Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 26, 2019

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: Project Number S5251041, H5251017, H5251018 and H5251019C

Dear Administrator:

On February 8, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 25, 2019 remain in effect.

Also on February 8, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy:

- Civil money penalty. (42 CFR 488.430 through 488.444)

On March 6, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 15, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 4, 2019 and an extended survey completed on January 23, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2019. We have determined, based on our visit, that your facility has corrected as of March 15, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 25, 2019 be rescinded as of March 15, 2019. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 18, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2019.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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RE: Project Number S5251041, H5251017, H5251018 and H5251019C

Dear Administrator:

On January 18, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 25, 2019.

You were also notified in our letter dated January 18, 2019 that this Department recommened to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy:

- Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on January 4, 2019 that included an investigation of complaint number H5251017 and H5251018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On January 23, 2019, an extended survey was completed at your facility by the Minnesota Department of Health to investigate complaint H5251019C number 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 24, 2019, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed. However, continued non-compliance remains at the lower scope and severity of G.

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy 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 March 25 2019, will remainin effect.

This Department is also continuing to recommend that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 25 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 25 2019, (42 CFR 488.417 (b)).

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of January 18, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2019. The change in date is due to the extended survey that was completed on January 23, 2019.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one of the follwoing: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care,

as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Riverview Hospital & Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 23, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 July 4, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

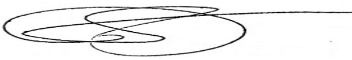
Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
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
	245251	A. BUILDING ______ B. WING ______	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced visit to investigate complaint H5251019C was conducted by the Minnesota Department of Health on 1/22/19 - 1/24/19. The complaint was substantiated and the survey resulted in an Immediate Jeopardy (IJ) at F689 due to the facility's failure to conduct comprehensive post fall assessments and implement interventions to minimize further falls and/or injury, impairment, or death. An extended survey was conducted by the Minnesota Department of Health on 1/23/19, through 1/24/19. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		2/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 02/18/2019

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

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F 689 Continued From page 1

by:
Based on observation, interview and document review, the facility failed to ensure resident safety which resulted in an increased risk for falls and the potential for serious harm, injury, or impairment to 1 of 3 residents (R1) reviewed for falls who was identified as at risk for falls, had dementia with impulsive behavior, anxiety and agitation which resulted in repeated self transfer attempts. On 1/16/19, R1 had repeated attempts to self transfer without adequate supervision and subsequently fell which resulted in pelvic fractures and another fall which resulted in spinal compression fractures at lumbar spine (L1, L2) and thoracic spine (T11). This failure resulted in an IJ for R1. In addition, the facility failed to implement alternative interventions to minimize the risk for falls for 1 of 3 residents (R3) who was also identified at risk for falls.

The immediate jeopardy began on 1/6/19, at 6:15 p.m. when the staff identified R1 was agitated yet allowed R1 to be unattended in the dining room. R1 attempted to self transfer and sustained a fall which resulted in pelvic fractures. The administrator and director of nursing (DON) were notified of the IJ on 1/23/19, at 3:18 p.m. The IJ was removed on 1/24/19, but noncompliance remained at the lower scope and severity of G - isolated, which indicated actual harm had occurred with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R1's Diagnoses Report dated 1/23/19, indicated R1 had diagnoses which included Alzheimer's disease, anxiety disorder, depression, hallucinations, delusional disorder, dementia with

F 689

Facility timely submits this response and plan of correction pursuant to Federal and State law requirements. This response and plan of correction are not admissions, or an agreement, that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it is not to be construed as an admission against the interest of the facility, the administrator, or any employees, agents, or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.

January 24, 2019

Problem: R1 is an 81-yer old female resident residing in our Memory Care Skilled-Nursing facility with the following diagnoses: Major depressive disorder, Presence of right artificial hip joint, Alzhiemer's disease, Dementia in other diseases classified elsewhere with behavioral disturbance, Anxiety Disorder, Delusional disorder(History of Hallucinations), osteoporosis, RLS, hypothyroidism, GERD, joint paint.

Review of Falls: R1 has experienced frequent falls, which most recently resulted in a fracture to the pubic ramus from a fall in the dining room on January 6, 2019. R1 has a repeat fall when she slid out of her recliner on January 12, 2019. R1 was admitted to the hospital on 01/12/19 for cholecystitis where imaging obtained for cholecystitis showed new

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F 689	Continued From page 2 behavioral disturbance and restless leg syndrome. R1's quarterly Minimum Data Set (MDS) dated 10/7/18, indicated R18 had severe cognitive impairment and required extensive assistance of one to two staff for all activities of daily living. The MDS also indicated R1 had experienced one fall without injury and one fall with major injury (bone fracture, joint dislocation, closed head injury with altered consciousness, subdural hematoma) since the prior assessment. R1's Falls Care Area Assessment (CAA) dated 4/29/18, indicated R18 used antidepressant, antipsychotic and pain medications. R1's medications were effective but R1 had experienced falls. Fall risk was 22 (high risk for falls). R1 used a walker and required extensive assistance of two for ambulation and also used a wheelchair due to mobility issues. R1 needed reminders and cues for wheelchair use and had tried to self transfer a number of times and had falls, usually without injury. However, one fall in March, resulted in a compression fracture of the spine. R1 had a silent bed alarm and a night light in her bathroom and by her bed. R1's Care Plan revised 10/10/18, indicated R1 was at risk for falling related to dementia, cognition and weakness and directed staff to implement the following interventions: -Bed alarm on to alert staff of movement. -May leave gait belt on loosely as gets up unexpectedly and starts moving before staff can get there. -Give verbal reminders not to ambulate/transfer without walker.	F 689	compression fractures to L1 and L2 and T11. R1 has had 18 falls in the past one year. The following are identified risk factors: Recent history of falls. Behavior, hx of fracture, environmental(Agitation with noise), medication side effects, mental status,(see diagnosis), visual impairment (wears glasses), gait disturbance with current pubic fracture (weight bearing as tolerated), catheter. R1 needs frequesnt redirection when attempting to stand. R1 has periods of agitation and anxiety with documented behaviors of screaming, crying, pounding on walls/doors. R1 has had recent medication adjustments by primary care provider (antidepressant changes). In discussing resident with primary care provider, Dr. Fashoro, he notes resident has long-standing history of psychotic disorder and was previously in a behavioral health unit in Bemidji, MN before being admitted to our Care Center on 11/7/17. R1 does respond to redirection, reassurance and re-approaching when she is having these agitated/anxious episodes. Currently seeking Pharmacy opinion on medications added for pain management related to fracture and increased fall risk. R1's family has noted that R1 appears to get agitated easily when other residents are also agitated. When possible, removing R1 away from other agitated resident appears to be helpful. NEW and IMMEDIATE INTERVENTIONS FOR R1/FALLS: Specific to R1 - Immediate review of	

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F 689

Continued From page 3

-Keep call light in reach at all times. Night light in bathroom to be on at all times.
-Obtain physical therapy (PT) consult for strength training, toning, positioning, transfer training, gait training, mobility devices, as needed.
-Provide an environment free of clutter.

R1's clinical record revealed the following information:

Progress Note (PN)/nurse's note dated 1/6/19, at 12:18 p.m. indicated R1 was agitated and yelling. R1 was noted to be yelling "I want to go home" and hitting a door with the palm of her hand. RN-A had directed the staff to call R1's family if the behavior continued. A subsequent PN at 12:25 p.m. indicated the staff had called the family and requested them to visit. Family member (FM)-B directed the staff to wheel R1 off of the memory care unit in an attempt to calm her. The staff reported they were unable to accommodate FM-B's request due to "staff issues." Another PN at 12:56 p.m. indicated R1 talked to FM-B on the phone and had calmed down. At 3:00 p.m. FM-A visited R1 at the facility.

A Safety Events- Fall report (incident report) dated 1/6/19, at 6:15 p.m. indicated R1 was found on the floor in the dining room. Staff attempted to move R1's right leg and she complained of pain. R1 was transferred to the hospital for further evaluation. The Post Fall Assessment for the 1/6/19, fall dated 1/7/19, indicated R1 was at high risk for falls and R1 had been agitated at the time of the fall on 1/6/19. The assessment indicated R1's plan to prevent further falls was to make sure R1 was escorted out of the dining room early. However, this fall intervention was not added to R1's care plan.

F 689

meds by Pharmacist d/t recent hospital discharge d/t high risk for falls and recent med changes.

Specific to R1 - Updated Care Plan with all interventions and review with staff at report. Staff signature required upon review. (As above.)

Specific to R1 - Inter-Disciplinary Team, (IDT), met on 1/24/19 to discuss R1's current intervention and discuss any new interventions. Input was gathered from staff on suggestions/concerns regarding R1's current high-fall risk.

Specific to R1 - Updated R1's Care Plan to reflect the new interventions listed below, Specific to R1.
NEW: Charge Nurse to implement every 15-minute rounding to resident during agitated/crying/weeping episodes to provide support, diversion, redirection and reassurance. Capture rounding by documenting on checklist. Checklist to be filed/scanned into resident's chart.

Specific to R1 - Educate/inservice staff on all above actions.
NEW INTERVENTIONS: Care Center team informed of all immediate interventions at morning huddle on 1/24/19 and will continue to be reported forward to oncoming staff by DON/Charge Nurse. Information on 15-minute rounding placed in communication book and will continue to be reported forward.

NEW INTERVENTIONS TO CORRECT

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RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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R1's Hospital Discharge Summary dated 1/9/19, indicated R1 had sustained right superior and inferior pubic rami (pelvis) fractures and had been diagnosed with a urinary tract infection. R1 was to return to the nursing facility and was allowed to bear weight as tolerated, as needed pain medications were prescribed (Percocet), an antianxiety medication (lorazepam) for agitation and an antibiotic for the treatment of the urinary tract infection. Review of R1's clinical record revealed upon R1's hospital return, a new comprehensive fall assessment and the implementation of interventions was not completed following the diagnosis of the fractures. In addition, R1's care plan had not included revisions following the hospital return.

PN dated 1/12/19, at 5:12 p.m. indicated R1 was "extremely anxious, restless and weepy." R1 was given as needed pain medications and slid out of her recliner. R1 did not express pain during the fall, however, was transferred to the emergency room due to facility's notification of abnormal laboratory levels from a previous blood draw due to R1's yellowish (jaundice) appearance. R1 was admitted to the hospital. The Safety Events-Fall report dated 1/12/19, at 5:20 p.m. indicated R1 had slid out of her recliner in her room, did not have pain but was sent to the emergency room due to abnormal lab values. The report lacked any assessment of the fall. An Incident Tracking/five day investigation form which was related to the 1/6/19, and was submitted by the facility to the State Agency dated 1/12/19, indicated R1 had sustained a fall 1/6/19, while at the facility resulting in pelvic fractures. The investigation form indicated R1 required "closer monitoring due to frequent attempts at

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DEFICIENCY AS IT RELATES TO THE INDIVIDUAL:
Care Plan Updated to Following Interventions:
- Environment free of clutter
- Recent Physical Therapy consult
- Recent Occupational Therapy consult
- Verbal reminders not to ambulate/transfer without assist
- May leave gait belt on loosely
- Bed alarm on bed
- Bed in lowest position
- Mats on floor by bed
- Mattress with raised edge
- Provide a quiet, non-hurried environment free of background noise and distractions.
- Immediate Pharmacy consult due to recent discharge from hospital with new medications on high-fall risk resident.
- Assisting resident as one of the first out of the dining room to nurses station area when meals are finished.
- During episodes of crying, weeping, and/or anxiety, charge nurse to implement every 15-minute rounding on resident by NAR.
- Antirollback device to wheelchair
- Room close to Nurses station

Problem Goal Approach Discipline (care plan copy)
Resident at risk for falling R/T Dementia/cognition/weakness
- Pharmacy consult on medications due to recent med changes with hospitalization to assess changes in risk for falls.
- Antirollback to wheelchair
- Bed in lowest position with mats on floor by bed

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F 689	Continued From page 5 standing/walking. Diversional activities of her interest when restless." However, R1's clinical record lacked identification of the root cause/unmet need resulting in the falls and identification of intervention(s) to minimize the risk of further falls. R1's Hospital Discharge Summary dated 1/16/19, at 1:23 p.m. indicated R1 was diagnosed with a gallbladder infection without gall stones and elevated liver functions, however, R1 was not a surgical candidate and was treated with intravenous antibiotics while at the hospital. R1's pain management was changed to Fentanyl patches. R1 returned to the facility. While hospitalized, a Cat Scan (CT) was performed which revealed newly diagnosed L1, L2 and T11 fractures. A PN dated 1/16/19, indicated R1 returned to the facility and a personal silent chair alarm was placed in the recliner. R1's care plan was not updated to reflect the new intervention. On 1/22/19, from 4:00 p.m. to 7:45 p.m. R1 was continuously observed in her room, seated in the recliner. The recliner was equipped with a silent personal alarm. A personal companion (PC)-A was seated next to her. On 1/22/19, at 4:52 p.m. registered nurse (RN)-A stated R1's family had hired the personal companion to sit with R1 a few hours a day. Shortly there-after, the DON stated R1's family had requested R1 to stay in her room and they had hired the companion. -At 5:20 p.m. licensed practical nurse (LPN)-A stated R1 had a history of attempting to transfer	F 689	- Due to resident frequent attempts to stand while dining, ensure safety of resident by assisting as one of the first out of dining room to Nurses station area where staff are present during transporting of residents from dining room. - During episodes of agitation, crying, weeping and/or anxiety, Charge Nurse to implement every 15-minute rounding on resident by NAR and/or Nursing to ensure safety from falls by providing reassurance, redirection, support,and/or diversion until resident appears calm. Family currently requesting resident remain in room with healing fractures. - Room close to Nurses station. - Scoop mattress (raised edges), on bed. Per family request, air mattress on bed for comfort due to current fracture. Reassess need for air mattress when fracture heals. - Bed alarm on bed to alert staff of movement. - May leave gait belt on loosely as resident gets up unexpectedly and starts moving before staff can close-the distance to reach the resident. - Provide verbal reminders not to ambulate/transfer without assistance. - Continue to keep call light within reach at all times when in resident room. - Night light in bathroom to be left on at all times. Obtain PT consult for _strength training, toning, positioning, transfer training, gait training, mobility devices, PRN). - Provide an environment free of clutter. AUDITING SYSTEM BY DIRECTOR OF	

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F 689	Continued From page 6 on her own. As the charge nurse, LPN-A stated when a resident fell, she assessed the resident for injury, monitored vital signs and neurological checks if the resident had hit their head. LPN-A stated R1 had a low bed, fall mats next to the bed and personal silent alarms on the bed and recliner. The staff were to check on R1 frequently, however, they did not document the "frequent" checks. LPN-A stated R1 was to receive every two hour monitoring and the staff were to document any care provided to R1 every two hours. LPN-A stated the family members had directed the staff to keep R1 in her room. -At 5:50 p.m. nursing assistant (NA)-A was observed to deliver a meal tray to R1's room. PC-A remained with the resident and assisted R1 with the meal. -At 6:28 p.m. NA-A stated R1 had sustained falls while at the facility and had fractured her pelvis on 1/6/19. NA-A stated R1 had been in the dining room on the evening of 1/6/19, as NA-A was escorting other residents out of the dining room when she saw R1 attempt to stand up and fall from a dining room chair. NA-A stated she was not close enough to R1 to guide her back into the chair before R1 fell. NA-A stated since R1 had returned to the facility, the staff had rearranged her room, placed the bed against the wall and were placing pillows underneath the bed sheets to ensure R1 did not crawl out of the bed. NA-A stated R1 was quick and did not remember that she was unable to ambulate on her own. -At 6:45 p.m. NA-A and NA-D were observed to assist R1 to bed. R1's bed was not observed to be against the wall. NA-A stated the room had been rearranged a second time to ensure a	F 689	NURSING TO MONITOR WEEKLY REVIEW OF ALL RESIDENTS OF RISK FOR FALLS, INCLUSIVE OF R1. DAILY STAFF HUDDLES TO PROVIDE CURRENT INFORMATION ON ANY RESIDENT CHANGES THAT WOULD INDICATE A POTENTIAL FOR INCREASED FALL RISK, AND NEW SOLUTIONS BASED ON IDENTIFIED RESIDENTS, AS IDENTIFIED ABOVE TO UPDATED CARE PLAN. POLICIES WERE REVIEWED AND UPDATED. SEE ATTACHMENTS A,B,C HOW TO MONITOR FOING FORWARD: RN/DON to do care plan audits, as noted above, at post-fall review (day 7). Will audit care plan, progress notes and communication of any recommended intervention at this time. Newly implemented root-cause analysis with IDT team with every fall daily. RN/DON to immediately place any new interventions to care plan and communicate to staff. DON to do weekly audit that al-root-cause analysis huddles were performed in a timely manner for every fall within the facility. At quarterly QAPI meeting, continue to discuss all falls within facility noting any trends in times and/or places. Will now add new agenda topic to discuss residents with high-risk for falls and residents with repeated falls in more detail to gather input from all disciplines.	

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F 689	Continued From page 7 personal recliner was able to fit in the room. R1 was transferred from the recliner to the bed with extensive assistance of one staff. R1 was positioned in a low bed, equipped with a concave mattress with a air mattress overlay inside of the concave mattress (per family request), fall mats were positioned on either side on the bed, a silent pressure pad alarm was positioned under R1's buttocks/lower back and pillows were positioned under the bed sheet to prevent R1 from rolling out of the bed. R1 was observed to be calm and rested quietly in the bed. -At 7:00 p.m. RN-B stated she had been working the evening of R1's fall on 1/6/19. RN-A stated R1 was seated in a dining room chair when she stood up independently and fell. RN-B stated R1 was supposed to have one to one supervision because she had been anxious earlier in the day. RN-B confirmed R1 was alone in the dining room when she fell. RN-B stated R1 had a history of falls and R1's fall interventions included providing her with diversional activities, a bed alarm, fall mats next to the bed, assist with toileting as needed or offer snacks. R1 was assessed for injury at the time of the fall and was sent to the emergency room. RN-B confirmed at the time of the fall, R1 was in the dining room without 1:1 direct supervision. -At 7:13 p.m. FM-A was interviewed via phone. FM-A stated in the past two weeks, R1 had sustained different fractures because of falls. FM-A felt the facility had enough staff to provide care for the residents, however, a personal companion had been privately hired to provide a few hours of additional supervision (24 hours a week).	F 689	Revise the facility Leader Evaluation Module (LEM), goal for further monitoring by senior leaders to reduce falls rate within the facility. Seek direction of Pharmacist, Primary Care Provider and/or Medical Director as appropriate for any concerns with possible infection, medication interactions, and clinical oversight, and other care areas identified. RiverView Care Center ATTACHMENT A: SUBJECT: Care Plan, Comprehensive, Interim, Short Term POLICY: Each resident will have a comprehensive plan of care developed no later than 7 days after the completion of the comprehensive assessment (21 days from admission) by the interdisciplinary team. The comprehensive care plan is evaluated and revised as necessary to reflect the resident□s current status as required by law and regulation. INTERDISCIPLINARY TEAM: Includes but not limited to: the resident where possible, resident□s legal guardian or chosen representative, attending physician, a registered nurse, social worker, activity, dietary, nursing rehabilitation, direct care givers (RN, LPN, CNA). PROCEDURE: The comprehensive	

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-At 7:23 p.m. NA-D stated R1 was to stay in her room at all times and was to be monitored for fall prevention. NA-D stated R1 had a history of falls and currently had a broken pelvis.

On 1/23/19, from 7:15 a.m. to 10:00 a.m. R1 was continuously observed.
-At 7:16 a.m. R1 was observed resting on her back in a low bed, equipped with fall mats on either side of the bed, a silent personal alarm, concave mattress with air mattress overlay, and pillows were positioned under the sheet on the right side. R1 was resting quietly.
-At 7:42 a.m. NA-A entered the room to transfer R1 from the bed to the recliner. R1 was not observed to express pain during the transfer.

On 1/23/19, at 7:55 a.m. RN-A stated a post fall assessment was to be completed by the RN on duty at the time of the fall or by the next oncoming RN if there was no RN in the building at the time of the fall. RN-A reviewed R1's clinical record and confirmed a post fall assessment was not completed after the fall on 1/12/19, and no further interventions had been implemented. RN-A stated upon R1's return from the hospital, no new fall interventions were put into place, but it was determined R1 would have a complete significant change MDS completed 14 days after returning. RN-A explained the significant change MDS would be completed on 1/23/19, and the care plan would be updated after the significant change assessment was done. RN-A confirmed R1's care plan had not been updated since the fall. Upon review of the CT scan dated 1/12/19, RN-A stated she was unaware of the newly diagnosed L1, L2 or T11 fractures as identified on the CT scan.

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(Interdepartmental) plan of care will:
1. Be developed by using the individual resident assessment data and the resident□s expectations and customary routine.
2. Have a problem or strength statement that is resident-focused and related to the care plan sequence.
3. List realistic and measurable goals related to the problem or strength statement and have timetables to meet long-term and short-term goals.
4. Intervention/approaches should be developed to help residents in meeting identified resident-focused goals.
5. Identify qualified individuals to implement identified interventions/approaches.
6. Identify Resident Susceptibility to Abuse by placing an * by the area assessed as making them Susceptible to Abuse.
7. Be reviewed a minimum of every 90 days.
8. Be reviewed with the resident, resident□s legal guardian or chosen representative. Social Services will be invited to the scheduled care conference.
9. All care plan intervention updates will be immediately placed on care plan. Care plan intervention updates will be brought to the attention of care center staff via report, huddle, communication book and nursing assistant care sheets.
MEMORY CARE:
In addition to the above, the Resident Plan of Care must include:
1. A statement of the behavioral reason for which the resident is placed in the unit,

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-At 9:18 a.m. NA-B stated R1 had a long history of falls and she was to have fall interventions in place. However, she could not recall any changes to R1's fall plan between 1/4/19-1/6/19. NA-B stated the staff members are accustomed to looking into R1's room as they walk by in the hallway, but they do not document each time they go by.

-At 9:20 a.m. the DON stated R1 sustained a fall resulting in pelvic fractures on 1/6/19, however, was unaware of the compression fractures at L1, L2 and T11 identified on the 1/12/19, CT scan. The DON confirmed R1 was impulsive and required increased supervision as identified during the 1/4/19, recertification survey and as indicated on the 1/12/19, five day investigation form submitted to the State Agency. The DON confirmed the facility had not completed a comprehensive analysis of the fall sustained on 1/6/19, alternative interventions to minimize falls were not implemented and R1 sustained an additional fall on 1/12/19, which resulted in additional fractures.

The undated Fall Prevention Program policy indicated the RN would evaluate the present use of fall prevention interventions as to whether or not they are keeping the resident safe from falls. If the resident had fallen despite fall prevention protocols already in place, the RN would identify the need to implement further protocols.

The undated Falls (Post-Fall Review) policy indicated the nurse working at the time of the fall would gather information and chart accordingly and activate further interventions as deemed necessary. A comprehensive post fall observation was to be completed within 24 hours.

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their causes, and the goals to be accomplished.
2. The treatment plans will be designed to correct or compensate for the behavioral problems.
3. Guardians and family members will be consulted when developing the plan of care.

Care Plan Focus
1. Delirium
2. Cognitive Loss
3. Sensory (Hearing, Vision)
4. Communication
5. ADL Functional
6. Rehabilitation
7. Toileting (continence, incontinence, diarrhea, constipation)
8. Psychosocial well-being
9. Mood State
10. Behavioral Symptoms
11. Activities
12. Falls
13. Nutritional Status
14. Potential for Choking
15. Feeding tubes
16. Dehydration/Fluid Maintenance
17. Oral/Dental Care
18. Pressure Ulcers Skin
19. Psychotropic Drug Use
20. Physical Restraints
21. Pain
22. Diagnosis-Related
23. Potential for Abuse
24. Self-Preservation
25. Advanced Directives
26. End of Life
27. Discharge plan

INTERIM CARE PLANS:
1. An interim care plan will be started on

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The policy also indicated all falls would be reviewed at weekly IDT meeting to assure proper interventions in place.

The Care Plan, Comprehensive, Interim, Short Term policy dated 12/8/05, indicated each resident was to have a comprehensive plan of care developed following a comprehensive assessment. The care plan was to be evaluated and revised as necessary to reflect the resident current status as required by law and regulation. The policy also directed the staff to implement interim care plans and short term care plans as needed.

On 1/23/19, at 2:50 p.m. the DON reviewed the care plan policy and confirmed the facility was not developing and utilizing short term care plans or making revisions to the care plans as needed. The DON stated the RN that had been in charge of care plan revisions was no longer working at the facility and it had been missed by the other staff members.

-At 3:18 p.m. the administrator and DON were informed of R1's frequent attempts to self transfer, lack of supervision, history of falls resulting in fractures, lack of comprehensive assessment of the falls along with implementation of interventions to minimize falls which resulted in IJ for R1.

The immediate jeopardy that began on 1/6/19, was removed on 1/24/19, at 3:35 p.m. but remained at a scope and severity level G - actual harm, after the facility implemented a removal plan which was verified by the staff included the following:

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admission/re-admission and when a significant change assessment is initiated.
2. The Interim Care plan will be filed in the resident overflow chart upon completion of the Comprehensive Plan of Care.

RiverView Care Center

ATTACHMENT B:

SUBJECT: Fall Prevention Program

POLICY: To implement and use a fall prevention and reduction program to provide prompt treatment and prevent further injury.

INTERNAL CARE CENTER PRACTICE: All residents admitted to the Care Center pose a risk for falls and require all staff to be observant and proactive in meeting their needs.

PROCEDURE: This program includes but is not limited to the following processes.

1. The fall risk assessment: a form used to assess a residence risk level for potential Falls which is completed at the time of the admission and quarterly thereafter.
2. Event report: an internal form is used to report all necessary information regarding a fall or incident. This form is completed by the LPN or RN as soon as possible following a fall or incident. This

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-Completed a comprehensive fall assessment for R1.
-Updated R1's care plan to direct the staff as to how monitor R1 when agitated.
-Updated and implemented policies and procedure regarding falls. Immediate interventions following a fall and care plan revision.
-Staff members were educated on the changes to R1's plan of care and revisions to the fall prevention policy.

R3's Diagnoses Report dated 1/23/19, indicated R1 had diagnoses which included dementia and Parkinson's disease.

R3's quarterly MDS dated 11/2/18, indicated R3 was alert and orientated and was independent in transfers, ambulation and activities of daily living. The MDS indicated R3 did not history of falls.

R3's Annual MDS dated 6/3/18, indicated R3 alert, orientated and independent with ambulation and activities of daily living. The MDS indicated R3 did not have a history of falls.

R3 did not require a Falls CAA at the time of the annual MDS.

R3's Care Plan dated 7/27/17, indicated R3 was at risk for falls related to utilizing a wheeled walker. The care plan interventions included:

-Give verbal reminders not to ambulate/transfer without walker or if feeling dizzy. Will walk at times without it.
-Keep call light in reach at all times.
-Obtain PT consult for strengthening training,

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form is completed on the computer system Matrix.
3. RN post-fall assessment observation: post-fall assessment is to be completed by an RN within 24 hours of the incident. This should include identified risk factors, protocols in place and what new or different interventions that were implemented.
4. Fall prevention protocols: a form which presents numerous fall prevention intervention ideas to be used in conjunction with the RN post-fall assessment. IDT will complete root cause analysis daily on each fall that has taken place within the facility Monday through Friday. On weekends, RN to review all falls for any immediate interventions/root cause and pass off to IDT team for review Monday.

Fall Risk Assessment
Fall risk assessments must be completed for each resident within 4-6 hours of admission (no later than 24 hours), quarterly and with a significant change in condition. Residents with a total score of 10 or greater are considered to be at risk for falls and will have fall prevention interventions initiated
1. Process
a. The admitting RN shall accurately complete the fall risk assessment form within 4-6 hours of admission or return from hospital (no later than 24 hours).
b. A total score of 10 or greater is to be considered high risk for potential falls and shall result in the implementation of fall prevention protocols.

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toning, positioning, transfer training, gait graining, mobility devices.
-Provide an environment free of clutter.

During the survey conducted on 1/22/19, from 4:00 p.m. to 8:00 p.m., on 1/23/19, from 7:00 a.m - 4:00 p.m. and on 1/24/19, from 8:00 a.m. to 4:00 p.m. R3 was observed to ambulate independently in her room without assistive devices. While ambulating in the hallway, R3 was observed to utilize a front wheeled walker. R3's gait was steady and no impairments were observed.

A Safety Events - Fall report dated 1/9/19, at 9:30 a.m. indicated R3 had been standing near two staff while observing an activity when R3 suddenly fell backwards onto her back and hit her head on the floor. R3 did not sustain an injury. The report indicated all care plan interventions were being followed and to were to be continued and no further interventions were required.

The Post Fall Assessment completed on 1/9/19, indicated R3 had been sustained a fall. The assessment indicated a new intervention was added to monitor R3's gait and any feelings of dizziness.

Review of R3's care plan lacked description or direction for the staff to monitor R3's gait or feelings of dizziness.

On 1/23/19, at 12:30 p.m. LPN-A stated R3 had the ability to ambulate on her own. LPN-A stated on 1/9/19, R3 had been observing an activity and just fell over.

- At 1:20 p.m. the DON confirmed R3 had the

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c. The quarterly, significant change and annual fall risk assessments will be the responsibility of the RN.
d. The RN or LPN and will document all for fall prevention interventions and update the residents care plan as needed.

Fall Event

The fall event report is used to report all necessary information regarding a fall or incident. This form is completed by the LPN or RN as soon as possible following a fall or incident. This form is completed on the computer system matrix.

The fall event report contains vital information regarding the resident condition prior to and after a fall or incident it is the LPN or RN's responsibility to evaluate the resident to determine if additional care is needed. The ultimate goal is to make sure the resident obtains the care and services needed following a fall or incident.

The family and MD must be notified of all incidents accidents or fall. The social services designee, Director of Nursing and administrator will be notified of incidents, accidents or Falls resulting in serious injury.

RN post-fall assessment observation

A registered nurse must complete a post fall observation following a resident fall or incident preferably on the shift the fall occurred or within 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING ______ B. WING ______	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 13

ability to ambulate on her own. She confirmed the Post Fall assessment included interventions to monitor R3's gait and to monitor feelings of dizziness. The DON confirmed the staff had identified new interventions for R3, however, the new interventions had not been added to the care plan. The DON confirmed the facility failed to update care plans to ensure continued care related to fall interventions.

F 689

1. Process
a. The RN must fill out the form as completely as possible according to the prompter questions on the computer.
b. The RN will evaluate the present use of fall prevention interventions as to whether or not they're keeping the resident safe from falls.
c. If the resident has fallen despite fall prevention protocols already in place, the RN will identify the need to implement further protocols. (See Fall Prevention Protocols for ideas).
d. Put all intervention protocols for the individual resident on the care plan to prevent further falls immediately and communicate new interventions to care center team via report, huddle, nursing assistant care sheets and communication book.

Fall Prevention Protocols/Interventions

Fall prevention protocols/interventions are implemented to prevent a safe environment for all residents. When a resident is identified to be at risk for a fall, fall prevention protocols/interventions will be implemented. It is important to remember that all residents that have the potential to self-transfer, they are required to have their mobility device within reach at all times when not in direct supervision of staff.

Fall prevention protocols/interventions

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F 689	Continued From page 14	F 689	may include but are not limited to: " Vital signs and neurological checks " laboratory testing or monitoring of therapeutic drug levels as applicable " BIMS to determine change in mental status " Sleep study " Diversional Activities " Bed at resident knee height if able to ambulate " Bed low to floor if requires Hoyer " ¿ Bed rail to aid in transfers " Use of anti-roll back device " Assistive device within reach at all times " Exercise maintenance program " Use of mats if requires Hoyer " Alteration of room arrangement " Toileting/walking programs " Use of transfer belt on continuous when up in chair when the risk of falls from sudden attempts to stand are present. Additional interventions to consider at time of fall with high-risk falls patients with history of falls include: 1) Immediate review of medications by pharmacist. 2) Primary care provider consult. 3)Medical director consult to review possible clinical oversite with chart review. 4) PT/OT evaluation. RiverView Care Center RiverView Care Center ATTACHMENT C:	

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F 689	Continued From page 15	F 689		

SUBJECT: Fall Prevention Program

POLICY: To implement and use a fall prevention and reduction program to provide prompt treatment and prevent further injury.

INTERNAL CARE CENTER PRACTICE: All residents admitted to the Care Center pose a risk for falls and require all staff to be observant and proactive in meeting their needs.

PROCEDURE: This program includes but is not limited to the following processes.

1. The fall risk assessment: a form used to assess a residence risk level for potential Falls which is completed at the time of the admission and quarterly thereafter.
2. Event report: an internal form is used to report all necessary information regarding a fall or incident. This form is completed by the LPN or RN as soon as possible following a fall or incident. This form is completed on the computer system Matrix.
3. RN post-fall assessment observation: post-fall assessment is to be completed by an RN within 24 hours of the incident. This should include identified risk factors, protocols in place and what new or different interventions that were implemented.
4. Fall prevention protocols: a form which presents numerous fall prevention intervention ideas to be used in conjunction with the RN post-fall

F 689 Continued From page 16 F 689

assessment. IDT will complete root cause analysis daily on each fall that has taken place within the facility Monday through Friday. On weekends, RN to review all falls for any immediate interventions/root cause and pass off to IDT team for review Monday.

Fall Risk Assessment
Fall risk assessments must be completed for each resident within 4-6 hours of admission (no later than 24 hours), quarterly and with a significant change in condition. Residents with a total score of 10 or greater are considered to be at risk for falls and will have fall prevention interventions initiated
1. Process
a. The admitting RN shall accurately complete the fall risk assessment form within 4-6 hours of admission or return from hospital (no later than 24 hours).
b. A total score of 10 or greater is to be considered high risk for potential falls and shall result in the implementation of fall prevention protocols.
c. The quarterly, significant change and annual fall risk assessments will be the responsibility of the RN.
d. The RN or LPN and will document all for fall prevention interventions and update the residents care plan as needed.

Fall Event

The fall event report is used to report all necessary information regarding a fall or incident. This form is completed by the LPN or RN as soon as possible following

F 689 Continued From page 17

F 689

a fall or incident. This form is completed on the computer system matrix.

The fall event report contains vital information regarding the resident condition prior to and after a fall or incident it is the LPN or RN's responsibility to evaluate the resident to determine if additional care is needed. The ultimate goal is to make sure the resident obtains the care and services needed following a fall or incident.

The family and MD must be notified of all incidents accidents or fall. The social services designee, Director of Nursing and administrator will be notified of incidents, accidents or Falls resulting in serious injury.

RN post-fall assessment observation

A registered nurse must complete a post fall observation following a resident fall or incident preferably on the shift the fall occurred or within 24 hours.

1. Process
a. The RN must fill out the form as completely as possible according to the prompter questions on the computer.
b. The RN will evaluate the present use of fall prevention interventions as to whether or not they're keeping the resident safe from falls.
c. If the resident has fallen despite fall prevention protocols already in place, the RN will identify the need to implement further protocols. (See Fall Prevention

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F 689	Continued From page 18	F 689	Protocols for ideas). d. Put all intervention protocols for the individual resident on the care plan to prevent further falls immediately and communicate new interventions to care center team via report, huddle, nursing assistant care sheets and communication book. Fall Prevention Protocols/Interventions Fall prevention protocols/interventions are implemented to prevent a safe environment for all residents. When a resident is identified to be at risk for a fall, fall prevention protocols/interventions will be implemented. It is important to remember that all residents that have the potential to self-transfer, they are required to have their mobility device within reach at all times when not in direct supervision of staff. Fall prevention protocols/interventions may include but are not limited to: " Vital signs and neurological checks " laboratory testing or monitoring of therapeutic drug levels as applicable " BIMS to determine change in mental status " Sleep study " Diversional Activities " Bed at resident knee height if able to ambulate " Bed low to floor if requires Hoyer " ¿ Bed rail to aid in transfers	

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F 689	Continued From page 19	F 689	" Use of anti-roll back device " Assistive device within reach at all times " Exercise maintenance program " Use of mats if requires Hoyer " Alteration of room arrangement " Toileting/walking programs " Use of transfer belt on continuous when up in chair when the risk of falls from sudden attempts to stand are present. Additional interventions to consider at time of fall with high-risk falls patients with history of falls include: 1) Immediate review of medications by pharmacist. 2) Primary care provider consult. 3)Medical director consult to review possible clinical oversite with chart review. 4) PT/OT evaluation.	
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may	F 712		2/18/19

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F 712	Continued From page 20 alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the faciltiy failed to ensure newly admitted residents received 30 day physican visits for the first ninety days for 1 of 3 residents (R4) reviewed for 30 day physican visits. In addition, the facility failed to ensure long term residents received routine physican visits (every 60 days) for 1 of 3 residents (R5) reviewed for routine physican care. Findings include: R4's Resident Face Sheet dated 6/14/18, indicated R4 was admitted to the facility on 6/14/18, with diagnoses including dementia with behavioral disturbances and chronic obstructive pulmonary disease. R4's clinical record indicated R4's physican had examined R4 on 7/18/18, 9/5/18, 11/13/18 and 1/9/19. On 1/24/19, at 11:00 a.m. the director of nurses (DON) confirmed R4 had not received every thirty day visits as required for a newly admitted resident. R5's Resident Face Sheet dated 12/14/16, indicated R5 was admitted to the facility on 12/14/16, with diagnosis including Alzheimer's Disease, psychosis, anxiety and major depression. R5's clinical record indicated R5's physican had	F 712	The facility Policy of Physician visits has been updated to replace current language of "periodic" being replaced by "The first physician visit must be conducted within the first 30 days of admission, and than at 30 day intervals up until 90 days after the admission date, After the first 90 days, visits must be conducted at least once every 60 days thereafter." Residents due for Physician visits will be reviewed during weekly IDT, (Inter-disciplinary meetings), to ensure timely compliance with this regulation. This will include all residents of the Care Center, including residents R4 and R5. Residents R4 and R5 will have their physician visit completed by 02/18/2019. PERFORMANCE WILL BE MONITORED FOR ALL RESIDENTS, BY REVIEWING RESIDENTS PHYSICAN VISIT DUE DATES,(INCLUSIVE OF R4 AND R5),FOR PHYSICIAN VISITS DUE WITHIN 30 DAYS. THESE REVIEWS WILL BE CONDUCTED DURING WEEKLY INTER-DISCIPLINARY TEAM MEETINGS. MONITORING WILL BE DONE THROUGH KEEPING TRACK OF RESIDENTS THAT ARE DUE WITHIN 30 DAYS IN THE NURSES PLANNER BOOK AT THE NURSES STATION. RESIDENTS WILL HAVE THEIR PHYSICIANS OFFICE CONTACTED WITHIN 2 WEEKS IN ADVANCE OF THE	

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F 712	Continued From page 21 examined R5 on 12/16/18, 9/26/18, 6/23/18 and 3/3/2018. R5's record lacked indicated R5 had received routine 60 day visits. On 1/24/19, at 11:00 a.m. the DON confirmed R5 had not received routine physican visits as directed. The DON stated a former registered nurse had kept track of when the physican was to visit each resident, however, when the RN had left the facility, some of the routine visits were missed. The Facility Admission: Application and Acceptance of Resident policy dated 5/1998, indicated residents were to agree to be examined by a physican periodically at intervals not to exceed the governmental established minimums. On 1/24/19, at 12:30 p.m. the facility administrator stated the facility admission policy was the only policy that addressed physican visits, however, he confirmed the policy did not direct the staff as to how frequently the residents were to be examined by a physican.	F 712	DATE DUE, AS A REMINDER TO ENSURE PROPER COMPLIANCE. THE DIRECTOR OF NURSING, OR DESIGNATED NURSE ON STAFF, WILL ESTABLISH CONTACT WITH THE PHYSICAN'S OFFICE TO REMIND THEM OF THE DEADLINE TO BE MET. AUDITS WILL BE PERFORMED MONTHLY FOR COMPLIANCE AND REVIEWED DURING QUARTERLY QAPI MEETINGS WITH THE MEDICAL DIRECTOR IN ATTENDANCE. The update to the Physician visits policy was completed on 02/13/2019.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this	F 838		2/23/19

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F 838	Continued From page 22 assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both	F 838		

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F 838	Continued From page 23 normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment of the facility needs to ensure an effective plan was in place to maintain the highest practicable care for all 20 residents residing at the facility. Findings include: During the course of the complaint survey conducted on 1/22/19 - 124/19, an immediate jeopardy level deficiency was identified related to a resident who had sustained multiple falls and the facility's failure to conduct comprehensive assessments following each fall and implement interventions in order to minimize/prevent further falls. (See F689) Review of the Facility Assessment dated 8/2018, revealed the facilty had identified the need to develop and implement policies and procedures for the provision of care. The facility assessment directed the facility to describe the process to determine if new or updated polices and procedures were needed and how they would ensure the care provided would be accomplished in accordance to the facility policies. However, this area of the Facility Assessment had not been	F 838	The Facility Assessment has been updated to address and identify the process to determine if new or updated policies and procedures are needed. This area of the Facility Assessment will be updated at least annually, to reflect any changes needed in procedures to ensure care would be provided according to policies. Policies will be updated and secured in the PolicyTech software system. The procedures will be reviewed throughout each year with our Emergency Preparedness Committee and through information sharing during weekly IDT,(Inter-Disciplinary Team), meetings. This Facility Assessment addressing the requirement of determining if new or updated policies and procedures are needed, was updated on 02/14/2019.	

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F 838	Continued From page 24 completed. On 1/24/19, at 12:30 p.m. the administrator reviewed the Facility assessment and confirmed the assessment area was blank. The administrator confirmed the facility did not have a system to ensure the facility policies and procedures were routinely reviewed and up to date. A policy related to the facilty assessment was requested and none was provided.	F 838		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 8, 2019

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

Re: State Nursing Home Licensing Orders - Complaint Number H5251019C

Dear Administrator:

A complaint investigation was completed on January 23, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
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

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	00470	A. BUILDING: ______ B. WING ______	C 01/23/2019

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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: An investigation of complaint H5251019C was completed. The complaint was substantiated. Correction order issued at State Licensing 4658.0520 Subp. 1 You have agreed to participate in the electronic	2 000	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.	

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RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/22/19, and 1/23/19, a surveyor of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	

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2 000	Continued From page 2 are the Suggested Method of Correction and 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident safety which resulted in an increased risk for falls and the potential for serious harm, injury, or impairment to 1 of 3 residents (R1) reviewed for falls who was identified as at risk for falls, had	2 830	corrected	2/18/19

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dementia with impulsive behavior, anxiety and agitation which resulted in repeated self transfer attempts. On 1/16/19, R1 had repeated attempts to self transfer without adequate supervision and subsequently fell which resulted in pelvic fractures and another fall which resulted in spinal compression fractures at lumbar spine (L1, L2) and thoracic spine (T11). This failure resulted in an IJ for R1. In addition, the facility failed to implement alternative interventions to minimize the risk for falls for 1 of 3 residents (R3) who was also identified at risk for falls.

The immediate jeopardy began on 1/6/19, at 6:15 p.m. when the staff identified R1 was agitated yet allowed R1 to be unattended in the dining room. R1 attempted to self transfer and sustained a fall which resulted in pelvic fractures. The administrator and director of nursing (DON) were notified of the IJ on 1/23/19, at 3:18 p.m. The IJ was removed on 1/24/19, but noncompliance remained at the lower scope and severity of G - isolated, which indicated actual harm had occurred with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R1's Diagnoses Report dated 1/23/19, indicated R1 had diagnoses which included Alzheimer's disease, anxiety disorder, depression, hallucinations, delusional disorder, dementia with behavioral disturbance and restless leg syndrome.

R1's quarterly Minimum Data Set (MDS) dated 10/7/18, indicated R18 had severe cognitive impairment and required extensive assistance of one to two staff for all activities of daily living. The MDS also indicated R1 had experienced one

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fall without injury and one fall with major injury (bone fracture, joint dislocation, closed head injury with altered consciousness, subdural hematoma) since the prior assessment.

R1's Falls Care Area Assessment (CAA) dated 4/29/18, indicated R18 used antidepressant, antipsychotic and pain medications. R1's medications were effective but R1 had experienced falls. Fall risk was 22 (high risk for falls). R1 used a walker and required extensive assistance of two for ambulation and also used a wheelchair due to mobility issues. R1 needed reminders and cues for wheelchair use and had tried to self transfer a number of times and had falls, usually without injury. However, one fall in March, resulted in a compression fracture of the spine. R1 had a silent bed alarm and a night light in her bathroom and by her bed.

R1's Care Plan revised 10/10/18, indicated R1 was at risk for falling related to dementia, cognition and weakness and directed staff to implement the following interventions:

-Bed alarm on to alert staff of movement.
-May leave gait belt on loosely as gets up unexpectedly and starts moving before staff can get there.
-Give verbal reminders not to ambulate/transfer without walker.
-Keep call light in reach at all times. Night light in bathroom to be on at all times.
-Obtain physical therapy (PT) consult for strength training, toning, positioning, transfer training, gait training, mobility devices, as needed.
-Provide an environment free of clutter.

R1's clinical record revealed the following information:

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Progress Note (PN)/nurse's note dated 1/6/19, at 12:18 p.m. indicated R1 was agitated and yelling. R1 was noted to be yelling "I want to go home" and hitting a door with the palm of her hand. RN-A had directed the staff to call R1's family if the behavior continued. A subsequent PN at 12:25 p.m. indicated the staff had called the family and requested them to visit. Family member (FM)-B directed the staff to wheel R1 off of the memory care unit in an attempt to calm her. The staff reported they were unable to accommodate FM-B's request due to "staff issues." Another PN at 12:56 p.m. indicated R1 talked to FM-B on the phone and had calmed down. At 3:00 p.m. FM-A visited R1 at the facility.

A Safety Events- Fall report (incident report) dated 1/6/19, at 6:15 p.m. indicated R1 was found on the floor in the dining room. Staff attempted to move R1's right leg and she complained of pain. R1 was transferred to the hospital for further evaluation. The Post Fall Assessment for the 1/6/19, fall dated 1/7/19, indicated R1 was at high risk for falls and R1 had been agitated at the time of the fall on 1/6/19. The assessment indicated R1's plan to prevent further falls was to make sure R1 was escorted out of the dining room early. However, this fall intervention was not added to R1's care plan.

R1's Hospital Discharge Summary dated 1/9/19, indicated R1 had sustained right superior and inferior pubic rami (pelvis) fractures and had been diagnosed with a urinary tract infection. R1 was to return to the nursing facility and was allowed to bear weight as tolerated, as needed pain medications were prescribed (Percocet), an antianxiety medication (lorazepam) for agitation and an antibiotic for the treatment of the urinary

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2 830	Continued From page 6 tract infection. Review of R1's clinical record revealed upon R1's hospital return, a new comprehensive fall assessment and the implementation of interventions was not completed following the diagnosis of the fractures. In addition, R1's care plan had not included revisions following the hospital return. PN dated 1/12/19, at 5:12 p.m. indicated R1 was "extremely anxious, restless and weepy." R1 was given as needed pain medications and slid out of her recliner. R1 did not express pain during the fall, however, was transferred to the emergency room due to facility's notification of abnormal laboratory levels from a previous blood draw due to R1's yellowish (jaundice) appearance. R1 was admitted to the hospital. The Safety Events-Fall report dated 1/12/19, at 5:20 p.m. indicated R1 had slid out of her recliner in her room, did not have pain but was sent to the emergency room due to abnormal lab values. The report lacked any assessment of the fall. An Incident Tracking/five day investigation form which was related to the 1/6/19, and was submitted by the facility to the State Agency dated 1/12/19, indicated R1 had sustained a fall 1/6/19, while at the facility resulting in pelvic fractures. The investigation form indicated R1 required "closer monitoring due to frequent attempts at standing/walking. Diversional activities of her interest when restless." However, R1's clinical record lacked identification of the root cause/unmet need resulting in the falls and identification of intervention(s) to minimize the risk of further falls. R1's Hospital Discharge Summary dated 1/16/19, at 1:23 p.m. indicated R1 was diagnosed with a gallbladder infection without gall stones and elevated liver functions, however, R1 was not a	2 830		

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surgical candidate and was treated with intravenous antibiotics while at the hospital. R1's pain management was changed to Fentanyl patches. R1 returned to the facility. While hospitalized, a Cat Scan (CT) was performed which revealed newly diagnosed L1, L2 and T11 fractures.

A PN dated 1/16/19, indicated R1 returned to the facility and a personal silent chair alarm was placed in the recliner. R1's care plan was not updated to reflect the new intervention.

On 1/22/19, from 4:00 p.m. to 7:45 p.m. R1 was continuously observed in her room, seated in the recliner. The recliner was equipped with a silent personal alarm. A personal companion (PC)-A was seated next to her.

On 1/22/19, at 4:52 p.m. registered nurse (RN)-A stated R1's family had hired the personal companion to sit with R1 a few hours a day. Shortly there-after, the DON stated R1's family had requested R1 to stay in her room and they had hired the companion.

-At 5:20 p.m. licensed practical nurse (LPN)-A stated R1 had a history of attempting to transfer on her own. As the charge nurse, LPN-A stated when a resident fell, she assessed the resident for injury, monitored vital signs and neurological checks if the resident had hit their head. LPN-A stated R1 had a low bed, fall mats next to the bed and personal silent alarms on the bed and recliner. The staff were to check on R1 frequently, however, they did not document the "frequent" checks. LPN-A stated R1 was to receive every two hour monitoring and the staff were to document any care provided to R1 every two hours. LPN-A stated the family members had

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directed the staff to keep R1 in her room.

-At 5:50 p.m. nursing assistant (NA)-A was observed to deliver a meal tray to R1's room. PC-A remained with the resident and assisted R1 with the meal.

-At 6:28 p.m. NA-A stated R1 had sustained falls while at the facility and had fractured her pelvis on 1/6/19. NA-A stated R1 had been in the dining room on the evening of 1/6/19, as NA-A was escorting other residents out of the dining room when she saw R1 attempt to stand up and fall from a dining room chair. NA-A stated she was not close enough to R1 to guide her back into the chair before R1 fell. NA-A stated since R1 had returned to the facility, the staff had rearranged her room, placed the bed against the wall and were placing pillows underneath the bed sheets to ensure R1 did not crawl out of the bed. NA-A stated R1 was quick and did not remember that she was unable to ambulate on her own.

-At 6:45 p.m. NA-A and NA-D were observed to assist R1 to bed. R1's bed was not observed to be against the wall. NA-A stated the room had been rearranged a second time to ensure a personal recliner was able to fit in the room. R1 was transferred from the recliner to the bed with extensive assistance of one staff. R1 was positioned in a low bed, equipped with a concave mattress with a air mattress overlay inside of the concave mattress (per family request), fall mats were positioned on either side on the bed, a silent pressure pad alarm was positioned under R1's buttocks/lower back and pillows were positioned under the bed sheet to prevent R1 from rolling out of the bed. R1 was observed to be calm and rested quietly in the bed.

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-At 7:00 p.m. RN-B stated she had been working the evening of R1's fall on 1/6/19. RN-A stated R1 was seated in a dining room chair when she stood up independently and fell. RN-B stated R1 was supposed to have one to one supervision because she had been anxious earlier in the day. RN-B confirmed R1 was alone in the dining room when she fell. RN-B stated R1 had a history of falls and R1's fall interventions included providing her with diversional activities, a bed alarm, fall mats next to the bed, assist with toileting as needed or offer snacks. R1 was assessed for injury at the time of the fall and was sent to the emergency room. RN-B confirmed at the time of the fall, R1 was in the dining room without 1:1 direct supervision.

-At 7:13 p.m. FM-A was interviewed via phone. FM-A stated in the past two weeks, R1 had sustained different fractures because of falls. FM-A felt the facility had enough staff to provide care for the residents, however, a personal companion had been privately hired to provide a few hours of additional supervision (24 hours a week).

-At 7:23 p.m. NA-D stated R1 was to stay in her room at all times and was to be monitored for fall prevention. NA-D stated R1 had a history of falls and currently had a broken pelvis.

On 1/23/19, from 7:15 a.m. to 10:00 a.m. R1 was continuously observed.
-At 7:16 a.m. R1 was observed resting on her back in a low bed, equipped with fall mats on either side of the bed, a silent personal alarm, concave mattress with air mattress overlay, and pillows were positioned under the sheet on the right side. R1 was resting quietly.
-At 7:42 a.m. NA-A entered the room to transfer

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R1 from the bed to the recliner. R1 was not observed to express pain during the transfer.

On 1/23/19, at 7:55 a.m. RN-A stated a post fall assessment was to be completed by the RN on duty at the time of the fall or by the next oncoming RN if there was no RN in the building at the time of the fall. RN-A reviewed R1's clinical record and confirmed a post fall assessment was not completed after the fall on 1/12/19, and no further interventions had been implemented. RN-A stated upon R1's return from the hospital, no new fall interventions were put into place, but it was determined R1 would have a complete significant change MDS completed 14 days after returning. RN-A explained the significant change MDS would be completed on 1/23/19, and the care plan would be updated after the significant change assessment was done. RN-A confirmed R1's care plan had not been updated since the fall. Upon review of the CT scan dated 1/12/19, RN-A stated she was unaware of the newly diagnosed L1, L2 or T11 fractures as identified on the CT scan.

-At 9:18 a.m. NA-B stated R1 had a long history of falls and she was to have fall interventions in place. However, she could not recall any changes to R1's fall plan between 1/4/19-1/6/19. NA-B stated the staff members are accustomed to looking into R1's room as they walk by in the hallway, but they do not document each time they go by.

-At 9:20 a.m. the DON stated R1 sustained a fall resulting in pelvic fractures on 1/6/19, however, was unaware of the compression fractures at L1, L2 and T11 identified on the 1/12/19, CT scan. The DON confirmed R1 was impulsive and required increased supervision as identified

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during the 1/4/19, recertification survey and as indicated on the 1/12/19, five day investigation form submitted to the State Agency. The DON confirmed the facility had not completed a comprehensive analysis of the fall sustained on 1/6/19, alternative interventions to minimize falls were not implemented and R1 sustained an additional fall on 1/12/19, which resulted in additional fractures.

The undated Fall Prevention Program policy indicated the RN would evaluate the present use of fall prevention interventions as to whether or not they are keeping the resident safe from falls. If the resident had fallen despite fall prevention protocols already in place, the RN would identify the need to implement further protocols.

The undated Falls (Post-Fall Review) policy indicated the nurse working at the time of the fall would gather information and chart accordingly and activate further interventions as deemed necessary. A comprehensive post fall observation was to be completed within 24 hours. The policy also indicated all falls would be reviewed at weekly IDT meeting to assure proper interventions in place.

The Care Plan, Comprehensive, Interim, Short Term policy dated 12/8/05, indicated each resident was to have a comprehensive plan of care developed following a comprehensive assessment. The care plan was to be evaluated and revised as necessary to reflect the resident current status as required by law and regulation. The policy also directed the staff to implement interim care plans and short term care plans as needed.

On 1/23/19, at 2:50 p.m. the DON reviewed the

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care plan policy and confirmed the facility was not developing and utilizing short term care plans or making revisions to the care plans as needed. The DON stated the RN that had been in charge of care plan revisions was no longer working at the facility and it had been missed by the other staff members.

-At 3:18 p.m. the administrator and DON were informed of R1's frequent attempts to self transfer, lack of supervision, history of falls resulting in fractures, lack of comprehensive assessment of the falls along with implementation of interventions to minimize falls which resulted in IJ for R1.

The immediate jeopardy that began on 1/6/19, was removed on 1/24/19, at 3:35 p.m. but remained at a scope and severity level G - actual harm, after the facility implemented a removal plan which was verified by the staff included the following:

-Completed a comprehensive fall assessment for R1.
-Updated R1's care plan to direct the staff as to how monitor R1 when agitated.
-Updated and implemented policies and procedure regarding falls. Immediate interventions following a fall and care plan revision.
-Staff members were educated on the changes to R1's plan of care and revisions to the fall prevention policy.

R3's Diagnoses Report dated 1/23/19, indicated R1 had diagnoses which included dementia and Parkinson's disease.

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R3's quarterly MDS dated 11/2/18, indicated R3 was alert and orientated and was independent in transfers, ambulation and activities of daily living. The MDS indicated R3 did not history of falls.

R3's Annual MDS dated 6/3/18, indicated R3 alert, orientated and independent with ambulation and activities of daily living. The MDS indicated R3 did not have a history of falls.

R3 did not require a Falls CAA at the time of the annual MDS.

R3's Care Plan dated 7/27/17, indicated R3 was at risk for falls related to utilizing a wheeled walker. The care plan interventions included:

-Give verbal reminders not to ambulate/transfer without walker or if feeling dizzy. Will walk at times without it.
-Keep call light in reach at all times.
-Obtain PT consult for strengthening training, toning, positioning, transfer training, gait graining, mobility devices.
-Provide an environment free of clutter.

During the survey conducted on 1/22/19, from 4:00 p.m. to 8:00 p.m., on 1/23/19, from 7:00 a.m - 4:00 p.m. and on 1/24/19, from 8:00 a.m. to 4:00 p.m. R3 was observed to ambulate independently in her room without assistive devices. While ambulating in the hallway, R3 was observed to utilize a front wheeled walker. R3's gait was steady and no impairments were observed.

A Safety Events - Fall report dated 1/9/19, at 9:30 a.m. indicated R3 had been standing near two staff while observing an activity when R3 suddenly fell backwards onto her back and hit her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: ______ B. WING ______	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

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2 830	Continued From page 14 head on the floor. R3 did not sustain an injury. The report indicated all care plan interventions were being followed and to were to be continued and no further interventions were required. The Post Fall Assessment completed on 1/9/19, indicated R3 had been sustained a fall. The assessment indicated a new intervention was added to monitor R3's gait and any feelings of dizziness. Review of R3's care plan lacked description or direction for the staff to monitor R3's gait or feelings of dizziness. On 1/23/19, at 12:30 p.m. LPN-A stated R3 had the ability to ambulate on her own. LPN-A stated on 1/9/19, R3 had been observing an activity and just fell over. - At 1:20 p.m. the DON confirmed R3 had the ability to ambulate on her own. She confirmed the Post Fall assessment included interventions to monitor R3's gait and to monitor feelings of dizziness. The DON confirmed the staff had identified new interventions for R3, however, the new interventions had not been added to the care plan. The DON confirmed the facility failed to update care plans to ensure continued care related to fall interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for falls to assure they are receiving the necessary treatment/services to prevent/minimize falls. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and	2 830		

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2 830	Continued From page 15 services are implemented; to minimize falls. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21295	MN Rule 4658.0710 Subp. 3 B Admission Orders and Physician Evaluations Subp. 3. Frequency of physician evaluations. B. Except as provided in this item, all required physician visits must be made by the physician personally. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner according to parts 5600.2600 to 5600.2670 chapters 6330 and 6340, and Minnesota Statutes, sections 147.34 and 148.235. This MN Requirement is not met as evidenced by: Based on interview and document review, the faciltiy failed to ensure newly admitted residents received 30 day physican visits for the first ninety days for 1 of 3 residents (R4) reviewed for 30 day physican visits. In addition, the facility failed to ensure long term residents received routine physican visits (every 60 days) for 1 of 3 residents (R5) reviewed for routine physican care. Findings include: R4's Resident Face Sheet dated 6/14/18, indicated R4 was admitted to the facility on	21295	corrected	2/18/19

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21295	Continued From page 16 6/14/18, with diagnoses including dementia with behavioral disturbances and chronic obstructive pulmonary disease. R4's clinical record indicated R4's physican had examined R4 on 7/18/18, 9/5/18, 11/13/18 and 1/9/19. On 1/24/19, at 11:00 a.m. the director of nurses (DON) confirmed R4 had not received every thirty day visits as required for a newly admitted resident. R5's Resident Face Sheet dated 12/14/16, indicated R5 was admitted to the facility on 12/14/16, with diagnosis including Alzheimer's Disease, psychosis, anxiety and major depression. R5's clinical record indicated R5's physican had examined R5 on 12/16/18, 9/26/18, 6/23/18 and 3/3/2018. R5's record lacked indicated R5 had received routine 60 day visits. On 1/24/19, at 11:00 a.m. the DON confirmed R5 had not received routine physican visits as directed. The DON stated a former registered nurse had kept track of when the physican was to visit each resident, however, when the RN had left the facility, some of the routine visits were missed. The Facility Admission: Application and Acceptance of Resident policy dated 5/1998, indicated residents were to agree to be examined by a physican periodically at intervals not to exceed the governmental established minimums. On 1/24/19, at 12:30 p.m. the facility administrator stated the facility admission policy	21295		

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21295	Continued From page 17	21295		

was the only policy that addressed physican visits, however, he confirmed the policy did not direct the staff as to how frequently the residents were to be examined by a physican.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all newly admitted resdients to ensure they had received the appropriate physician services upon admission and every 60 days thereafter. The director of nursing or designee, could conduct random audits to ensure compliance and provide education to the staff. The director of nursing could then report to the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.