DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2025

Administrator
Luther Haven
1109 EAST HIGHWAY 7
MONTEVIDEO, MN 56265

RE: CCN: 245259
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 24, 2025 we notified you a remedy was imposed. On July 10,2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 7, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 7, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 24, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 7, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 7, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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August 13, 2025

Administrator
Luther Haven
1109 EAST HIGHWAY 7
MONTEVIDEO, MN 56265

Re: Reinspection Results
Event ID: D8O212

Dear Administrator:

On July 10, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 5,2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: CCN: 245259
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 9, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 9, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 9, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by July 9, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Luther Haven will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 9, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 5, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

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
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2025

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: State Nursing Home Licensing Orders
Event ID: D8O211

Dear Administrator:

The above facility was surveyed on June 3, 2025 through June 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

(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	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/3/25 through 6/5/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52594818C (MN00113020) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility did not assess or analyze trends of falls to determine causal factors or root cause and implement interventions to prevent or reduce the risk of falls with major injury for 1 of 3 residents (R1) reviewed who had falls. This resulted in actual harm when R1 suffered spinal compression fracture at T12 (thoracic spine last vertebrae), L1 and L2 (lumbar spine between the top two vertebrae) and a rib fracture as a result of two unsupervised falls.	2 830	Corrected.	7/7/25

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2 830	Continued From page 3 Findings include: R1's face sheet dated 6/5/25, identified diagnoses of Parkinson's disease (condition that affects movements), dementia (decline in mental ability), and depression (mood disorder characterized by persistent sadness). R1's quarterly Minimum Data Set (MDS) dated 3/31/25, indicated severe cognitive impairment with diagnoses of Parkinson's Disease, dementia with behaviors, and depression. R1 had no behaviors, rejection of cares or wandering. R1 required maximal assist of one staff person for activities of daily living (ADL)s, bed mobility and transfers. R1 was occasionally incontinent of bowel and bladder and did not have a toileting schedule. R1 walked and used a walker and wheelchair. R1 received antipsychotics, antidepressants and anticoagulants. R1 did not have restraints or alarms. R1's physician orders indicated on 11/27/24 to walk resident with assist of 1-2 with gait belt followed by wheelchair to meals. Also, document when restless. R1 fall risk assessment dated 3/28/25, indicated high risk for falls score of 18, indicating R1 was at high risk for falls. Review of facility incident report list from 3/28/25 thru 6/3/25, indicated R1 had seven falls as follows: Fall 3/28/25 R1's progress notes dated 3/28/25 at 4:25 p.m. R1 was in wheelchair in dining room, R1 attempted to get up out of wheelchair and walk;	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 staff witnessed resident fall, he did not hit his head, denied pain, and there was no injury noted at this time. When asked what he was doing R1 replied, "this happens 2-3 x's a week." R1 vital signs stable. R1 encouraged to get assistance with transferring or walking, R1 was redirected with activity, food, drink, and toileting. Will encourage fluids. Family, director of nursing, nurse manager notified and telephone order on clipboard. Facility event report dated 3/28/25, indicated R1 had a witnessed fall in the dinning room at 3:30 p.m. R1 just had a snack and denied any injury or pain after the fall, R1 had good range of motion (ROM). Staff listed possible causes as cardiac/respiratory disease, and the use of analgesic and antipsychotics. Intervention included educating R1 to ask for help when getting out of chair, and redirection with activity, food, fluids, and toileting. These interventions were effective, and the care plan was followed. The incident report lacked a root cause analysis of the fall. R1's interdisciplinary note (IDT) dated 3/31/25, indicated witnessed fall, no injuries noted. R1 had diagnoses of dementia and has poor safety awareness. R1 was impulsive and restless at times. Evening staff will walk with resident at beginning of shift. R1's fall care plan was revised 3/31/25 with the following interventions; staff to ambulate R1 at beginning of evening shift at approximately 3:30 p.m., due to R1 frequently getting restless at this time. Review of R1's ambulation record from 1/1/25 thru 6/5/25 indicated an order dated 11/27/24, to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 5 walk R1 to meals with assist of 1-2 staff with gait belt to all meals, follow with wheelchair. Also document when restless. The following documentation was identified: January 2025- no documentation record. February 2025-ambulated twice on the 2/4 and twice on 2/11. March 2025- no documentation sheet. April 2025- ambulated 4/6 and 4/20 the rest were blank May 2025- blank June 2025- blank. R1's physician note dated 4/8/25, indicated R1 had Parkinson's Disease, dementia without behavioral disturbance and was stable. R1 had recurrent falls, and gait instability. He was impulsive and may not wait for staff assistance related to the dementia. R1 was on Zyprexa to assist with this. There were no new orders or interventions listed. Fall 4/12/25 R1's progress note dated 4/12/25 at 12:49 p.m., R1 was found lying on the floor on his back by the foot of the bed. Wheelchair was noted next to bedside table. R1 was lifted via total mechanical lift with three staff assist. R1 complained of pain to his forehead and knees, ice applied and scheduled Tylenol given. R1 had a 3.0 centimeter (cm) x 3.0 cm bump with 2.0 cm x 1.0 cm abrasion/bruise on the left side of forehead. He also had a 1 cm x 1 cm abrasion to left elbow. Staff were educated not to leave R1 alone in room with a known history of self-transfers. Range of motion (ROM), vital signs and neuros within normal limits for R1. Family, and physician	2 830		

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2 830	Continued From page 6 notified. Facility event report dated 4/12/25, indicated R1 had an unwitnessed fall at 11:40 a.m., in his room. R1 was sitting in his wheelchair and not able to identify what happened. R1 had moderate pain in his forehead and knees, with a bump and abrasion to his forehead. Possible contributing factors included R1 does self-transfers and received analgesics and antipsychotics. Immediate interventions were neurological checks as fall was unwitnessed and had a head injury. R1's interdisciplinary team (IDT) note date 4/14/25 at 8:45 a.m., and updated R1's care plan to not leave R1 alone in his room when he is in the wheelchair. Fall 4/19/25 R1's progress note dated 4/19/25 at 6:41 p.m., indicated R1 was found on floor in Haven lounge. R1 had been sitting in recliner watching TV and eating popcorn, with gripper socks on. R1's wheelchair was beside the recliner and was found laying on his back and on the foot pedals of another resident's wheelchair. Four staff attempted to use a full mechanical lift sheet but R1 yelled out in pain and pointed to his left eye and groin area. R1 was sent to the hospital, family, physician and management were notified. Facility's event report dated 4/19/25 at 5:54 p.m., indicated R1 had an unwitnessed fall on 4/19/25 in the Haven Lounge. R1 complained of moderate pain in his stomach and head. R1 had a possible head and hip injuries and was sent to the emergency department (ED). There were no	2 830		

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2 830	Continued From page 7 deformities noted but R1 had pain with range of motion (ROM). The event report did not list any contributing factors for the fall and R1 was on antipsychotics. Care plan was followed and event report lacked a root cause analysis of the fall. R1's ED physician note dated 4/19/25, indicated R1 being found down after an unwitnessed fall at facility with trauma to his occipital (back of head) scalp area with an occipital scalp Wheaton (swollen bruise). CT report indicated T12 compression deformity, newly visualized since 2024, recommend correlation with point tenderness. Lidoderm (pain) patch applied and Tylenol 650 mg every 6 hours as needed for pain. R1 was discharged back to the facility to follow up with primary care physician as needed. R1's IDT note dated 4/21/25 at 9:00 a.m., indicated R1 had fall with injury and was sent to the ED. R1 has T12 fracture. R1's nursing home physician round note 4/23/25, indicated follow up ED visit. Nursing notes indicated that R1 was not having pain symptoms or discomfort. R1 has advanced dementia. R1 had improved back to his baseline health status. No new orders or fall interventions were identified. Fall 5/6/25 R1's progress note dated 5/6/25 at 4:16 p.m., indicated R1 had an unwitnessed fall and was found lying on his right side by nurses' station. Staff previously spoke to resident 5 minutes prior. R1 sent to ED. Facility's event report dated 5/6/25, indicated R1 had an unwitnessed fall at 4:14 p.m., by the	2 830		

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2 830	Continued From page 8 nurses' station. R1 would not allow ROM to hips/legs, had no pain and was sent to the ED for evaluation due to previous fracture. R1 had dementia, and this was a possible contributing factor. R1 received analgesics and antipsychotics. Immediate intervention was to send R1 to the ED for evaluation. Family, physician and management were notified. Care plan was being followed at the time of the fall. R1's ED physician progress note dated 5/6/25, indicated R1 was brought to ED after a fall with right shoulder pain. R1 had recent T-spine fracture. CT of chest, abdomen, and pelvis revealed unchanged T12 vertebral body compression fracture. No acute fractures. Kidney stone noted and urinalysis had abnormal finding and R1 was started on antibiotic and returned to the facility. R1's IDT note dated 5/7/25, R1 had unwitnessed fall at the nurse's station. R1 went to the ED, no injuries and diagnosed with urinary tract infection (UTI) and toileting plan was updated. R1's care plan intervention dated 5/7/25, identified staff to toilet after supper. Fall 5/12/25 R1's progress note dated 5/12/25 at 8:10 p.m., R1 had unwitnessed fall at nurses' desk. Activity aide (AA)-A who was near R1 heard R1 hit the floor and called for help. Two nurses and one NA assisted R1 off the floor via a sit to stand lift. R1 was complaining of pain to back, head, and right leg. Vital signs were stable and sent to the ED. Review of facility's event report dated 5/12/25, indicated R1 had an unwitnessed fall at the	2 830		

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2 830	Continued From page 9 nurses station. The report listed AA-A was in the vicinity. R1 complained of moderate pain in head, back and right leg. R1 had no visible injuries and complained of pain with ROM to lower extremities. The event report further indicated R1's neurological disorder was a possible contributing factor. R1's ED note dated 5/12/25, identified R1 was brought in by ambulance for evaluation after an unwitnessed fall. R1 was complaining of pain of headache and back pain. CT was done of thoracic spine and revealed acute non-displaced fracture of L1 and L2 spinous process (a small wing-like bone projection that extends outward from each vertebra along the spine). R1 discharged back to the facility and advised to continue pain patch, follow up with primary physician, and return to ED for any concern or any worsening symptoms. R1's IDT note dated 5/13/25 at 9:04 a.m., indicated R1 had become weak related to not ambulating as often. Orders for physical therapy (PT) to evaluate for strengthening and occupational therapy (OT) to evaluate for wheelchair positioning. R1's care plan intervention dated 5/13/25, identified physical therapy (PT) to evaluate for strengthening and occupational therapy (OT) to evaluate for wheelchair positioning. Fall 5/15/25 R1's progress note dated 5/15/25 at 12:57 a.m., indicated R1 was found sitting on the mat/floor, holding onto the grab bar. R1 was sent to the ED for evaluation due to his previous fractures was	2 830		

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2 830	Continued From page 10 listed as the intervention. R1's ED physician progress note dated 5/15/25, identified R1 had been seen after a fall out of bed. Chest, abdomen and pelvis computed tomography scan (CT) identified R1 had a minimally displaced acute-appearing fracture of the right anterior seventh rib,constipation, and lung opacity (hazy gray areas on CT or x-rays) favoring mild infectious/inflammatory process. He was started on Augmentin (antibiotic) and to follow up with physician, use pain medication as previously directed and was discharged back to facility. R1's safety event-fall report dated 5/15/25, identified R1 had an unwitnessed fall at 12:57 a.m., and was found in his room sitting on the mat holding the grab. R1 had been observed at 11:30 p.m., and was sleeping in bed. R1 had complaints of pain in knees and was sent to the emergency department (ED) for evaluation. R1's fall focus care plan intervention were revised 5/15/25, identified R1's bed to be in lowest position with mat on floor and pharmacist review of medications. R1's pharmacy review dated 5/15/25, identified a medication review had been requested due to R1 falling three times in past week. R1 was on an antibiotic on 5/15/25 for lung opacity after being seen in the ED. R1 had multiple medications with potential side effects of dizziness, and ortho hypotension (a sudden drop in blood pressure that occurs when a person stands up after sitting, or lying down) which could contribute to falls. These medication included Fluoxetine, Mirtazapine, Olanzapine, Quetiapine, Sinemet, and Tamsulosin. Pharmacist's suggested course	2 830		

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2 830	Continued From page 11 of action included: 1- Consider doing orthostatic blood pressure twice daily for three days to rule out hypotension as a contributor to falls. 2- If recent labs have not been done, could consider a complete metabolic panel (CMP) or a complete blood count (CBC). 3- Please review the above listed medication with the potential side effect for dizziness. R1 was receiving Seroquel 50 mg twice daily, Olanzapine 2.5 mg daily, Mirtazapine 30 mg at bedtime and Fluoxetine 10 mg daily. Could consider a trial decrease on Olanzapine to 1.25 mg if appropriate for R1. Review of R1's medication and treatment administration record dated 5/1/25 through 5/31/25 did not identify any orthostatic blood pressures were completed. Interview on 6/4/25 at 4:21 p.m., nurse manager (NM)-A stated the pharmacist recommendations were faxed three times to MD-A and faxed back without any changes. NM-A further stated the MD-A was rounding on 6/5/25 and would address the recommendations with him at that time. NM-A stated they have not completed any orthostatic blood pressures for his falls. They do not think it was an orthostatic issue but were related to his impulsivity. Fall 6/3/25 R1's progress note dated 6/3/25 at 7:10 p.m., identified R1 had just been in dining room finishing supper and was found five minutes later on the floor in front of a room. R1 was toileted at 3:00 p.m., and had gripper socks on at the time of the fall. R1 was transferred off the floor with a total mechanical lift and blood pressure was	2 830		

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2 830	Continued From page 12 noted to be lower than normal. ROM good to all extremities with no pain or injuries noted. R1 was taken to the bathroom and had a large bowel movement. R1 was highly agitated yelling, and combative with neuros. R1's fall event report dated 6/3/25, identified R1 had an unwitnessed fall at 6:56 p.m. in the hallway. Immediate intervention of toileted and neurological checks. R1's progress note dated 6/4/24 at 6:45 a.m., identified medication nurse was interviewed and R1 was agitated and combative with all evening cares and when nursing assistants attempted to toilet R1 at 5:00 p.m. and 6:00 p.m., R1 would not allow nursing assistants to take him to the bathroom. Intervention included 1:1, bring R1 to quiet area, feed him supper, warm blanket, and attempt other staff to toilet him. Toileting schedule set up before supper to prevent R1 from getting agitated when he had the urge to have a bowel movement. Medical doctor (MD) will round on 6/5/25 and pharmacist wil be consulted on medication times if there are other options for psychotropic (drug that affects a person's mental state) medications related to dementia and Parkinson's disease. R1's physician progress notes dated 6/5/25, identified R1 had six falls since March had Parkinson's symptoms that were stable along with dementia without behavioral disturbance. R1 continued to be impulsive and get up on own, mainly in the afternoon. Had 6 falls since March. Continue diligence as able. R1 currently taking Seroquel by neurology, will continue this. R1 also taking Remeron and Prozac, which could contribute to increased agitation and R1 getting up without assistance. MD-A recommended	2 830		

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2 830	Continued From page 13 decreasing dose of Remeron to 15 mg and to discontinue the Prozac. R1 also takes blood thinner due to history if pulmonary embolism and deep vein thrombosis. If falls continue, may need to discuss with family on discontinuing this medication. R1's falls care plan start date of 3/1/24, indicated R1 was at risk for falls due to Parkinson's disease, impaired cognition, weakness and history of falls. Interventions included: -R1 will not be left unattended in the BR due to impulsivity, decreased safety awareness and history of self-transferring/falls, dated 7/22/24; -Dycem gripping material placed under wheelchair cushion to promote positioning, dated 8/16/24; -R1 to wear gripper socks at bedtime and gripper socks or shoes during the day, dated 8/27/24; -Remove wheelchair foot pedals and place in storage bag located on wheelchair when not transporting, dated 9/9/24; -Gripper tape placed in front of bed, dated 9/16/24 -Physical and Occupational Therapy referral as needed to promote strength, endurance and mobility, dated 11/18/24; -Due to increased restlessness encourage R1 to rest in recliner throughout the day, dated 1/3/25; -Staff to walk with R1 at beginning of evening shift approximately at 3:30 p.m., due to R1 frequently getting restless at this time, dated 3/31/25; -Do not leave alone in room in wheelchair, dated 4/14/25; -Toilet before supper 5/7/25; -Physical therapy to eval for strengthening and Occupational therapy to eval for wheelchair positioning, dated 5/13/25;	2 830		

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2 830	Continued From page 14 -Bed in lowest position, dated 5/15/25; and -Pharmacist review of medications, dated 5/15/25. Interview on 6/3/25 registered nurse (RN)-B stated the R1 had numerous falls in the past three months, with two fractures. RN-B was not able to articulate the R1 was to be toileted at 2:30 p.m. and before supper or that R1 was to ambulate to meals. Interview on 6/3/25 nursing assistant (NA)-P stated try to prevent falls with R1, make sure that R1 is at the nurses' station, give him snack, help him watch TV. Was not able to articulate that R1 had a ambulation or toileting schedule. During clarification interview on 6/6/25, NA-P was able to get the West walk book and identified R1's walking sheet. NA-P verified that nothing was signed off for the month of June. Interview on 6/4/25 NA-D stated R1 was to be toileted every 2 hours and when he was agitated. NA-D could not articulate that R1 was to be walked to meals and when agitated. Interview on 6/4/25 NA-V stated R1 did not have a walking program, and there was not a toileting schedule for R1. Interview on 6/6/25 NM-A was not able to provide needed documentation of R1's ambulating to meals or the toileting times of 2:20 p.m. and before supper were being completed. Interview on 6/4/25 at 9:00 a.m., director of nursing (DON) reviewed falls and was unable to identify the root cause of R1's falls or if the care plan was being followed. DON further stated her expectation was that staff identified the root	2 830		

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2 830	Continued From page 15 cause and that immediate interventions were put into place. The interdisciplinary team also reviewed the fall with interventions to make sure the interventions were evaluated for appropriateness. Although the facility identified interventions, there was no indication these interventions were being implemented consistently, nor were there any ongoing analysis of the falls to determine if the interventions were effective. Interview on 6/4/25 at 4:25 a.m., administrator stated the facility was notified of funding availability for a performance-based incentive payment program (PIPP) project for a fall prevention program which they plan to start this month. All falls need to have appropriate immediate intervention implemented at the time of the fall and then the IDT reviews it at their next meeting to verify the intervention is appropriate and working to prevent further falls. Facility quality assurance and performance improvement (QAPI) notes from January 2025 thru May 2025, indicated the following: -January 14, 2025, QAPI discussed F689 as part of the plan of correction (POC), audits regarding their surveys. Audit had been completed three times a week. Results overall have been successful. Some concerns noted with getting them all completed, especially on the weekend when leadership is not present. Audits will be reduced to one time per week and management will look at new education topic to be covered. Administrator fur reviewed the Minnesota quality indicators with the committee, which included falls with injury. The facility had a significant number of falls during the past three to four months, but the injuries have decreased significantly. Committee	2 830		

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2 830	Continued From page 16 to continue to monitor. -February 11, 2025, facility level quality marker report was reviewed by administrator with committee. Area's facility is falling in the high percentile included falls and falls with injury. Committee discussed involving therapy more especially at the time of admission and utilizing the screening forms by staff. The fall risk form being completed was also discussed regarding what actions to take after the form is completed. At risk resident were also being monitored each week at the weekly risk meeting. -April 8, 2025, March falls were reviewed. There were 34 falls for the month, one resident had 13 falls, eight residents had 2 or more falls, and 20 of the falls occurred during the evening and nights shifts. There was one fall with injury. The committee discussed how falls could also be a possible PIPP project. The facility fall policy dated 9/2024, did not indicate that an immediate fall intervention should be implemented. Facility undated procedure entitled "Events" indicated an attached table that indicated when a fall even should be open and under who fills out indicated for licensed staff at time of fall that assesses resident with pertinent fall information; charge nurse assigned to resident for shift will complete remaining sections ***BE SURE TO IMPLEMENT AN IMMEDIATE INTERVENTION AND USE CRITICAL THINKING TO DETERMINE THE CAUSE OF THE FALL*** SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analaysis of falls occurs for fall	2 830		

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2 830	Continued From page 17 prevention. The director of nursing or designee, should conduct measurable audits of fall to ensure analysis of the root cause if completed and identify if appropriate interventions are in place to prevent falls. The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		

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F 000	INITIAL COMMENTS On 6/3/25 through 6/5/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52594818C (MN00113020) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not assess or analyze trends of falls to	F 689	This deficient practice had the ability to affect all residents residing in the facility. A	7/7/25

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

Electronically Signed | 07/02/2025

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

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F 689	Continued From page 1 determine causal factors or root cause and implement interventions to prevent or reduce the risk of falls with major injury for 1 of 3 residents (R1) reviewed who had falls. This resulted in actual harm when R1 suffered spinal compression fracture at T12 (thoracic spine last vertebrae), L1 and L2 (lumbar spine between the top two vertebrae) and a rib fracture as a result of two unsupervised falls. Findings include: R1's face sheet dated 6/5/25, identified diagnoses of Parkinson's disease (condition that affects movements), dementia (decline in mental ability), and depression (mood disorder characterized by persistent sadness). R1's quarterly Minimum Data Set (MDS) dated 3/31/25, indicated severe cognitive impairment with diagnoses of Parkinson's Disease, dementia with behaviors, and depression. R1 had no behaviors, rejection of cares or wandering. R1 required maximal assist of one staff person for activities of daily living (ADL)s, bed mobility and transfers. R1 was occasionally incontinent of bowel and bladder and did not have a toileting schedule. R1 walked and used a walker and wheelchair. R1 received antipsychotics, antidepressants and anticoagulants. R1 did not have restraints or alarms. R1's physician orders indicated on 11/27/24 to walk resident with assist of 1-2 with gait belt followed by wheelchair to meals. Also, document when restless. R1 fall risk assessment dated 3/28/25, indicated high risk for falls score of 18, indicating R1 was at	F 689	medication review was completed for resident R1 by the consulting pharmacist and primary care physician. Medication changes were implemented. Referral was made for physical and occupational therapy for R1. Both were completed by June 27, 2025. To determine which residents were impacted by the same deficient practice, the IDT will complete a Root Cause Analysis (RCA) for falls that occurred between June 5, 2025 and June 24, 2025. In addition, an analysis of the interventions implemented will also be conducted by IDT. This will be completed by July 3, 2025. To ensure the deficient practice does not occur again, the facility has reviewed and revised its fall policy and fall event form. The fall policy now includes completing an RCA after each fall as well as completing a weekly analysis of the fall interventions by IDT. The fall event form now includes immediate interventions for staff to choose from to implement as well as an evaluation section for the weekly analysis for IDT to complete. An RCA progress note was created for IDT to complete after each fall. The RCA progress note will include: Determined what happened, Identify what factors contributed to the event, and Action plan to reduce likelihood of similar event (intervention). This was completed on July 1, 2025. Education will be provided to nursing staff starting July 1, 2025. They will receive	

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F 689	Continued From page 2 high risk for falls. Review of facility incident report list from 3/28/25 thru 6/3/25, indicated R1 had seven falls as follows: Fall 3/28/25 R1's progress notes dated 3/28/25 at 4:25 p.m. R1 was in wheelchair in dining room, R1 attempted to get up out of wheelchair and walk; staff witnessed resident fall, he did not hit his head, denied pain, and there was no injury noted at this time. When asked what he was doing R1 replied, "this happens 2-3 x's a week." R1 vital signs stable. R1 encouraged to get assistance with transferring or walking, R1 was redirected with activity, food, drink, and toileting. Will encourage fluids. Family, director of nursing, nurse manager notified and telephone order on clipboard. Facility event report dated 3/28/25, indicated R1 had a witnessed fall in the dinning room at 3:30 p.m. R1 just had a snack and denied any injury or pain after the fall, R1 had good range of motion (ROM). Staff listed possible causes as cardiac/respiratory disease, and the use of analgesic and antipsychotics. Intervention included educating R1 to ask for help when getting out of chair, and redirection with activity, food, fluids, and toileting. These interventions were effective, and the care plan was followed. The incident report lacked a root cause analysis of the fall. R1's interdisciplinary note (IDT) dated 3/31/25, indicated witnessed fall, no injuries noted. R1 had diagnoses of dementia and has poor safety	F 689	education on the updated fall policy and updated fall event form. In addition, they will receive education on the RCA process and weekly analysis. Re-education on care sheets will also be provided. This will be completed by the Director of Nursing or Nurse Managers. The facility will be completing a Falls Management Audit weekly for four weeks, then bi-weekly for four weeks, and then monthly thereafter. Audit results will be brought to QAPI for review. Audits will be completed by the Administrator or designee. Next QAPI is 7/8/2025.	

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F 689	Continued From page 3 awareness. R1 was impulsive and restless at times. Evening staff will walk with resident at beginning of shift. R1's fall care plan was revised 3/31/25 with the following interventions; staff to ambulate R1 at beginning of evening shift at approximately 3:30 p.m., due to R1 frequently getting restless at this time. Review of R1's ambulation record from 1/1/25 thru 6/5/25 indicated an order dated 11/27/24, to walk R1 to meals with assist of 1-2 staff with gait belt to all meals, follow with wheelchair. Also document when restless. The following documentation was identified: January 2025- no documentation record. February 2025-ambulated twice on the 2/4 and twice on 2/11. March 2025- no documentation sheet. April 2025- ambulated 4/6 and 4/20 the rest were blank May 2025- blank June 2025- blank. R1's physician note dated 4/8/25, indicated R1 had Parkinson's Disease, dementia without behavioral disturbance and was stable. R1 had recurrent falls, and gait instability. He was impulsive and may not wait for staff assistance related to the dementia. R1 was on Zyprexa to assist with this. There were no new orders or interventions listed. Fall 4/12/25 R1's progress note dated 4/12/25 at 12:49 p.m.,	F 689		

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F 689	Continued From page 4 R1 was found lying on the floor on his back by the foot of the bed. Wheelchair was noted next to bedside table. R1 was lifted via total mechanical lift with three staff assist. R1 complained of pain to his forehead and knees, ice applied and scheduled Tylenol given. R1 had a 3.0 centimeter (cm) x 3.0 cm bump with 2.0 cm x 1.0 cm abrasion/bruise on the left side of forehead. He also had a 1 cm x 1 cm abrasion to left elbow. Staff were educated not to leave R1 alone in room with a known history of self-transfers. Range of motion (ROM), vital signs and neuros within normal limits for R1. Family, and physician notified. Facility event report dated 4/12/25, indicated R1 had an unwitnessed fall at 11:40 a.m., in his room. R1 was sitting in his wheelchair and not able to identify what happened. R1 had moderate pain in his forehead and knees, with a bump and abrasion to his forehead. Possible contributing factors included R1 does self-transfers and received analgesics and antipsychotics. Immediate interventions were neurological checks as fall was unwitnessed and had a head injury. R1's interdisciplinary team (IDT) note date 4/14/25 at 8:45 a.m., and updated R1's care plan to not leave R1 alone in his room when he is in the wheelchair. Fall 4/19/25 R1's progress note dated 4/19/25 at 6:41 p.m., indicated R1 was found on floor in Haven lounge. R1 had been sitting in recliner watching TV and eating popcorn, with gripper socks on. R1's	F 689		

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F 689	Continued From page 5 wheelchair was beside the recliner and was found laying on his back and on the foot pedals of another resident's wheelchair. Four staff attempted to use a full mechanical lift sheet but R1 yelled out in pain and pointed to his left eye and groin area. R1 was sent to the hospital, family, physician and management were notified. Facility's event report dated 4/19/25 at 5:54 p.m., indicated R1 had an unwitnessed fall on 4/19/25 in the Haven Lounge. R1 complained of moderate pain in his stomach and head. R1 had a possible head and hip injuries and was sent to the emergency department (ED). There were no deformities noted but R1 had pain with range of motion (ROM). The event report did not list any contributing factors for the fall and R1 was on antipsychotics. Care plan was followed and event report lacked a root cause analysis of the fall. R1's ED physician note dated 4/19/25, indicated R1 being found down after an unwitnessed fall at facility with trauma to his occipital (back of head) scalp area with an occipital scalp Wheaton (swollen bruise). CT report indicated T12 compression deformity, newly visualized since 2024, recommend correlation with point tenderness. Lidoderm (pain) patch applied and Tylenol 650 mg every 6 hours as needed for pain. R1 was discharged back to the facility to follow up with primary care physician as needed. R1's IDT note dated 4/21/25 at 9:00 a.m., indicated R1 had fall with injury and was sent to the ED. R1 has T12 fracture. R1's nursing home physician round note 4/23/25, indicated follow up ED visit. Nursing notes indicated that R1 was not having pain symptoms	F 689		

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F 689	Continued From page 6 or discomfort. R1 has advanced dementia. R1 had improved back to his baseline health status. No new orders or fall interventions were identified. Fall 5/6/25 R1's progress note dated 5/6/25 at 4:16 p.m., indicated R1 had an unwitnessed fall and was found lying on his right side by nurses' station. Staff previously spoke to resident 5 minutes prior. R1 sent to ED. Facility's event report dated 5/6/25, indicated R1 had an unwitnessed fall at 4:14 p.m., by the nurses' station. R1 would not allow ROM to hips/legs, had no pain and was sent to the ED for evaluation due to previous fracture. R1 had dementia, and this was a possible contributing factor. R1 received analgesics and antipsychotics. Immediate intervention was to send R1 to the ED for evaluation. Family, physician and management were notified. Care plan was being followed at the time of the fall. R1's ED physician progress note dated 5/6/25, indicated R1 was brought to ED after a fall with right shoulder pain. R1 had recent T-spine fracture. CT of chest, abdomen, and pelvis revealed unchanged T12 vertebral body compression fracture. No acute fractures. Kidney stone noted and urinalysis had abnormal finding and R1 was started on antibiotic and returned to the facility. R1's IDT note dated 5/7/25, R1 had unwitnessed fall at the nurse's station. R1 went to the ED, no injuries and diagnosed with urinary tract infection (UTI) and toileting plan was updated.	F 689		

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F 689	Continued From page 7 R1's care plan intervention dated 5/7/25, identified staff to toilet after supper. Fall 5/12/25 R1's progress note dated 5/12/25 at 8:10 p.m., R1 had unwitnessed fall at nurses' desk. Activity aide (AA)-A who was near R1 heard R1 hit the floor and called for help. Two nurses and one NA assisted R1 off the floor via a sit to stand lift. R1 was complaining of pain to back, head, and right leg. Vital signs were stable and sent to the ED. Review of facility's event report dated 5/12/25, indicated R1 had an unwitnessed fall at the nurses station. The report listed AA-A was in the vicinity. R1 complained of moderate pain in head, back and right leg. R1 had no visible injuries and complained of pain with ROM to lower extremities. The event report further indicated R1's neurological disorder was a possible contributing factor. R1's ED note dated 5/12/25, identified R1 was brought in by ambulance for evaluation after an unwitnessed fall. R1 was complaining of pain of headache and back pain. CT was done of thoracic spine and revealed acute non-displaced fracture of L1 and L2 spinous process (a small wing-like bone projection that extends outward from each vertebra along the spine). R1 discharged back to the facility and advised to continue pain patch, follow up with primary physician, and return to ED for any concern or any worsening symptoms. R1's IDT note dated 5/13/25 at 9:04 a.m., indicated R1 had become weak related to not	F 689		

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F 689	Continued From page 8 ambulating as often. Orders for physical therapy (PT) to evaluate for strengthening and occupational therapy (OT) to evaluate for wheelchair positioning. R1's care plan intervention dated 5/13/25, identified physical therapy (PT) to evaluate for strengthening and occupational therapy (OT) to evaluate for wheelchair positioning. Fall 5/15/25 R1's progress note dated 5/15/25 at 12:57 a.m., indicated R1 was found sitting on the mat/floor, holding onto the grab bar. R1 was sent to the ED for evaluation due to his previous fractures was listed as the intervention. R1's ED physician progress note dated 5/15/25, identified R1 had been seen after a fall out of bed. Chest, abdomen and pelvis computed tomography scan (CT) identified R1 had a minimally displaced acute-appearing fracture of the right anterior seventh rib,constipation, and lung opacity (hazy gray areas on CT or x-rays) favoring mild infectious/inflammatory process. He was started on Augmentin (antibiotic) and to follow up with physician, use pain medication as previously directed and was discharged back to facility. R1's safety event-fall report dated 5/15/25, identified R1 had an unwitnessed fall at 12:57 a.m., and was found in his room sitting on the mat holding the grab. R1 had been observed at 11:30 p.m., and was sleeping in bed. R1 had complaints of pain in knees and was sent to the emergency department (ED) for evaluation.	F 689		

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F 689	Continued From page 9 R1's fall focus care plan intervention were revised 5/15/25, identified R1's bed to be in lowest position with mat on floor and pharmacist review of medications. R1's pharmacy review dated 5/15/25, identified a medication review had been requested due to R1 falling three times in past week. R1 was on an antibiotic on 5/15/25 for lung opacity after being seen in the ED. R1 had multiple medications with potential side effects of dizziness, and ortho hypotension (a sudden drop in blood pressure that occurs when a person stands up after sitting, or lying down) which could contribute to falls. These medication included Fluoxetine, Mirtazapine, Olanzapine, Quetiapine, Sinemet, and Tamsulosin. Pharmacist's suggested course of action included: 1- Consider doing orthostatic blood pressure twice daily for three days to rule out hypotension as a contributor to falls. 2- If recent labs have not been done, could consider a complete metabolic panel (CMP) or a complete blood count (CBC). 3- Please review the above listed medication with the potential side effect for dizziness. R1 was receiving Seroquel 50 mg twice daily, Olanzapine 2.5 mg daily, Mirtazapine 30 mg at bedtime and Fluoxetine 10 mg daily. Could consider a trial decrease on Olanzapine to 1.25 mg if appropriate for R1. Review of R1's medication and treatment administration record dated 5/1/25 through 5/31/25 did not identify any orthostatic blood pressures were completed. Interview on 6/4/25 at 4:21 p.m., nurse manager	F 689		

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F 689	Continued From page 10 (NM)-A stated the pharmacist recommendations were faxed three times to MD-A and faxed back without any changes. NM-A further stated the MD-A was rounding on 6/5/25 and would address the recommendations with him at that time. NM-A stated they have not completed any orthostatic blood pressures for his falls. They do not think it was an orthostatic issue but were related to his impulsivity. Fall 6/3/25 R1's progress note dated 6/3/25 at 7:10 p.m., identified R1 had just been in dining room finishing supper and was found five minutes later on the floor in front of a room. R1 was toileted at 3:00 p.m., and had gripper socks on at the time of the fall. R1 was transferred off the floor with a total mechanical lift and blood pressure was noted to be lower than normal. ROM good to all extremities with no pain or injuries noted. R1 was taken to the bathroom and had a large bowel movement. R1 was highly agitated yelling, and combative with neuros. R1's fall event report dated 6/3/25, identified R1 had an unwitnessed fall at 6:56 p.m. in the hallway. Immediate intervention of toileted and neurological checks. R1's progress note dated 6/4/24 at 6:45 a.m., identified medication nurse was interviewed and R1 was agitated and combative with all evening cares and when nursing assistants attempted to toilet R1 at 5:00 p.m. and 6:00 p.m., R1 would not allow nursing assistants to take him to the bathroom. Intervention included 1:1, bring R1 to quiet area, feed him supper, warm blanket, and attempt other staff to toilet him. Toileting schedule	F 689		

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F 689	Continued From page 11 set up before supper to prevent R1 from getting agitated when he had the urge to have a bowel movement. Medical doctor (MD) will round on 6/5/25 and pharmacist wil be consulted on medication times if there are other options for psychotropic (drug that affects a person's mental state) medications related to dementia and Parkinson's disease. R1's physician progress notes dated 6/5/25, identified R1 had six falls since March had Parkinson's symptoms that were stable along with dementia without behavioral disturbance. R1 continued to be impulsive and get up on own, mainly in the afternoon. Had 6 falls since March. Continue diligence as able. R1 currently taking Seroquel by neurology, will continue this. R1 also taking Remeron and Prozac, which could contribute to increased agitation and R1 getting up without assistance. MD-A recommended decreasing dose of Remeron to 15 mg and to discontinue the Prozac. R1 also takes blood thinner due to history if pulmonary embolism and deep vein thrombosis. If falls continue, may need to discuss with family on discontinuing this medication. R1's falls care plan start date of 3/1/24, indicated R1 was at risk for falls due to Parkinson's disease, impaired cognition, weakness and history of falls. Interventions included: -R1 will not be left unattended in the BR due to impulsivity, decreased safety awareness and history of self-transferring/falls, dated 7/22/24; -Dycem gripping material placed under wheelchair cushion to promote positioning, dated 8/16/24; -R1 to wear gripper socks at bedtime and gripper	F 689		

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F 689	Continued From page 12 socks or shoes during the day, dated 8/27/24; -Remove wheelchair foot pedals and place in storage bag located on wheelchair when not transporting, dated 9/9/24; -Gripper tape placed in front of bed, dated 9/16/24 -Physical and Occupational Therapy referral as needed to promote strength, endurance and mobility, dated 11/18/24; -Due to increased restlessness encourage R1 to rest in recliner throughout the day, dated 1/3/25; -Staff to walk with R1 at beginning of evening shift approximately at 3:30 p.m., due to R1 frequently getting restless at this time, dated 3/31/25; -Do not leave alone in room in wheelchair, dated 4/14/25; -Toilet before supper 5/7/25; -Physical therapy to eval for strengthening and Occupational therapy to eval for wheelchair positioning, dated 5/13/25; -Bed in lowest position, dated 5/15/25; and -Pharmacist review of medications, dated 5/15/25. Interview on 6/3/25 registered nurse (RN)-B stated the R1 had numerous falls in the past three months, with two fractures. RN-B was not able to articulate the R1 was to be toileted at 2:30 p.m. and before supper or that R1 was to ambulate to meals. Interview on 6/3/25 nursing assistant (NA)-P stated try to prevent falls with R1, make sure that R1 is at the nurses' station, give him snack, help him watch TV. Was not able to articulate that R1 had a ambulation or toileting schedule. During clarification interview on 6/6/25, NA-P was able to get the West walk book and identified R1's	F 689		

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F 689	Continued From page 13 walking sheet. NA-P verified that nothing was signed off for the month of June. Interview on 6/4/25 NA-D stated R1 was to be toileted every 2 hours and when he was agitated. NA-D could not articulate that R1 was to be walked to meals and when agitated. Interview on 6/4/25 NA-V stated R1 did not have a walking program, and there was not a toileting schedule for R1. Interview on 6/6/25 NM-A was not able to provide needed documentation of R1's ambulating to meals or the toileting times of 2:20 p.m. and before supper were being completed. Interview on 6/4/25 at 9:00 a.m., director of nursing (DON) reviewed falls and was unable to identify the root cause of R1's falls or if the care plan was being followed. DON further stated her expectation was that staff identified the root cause and that immediate interventions were put into place. The interdisciplinary team also reviewed the fall with interventions to make sure the interventions were evaluated for appropriateness. Although the facility identified interventions, there was no indication these interventions were being implemented consistently, nor were there any ongoing analysis of the falls to determine if the interventions were effective. Interview on 6/4/25 at 4:25 a.m., administrator stated the facility was notified of funding availability for a performance-based incentive payment program (PIPP) project for a fall prevention program which they plan to start this	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	C 06/05/2025

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F 689	Continued From page 14 month. All falls need to have appropriate immediate intervention implemented at the time of the fall and then the IDT reviews it at their next meeting to verify the intervention is appropriate and working to prevent further falls. Facility quality assurance and performance improvement (QAPI) notes from January 2025 thru May 2025, indicated the following: -January 14, 2025, QAPI discussed F689 as part of the plan of correction (POC), audits regarding their surveys. Audit had been completed three times a week. Results overall have been successful. Some concerns noted with getting them all completed, especially on the weekend when leadership is not present. Audits will be reduced to one time per week and management will look at new education topic to be covered. Administrator fur reviewed the Minnesota quality indicators with the committee, which included falls with injury. The facility had a significant number of falls during the past three to four months, but the injuries have decreased significantly. Committee to continue to monitor. -February 11, 2025, facility level quality marker report was reviewed by administrator with committee. Area's facility is falling in the high percentile included falls and falls with injury. Committee discussed involving therapy more especially at the time of admission and utilizing the screening forms by staff. The fall risk form being completed was also discussed regarding what actions to take after the form is completed. At risk resident were also being monitored each week at the weekly risk meeting. -April 8, 2025, March falls were reviewed. There were 34 falls for the month, one resident had 13 falls, eight residents had 2 or more falls, and 20 of the falls occurred during the evening and	F 689		

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F 689	Continued From page 15 nights shifts. There was one fall with injury. The committee discussed how falls could also be a possible PIPP project. The facility fall policy dated 9/2024, did not indicate that an immediate fall intervention should be implemented. Facility undated procedure entitled "Events" indicated an attached table that indicated when a fall even should be open and under who fills out indicated for licensed staff at time of fall that assesses resident with pertinent fall information; charge nurse assigned to resident for shift will complete remaining sections ***BE SURE TO IMPLEMENT AN IMMEDIATE INTERVENTION AND USE CRITICAL THINKING TO DETERMINE THE CAUSE OF THE FALL***	F 689		