Electronically delivered
November 7, 2022

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

Re: State Nursing Home Licensing Orders
Event ID: ITLU11

Dear Administrator:

The above facility was surveyed on October 25, 2022 through October 26, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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November 7, 2022

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

RE: CCN: 245273
Cycle Start Date: October 26, 2022

Dear Administrator:

On October 26, 2022, a survey was completed at your facility by the Minnesota Departments 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

To be acceptable, a provider's ePOC must include the following:

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 26, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 26, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	900 3RD STREET SOUTH FRANKLIN, MN 55333

(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 10/25/22 and 10/26/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52735207C (MN00087714), with a licensing order issued at 0810 and 0830. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure registered nurse (RN) coverage for 8 consecutive hours per day, 7 days per week This had the potential to affect all 30 residents. Finding include: Review of the 10/9/22 through 10/26/22, facility nursing staff schedules identified no RN coverage existed for 10/17/22, 10/18/22, 10/19/22, 10/22/22, 10/23/22, and 10/24/22. Review of the facility form titled, "Audit F727 RN 8 hours/7days/wk.,Full-Time DON" identified no RN coverage on 10/01/22, 10/2/22, 10/15/22, and 10/22/22. During an interview 10/25/22 at 12:25 p.m., the assistant administrator indicated the facility did	2 810	Corrected	11/28/22

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2 810	Continued From page 3 not meet the requirement of RN coverage due to not having RN coverage on the weekends but thought they had a waiver. Further interview at 3:30 p.m. identified the facility did not have a waiver, were aware of the lack of RN coverage, and were cited on the previous survey. During an interview on 10/26/22 at 12:45 p.m., the administrator verified the facility was lacking the required RN coverage. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810		
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	2 830		11/28/22

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2 830	Continued From page 4 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 comprehensively assess resident falls to ensure appropriate interventions were implemented to reduce the risk of falls for 3 of 3 residents (R1, R2, and R3) reviewed for falls. Findings include: R1 was observed on 10/25/2022, at 11:20 a.m. sitting in a wheelchair in the doorway of his room with a splint on his right wrist. R1 stated he had hurt his hand but couldn't remember how he did it. R1's medical diagnosis list dated 10/25/22, included diagnoses of traumatic brain injury, essential tremor, and chronic pain. R1's quarterly Minimum Data Set (MDS) dated 8/18/22, indicated R1 had moderate cognitive impairment. MDS identified R1 required extensive assistance from one staff for toileting and required extensive assistance of two or more staff for walking, bed mobility and transfers. R1's fall risk assessment dated 8/7/22, indicated high risk for falls with documented risk factors of disorientation and 1-2 falls in the prior three months. R1 also required assistance with toileting, had balance problems with standing and walking, and 1-2 diseases that can contribute to falls.	2 830	Corrected	

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2 830	Continued From page 5 R1's care plan printed 10/19/22, indicated R1 was at risk for falls related to balance problems, incontinence, poor communication and is unaware of safety needs with noted falls on 12/6/21, 12/27/21, 1/3/22, 5/14/22, 7/17/22, 10/2/22, and 10/12/22. Care plan interventions included: -Anticipate and meet the resident's needs; call light is within resident reach and encourage to use it, resident needs prompt response to all requests for assistance; PT (physical therapy) to evaluate and treat as or ordered or as needed; resident needs activities that minimize the potential for falls will providing diversion and distractions (initiated 5/19/21) -Utilize "team approach" and ensure someone else is watching when CNA (certified nursing assistant) is otherwise occupied (initiated 12/6/21) -Bed against wall so he is aware of boundaries of bed (initiated 12/27/21) -Keep wheelchair locked at bedside (initiated 1/3/22) -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Remove any potential causes if possible and educate resident/family/caregivers/IDT (interdisciplinary team (initiated on 1/12/22) -Environmental assessment of sidewalk to be completed (initiated 5/14/22) -Complete bowel and bladder monitoring (initiated 1/9/22, revised on 7/18/22) R1's incident report for 10/2/22, indicated R1 had an un-witnessed fall in the common area. R1 was on his hands and knees on the floor in front of his wheelchair, he was assisted back to his wheelchair and no injuries noted. R1 stated he fell. An associated progress note indicated the	2 830		

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2 830	Continued From page 6 same information. The medical record lacked evidence of a comprehensive fall assessment, root cause analysis, or immediate interventions implemented to reduce the risk of further falls or injury. R1's incident report for 10/12/22, indicated R1 had an un-witnessed fall in the dining room, R1 was noted to be sitting on the floor with the left hand on the wheelchair. Another resident reported R1 stood up from the wheelchair and tried sitting back but missed the wheelchair and ended up on floor. R1 was lifted off the floor and no injuries were identified. R1 was unable to give description of fall at the time. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment, root cause analysis of fall, or immediate interventions implemented to reduce the risk of further falls or injury. R1's progress notes dated 10/15/22, indicated R1 was noted to have swelling and bruising to his right hand and family member took him to the emergency room. R1 returned with a closed fracture to the right hand and orders for a splint to be kept on day and night, pain medication, and follow-up orthopedic appointment. R1's progress notes for 10/17/22, was reviewed and indicated a family member reported that R1 fell out of his wheelchair while at the clinic earlier that day. No incident report, fall risk assessment, or root cause analysis was provided for the reported fall. Noted intervention was to provide the resident with a more appropriately fitting wheelchair. R1's care plan revised on 10/17/22 identified	2 830		

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2 830	Continued From page 7 intervention of appropriate fitting wheelchair was added. Additional intervention was added on 10/19/22 to ensure resident was wearing appropriate footwear (gripper socks) when ambulating or mobilizing wheelchair. However, the record did not identify reason this intervention was added. R2 During an observation 10/25/22, at 10:16 a.m. R2 was observed sitting in his specialized wheelchair slightly reclined in front of his television in his room. R2's diagnosis list dated 10/25/22, included diagnoses of diabetes, dementia, and macular degeneration (difficulty seeing). R2's quarterly MDS assessment dated 9/12/22, indicated R2 had severe cognitive impairment. The MDS identified R2 did not walk, and required extensive assistance from two or more staff for bed mobility, transfers, and toileting. R2's most recent fall risk assessment dated 9/18/22, indicated he was a high fall risk. R2's fall care plan, indicated R2 was at risk for falls related to poor balance and previous falls on 4/19/22, 6/26/22, 9/6/22, and 9/10/22. R2's fall interventions included: -bed in low position, call light in reach (initiated 1/8/22) -refer to therapy (initiated 4/19/22) -med review (initiated 6/26/22) -no weight bearing for three (3) weeks; wheelchair by bedside always with locked breaks; bed in lowest position (initiated 9/6/22) -edge defining mattress on bed, toileting schedule added to his daily routine (initiated 9/10/22)	2 830		

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2 830	Continued From page 8 R2's fall incident report dated 9/10/22, indicated an un-witnessed fall in resident room with a bruise on left arm. The report identified R2 often tried to self-ambulate to the bathroom. The medical record lacked evidence of a comprehensive fall assessment and analysis. Although assessment was not evident the care plan was revised with interventions. R2's care plan revised on 9/10/22, included intervention of toileting schedule was added to his daily routine; however, a comprehensive toileting assessment was not evident. Additional intervention on 9/10/22 was adding an edge defining mattress on R2's bed. R2's fall incident report dated 9/14/22, indicated an un-witnessed fall in his room with no signs of injury. The report identified R2 was trying to self-ambulate to the bathroom. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment. It was not evident R2's toileting plan was evaluated for appropriateness and not evident further assessment was completed. Additionally, was not evident immediate appropriate interventions were implemented. R2's care plan revised on 9/14/22, indicated an edge defined mattress was added to the bed even though an edge mattress was already added to R2's bed on 9/10/22. R2's nurse progress note dated 9/18/22, indicated a fall in the bathroom resulting in R1 hitting his head. Further indicated R1 self-transferred to the bathroom due to the need to use the toilet. An incident report was	2 830		

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(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
2 830	Continued From page 9 requested but not provided. The medical record lacked evidence of a comprehensive fall assessment or appropriate interventions implemented to reduce the risk of further falls or injury. R2's care plan revised on 9/19/22 identified intervention to use call light signs on bathroom door and on wall by bed (initiated 9/19/22). R3 R3 diagnosis list created 4/1/22, included diagnoses of Parkinson's disease (causing difficulty walking and tremors), anxiety disorder, dizziness, urine retention, and glaucoma. R3's quarterly MDS dated 9/15/22, indicated moderate cognitive impairment. MDS identified R3 required extensive assistance of one staff for bed mobility and toileting and limited assistance from one staff for walking and transfers. R3's most recent fall risk assessment dated 10/2/22, indicated he was a high risk for falls. R3's fall care plan, indicated he was admitted on 4/22/22 and was at high risk for falls related to poor balance and Parkinson's disease. Further indicated actual falls on 4/23/22, 4/30/22, 5/6/22, 5/7/22 x2, 5/17/22 x 2, 5/20/22, 5/22/22, 6/16/22, 6/28/22, 7/7/22 x 3, 7/10/22, 7/19/22, 7/21/22, 7/23/22, 7/27/22, 8/5/22, 8/12/22, 8/20/22, and 9/2/22. Fall prevention interventions were present but lacked any revisions or additional interventions after fall on 9/2/22. R3's nurse progress notes on 9/19/22, indicated resident was reaching for something and rolled out of bed. An incident report was requested but	2 830		

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	00934	A. BUILDING: _____ B. WING _____	C 10/26/2022

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2 830	Continued From page 10 not provided. The medical record lacked evidence of a comprehensive fall assessment, a root cause analysis of fall, or appropriate interventions implemented to reduce the risk of further falls or injury. R3 incident report dated 9/22/22, indicated an un-witness fall out of bed. It further indicated the resident was reaching for something and fell out of bed. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment and no evidence immediate appropriate interventions were implemented. R3's incident report dated 9/23/22, indicated an un-witnessed fall in resident's room. It further indicated resident had tried to self-transfer to the bathroom. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment and immediate interventions implemented. R3's incident report dated 10/3/22, indicated an un-witnessed fall in resident room. It further indicated he was self-transferring to the bathroom because nobody was coming to help, and the immediate intervention was to remind him to use his call light. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment and appropriate interventions implemented to reduce the risk of further falls or injury. During an interview on 10/25/22, at 2:30 p.m. LPN-A stated after a fall an assessment of the resident's condition, risk management report, contact the appropriate people, and document the	2 830		

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2 830	Continued From page 11 fall in the progress notes. During an interview on 10/25/22, at 4:05 p.m. DON (director of nursing) and the assistant administrator stated they were both very new to the facility and reviewed the progress notes, care plans, and incident reports. They verified the fall risk assessments were not completed, the root cause analysis of the falls was not getting done, and appropriate interventions were not being implemented to prevent further falls and/or injuries from the falls. Further stated the resident care plans need to be updated and staff need some education related to fall prevention and follow-up. A review of the facility policy titled, Fall-Clinical Protocol, dated 10/4/2021, indicated staff were to assess the resident after a fall and identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. A review of the facility policy titled, Assessing Falls and Their Causes last revised 03/2018, indicated the purpose of the procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall and further provides actions to be taken after a resident fall, included a post-fall evaluation, assessment data, interventions administered, notifications of physician and family as indicated, completion of a falls risk assessment, appropriate interventions taken to prevent future falls, and documentation of the above in the resident medical record.	2 830		

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2 830	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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F 000	INITIAL COMMENTS On 10/25/22 and 10/26/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52735207C (MN00087714), with a deficiencies cited at F689 and F727. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	This plan of correction (POC) does not	11/28/22

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

Electronically Signed | 11/15/2022

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

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F 689	Continued From page 1 review, the facility failed to comprehensively assess resident falls to ensure appropriate interventions were implemented to reduce the risk of falls for 3 of 3 residents (R1, R2, and R3) reviewed for falls. Findings include: R1 was observed on 10/25/2022, at 11:20 a.m. sitting in a wheelchair in the doorway of his room with a splint on his right wrist. R1 stated he had hurt his hand but couldn't remember how he did it. R1's medical diagnosis list dated 10/25/22, included diagnoses of traumatic brain injury, essential tremor, and chronic pain. R1's quarterly Minimum Data Set (MDS) dated 8/18/22, indicated R1 had moderate cognitive impairment. MDS identified R1 required extensive assistance from one staff for toileting and required extensive assistance of two or more staff for walking, bed mobility and transfers. R1's fall risk assessment dated 8/7/22, indicated high risk for falls with documented risk factors of disorientation and 1-2 falls in the prior three months. R1 also required assistance with toileting, had balance problems with standing and walking, and 1-2 diseases that can contribute to falls. R1's care plan printed 10/19/22, indicated R1 was at risk for falls related to balance problems, incontinence, poor communication and is unaware of safety needs with noted falls on 12/6/21, 12/27/21, 1/3/22, 5/14/22, 7/17/22, 10/2/22, and 10/12/22. Care plan interventions	F 689	necessarily reflect that we are in agreement that these alleged deficiencies did actually exist. However, our response in this POC is to ensure that the health, safety, and well-being of our residents is being met and protected. 1. No other residents were found to be affected in this area. 2. All residents have the potential to be affected in this area. 3. R1, R2, and R3 Care Plans have been comprehensively assessed and reviewed for toot cause and updated to reflect appropriate interventions to reduce the risk of falls. Fall Risk Assessments have been updated as applicable. To prevent similar situations, residents with high-risk for falls were comprehensively assessed, root cause identified, and care plan reviewed and revised for appropriateness. Education provided to nursing staff on assessments, root cause, and immediate interventions after a fall. Education provided to nursing and floor staff on communicating and following interventions put into place. 4. An audit will be used to monitor appropriate interventions are completed in Fall Risk Assessments, Care Plans, and implemented for all residents/each incident. These audits will be completed during IDT Standup meetings with the IDT Team. The audit will be completed by DNS, Assistant Administrator, or designee weekly x 4 weeks, and monthly x 6 months with the results of the audits to the QAPI committee for further recommendations.	

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F 689	Continued From page 2 included: -Anticipate and meet the resident's needs; call light is within resident reach and encourage to use it, resident needs prompt response to all requests for assistance; PT (physical therapy) to evaluate and treat as or ordered or as needed; resident needs activities that minimize the potential for falls will providing diversion and distractions (initiated 5/19/21) -Utilize "team approach" and ensure someone else is watching when CNA (certified nursing assistant) is otherwise occupied (initiated 12/6/21) -Bed against wall so he is aware of boundaries of bed (initiated 12/27/21) -Keep wheelchair locked at bedside (initiated 1/3/22) -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Remove any potential causes if possible and educate resident/family/caregivers/IDT (interdisciplinary team (initiated on 1/12/22) -Environmental assessment of sidewalk to be completed (initiated 5/14/22) -Complete bowel and bladder monitoring (initiated 1/9/22, revised on 7/18/22) R1's incident report for 10/2/22, indicated R1 had an un-witnessed fall in the common area. R1 was on his hands and knees on the floor in front of his wheelchair, he was assisted back to his wheelchair and no injuries noted. R1 stated he fell. An associated progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment, root cause analysis, or immediate interventions implemented to reduce the risk of further falls or injury.	F 689		

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F 689	Continued From page 3 R1's incident report for 10/12/22, indicated R1 had an un-witnessed fall in the dining room, R1 was noted to be sitting on the floor with the left hand on the wheelchair. Another resident reported R1 stood up from the wheelchair and tried sitting back but missed the wheelchair and ended up on floor. R1 was lifted off the floor and no injuries were identified. R1 was unable to give description of fall at the time. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment, root cause analysis of fall, or immediate interventions implemented to reduce the risk of further falls or injury. R1's progress notes dated 10/15/22, indicated R1 was noted to have swelling and bruising to his right hand and family member took him to the emergency room. R1 returned with a closed fracture to the right hand and orders for a splint to be kept on day and night, pain medication, and follow-up orthopedic appointment. R1's progress notes for 10/17/22, was reviewed and indicated a family member reported that R1 fell out of his wheelchair while at the clinic earlier that day. No incident report, fall risk assessment, or root cause analysis was provided for the reported fall. Noted intervention was to provide the resident with a more appropriately fitting wheelchair. R1's care plan revised on 10/17/22 identified intervention of appropriate fitting wheelchair was added. Additional intervention was added on 10/19/22 to ensure resident was wearing appropriate footwear (gripper socks) when ambulating or mobilizing wheelchair. However,	F 689		

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F 689	Continued From page 4 the record did not identify reason this intervention was added. R2 During an observation 10/25/22, at 10:16 a.m. R2 was observed sitting in his specialized wheelchair slightly reclined in front of his television in his room. R2's diagnosis list dated 10/25/22, included diagnoses of diabetes, dementia, and macular degeneration (difficulty seeing). R2's quarterly MDS assessment dated 9/12/22, indicated R2 had severe cognitive impairment. The MDS identified R2 did not walk, and required extensive assistance from two or more staff for bed mobility, transfers, and toileting. R2's most recent fall risk assessment dated 9/18/22, indicated he was a high fall risk. R2's fall care plan, indicated R2 was at risk for falls related to poor balance and previous falls on 4/19/22, 6/26/22, 9/6/22, and 9/10/22. R2's fall interventions included: -bed in low position, call light in reach (initiated 1/8/22) -refer to therapy (initiated 4/19/22) -med review (initiated 6/26/22) -no weight bearing for three (3) weeks; wheelchair by bedside always with locked breaks; bed in lowest position (initiated 9/6/22) -edge defining mattress on bed, toileting schedule added to his daily routine (initiated 9/10/22) R2's fall incident report dated 9/10/22, indicated an un-witnessed fall in resident room with a bruise on left arm. The report identified R2 often	F 689		

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F 689	Continued From page 5 tried to self-ambulate to the bathroom. The medical record lacked evidence of a comprehensive fall assessment and analysis. Although assessment was not evident the care plan was revised with interventions. R2's care plan revised on 9/10/22, included intervention of toileting schedule was added to his daily routine; however, a comprehensive toileting assessment was not evident. Additional intervention on 9/10/22 was adding an edge defining mattress on R2's bed. R2's fall incident report dated 9/14/22, indicated an un-witnessed fall in his room with no signs of injury. The report identified R2 was trying to self-ambulate to the bathroom. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment. It was not evident R2's toileting plan was evaluated for appropriateness and not evident further assessment was completed. Additionally, was not evident immediate appropriate interventions were implemented. R2's care plan revised on 9/14/22, indicated an edge defined mattress was added to the bed even though an edge mattress was already added to R2's bed on 9/10/22. R2's nurse progress note dated 9/18/22, indicated a fall in the bathroom resulting in R1 hitting his head. Further indicated R1 self-transferred to the bathroom due to the need to use the toilet. An incident report was requested but not provided. The medical record lacked evidence of a comprehensive fall assessment or appropriate interventions	F 689		

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F 689	Continued From page 6 implemented to reduce the risk of further falls or injury. R2's care plan revised on 9/19/22 identified intervention to use call light signs on bathroom door and on wall by bed (initiated 9/19/22). R3 R3 diagnosis list created 4/1/22, included diagnoses of Parkinson's disease (causing difficulty walking and tremors), anxiety disorder, dizziness, urine retention, and glaucoma. R3's quarterly MDS dated 9/15/22, indicated moderate cognitive impairment. MDS identified R3 required extensive assistance of one staff for bed mobility and toileting and limited assistance from one staff for walking and transfers. R3's most recent fall risk assessment dated 10/2/22, indicated he was a high risk for falls. R3's fall care plan, indicated he was admitted on 4/22/22 and was at high risk for falls related to poor balance and Parkinson's disease. Further indicated actual falls on 4/23/22, 4/30/22, 5/6/22, 5/7/22 x2, 5/17/22 x 2, 5/20/22, 5/22/22, 6/16/22, 6/28/22, 7/7/22 x 3, 7/10/22, 7/19/22, 7/21/22, 7/23/22, 7/27/22, 8/5/22, 8/12/22, 8/20/22, and 9/2/22. Fall prevention interventions were present but lacked any revisions or additional interventions after fall on 9/2/22. R3's nurse progress notes on 9/19/22, indicated resident was reaching for something and rolled out of bed. An incident report was requested but not provided. The medical record lacked evidence of a comprehensive fall assessment, a	F 689		

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F 689	Continued From page 7 root cause analysis of fall, or appropriate interventions implemented to reduce the risk of further falls or injury. R3 incident report dated 9/22/22, indicated an un-witness fall out of bed. It further indicated the resident was reaching for something and fell out of bed. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment and no evidence immediate appropriate interventions were implemented. R3's incident report dated 9/23/22, indicated an un-witnessed fall in resident's room. It further indicated resident had tried to self-transfer to the bathroom. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment and immediate interventions implemented. R3's incident report dated 10/3/22, indicated an un-witnessed fall in resident room. It further indicated he was self-transferring to the bathroom because nobody was coming to help, and the immediate intervention was to remind him to use his call light. An associated nurse progress note indicated the same information. The medical record lacked evidence of a comprehensive fall assessment and appropriate interventions implemented to reduce the risk of further falls or injury. During an interview on 10/25/22, at 2:30 p.m. LPN-A stated after a fall an assessment of the resident's condition, risk management report, contact the appropriate people, and document the fall in the progress notes.	F 689		

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F 689	Continued From page 8 During an interview on 10/25/22, at 4:05 p.m. DON (director of nursing) and the assistant administrator stated they were both very new to the facility and reviewed the progress notes, care plans, and incident reports. They verified the fall risk assessments were not completed, the root cause analysis of the falls was not getting done, and appropriate interventions were not being implemented to prevent further falls and/or injuries from the falls. Further stated the resident care plans need to be updated and staff need some education related to fall prevention and follow-up. A review of the facility policy titled, Fall-Clinical Protocol, dated 10/4/2021, indicated staff were to assess the resident after a fall and identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. A review of the facility policy titled, Assessing Falls and Their Causes last revised 03/2018, indicated the purpose of the procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall and further provides actions to be taken after a resident fall, included a post-fall evaluation, assessment data, interventions administered, notifications of physician and family as indicated, completion of a falls risk assessment, appropriate interventions taken to prevent future falls, and documentation of the above in the resident medical record.	F 689		

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F 727	Continued From page 9	F 727		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure registered nurse (RN) coverage for 8 consecutive hours per day, 7 days per week This had the potential to affect all 30 residents. Finding include: Review of the 10/9/22 through 10/26/22, facility nursing staff schedules identified no RN coverage existed for 10/17/22, 10/18/22, 10/19/22, 10/22/22, 10/23/22, and 10/24/22. Review of the facility form titled, "Audit F727 RN 8 hours/7days/wk.,Full-Time DON" identified no RN coverage on 10/01/22, 10/2/22, 10/15/22, and 10/22/22. During an interview 10/25/22 at 12:25 p.m., the assistant administrator indicated the facility did	F 727	1. A designate a registered nurse to serve as the director of nursing had been in place and is in the facility for 40 hours/wk. The facility reapplied for the RN Waiver Request. 2. All residents have the potential to be affected in this area. 3. The designated registered nurse took the interim DON position on October 21, 2022, she is in the facility 40 hours/wk. and this requirement has been communicated and understood. She is punching in to verify her hours. When designated RN/interim DON is not in the facility and there is no RN in the facility, the facility is directed, as needed, to send resident to ER immediately. The facility has been and will continue to recruit through various methods such as social media, newspaper, flyers, and new digital	11/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 727	Continued From page 10 not meet the requirement of RN coverage due to not having RN coverage on the weekends but thought they had a waiver. Further interview at 3:30 p.m. identified the facility did not have a waiver, were aware of the lack of RN coverage, and were cited on the previous survey. During an interview on 10/26/22 at 12:45 p.m., the administrator verified the facility was lacking the required RN coverage. Facility policy was not received	F 727	outlooks. 4. An audit will be used to monitor the hours of RN/DON coverage. The audit will be completed by the Business Office Manager and/or Assistant Administrator or designee with the results of the audits to the QAPI committee for further recommendations. The audit will be done weekly x 6 weeks and once monthly x 2 months.	