*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 5, 2023

Administrator
St. Clare Living Community of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: July 27, 2023

Dear Administrator:

On August 15, 2023, we notified you a remedy was imposed. On October 3, 2023, the Minnesota Department(s) 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 October 2, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 30, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 15, 2023, 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 August 30, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 2, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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October 5, 2023

Administrator
St. Clare Living Community of Mora
110 North 7th Street
Mora, MN 55051

Re: Reinspection Results
Event ID: E84812

Dear Administrator:

On September 6, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 27, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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August 15, 2023

Administrator
St Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: July 27, 2023

Dear Administrator:

On July 27, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 30, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 30, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 2023.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; 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 August 30, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Clare Living Community Of Mora will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 27, 2024 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245291 | A. BUILDING ______ B. WING ______ | C 07/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CLARE LIVING COMMUNITY OF MORA | 110 NORTH 7TH STREET MORA, MN 55051 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 7/25/23 through 7/27/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed. H52914011C (MN00092196), H52914009C (MN00093837), H52914010C (MN00095107) with a deficiency issued at F689.<br><br>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.<br><br>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)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 689 | It is the policy of St. Clare Living | 9/1/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 08/24/2023

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

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| F 689 | Continued From page 1<br>review, the facility failed to appropriately assess and implement appropriate interventions to prevent repeated falls for 2 of 2 residents (R1 and R3), who were at high risk for falls. This failure resulted in actual harm for R1 who sustained a mildly displaced right femoral neck fracture, right hip fracture, which required surgical repair and sustained a right periprosthetic femur fracture.<br><br>Findings include:<br><br>R1's face sheet undated, identified R1 had the following diagnoses: Alzheimer's disease, dementia, adult failure to thrive, ataxic gait, muscle weakness, syncope with collapse, repeated falls and unsteadiness on feet.<br><br>R1's significant change Minimum Data Set (MDS) dated 5/2/23, identified R1 had significantly impaired cognition, required one person assist with transfers, toileting, dressing and locomotion on the unit. R1 was not steady and only able to stabilize with human assistance for balance during transitions and walking. MDS identified R1 used a wheelchair for mobility. R1 was occasionally incontinent of bowel and bladder with no bowel or bladder toileting program.<br><br>R1's bladder assessment, dated 7/12/23, identified R1 was frequently incontinent with risk factors of impaired mobility and dependent transfer. R1 has urine leakage on the way to bathroom and has wet close or wet incontinent pads. Environment limitations included impaired mobility and decreased manual dexterity with contributing diagnosis of Alzheimer's, diabetes, falls and pain with movements. Medications may be contributing to bladder dysfunction includes antidepressants, diuretics, and narcotics. Stress | F 689 | Community of Mora to provide an environment as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.<br>For resident R1 fall risk assessment, bladder assessment, bowel assessment was completed on 8/7/23. R1's care plan and nursing assistant group worksheets were reviewed and revised to reflect current interventions on 8/7/23.<br>Individualized toileting plan was implemented as a result of assessments and staff interview on 8/7/23.<br>For resident R3 fall risk assessment, bladder assessment, bowel assessment was completed on 8/11/23. R1's care plan and nursing assistant group worksheets were reviewed and revised to reflect current interventions on 8/11/23.<br>Individualized toileting plan was implemented as a result of assessments and staff interview on 8/11/23.<br>For all other like resident who were identified using facilities Quality Measures with focus on residents who triggered for falls with major injury and falls. The facility also identified all other like residents by review of current resident fall report in the past 90 days with focus on residents who have sustained more than one fall.<br>For all other like residents, a fall risk assessment, bladder assessment and bowel assessment will be completed by 9/1/23. Residents care plans and nursing assistant group worksheets will be reviewed and revised as appropriate by 9/1/23.<br>Urinary Continence and Incontinence | |

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| F 689 | Continued From page 2<br>incontinence includes incontinence without sensation of loss of urine as well as urge urinary incontinence with strong uncontrolled urgency prior to incontinence and urine loss on the way to toilet. Scheduled toileting/habit training schedule includes every two hours with no further information.<br><br>Fall care plan dated 3/28/23 identified R1 to be at risk for falls and interventions in place included soft touch call light, assist of one using EZ-Stand (mechanical lift) for transfers, wheelchair for mobility, nonskid footwear, nursing staff to encourage out of room activities, room close to nursing station and nursing staff to toilet ever two hours and as need to reduce risk of falls.<br><br>Mobility care plan dated 5/25/23 identified R1 to have impaired mobility and history of repeated falls and unsteadiness on feet, R1 required assist of one person using front wheeled walker for transfers, ambulation, and toileting. R1 used wheelchair for mobility and can propel independently or with assist of one person as needed. R1 requires gripper socks at all times.<br><br>The following Fall Risk Assessments were completed with a score of over ten indicating a high risk of falls. 12/21/23 with a score of 17, 3/22/23 with a score of 17, 3/28/23 with a score of 20, 5/1/23 with a score of 21, 7/12/23 with a score of 23, and 7/25/23 with a score of 19.<br>Fall Risk Observations Reviewed:<br>Dated 3/28/23 - Fall risk assessment summary: recent falls in the past three months and a score of 20 indicating high risk.<br>Dated 5/1/23 - Fall risk assessment summery: Resident had unwitnessed fall on 3/23 resulting in a femur fracture. Requires the | F 689 | Assessment and Management policy and procedure was reviewed and revised on 8/21/23. Accident/Incident policy, Fall Risk Observation, and Falls and Fall Risk managing policies were reviewed and revised on 8/22/23.<br>Education provided for staff members regarding Accident/Incident policy, Fall Risk Observation, and Falls and Fall Risk managing, and Urinary Continence and Incontinence Assessment and Management policy on 8/22/23 and 8/23/23. IDT will continue to meet daily on working days to review all accidents/incidents for root cause analysis. A Fall Risk assessment will be completed post fall by RN Managers or designee.<br>Resident fall risk and assessment/management of urinary continence/incontinence education will continue to be provided to all new employees, through orientation and annual training programs. These programs include but are not limited to formal in-service presented by licensed staff, online education, and review of policies and procedures. All resident falls, and post Fall Risk Assessments will be audited to ensure appropriate interventions are implemented to resident's individual plan of care. All resident Bowel and Bladder assessments will be reviewed and/or updated if applicable. Further system revision and staff education will be provided if indicated by audits and/or recommended by the QA/QI committee. The Director of Nursing or designee is responsible for monitoring | |

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| F 689 | Continued From page 3<br>EZ-stand lift to assist with transfers with a diagnosis of Alzheimer's disease, dementia, ataxic gait, generalized muscle weakness and a history of falls.<br>Dated 7/12/23- Fall risk assessment summary: At risk of falls with a score of 23 (high fall risk), Resident was alert but had confusion. Pivot transfers- do not walk with history of falls. Had multiple medications and diagnoses with potential to contribute to a fall.<br><br>The following Fall Events and internal investigations were reviewed:<br>Fall event 2/5/23 at 8:05 p.m., unwitnessed fall in room with walker and R1 sustained scratch and bump on head and small abrasion on left knee.<br>Fall event 2/9/23 at 7:15 p.m., unwitnessed fall in bathroom attempting to self-transfer onto toilet without injuries.<br>Fall event 3/23/23 at 4:45 a.m., unwitnessed fall in resident room self-transferring, wheelchair found outside the bathroom. Resident reported to the charge nurse he was attempting to get to the bathroom. Fall required hospitalization and found to sustain a right femur fracture requiring surgical repair. Internal investigation requested, however not received.<br>Fall event 3/30/23 at 11:15 a.m., , unwitnessed fall in bathroom attempting to self-transfer from wheelchair onto toilet without injuries.<br>Fall event 4/15/23 at 7:45 p.m., unwitnessed fall in bathroom attempting to self-transfer from wheelchair onto toilet.<br>Fall event 5/6/23 at 7:50 p.m., unwitnessed fall in bathroom attempting to self-transfer from wheelchair onto toilet without injuries.<br>Fall event 5/25/23 at 12:30 p.m, unwitnessed | F 689 | on-going compliance.<br>Date Certain-9/1/23 | |

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| F 689 | | F 689 | | |

Continued From page 4

fall in bathroom attempting to self-transfer with skin tear an inch long on wrist. Internal investigation identified gripper socks on but was not able to safely transfer without the use of an EZ stand lift and nursing staff to assist. R1 was last toileted at 10:30 and fall happened at 12:30.
Fall event 7/6/23 6:27 p.m., unwitnessed fall in R1's room, resident on floor, w/c tipped over and walker next to wheelchair. Fall required hospitalization and identification of periprosthetic femur fracture.

Review of facility's internal investigation notes indicated a patterned statement of root cause was due to resident's impaired level of mobility, cognitive status and generalized weakness. The internal investigation lacked evidence of a general assessment for pattern of falls, reason for falling (time, toileting needs, supervision) and lacked fall interventions to prevent future falls.

R1's group assignment sheet information noted to be on two separate group sheets as indicated below.

-R1's float group assignment sheet undated, identified R1 to require assist of one person with the use of EZ-Stand and toilet every two hours. Safety considerations include history of self-transfers, poor safety awareness/impulsive. Comments include bed in low position, lotion to feet/legs at night.
-R1's west group assignment sheet dated 7/25/23 consistently notes assist of one person with use of EZ-Stand and toilet every two hours. Safety consideration includes history of self-transfers with bathroom, and comments include bed in low position, lotion to feet/legs every two hours, hip precautions, no bending past 90 degrees, no

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| F 689 | | F 689 | | |

Continued From page 5

crossing legs. Incontinent of bowel and bladder, alert to self, forgetful needs cues.

After visit hospital summery printed 3/27/23, indicated that R1 was hospitalized on 3/23/23 and admitted for evaluation and management of mildly displaced right femoral neck fracture due to R1 falling under unclear circumstances at skilled nursing home facility. Note further identifies that resident required surgical repair on 3/24/23 for a right hip fracture due to an unwitnessed fall.

After visit hospital summery signed on 7/11/23, indicates R1 was hospitalized on 7/7/23 and discharged on 7/11/23 for a right periprosthetic femur fracture. It was determined to be treated non operatively.

Group assignment sheets directing nursing aids provided inconsistent information, lacked information from the care plan and safety consideration for R1, including resident FALL RISK and care following femur fracture.

During interview on 7/25/23 at 3:29 p.m., R1 indicated the staff are too busy so he uses the bathroom independently. R1 indicated to know how to use the call light, but he likes to take himself to the bathroom.

During interview on 7/25/23 at 3:40 p.m., nurse aid (NA)-E indicated they used the the group sheets to know what care the residents need and if residents were a high fall risk, by the group sheet indicating *High Fall Risk.*

During interview on 7/25/23 at 4:16 p.m., license practical nurse (LPN)-A indicated care group sheets should never have discrepancies from

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| ST CLARE LIVING COMMUNITY OF MORA | 110 NORTH 7TH STREET MORA, MN 55051 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 689 | | F 689 | | |

Continued From page 6
either the care plan or if a resident were to be on different groups.

During interview on 7/25/23 at 4:59 p.m., LPN-B indicated R1 was a high fall risk only when in bed and interventions include floor mat, bed to the lowest position, and call light within reach to prevent falls. LPN-B declined R1 to be a fall risk from wheelchair and had never been notified R1 tries to self-transfer onto the toilet, just from the bed.

During interview on 7/27/23 at 2:11 p.m., NA-C indicated R1 had a walker in his room however shouldn't be in his room because he doesn't use it and either should the nursing staff. NA-C indicated R1 did not use call light and would attempt to transfer from the wheelchair to the toilet on his own. NA-C indicated to be aware of R1's behaviors as R1 tends to wheel his wheelchair close to the bathroom door when he needs to go to the bathroom and R1 was not always incontinent and will request to use the toilet when needed.

During interview on 7/27/23 at 9:00 a.m., physical therapist (PT)-A indicated R1 was a high fall risk and it was therapy's recommendation for nursing staff to use EZ-Stand for transfers for safety. PT-A indicated R1 was unsafe to transfer independently and unable to correctly position wheelchair or lock brakes to transfer to the toilet and does not follow the steps required to complete a safe and independent transfer, further R1 was impulsive with cognitive deficits. PT-A confirmed fall mat, high low bed and soft touch bedroom call light would not prevent or address a safety concern from R1 attempting to transfer to toilet.

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During interview on 7/27/23 at 9:04 a.m., RN-B indicated R1 had a room closer to the nurses station, high low bed, soft touch call light and slipper socks as interventions implemented prior to February of 2023 frequent monitoring is encouraged, however no formal protocol or time frame of the expectation. RN-B indicated there should never be discrepancies on care cards or group guides and it was identified the care guides directed nursing assistance to use EZ-Stand, however the care plan reflected assist of one person with walker and it was identified on 7/25/23 as a discrepancy. Upon reviewing interventions for falls for R1, RN-B indicated the current interventions do not prevent or address R1 from self-transferring in the bathroom and an intervention should have been in place. RN-B furthermore reflected there was not enough causal analysis of stopping and preventing falls in the bathroom and if frequent checks are encouraged it should be care planned and on the group guides. Fall risk assessment scores reviewed and noted an upward trend from 12/21/23 to 7/25/23 with no preventative action.

During interview on 7/27/23 at 2:27 p.m., (PT)-B indicated it was not therapies recommendation for nursing staff to use the walker with R1, however sees no issue with it being accessible in his room. PT-B indicated the first functional bathroom transfer assessment was completed on 7/25/23 and not addressed prior. PT-B declined occupational therapy to be involved or evaluate or provide recommendations for functional transfer training in bathroom or cognitive based interventions.

During interview on 7/27/23 at 10:10 a.m., fall

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| F 689 | Continued From page 8<br>review completed with director of nursing (DON) and noted 3/23/23 root cause of fall to be R1's cognition and fall happened due to self-transferring and R1 not consistently use call light. Following the fall on 3/23/23, the wheelchair was implemented for mobility, mat and high low bed were also implemented (changes were not reflected on care plan dated 3/28/23). DON indicated for the 3/30/23, 4/15/23, 5/6/23 falls without interventions in place she would expect something more have been in place and frequent checks should have been put in both the care plans and group sheets. R1 was screened by physical therapy after 5/6/23 fall, however it was not indicated for therapy to see him on caseload and R1 was transferring with the EZ-Stand per therapy recommendation at that time with nursing. After the 5/25/23 fall also did not have interventions placed and the DON indicated the facility should have done something more including identified, trend tracking of self-transferring, placed interventions to protect R1 and recognition current toileting schedule was not preventing falls. DON added, the 7/6/23 fall was reviewed and the intervention that was placed was anti-lock brakes on to the wheelchair to prevent it from sliding as well as initiating therapy (changes were not reflected on care plan dated 3/28/23). Reviewed group sheets with DON which identified the Float and West group sheet were not consistent, DON indicated care plans and care guides should not have conflicting transfer status as it could pose a safety risk to the resident. DON indicated R1 should not have a walker in his room and could lead to additional falls and could encourage him to self-initiate ambulation or self-transfer.<br><br>R3's face sheet undated, identified R3 had the | F 689 | | |

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| F 689 | Continued From page 9<br>following diagnoses: Osteoarthritis of right knee, pain in right knee, right patella fracture, diabetes, chronic congestive heart failure, history of diseases of the digestive system, GI bleed, chronic kidney disease, and constipation.<br><br>R3's quarterly Minimum Data Set (MDS) dated 6/22/23, identified R3 was cognitive and required one person assist with toileting and transfers, also identified R3 to be occasionally incontinent, however did not require a toileting program.<br><br>Fall care plan dated 5/11/21, identified R3 to be at risk for falls and interventions in place included having call light within reach, non-skid footwear with all transfers/ambulation and assist of 1 with transfers and ambulation using four-wheel walker. Additionally, intervention dated 3/16/23 directed staff to follow wheelchair behind when ambulating and remove the footrests for safety.<br><br>Mobility care plan dated 5/11/21 identified R3 to require assist of one person and four wheeled walker to assist for both transfers and ambulation and assist of one person to propel wheelchair on and off unit.<br><br>R3's group sheet indicated R3 required assist of one person with walker for transfers, ambulation and toileting/peri care. R3's group sheet lacks information regarding high fall risk, requiring wheelchair follow when ambulating nor need for slipper socks.<br><br>R3's bladder assessments dated 6/17/23 indicate R3 was occasionally incontinent, impaired mobility and ambulation with contributing diagnosis and medications related to bladder dysfunction and both stress and urge | F 689 | | |

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incontinence. Based off assessment a scheduled toileting program was indicated, however lacks details on program type and frequency.

The following Fall Events and internal investigation was reviewed:
5/15/23 witnessed fall in bathroom lowered to floor due to bucking knees and sustained a 4 cm scratch on back. Fall event identified R3's knees are buckling.
5/28/23 unwitnessed fall in bathroom- attempting to self-transfer and legs gave out and was wearing non-skid footwear.
6/21/23 unwitnessed fall in bathroom- attempting to self-transfer and legs gave out. Was wearing non-skid footwear.
Root cause of falls were due to residents increased weakness and impaired level of mobility, balance with transfers and ambulation.

During interview on 7/27/23 at 2:20 p.m., NA-E indicated working with R3 and she had intervened and needed to stop R3 from self-transferring and it was common behavior. R3 tends to self-transfer after meals and mainly in the afternoon.

During interview on 7/25/23 at 1:44 p.m., trained medication aid (TMA)-A identified to have worked with R3 and observes her as cognitively intact, pleasant and not impulsive. TMA-A indicated to be aware of R3's falls as R3 attempts to self transfer onto the toilet. TMA-A was unaware of any interventions in place to prevent falls as R3 uses the call light appropriately, R3 was just impatient.

During interview on 7/27/23 at 1:53 p.m., NA-C was aware of R3's falls and indicated its due to R3 self-transferring. NA-C reported R3's knees

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are "bouncy" and give out during transferring, R3 will use the call light in the mornings, but doesn't typically use to call for help in the afternoons and would self-transfer from the wheelchair to the toilet. NA-C had not observed her self-transfer elsewhere. NA-C indicated R3 was at high risk of falls after lunch or following mealtimes as it was when she was in the wheelchair and her wheelchair was a surface she could physically self-transfer from.

During interview on 7/27/23 at 2:28 p.m., PT-B indicated therapy had been involved to assessed R3 on both 5/25/23 and 6/26/23 and was aware of R3's "bouncy knees", however when therapy assessed R3 did not exhibit bouncy knees and there was no clinical diagnosis. Additionally, no recommendations were made to the floor staff from therapy as they did not identify any concerns. PT-B indicated R3 did well with therapy involvement and makes progress and R3 knee concerns started when she was taken off caseload from therapy. PT-B declined therapy involvement with causal analysis when it comes to falls and typically done within the management meetings with nurse managers and DON.

During interview on 7/27/23 at 3:30 p.m., DON indicated she was unaware R3 was known to be self-transferring from wheelchair to toilet. DON indicated the bowel and bladder assessments should identify individual needs and identifies risk factors related to self-transferring in relation to toileting. Reviewed bowel and bladder assessments completed on 3/30/23 and 6/17/23, however there was not a bladder assessment on or near 5/28/23 despite R3 falling next to the toilet. R3's bladder assessment on 6/17/23 lacked any individualized recommendation.

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Facility policy titled "Accident Prevention- Fall Risk Observation" dated 2/2023 indicates the purpose of the policy was for residents to be assessed for his/her risk for falls and or accidents. Residents identified to be at risk for falls have interventions implemented through the care plan and the licensed nurse was responsible.

-It was to be used as a consistent method to determine residents at risk for falls in addition to the MDS, Corresponding Care Area assessment (CAA) for falls, cognitive loss/dementia, physical restraints, and psychotropic drug use are completed to identify additional risk factors and interventions.
-Residents at risk for falls/accidents have an individualized care plan developed. Care plan interventions are based on the findings of fall risk observation.
-Additional professionals may be contracted to provide assessment regarding fall risk and prevention including but not limited to attending physician, pharmacist, physical therapist and occupational therapist.

Facility policy titled "transfer/lifting policy and Procedure dated 3/2023 indicates the purpose of the policy was to provide safe transfer techniques to reduce incidents or injuries to all residents and staff, as well as to establish and communicate transfer and lifting policies for facility. The expected transfer plan for each resident was to be found on the care plan and the nursing assistant group sheet and it's the responsibility of all employees to follow the care plan and designated lifting policy for each resident for their personal safety as well as responsibility to report

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| F 689 | Continued From page 13 problems that would make compliance difficult. | F 689 | | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 15, 2023

Administrator
St. Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

Re: State Nursing Home Licensing Orders
Event ID: E84811

Dear Administrator:

The above facility was surveyed on July 25, 2023 through July 27, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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| 2 000 | Initial Comments | 2 000 | | |

*****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 7/25/23 through 7/27/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed. H52914011C (MN00092196) , H52914009C (MN00093837) , H52914010C (MN00095107) with a licensing order issued at 0830.<br><br>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.<br><br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>not required at the bottom of the first page of state form.<br><br>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<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to appropriately assess and implement appropriate interventions to prevent repeated falls for 2 of 2 residents (R1 and R3), who were at high risk for falls. This failure resulted in actual harm for R1 who sustained a mildly displaced right femoral neck fracture, right hip fracture, which required surgical repair and sustained a right periprosthetic femur fracture. | 2 830 | It is the policy of St. Clare Living Community of Mora to provide an environment as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.<br>For resident R1 fall risk assessment, bladder assessment, bowel assessment was completed on 8/7/23. R1's care plan and nursing assistant group worksheets | 9/1/23 |

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| 2 830 | Continued From page 3<br>Findings include:<br><br>R1's face sheet undated, identified R1 had the following diagnoses: Alzheimer's disease, dementia, adult failure to thrive, ataxic gait, muscle weakness, syncope with collapse, repeated falls and unsteadiness on feet.<br><br>R1's significant change Minimum Data Set (MDS) dated 5/2/23, identified R1 had significantly impaired cognition, required one person assist with transfers, toileting, dressing and locomotion on the unit. R1 was not steady and only able to stabilize with human assistance for balance during transitions and walking. MDS identified R1 used a wheelchair for mobility. R1 was occasionally incontinent of bowel and bladder with no bowel or bladder toileting program.<br><br>R1's bladder assessment, dated 7/12/23, identified R1 was frequently incontinent with risk factors of impaired mobility and dependent transfer. R1 has urine leakage on the way to bathroom and has wet close or wet incontinent pads. Environment limitations included impaired mobility and decreased manual dexterity with contributing diagnosis of Alzheimer's, diabetes, falls and pain with movements. Medications may be contributing to bladder dysfunction includes antidepressants, diuretics, and narcotics. Stress incontinence includes incontinence without sensation of loss of urine as well as urge urinary incontinence with strong uncontrolled urgency prior to incontinence and urine loss on the way to toilet. Scheduled toileting/habit training schedule includes every two hours with no further information.<br><br>Fall care plan dated 3/28/23 identified R1 to be at risk for falls and interventions in place included | 2 830 | were reviewed and revised to reflect current interventions on 8/7/23.<br>Individualized toileting plan was implemented as a result of assessments and staff interview on 8/7/23.<br>For resident R3 fall risk assessment, bladder assessment, bowel assessment was completed on 8/11/23. R1's care plan and nursing assistant group worksheets were reviewed and revised to reflect current interventions on 8/11/23.<br>Individualized toileting plan was implemented as a result of assessments and staff interview on 8/11/23.<br>For all other like resident who were identified using facilities Quality Measures with focus on residents who triggered for falls with major injury and falls. The facility also identified all other like residents by review of current resident fall report in the past 90 days with focus on residents who have sustained more than one fall.<br>For all other like residents, a fall risk assessment, bladder assessment and bowel assessment will be completed by 9/1/23. Residents care plans and nursing assistant group worksheets will be reviewed and revised as appropriate by 9/1/23.<br>Urinary Continence and Incontinence Assessment and Management policy and procedure was reviewed and revised on 8/21/23. Accident/Incident policy, Fall Risk Observation, and Falls and Fall Risk managing policies were reviewed and revised on 8/22/23.<br>Education provided for staff members regarding Accident/Incident policy, Fall Risk Observation, and Falls and Fall Risk managing, and Urinary Continence and | |

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soft touch call light, assist of one using EZ-Stand (mechanical lift) for transfers, wheelchair for mobility, nonskid footwear, nursing staff to encourage out of room activities, room close to nursing station and nursing staff to toilet ever two hours and as need to reduce risk of falls.

Mobility care plan dated 5/25/23 identified R1 to have impaired mobility and history of repeated falls and unsteadiness on feet, R1 required assist of one person using front wheeled walker for transfers, ambulation, and toileting. R1 used wheelchair for mobility and can propel independently or with assist of one person as needed. R1 requires gripper socks at all times.

The following Fall Risk Assessments were completed with a score of over ten indicating a high risk of falls. 12/21/23 with a score of 17, 3/22/23 with a score of 17, 3/28/23 with a score of 20, 5/1/23 with a score of 21, 7/12/23 with a score of 23, and 7/25/23 with a score of 19.
Fall Risk Observations Reviewed:
Dated 3/28/23 - Fall risk assessment summary: recent falls in the past three months and a score of 20 indicating high risk.
Dated 5/1/23 - Fall risk assessment summery: Resident had unwitnessed fall on 3/23 resulting in a femur fracture. Requires the EZ-stand lift to assist with transfers with a diagnosis of Alzheimer's disease, dementia, ataxic gait, generalized muscle weakness and a history of falls.
Dated 7/12/23- Fall risk assessment summary: At risk of falls with a score of 23 (high fall risk), Resident was alert but had confusion. Pivot transfers- do not walk with history of falls. Had multiple medications and diagnoses with potential to contribute to a fall.

Incontinence Assessment and Management policy on 8/22/23 and 8/23/23. IDT will continue to meet daily on working days to review all accidents/incidents for root cause analysis. A Fall Risk assessment will be completed post fall by RN Managers or designee.
Resident fall risk and assessment/management of urinary continence/incontinence education will continue to be provided to all new employees, through orientation and annual training programs. These programs include but are not limited to formal in-service presented by licensed staff, online education, and review of policies and procedures. All resident falls, and post Fall Risk Assessments will be audited to ensure appropriate interventions are implemented to resident’s individual plan of care. All resident Bowel and Bladder assessments will be reviewed and/or updated if applicable. Further system revision and staff education will be provided if indicated by audits and/or recommended by the QA/QI committee. The Director of Nursing or designee is responsible for monitoring on-going compliance.
Date Certain-9/1/23

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The following Fall Events and internal investigations were reviewed:

Fall event 2/5/23 at 8:05 p.m., unwitnessed fall in room with walker and R1 sustained scratch and bump on head and small abrasion on left knee.

Fall event 2/9/23 at 7:15 p.m., unwitnessed fall in bathroom attempting to self-transfer onto toilet without injuries.

Fall event 3/23/23 at 4:45 a.m., unwitnessed fall in resident room self-transferring, wheelchair found outside the bathroom. Resident reported to the charge nurse he was attempting to get to the bathroom. Fall required hospitalization and found to sustain a right femur fracture requiring surgical repair. Internal investigation requested, however not received.

Fall event 3/30/23 at 11:15 a.m., , unwitnessed fall in bathroom attempting to self-transfer from wheelchair onto toilet without injuries.

Fall event 4/15/23 at 7:45 p.m., unwitnessed fall in bathroom attempting to self-transfer from wheelchair onto toilet.

Fall event 5/6/23 at 7:50 p.m., unwitnessed fall in bathroom attempting to self-transfer from wheelchair onto toilet without injuries.

Fall event 5/25/23 at 12:30 p.m, unwitnessed fall in bathroom attempting to self-transfer with skin tear an inch long on wrist. Internal investigation identified gripper socks on but was not able to safely transfer without the use of an EZ stand lift and nursing staff to assist. R1 was last toileted at 10:30 and fall happened at 12:30.

Fall event 7/6/23 6:27 p.m., unwitnessed fall in R1's room, resident on floor, w/c tipped over and walker next to wheelchair. Fall required hospitalization and identification of periprosthetic femur fracture.

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| 2 830 | Continued From page 6<br>Review of facility's internal investigation notes indicated a patterned statement of root cause was due to resident's impaired level of mobility, cognitive status and generalized weakness. The internal investigation lacked evidence of a general assessment for pattern of falls, reason for falling (time, toileting needs, supervision) and lacked fall interventions to prevent future falls.<br><br>R1's group assignment sheet information noted to be on two separate group sheets as indicated below.<br><br>-R1's float group assignment sheet undated, identified R1 to require assist of one person with the use of EZ-Stand and toilet every two hours. Safety considerations include history of self-transfers, poor safety awareness/impulsive. Comments include bed in low position, lotion to feet/legs at night.<br>-R1's west group assignment sheet dated 7/25/23 consistently notes assist of one person with use of EZ-Stand and toilet every two hours. Safety consideration includes history of self-transfers with bathroom, and comments include bed in low position, lotion to feet/legs every two hours, hip precautions, no bending past 90 degrees, no crossing legs. Incontinent of bowel and bladder, alert to self, forgetful needs cues.<br><br>After visit hospital summery printed 3/27/23, indicated that R1 was hospitalized on 3/23/23 and admitted for evaluation and management of mildly displaced right femoral neck fracture due to R1 falling under unclear circumstances at skilled nursing home facility. Note further identifies that resident required surgical repair on 3/24/23 for a right hip fracture due to an unwitnessed fall.<br><br>After visit hospital summery signed on 7/11/23, | 2 830 | | |

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indicates R1 was hospitalized on 7/7/23 and discharged on 7/11/23 for a right periprosthetic femur fracture. It was determined to be treated non operatively.

Group assignment sheets directing nursing aids provided inconsistent information, lacked information from the care plan and safety consideration for R1, including resident FALL RISK and care following femur fracture.

During interview on 7/25/23 at 3:29 p.m., R1 indicated the staff are too busy so he uses the bathroom independently. R1 indicated to know how to use the call light, but he likes to take himself to the bathroom.

During interview on 7/25/23 at 3:40 p.m., nurse aid (NA)-E indicated they used the the group sheets to know what care the residents need and if residents were a high fall risk, by the group sheet indicating *High Fall Risk.*

During interview on 7/25/23 at 4:16 p.m., license practical nurse (LPN)-A indicated care group sheets should never have discrepancies from either the care plan or if a resident were to be on different groups.

During interview on 7/25/23 at 4:59 p.m., LPN-B indicated R1 was a high fall risk only when in bed and interventions include floor mat, bed to the lowest position, and call light within reach to prevent falls. LPN-B declined R1 to be a fall risk from wheelchair and had never been notified R1 tries to self-transfer onto the toilet, just from the bed.

During interview on 7/27/23 at 2:11 p.m., NA-C indicated R1 had a walker in his room however

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shouldn't be in his room because he doesn't use it and either should the nursing staff. NA-C indicated R1 did not use call light and would attempt to transfer from the wheelchair to the toilet on his own. NA-C indicated to be aware of R1's behaviors as R1 tends to wheel his wheelchair close to the bathroom door when he needs to go to the bathroom and R1 was not always incontinent and will request to use the toilet when needed.

During interview on 7/27/23 at 9:00 a.m., physical therapist (PT)-A indicated R1 was a high fall risk and it was therapy's recommendation for nursing staff to use EZ-Stand for transfers for safety. PT-A indicated R1 was unsafe to transfer independently and unable to correctly position wheelchair or lock brakes to transfer to the toilet and does not follow the steps required to complete a safe and independent transfer, further R1 was impulsive with cognitive deficits. PT-A confirmed fall mat, high low bed and soft touch bedroom call light would not prevent or address a safety concern from R1 attempting to transfer to toilet.

During interview on 7/27/23 at 9:04 a.m., RN-B indicated R1 had a room closer to the nurses station, high low bed, soft touch call light and slipper socks as interventions implemented prior to February of 2023 frequent monitoring is encouraged, however no formal protocol or time frame of the expectation. RN-B indicated there should never be discrepancies on care cards or group guides and it was identified the care guides directed nursing assistance to use EZ-Stand, however the care plan reflected assist of one person with walker and it was identified on 7/25/23 as a discrepancy. Upon reviewing interventions for falls for R1, RN-B indicated the

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current interventions do not prevent or address R1 from self-transferring in the bathroom and an intervention should have been in place. RN-B furthermore reflected there was not enough causal analysis of stopping and preventing falls in the bathroom and if frequent checks are encouraged it should be care planned and on the group guides. Fall risk assessment scores reviewed and noted an upward trend from 12/21/23 to 7/25/23 with no preventative action.

During interview on 7/27/23 at 2:27 p.m., (PT)-B indicated it was not therapies recommendation for nursing staff to use the walker with R1, however sees no issue with it being accessible in his room. PT-B indicated the first functional bathroom transfer assessment was completed on 7/25/23 and not addressed prior. PT-B declined occupational therapy to be involved or evaluate or provide recommendations for functional transfer training in bathroom or cognitive based interventions.

During interview on 7/27/23 at 10:10 a.m., fall review completed with director of nursing (DON) and noted 3/23/23 root cause of fall to be R1's cognition and fall happened due to self-transferring and R1 not consistently use call light. Following the fall on 3/23/23, the wheelchair was implemented for mobility, mat and high low bed were also implemented (changes were not reflected on care plan dated 3/28/23). DON indicated for the 3/30/23, 4/15/23, 5/6/23 falls without interventions in place she would expect something more have been in place and frequent checks should have been put in both the care plans and group sheets. R1 was screened by physical therapy after 5/6/23 fall, however it was not indicated for therapy to see him on caseload and R1 was transferring with the EZ-Stand per

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therapy recommendation at that time with nursing. After the 5/25/23 fall also did not have interventions placed and the DON indicated the facility should have done something more including identified, trend tracking of self-transferring, placed interventions to protect R1 and recognition current toileting schedule was not preventing falls. DON added, the 7/6/23 fall was reviewed and the intervention that was placed was anti-lock brakes on to the wheelchair to prevent it from sliding as well as initiating therapy (changes were not reflected on care plan dated 3/28/23). Reviewed group sheets with DON which identified the Float and West group sheet were not consistent, DON indicated care plans and care guides should not have conflicting transfer status as it could pose a safety risk to the resident. DON indicated R1 should not have a walker in his room and could lead to additional falls and could encourage him to self-initiate ambulation or self-transfer.

R3's face sheet undated, identified R3 had the following diagnoses: Osteoarthritis of right knee, pain in right knee, right patella fracture, diabetes, chronic congestive heart failure, history of diseases of the digestive system, GI bleed, chronic kidney disease, and constipation.

R3's quarterly Minimum Data Set (MDS) dated 6/22/23, identified R3 was cognitive and required one person assist with toileting and transfers, also identified R3 to be occasionally incontinent, however did not require a toileting program.

Fall care plan dated 5/11/21, identified R3 to be at risk for falls and interventions in place included having call light within reach, non-skid footwear with all transfers/ambulation and assist of 1 with transfers and ambulation using four-wheel

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walker. Additionally, intervention dated 3/16/23 directed staff to follow wheelchair behind when ambulating and remove the footrests for safety.

Mobility care plan dated 5/11/21 identified R3 to require assist of one person and four wheeled walker to assist for both transfers and ambulation and assist of one person to propel wheelchair on and off unit.

R3's group sheet indicated R3 required assist of one person with walker for transfers, ambulation and toileting/peri care. R3's group sheet lacks information regarding high fall risk, requiring wheelchair follow when ambulating nor need for slipper socks.

R3's bladder assessments dated 6/17/23 indicate R3 was occasionally incontinent, impaired mobility and ambulation with contributing diagnosis and medications related to bladder dysfunction and both stress and urge incontinence. Based off assessment a scheduled toileting program was indicated, however lacks details on program type and frequency.

The following Fall Events and internal investigation was reviewed:
5/15/23 witnessed fall in bathroom lowered to floor due to bucking knees and sustained a 4 cm scratch on back. Fall event identified R3's knees are buckling.
5/28/23 unwitnessed fall in bathroom- attempting to self-transfer and legs gave out and was wearing non-skid footwear.
6/21/23 unwitnessed fall in bathroom- attempting to self-transfer and legs gave out. Was wearing non-skid footwear.
Root cause of falls were due to residents increased weakness and impaired level of

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| 2 830 | Continued From page 12<br>mobility, balance with transfers and ambulation.<br><br>During interview on 7/27/23 at 2:20 p.m., NA-E indicated working with R3 and she had intervened and needed to stop R3 from self-transferring and it was common behavior. R3 tends to self-transfer after meals and mainly in the afternoon.<br><br>During interview on 7/25/23 at 1:44 p.m., trained medication aid (TMA)-A identified to have worked with R3 and observes her as cognitively intact, pleasant and not impulsive. TMA-A indicated to be aware of R3's falls as R3 attempts to self transfer onto the toilet. TMA-A was unaware of any interventions in place to prevent falls as R3 uses the call light appropriately, R3 was just impatient.<br><br>During interview on 7/27/23 at 1:53 p.m., NA-C was aware of R3's falls and indicated its due to R3 self-transferring. NA-C reported R3's knees are "bouncy" and give out during transferring, R3 will use the call light in the mornings, but doesn't typically use to call for help in the afternoons and would self-transfer from the wheelchair to the toilet. NA-C had not observed her self-transfer elsewhere. NA-C indicated R3 was at high risk of falls after lunch or following mealtimes as it was when she was in the wheelchair and her wheelchair was a surface she could physically self-transfer from.<br><br>During interview on 7/27/23 at 2:28 p.m., PT-B indicated therapy had been involved to assessed R3 on both 5/25/23 and 6/26/23 and was aware of R3's "bouncy knees", however when therapy assessed R3 did not exhibit bouncy knees and there was no clinical diagnosis. Additionally, no recommendations were made to the floor staff from therapy as they did not identify any | 2 830 | | |

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concerns. PT-B indicated R3 did well with therapy involvement and makes progress and R3 knee concerns started when she was taken off caseload from therapy. PT-B declined therapy involvement with causal analysis when it comes to falls and typically done within the management meetings with nurse managers and DON.

During interview on 7/27/23 at 3:30 p.m., DON indicated she was unaware R3 was known to be self-transferring from wheelchair to toilet. DON indicated the bowel and bladder assessments should identify individual needs and identifies risk factors related to self-transferring in relation to toileting. Reviewed bowel and bladder assessments completed on 3/30/23 and 6/17/23, however there was not a bladder assessment on or near 5/28/23 despite R3 falling next to the toilet. R3's bladder assessment on 6/17/23 lacked any individualized recommendation.

Facility policy titled "Accident Prevention- Fall Risk Observation" dated 2/2023 indicates the purpose of the policy was for residents to be assessed for his/her risk for falls and or accidents. Residents identified to be at risk for falls have interventions implemented through the care plan and the licensed nurse was responsible.

-It was to be used as a consistent method to determine residents at risk for falls in addition to the MDS, Corresponding Care Area assessment (CAA) for falls, cognitive loss/dementia, physical restraints, and psychotropic drug use are completed to identify additional risk factors and interventions.
-Residents at risk for falls/accidents have an individualized care plan developed. Care plan interventions are based on the findings of fall risk

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| 2 830 | Continued From page 14<br><br>observation.<br>-Additional professionals may be contracted to provide assessment regarding fall risk and prevention including but not limited to attending physician, pharmacist, physical therapist and occupational therapist.<br><br>Facility policy titled "transfer/lifting policy and Procedure dated 3/2023 indicates the purpose of the policy was to provide safe transfer techniques to reduce incidents or injuries to all residents and staff, as well as to establish and communicate transfer and lifting policies for facility. The expected transfer plan for each resident was to be found on the care plan and the nursing assistant group sheet and it's the responsibility of all employees to follow the care plan and designated lifting policy for each resident for their personal safety as well as responsibility to report problems that would make compliance difficult.<br><br>SUGGESTED METHOD OF CORRECTION:<br>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.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |