff was unable to catch R2 from falling. R2 was sent to the emergency room for evaluation and sustained a hematoma (bruising when blood collects under the skin) to the back of R2's head where staples from previous fall were located and RN-A stated immediate intervention was call bell placed in commons area. Further RN-A stated R2 was "emotionally afraid" of the alarms and she didn't like the loud noise and due to dignity concern the alarms were removed from R2 for a while before bringing them back. RN-A indicated the bed and chair alarms are not monitored and staff are not expected to chart on the alarms to identify any trends or patterns they are solely used for staff purpose to know when a resident is attempting to get up without assistance

R3's quarterly MDS dated 2/1/22, indicated R3 had a diagnosis of dementia and had severe cognitive impairment. R3 required extensive assist of two staff for bed mobility, transfers, and toileting. The MDS indicated R2 had one fall with injury since the previous assessment.

R3's Face Sheet printed 4/12/22, indicated R4 discharged on 3/13/22.

R3's care plan revised 2/17/22, indicated R2 was at risk for falls related to dementia diagnosis and arthritis in knees. The care plan indicated R3 had

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2 830	Continued From page 11 falls that occurred on 10/21/21, 11/6/21, 12/14/21, and 2/13/21. R3'a fall interventions included chair and bed alarms implemented on 2/17/22, provide toileting assistance in early morning -resident to be one of the first ones up implemented on 12/16/21, and provide proper non-slip footwear implemented on 5/31/21. Review of R3's falls: On 10/21/21, at 8:30 a.m. Post Fall Huddle Form indicated R3 had an witnessed fall in room while attempting to straighten bed linens and no injury was noted. Immediate intervention implemented was frequently checks. On 11/6/21, R3's medical record lacked evidence a Post Fall Huddle Form was completed for this incident per facility policy. On 12/14/21, at 8:10 a.m. Post Fall Huddle Form indicated R3 had an unwitnessed fall in room while attempting to self-transfer to bathroom or get dressed. No injury was noted. Immediate intervention implemented to wake R3 up by 7:00 a.m. and assist with cares. On 2/13/22, at 3:00 a.m. Post Fall Huddle Form indicated R3 had an unwitnessed fall in room while attempting to self-transfer to the bathroom. R3 was noted to report worsening back pain and had bruising on right hand. Immediate intervention implemented was encourage resident not to self-transfer. Review of R3's x-ray results dated 2/15/22, revealed slight compression of the superior end plate of T12 noted of indeterminate age. Review of R3's Safety Event-Fall reports, which is	2 830		

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2 830	Continued From page 12 the facility's process of completing the form as an interdisciplinary team (IDT) to determine casuative factors and review of interventions, was not completed following R3's falls which occurred 10/21/21, and 11/6/21. On 4/6/22, at 3:07 p.m. licensed practical nurse (LPN)-A was interviewed and stated R1 was a "huge" fall risk and R1's fall interventions included low bed, fall mat, frequent checks, and re-education to use his call light for assistance. LPN-A stated R2 was a high fall risk and interventions included bed and chair alarms, and constant reminders to call for assistance. LPN-A stated R3 had a couple falls but was unsure what interventions were in place to prevent falls for R3. On 4/6/22, at 3:37 p.m. LPN-B stated R2 was at risk for falls and interventions included bed and chair alarms; however, at times the alarms would "malfunction." Further, LPN-B stated the licensed nurses were expected to complete a progress note and a fall sheet after a fall incident and notify family, doctor and DON as well as implementing an immediate intervention. In addition, LPN-B stated the supervising RN will investigate the root cause of the fall and implementing a different intervention to prevent another fall if needed. On 4/7/22, at 9:25 a.m. nursing assistant (NA)-A stated R1 was at risk for falls and interventions included low bed and fall mat on floor while in bed, frequent checks making sure he was "good", promptly answering call light and a chair alarm. NA-A stated R2 was also a high fall risk and interventions included bed and chair alarm, toileting program, and offering activities. Further, NA-A stated R2 disliked the bed and chair alarms and R2 would attempt to shut off the alarms and silence the box so staff would not hear R2	2 830		

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2 830	Continued From page 13 attempting to self transfer. NA-A stated staff were not monitoring the alarms or charting when the alarm was going off but stated it was to alert staff if R2 was attempting to self-transfer. On 4/7/22, at 12:04 p.m. RN-A stated R3 was noted to self-transfer, which put her at risk for falls. RN-A stated R3 had a fall that occurred on 10/21/21, with an intervention of check on R3 frequently however was not sure what "frequently" meant and confirmed no additional interventions were added to R3's care plan following the fall. RN-A stated R3 had another fall on 11/8/21, but was unsure what the root cause of the fall was or what interventions were put in place as electronic medical record lacked evidence. When asked about the facility's fall procedure, RN-A stated the nurse on duty when the fall occurs were expected to complete the top portion of the Post Fall Huddle Form and implement an immediate intervention determined on cause and the completed form would be forwarded to the RN supervisors, which included RN-A, RN-B, and DON, who review the form as a team and determine a root cause for the fall to determine an appropriate intervention and update the care plan. Further, RN-A stated she should be completing the bottom of the Post Fall Huddle forms and confirmed "these things I need to work on obviously". In addition, RN-A stated with recent staffing changes clarification was needed on who was supposed to complete what following a fall. On 4/7/22, at 3:19 p.m. the DON was interviewed and stated when a resident falls, the licensed nurse on duty when the fall occurred should complete an assessment and report the fall to the DON, administrator, family and provider. The nurse is expected to complete the Post Fall	2 830		

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2 830	Continued From page 14 Huddle form and a head-to-toe assessment and implement an immediate intervention. Further, DON stated the team meets every morning and will determine a root cause for the fall and determine an intervention for "long term" to keep them the safest when they fall. At this time, the resident's care plan is updated to reflect the new intervention and put a note in the communication log for staff to be educated. In addition, DON stated R2 disliked the chair and bed alarms due to the noise, so they were discontinued, however R2 continued to self-transfer so staff re-established the alarms. DON stated alarms are initiated as "a last resort intervention" since they don't prevent falls. When asked how staff are monitoring the alarms, DON stated staff are expected to monitor if the alarm was functioning appropriately other than that there was no additional monitoring for alarms and the alarms are used for staff purpose to respond quickly. The facility policy Bed and Chair alarms dated 2022, directed residents with confusion and dementia who may get out of bed or chair without assistance, demonstrate potential for falling, history of falling are guidelines for staff for the use of bed or chair alarms. Further, policy indicates bed and chair alarms will be used in accordance to manufacturers instructions however, policy lacks criteria for when a resident would begin the use of alarms, monitoring alarms for trends and patterns or criteria for alarms being removed. The facility policy Falls revised 01/22, directed nursing home procedure included after resident is determined safe immediately complete a post fall huddle and put an appropriate intervention into place, notify the DON immediately, notify the provider or on-call medical provider, notify family, and report fall to on-coming personnel. Further,	2 830		

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2 830	Continued From page 15 facility's documentation procedure post fall included immediately complete the post fall huddle and investigation tool in its entirety, give the form to the RN unit coordinator or DON, the form will be reviewed at the interdisciplinary team meetings, the form will be handed to the falls prevention coordinator and discussed at the next fall prevention meeting. In addition, the RN staff will enter the event into the electronic incident reporting tool and update the care plan accordingly. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was	21545		5/9/22

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21545	Continued From page 16 prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication to prevent blood clotting was held in accordance with	21545	05/04/2022 Staff meeting: Reviewed the Medication and Treatment Orders policy, the Medication and Treatment	

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21545	Continued From page 17 physician orders for 1 of 1 residents (R2) reviewed who fell and sustained a hematoma (solid swelling from localized area of bleeding) to the back of the head. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/25/22, indicated R2 was cognitively intact, was able to understand others and others understood her, and required extensive physical assist for cares. The MDS indicated R2's diagnoses included cerebrovascular accident (CVA, a stroke) with weakness on her left side and difficulty with walking and mobility. The MDS indicated R2 fell two or more times with no injuries since her prior MDS assessment. R2's discharge MDS dated 3/25/22, identified R2 discharged back to the community on 3/25/22. On 3/6/22, at 10:21 p.m. a Mahnomen Health Center Plan of Care report identified an instruction order for R2 which read, "STOP ASPIRIN For 4 weeks." In addition, the reason for the visit indicated "Fall" with diagnosis of "Intraparenchymal hemorrhage (bleeding from ruptured vessels) of brain," along with closed head injury, hematoma of scalp, contusion (bruising) of left shoulder, and arterial ischemic stroke. The report lacked documented information which indicated R2's order was processed by facility staff on 3/6/22. On 3/6/22, at 10:48 p.m. a R2's progress note indicated the following: Instructions from the ER (emergency room) recommend stopping Aspirin for 4 weeks, and R2 did sustain a hematoma to the back left occipital area of her head, visible bruising and slight swelling visible. The note	21545	Administration policy, the Medication Error reporting policy. It was re-inforced: • All orders need a 2 person nurse verification to ensure transcription accuracy. • All orders will go the RN MDS/Unit Coordinator office when completed for review by DON or designee to ensure accuracy and orders are scanned in. • Documentation requirements with new orders • Process for ALL medication errors…who to notify, what to document, where to document and definition of a med error. • Reviewed how to enter an order to ensure that it shows up on the MAR…if it is put into the wrong flowsheet it will not show up. All nursing staff were educated on this to prevent orders from being missed. DON or designee will perform daily audits as orders are reviewed to ensure accuracy until goals are met. This will be monitored monthly through QAPI QAPI meeting will be held 05/09/2022 to discuss these concerns and plan of correction.	

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21545	Continued From page 18	21545		

continued to indicate, "Will report to RN (registered nurse) on call and call resident's daughter too to give her updates."

A progress note dated 3/6/22, at 11:15 p.m. recorded the following: "Called and updated resident's daughter about her current state, no concerns."

Progress notes from 3/6/22 - 3/7/22 lacked documentation RN on call was notified of R2's aspirin hold order.

A progress note dated 3/7/22, at 2:50 p.m. identified a post fall follow up note in which R2 continued to self-transfer that shift and "[R2] does appear more dazed or glossed over in look. Resident's face appears more swollen." The note lacked documented information which pertained to R2's aspirin hold orders.

R2's Medications Administration History record (MAR), dated 3/6/22 to 3/22/22, identified R2 was provided aspirin 81 mg (milligrams) once a day on 3/7/22, 3/8/22, 3/9/22, 3/10/22, 3/11/22, 3/12, 22, 3/13/22, 3/14/22, 3/15/22, 3/16/22, 3/17/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, and 3/22/22. The start date of the order listed a date of 1/13/22 and an end date of "Open Ended." No further doses of aspirin were provided to R2 according to the MAR.

R2's Sanford-Pharmacist Drug Regimen Review Observation, dated 3/11/22, identified the following: "1. Nursing - Per 3/6/2022 orders from ER visit, provider ordered Aspirin to be stopped for a duration of 4 weeks. However, per eMAR, resident continues to receive Aspirin daily. Please clarify why Aspirin is not currently being held per 3/2022 provider order." Further, the review

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21545	Continued From page 19 identified on 3/22/22, at 8:01 a.m. a staff nurse reviewed the observation documentation and commented "Pharm review noted, will update provider." On 4/7/22, at 12:04 p.m. registered nurse (RN)-A indicated on 3/6/22, R2 had a fall which resulted in R2 being transferred to the emergency room for further evaluation following a head strike. R2 sustained a hematoma to the back of the occipital area of the head, had visible bruising and swelling and may have had a possible cranial internal bleeding per emergency room report. Further, RN-A indicated R2 returned from the emergency room with orders to "stop" aspirin for four weeks and monitor closely however, her aspirin was not stopped "right away" until 3/22/22. RN-A was not sure what happened related to this incident but confirmed she found this medication error on 3/22/22, and was unsure if this medication was reported to the director of nursing (DON). RN-A indicated the importance of holding aspirin following a head strike was because R2 could have had a brain bleed and had major injuries. On 4/7/22, at 3:19 p.m. DON indicated she was not aware the medication error for R2 pertaining to holding the aspirin following a head strike and stated, "I am assuming RN-A and RN-B took car of that". Further DON indicated holding aspirin following a head strike would be important due to the possibility of R2 having a brain bleed. On 4/8/22, at 12:20 p.m. DON indicated staff were expected to follow facility policy of one nurse enters the order into the computer and the second nurse will verify the order was transcribed correctly. Further, DON indicated R2's order to	21545		

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21545	Continued From page 20 hold aspirin "was not signed off it was missed." Further, DON indicated the emergency department was expected to give facility nurse an "Interagency Transfer Form" and if the resident does not return with one the facility staff was expected to request it from the emergency department. DON indicated with the change in staff this process does not seem to get communicated and RN-D who was the nurse on shift was from the travel agency which "he wouldn't know to even ask for that form". In addition, DON indicated the mediation error was identified on 3/22/22, by the pharmacy consultant and RN-A was aware. DON confirmed a medication error form was not completed for this incident, as staff are expected, and DON was not made aware of the error to follow up on for the investigation, corrective actions, or education that may be needed. On 4/11/22, at 8:44 a.m. RN-D indicated he was the nurse on shift on 3/6/22, when R2 returned to the facility from the emergency room. RN-A indicated R2 returned to the facility with "bleeding precautions" and RN-A recalled seeing an order to hold aspirin as part of the precautions. Further, RN-D indicated R2 did not require medications on his shift, so he reported these precautions to the on-coming nurse and added the order to the report sheet. RN-A indicated if a resident returns with new order on the over-night shift and "if it doesn't have to be done that night" the over night staff leave the order and report the new order to the oncoming morning shift to add into the resident's medical record. In addition, RN-A indicated the importance of holding aspirin following a head strike was due to the increased risk of bleeding. On 4/11/22, at 3:35 p.m. medical doctor (MD)	21545		

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21545	Continued From page 21 indicated he was made aware of R2's medication error on 3/22/22, when the facility identified the error from the pharmacy consultant. MD indicated there was not an adverse outcome for R2 due to the medication error. In addition, MD indicated holding the aspirin following the fall with head strike would be important since R2 "had a little intracranial bleed" and don't want it to continue or keep bleeding. A policy Medication and Treatment Orders, dated 11/2020, directed "Orders must be received by a licensed nurse...any orders needing clarification must be communicated with the prescribing provider." "A nurse's note should be made in the Residents chart regarding the new order... Licensed nurse changes or adds the order on physician orders in electronic record. New orders will be verified and signed off by two licensed nurses to ensure transcription accuracy. The order is faxed to the resident's preferred pharmacy." Review of facility policy titled Medication Error and Reporting Policy revised 2022, indicated when a medication error occurs, the person noting the error will complete a safety event in out electronic safety reporting system and a Medication Error Report form filled out,notify the medical director and DON. In addition, licensed nursing personnel will be responsible for monitoring for any potential side effects or adverse reactions related to medication error. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for medication administration to include processes related to how medication is ordered and transcribed into the electronic medical record. Staff could be	21545		

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21545	Continued From page 22 educated on the need to clarify discrepancies in medication orders. The DON or designee could review all current resident medication orders to ensure accuracy and audit new medication orders per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		