DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PBXL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00730

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245299**
2.STATE VENDOR OR MEDICAID NO.
(L2) **972153000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2004**

6. DATE OF SURVEY **12/08/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
LeAnn Huseth, Unit Supervisor 12/09/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/09/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 9, 2021

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: September 24, 2021

Dear Administrator:

On October 14, 2021, we notified you a remedy was imposed. On December 7, 2021 the Minnesota Department(s) of Health and Public Safety 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 November 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 16, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 14, 2021, 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 November 16, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 15, 2021, 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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 9, 2021

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

Re: Reinspection Results
Event ID: 3G3U12

Dear Administrator:

On December 7, 2021 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 December 7, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered November 19, 2021

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: September 24, 2021

Dear Administrator:

On October 14, 2021, we informed you of imposed enforcement remedies.

On November 4, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On November 4, 2021, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effectiveNovember 16, 2021, will remain in effect.

This Department continues to recommend that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 16, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 16, 2021.

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.

As we notified you in our letter of October 14, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 16, 2021. However, due to the extended survey the new NATCEP loss date is November 4, 2021.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Frazee Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 4, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 March 24, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/3/21, to 11/4/21, 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 complaint was found to be SUBSTANTIATED: H5299039C (MN00077696), with a deficiency cited at F689. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility had failed to implement appropriate interventions to prevent falls for 1 of 1 residents (R1) which included not following the care plan for appropriate foot wear and use of gait belt for safety while transferring in bathroom. The IJ began on 10/14/21, and the immediacy was removed on 11/4/21. The above findings constituted substandard quality of care, and an extended survey was conducted on 11/4/21. 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	Free of Accident Hazards/Supervision/Devices	F 689		11/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/29/2021

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 SS=J	Continued From page 1 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement appropriate foot wear and use of a gait belt during transfers for 1 of 1 residents (R1) reviewed for falls. These findings resulted in an immediate jeopardy (IJ) situation for R1 when R1 fell during a transfer while wearing regular socks and staff were not using a gait belt. R1 required surgical repair of the fractured hip. All residents have the potential for serious injury, impairment or death with improper use of transfer devices and improper footwear. The immediate jeopardy began on 10/14/21, when R1 was transferred without appropriate foot wear and use of a gait belt for safety and had a fall, which resulted in R1 obtaining a serious injury, was transferred to the hospital and it was identified he had an intertrochanteric (hip) fracture. The director of nursing (DON), administrator and the facility consultant were notified of the immediate jeopardy on 11/3/21, at 7:09 p.m. The immediate jeopardy was removed on 11/4/21, at 4:13 p.m. when the facility implemented measures to prevent falls for other residents who were at risk for falls, however, noncompliance remained at the lower pattern scope and severity level D, which indicated no	F 689	F689 1. Resident #1 had expired upon receipt of the 2467 so no specific measures were taken for him. 2. All other residents at risk for falls have the potential to be affected. Residents were reviewed to determine current fall interventions were accurate and care plans were updated. All residents identified as having fall interventions have had confirmation of appropriate interventions in place by observation. All resident having falls interventions Kardex have been update in electronic health record for staff to have quick access to interventions to prevent falls. 3. Nursing staff educated on proper use of transfer belts; transfers; and following plan of care for interventions to prevention falls. Nursing staff showed return demonstration with competency in use of transfer belts Nursing staff educated on use of Kardex and location of falls interventions in E.H.R. 4. Audits of use of transfer belts will be	

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F 689	Continued From page 2 actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had severe cognitive impairment and had diagnoses which included: stroke, malnutrition, depression and anxiety. R1's MDS indicated R1 required extensive assistance with transfers, toileting, dressing and grooming. R1's MDS identified he used a walker and wheelchair, had range of motion impairment on one upper and lower side, was not steady and only able to stabilize with staff assistance. R1's MDS indicated he had no falls and received hospice care. R1's Significant Change in Status Care Area Assessment (CAA) dated 5/4/21, identified R1 was at risk for falls due to a history of a falls related to cerebrovascular accident (stroke) and cognitive impairment. R1's CAA identified falls would be addressed on R1's care plan to slow or minimize decline, avoid complications and minimize risk. R1's Fall risk Screening tool dated 8/16/21, identified R1 had no fall history and had poor safety awareness and noted some cognitive impairment. The tool identified R1 was at risk for falls due to left sided weakness. R1's Fall Risk Screening tool dated identified R1 had one to three falls in three months. R1's tool identified underlying diseases or conditions which included: psychiatric or cognitive conditions, orthopedic/joint/arthritis, neuromuscular/functional loss, CVA	F 689	done 5 days a week for 2 weeks and then 3 times per week for 2 weeks and weekly for 2 months. Audits of proper transfers will be done 5 days a week for 2 weeks and then 3 times per week for 2 weeks and weekly for 2 months. Audits of following the plan of care for falls interventions will be done 5 days a week for 2 weeks and then 3 times per week for 2 weeks and weekly for 2 months. Audits of use of Kardex for access to plan of care interventions will be done 5 days a week for 2 weeks and then 3 times per week for 2 weeks and weekly for 2 months. Findings of audits are to be reported to the QA committee monthly for a year. Those findings will be reviewed and revised pursuant to our QA process. 5 Date of Compliance – 11/4/21	

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F 689	Continued From page 3	F 689		

(cerebrovascular accident, stroke) and hip fracture. The tool indicated R1 had recent medication changes due to being on hospice medications for end of life. The tool identified R1 had mobility problems, used assistive devises, and R1 was at risk for falls.

R1's care plan dated 10/20/21, identified R1 was at risk for falls related to gait/balance problems. R1's fall interventions included: ensure R1 was wearing appropriate footwear when ambulating, anti-skid strips placed on floor in R1's bathroom and at bedside, and bed in low position at night. R1's care plan indicated R1 had activities of daily living (ADL) self care performance deficit related to disease process, impaired balance and required 1 staff participation to use toilet. R1's care plan identified R1 required Hoyer (mechanical lift) transfers.

R1's incident report titled Fall-Witnessed dated 10/14/21, at 10:00 p.m. identified staff were in the bathroom with R1 when R1 turned and leaned toward the garbage can to spit, lost his balance and fell, landing on his buttocks and bumped the top of his head on the other door. R1 was initially able to move all extremities. When staff assisted R1 to stand it was noted R1 unable to move his left leg and complained of pain in his hip. R1 was assisted into a wheelchair. Injuries observed at the time of the incident included an abrasion to the top of R1's scalp and fracture of left trochanter (hip). Other information listed on the report identified R1 had regular stockings on his feet instead of the gripper socks.

R1's Interdisciplinary Team (IDT) Post Fall Review dated 10/14/21, identified R1 fell on 10/14/21, at 10:00 p.m. The review identified R1

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FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544**

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F 689	Continued From page 4	F 689		

had turned and was bending over the garbage to spit, lost his balance and fell. R1's current interventions included dycem (non-slip material) in chair and gripper socks on feet. R1's review identified R1 did not have gripper socks on at the time of the fall.

On 11/3/21, at 1:23 p.m. during a telephone interview, nursing assistant (NA)-A confirmed R1 was wearing regular socks at the time of the incident instead of the gripper socks. NA-A confirmed he did not have a hold of the gait belt when R1 fell. NA-A stated when NA-A assisted R1 off of the toilet, R1 leaned over to spit as he normally did, lost his balance and fell backwards. NA-A stated he let go of the gait belt as R1 bent over to spit as he felt there was not enough room to hang on to the gait belt. NA-A indicated no follow up education had been provided by the facility.

On 11/3/21, at 1:28 p.m. during a telephone interview, licensed practical nurse (LPN)-A stated she had completed the initial assessment after R1's fall. LPN-A confirmed R1 wore regular socks instead of the gripper socks when the fall occurred. Additionally, LPN-A stated NA-A informed her he had let go of R1's gait belt in the bathroom before R1 fell. LPN-A stated she had received no education regarding fall prevention following the incident.

On 11/3/21, at 1:35 p.m. NA-C indicated R1 required assistance of one staff with a gait belt and walker and at times would require the use of the PAL or Hoyer lift for transfers. NA-C stated she always held onto R1's gait belt when he stood, transferred or walked, and indicated R1 would always turn the same way each time he

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	245299	A. BUILDING _____ B. WING _____	C 11/04/2021

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was transferred off the toilet. NA-C stated she had not received education following R1's incident.

On 11/3/21, at 2:59 p.m. NA-B stated R1 required assistance of one staff and a gait belt for transfers. NA-B indicated she would always hold the gait belt when R1 was transferred. NA-B stated R1 at times required a PAL lift when R1 was very tired. NA-B indicated she had not received any education after R1's fall.

On 11/3/21, at 3:30 p.m. registered nurse (RN)-A indicated she always utilized a walker and gait belt when assisting R1 to the bathroom. RN-A stated R1 had a shuffling gait and would always turn to spit in the garbage can. RN-A indicated staff were aware R1 would "trip up" during the transfer, however R1 never fell in the bathroom prior to the 10/14/21, fall. RN-A stated R1 became unsteady when he would turn to spit. RN-A confirmed the facility had not provided education to staff following R1's fall.

On 11/3/21, at 3:40 p.m. clinical manager (CM)-A stated prior to R1's 10/14/21, fall, R1 required assistance of one staff while utilizing a walker and gait belt for transfers and walking. CM-A indicated R1 had a shuffling gait, was unsteady and staff were expected to always use a gait belt and walker when transferring him. CM-A stated staff were expected to utilize the gait belt when transferring R1 off of the toilet as R1 would routinely lean and spit into the garbage can prior to exiting the bathroom.

Review of R1's progress notes from 10/14/21, to 10/20/21, identified the following:

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F 689	Continued From page 6	F 689		

-10/14/21, at 10:30 p.m. alerted by nursing assistant (NA), R1 found on floor in bathroom, feet outside bathroom door and head next to opposite door. NA stated R1 turned to leave bathroom, bent over garbage to spit, lost his balance and fell hard on his bottom and bumped his head on opposite door. Initially, R1 was able to move all 4 extremities while lying down. Once staff assisted R1 off the floor, it was noted R1 was unable to move his leg and complained of pain. Hospice and family were contacted and agreed to transfer R1 to emergency room for x-rays and pain management. R1 transferred to emergency room per ambulance.
-10/15/21, at 2:30 a.m. facility staff received a call from the hospital, R1 had a fractured hip and the plan was for surgery tomorrow or the next day.
-10/18/21, at 4:42 p.m. R1 transferred from hospital back to the facility. R1 had right hip surgery on 10/15/21, after a witnessed fall at facility. R1 was admitted to hospice.
-10/20/21, at 9:20 a.m. R1 passed away peacefully about 9:05 a.m. with family present. Hospice and the funeral home were notified and the body was removed.

R1's Emergency Department (ED) Provider Notes dated 10/14/21, identified R1 was admitted to the emergency room with complaint of left hip pain after a fall. The note identified R1 had a small laceration to his head and some discomfort there as well. The ED course identified R1's small laceration to the back of his head was cleansed thoroughly and adhesive was placed over the wound for closure. R1 was on Hospice and R1 revoked his hospice care at the time. R1's X-ray of the hip demonstrated an intertrochanteric (hip) fracture.

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R1's Hospital Discharge Summary dated 10/18/21, identified R1 was admitted from the facility where he was on hospice services. R1 had fallen with a left hip fracture. R1 was admitted and hospice was discontinued to surgically repair the hip for comfort measures. R1 was slow to mobilize with therapy and did not return to his pre-surgical condition mentally. R1 had some improvement, however, was noted to be choking on fluids yesterday, discussion held with family and agreed to have R1 transferred back to the facility on hospice. Hospice consulted with plans to admit R1 later today at the facility.

R1's Orthopedic Surgery Discharge Summary dated 10/18/21, identified R1 was admitted to hospital on 10/14/21, for a principle and pre-operative diagnoses of closed left intertrochanteric (hip) fracture. R1 had a surgical repair which consisted of a left trochanteric fixation and nailing.

R1's Documentation Of Death form, undated, identified R1 died on 10/20/21, of acute respiratory distress syndrome, and presumed aspiration pneumonia. The form identified other significant concerns contributing to death was the fall resulting in hip fracture 10/14/21, and R1 underwent surgery on 10/15/21.

On 11/3/21, at 3:33 p.m. administrator indicated after R1's fall, the nurse assessed him and noted R1 had no pain, however, after a short time R1 developed pain and was transferred to the hospital. The facility received notification R1 had a fracture and had chosen surgery. Administrator indicated when R1 was re-admitted to the facility, R1 was placed back on hospice services. Administrator stated he completed the five day

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investigation after R1's fall which included interviewing NA-A who was present during R1's fall, LPN-A who assessed R1 after his fall and CM-A. Administrator confirmed he had not been aware R1's fall prevention interventions were not being followed, or any concerns with how NA assisted R1 in the bathroom or during his transfer, which resulted in R1's fall. Administrator confirmed he had not been aware it was identified on R1's IDT Post Fall Review R1 had been wearing regular socks instead of the gripper socks. Administrator confirmed the facility had not provided any education to the staff following R1's fall, as he believed at the time NA-A had followed the facility procedures.

The facility policy titled Accidents/Falls-HDRG revised 5/20, identified the facility strived to promote safety, dignity, and overall quality of life for its residents by providing an environment that was free from any hazards for which the facility had control and by providing appropriate supervision and interventions to prevent avoidable accidents. The policy further identified a care plan for fall risk would be developed and communicated to all appropriate staff. The policy identified that each incident/accident or fall would be investigated and/or assessed to determine the cause of the episode to prevent any further injury and the interdisciplinary team would review all incident/accident reports whenever possible.

The facility policy titled Gait/Transfer Belt, revised 4/09, identified gait/transfer belts may be used to prevent injury to employees and the resident when transferring the resident. The policy procedures included applying the belt around the resident's waist over his/her clothing, allowing enough room between the belt and his/her

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F 689	Continued From page 9 clothing for a flat hand to be inserted and after the transfer removed the belt. The IJ which began on 10/14/21, was removed on 11/4/21, when the facility successfully implemented a removal plan which included: review of the policies for accidents and incidents, development of person-centered care plans, and gait belt for transfers, review of current residents' care plans and Kardex to determine fall interventions were appropriate and accurate, with observations made to assure appropriate interventions were in place. The facility provided education to nursing staff on proper use of transfer belts, transfers, following the care plan for interventions to prevent falls, and use of Kardex for location of fall interventions. The facility performed competency testing of staff for use of transfer belts as well. The facility provided education to the staffing director to ensure nursing staff were checked off on education list and to notify the DON/designee to educate staff prior to working their next shift. On 11/4/21, between 1:40 p.m. to 4:00 p.m. interviews with staffing director, nursing staff and management verified training on transfer belts, transfers, fall interventions and Kardex was completed, as well as all residents were reviewed to assure fall interventions were in place and accurate. The facility had a plan in place and check off system to assure all staff would be educated prior to working their next shift.	F 689		
F 840 SS=C	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific	F 840		12/2/21

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F 840	Continued From page 10 service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an emergency dental agreement had been completed which had the potential to affect all 37 residents residing in the facility reviewed during the extended survey. Findings include: During the extended survey document review on 11/4/21, at 2:27 p.m. a copy of the facility dental agreement was requested. The facility was unable to provide a copy of an agreement. The Administrator confirmed the facility did not have a current dental agreement in place.	F 840	F840 1. All residents have the potential to be affected. 2. A dental contract for emergency services will be obtained through a local dental provider. 3. Nursing staff will be educated on the dental services availability. 4. Date of compliance – 12/2/21	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2021

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

Re: State Nursing Home Licensing Orders
Event ID: 3G3U11

Dear Administrator:

The above facility was surveyed on November 3, 2021 through November 4, 2021 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/3/21, to 11/4/21, 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: H5299039C (MN00077696) with a licensing order issued at 0830 . Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement appropriate foot wear and use of a gait belt during transfers for 1 of 1 residents (R1) reviewed for falls. These findings resulted in an immediate jeopardy (IJ) situation for R1 when R1 fell during a transfer while wearing regular socks and staff were not using a gait belt. R1 required surgical repair of the fractured hip. All residents have the potential for serious injury, impairment or death with improper use of transfer devices and improper footwear.	2 830	Corrected	11/4/21

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2 830	Continued From page 3 The immediate jeopardy began on 10/14/21, when R1 was transferred without appropriate foot wear and use of a gait belt for safety and had a fall, which resulted in R1 obtaining a serious injury, was transferred to the hospital and it was identified he had an intertrochanteric (hip) fracture. The director of nursing (DON), administrator and the facility consultant were notified of the immediate jeopardy on 11/3/21, at 7:09 p.m. The immediate jeopardy was removed on 11/4/21, at 4:13 p.m. when the facility implemented measures to prevent falls for other residents who were at risk for falls, however, noncompliance remained at the lower pattern scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/17/21, identified R1 had severe cognitive impairment and had diagnoses which included: stroke, malnutrition, depression and anxiety. R1's MDS indicated R1 required extensive assistance with transfers, toileting, dressing and grooming. R1's MDS identified he used a walker and wheelchair, had range of motion impairment on one upper and lower side, was not steady and only able to stabilize with staff assistance. R1's MDS indicated he had no falls and received hospice care. R1's Significant Change in Status Care Area Assessment (CAA) dated 5/4/21, identified R1 was at risk for falls due to a history of a falls related to cerebrovascular accident (stroke) and cognitive impairment. R1's CAA identified falls would be addressed on R1's care plan to slow or minimize decline, avoid complications and	2 830		

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2 830	Continued From page 4 minimize risk. R1's Fall risk Screening tool dated 8/16/21, identified R1 had no fall history and had poor safety awareness and noted some cognitive impairment. The tool identified R1 was at risk for falls due to left sided weakness. R1's Fall Risk Screening tool dated identified R1 had one to three falls in three months. R1's tool identified underlying diseases or conditions which included: psychiatric or cognitive conditions, orthopedic/joint/arthritis, neuromuscular/functional loss, CVA (cerebrovascular accident, stroke) and hip fracture. The tool indicated R1 had recent medication changes due to being on hospice medications for end of life. The tool identified R1 had mobility problems, used assistive devises, and R1 was at risk for falls. R1's care plan dated 10/20/21, identified R1 was at risk for falls related to gait/balance problems. R1's fall interventions included: ensure R1 was wearing appropriate footwear when ambulating, anti-skid strips placed on floor in R1's bathroom and at bedside, and bed in low position at night. R1's care plan indicated R1 had activities of daily living (ADL) self care performance deficit related to disease process, impaired balance and required 1 staff participation to use toilet. R1's care plan identified R1 required Hoyer (mechanical lift) transfers. R1's incident report titled Fall-Witnessed dated 10/14/21, at 10:00 p.m. identified staff were in the bathroom with R1 when R1 turned and leaned toward the garbage can to spit, lost his balance and fell, landing on his buttocks and bumped the top of his head on the other door. R1 was initially	2 830		

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able to move all extremities. When staff assisted R1 to stand it was noted R1 unable to move his left leg and complained of pain in his hip. R1 was assisted into a wheelchair. Injuries observed at the time of the incident included an abrasion to the top of R1's scalp and fracture of left trochanter (hip). Other information listed on the report identified R1 had regular stockings on his feet instead of the gripper socks.

R1's Interdisciplinary Team (IDT) Post Fall Review dated 10/14/21, identified R1 fell on 10/14/21, at 10:00 p.m. The review identified R1 had turned and was bending over the garbage to spit, lost his balance and fell. R1's current interventions included dycem (non-slip material) in chair and gripper socks on feet. R1's review identified R1 did not have gripper socks on at the time of the fall.

On 11/3/21, at 1:23 p.m. during a telephone interview, nursing assistant (NA)-A confirmed R1 was wearing regular socks at the time of the incident instead of the gripper socks. NA-A confirmed he did not have a hold of the gait belt when R1 fell. NA-A stated when NA-A assisted R1 off of the toilet, R1 leaned over to spit as he normally did, lost his balance and fell backwards. NA-A stated he let go of the gait belt as R1 bent over to spit as he felt there was not enough room to hang on to the gait belt. NA-A indicated no follow up education had been provided by the facility.

On 11/3/21, at 1:28 p.m. during a telephone interview, licensed practical nurse (LPN)-A stated she had completed the initial assessment after R1's fall. LPN-A confirmed R1 wore regular socks instead of the gripper socks when the fall occurred. Additionally, LPN-A stated NA-A

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informed her he had let go of R1's gait belt in the bathroom before R1 fell. LPN-A stated she had received no education regarding fall prevention following the incident.

On 11/3/21, at 1:35 p.m. NA-C indicated R1 required assistance of one staff with a gait belt and walker and at times would require the use of the PAL or Hoyer lift for transfers. NA-C stated she always held onto R1's gait belt when he stood, transferred or walked, and indicated R1 would always turn the same way each time he was transferred off the toilet. NA-C stated she had not received education following R1's incident.

On 11/3/21, at 2:59 p.m. NA-B stated R1 required assistance of one staff and a gait belt for transfers. NA-B indicated she would always hold the gait belt when R1 was transferred. NA-B stated R1 at times required a PAL lift when R1 was very tired. NA-B indicated she had not received any education after R1's fall.

On 11/3/21, at 3:30 p.m. registered nurse (RN)-A indicated she always utilized a walker and gait belt when assisting R1 to the bathroom. RN-A stated R1 had a shuffling gait and would always turn to spit in the garbage can. RN-A indicated staff were aware R1 would "trip up" during the transfer, however R1 never fell in the bathroom prior to the 10/14/21, fall. RN-A stated R1 became unsteady when he would turn to spit. RN-A confirmed the facility had not provided education to staff following R1's fall.

On 11/3/21, at 3:40 p.m. clinical manager (CM)-A stated prior to R1's 10/14/21, fall, R1 required assistance of one staff while utilizing a walker and gait belt for transfers and walking. CM-A indicated

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2 830	Continued From page 7 R1 had a shuffling gait, was unsteady and staff were expected to always use a gait belt and walker when transferring him. CM-A stated staff were expected to utilize the gait belt when transferring R1 off of the toilet as R1 would routinely lean and spit into the garbage can prior to exiting the bathroom. Review of R1's progress notes from 10/14/21, to 10/20/21, identified the following: -10/14/21, at 10:30 p.m. alerted by nursing assistant (NA), R1 found on floor in bathroom, feet outside bathroom door and head next to opposite door. NA stated R1 turned to leave bathroom, bent over garbage to spit, lost his balance and fell hard on his bottom and bumped his head on opposite door. Initially, R1 was able to move all 4 extremities while lying down. Once staff assisted R1 off the floor, it was noted R1 was unable to move his leg and complained of pain. Hospice and family were contacted and agreed to transfer R1 to emergency room for x-rays and pain management. R1 transferred to emergency room per ambulance. -10/15/21, at 2:30 a.m. facility staff received a call from the hospital, R1 had a fractured hip and the plan was for surgery tomorrow or the next day. -10/18/21, at 4:42 p.m. R1 transferred from hospital back to the facility. R1 had right hip surgery on 10/15/21, after a witnessed fall at facility. R1 was admitted to hospice. -10/20/21, at 9:20 a.m. R1 passed away peacefully about 9:05 a.m. with family present. Hospice and the funeral home were notified and the body was removed. R1's Emergency Department (ED) Provider Notes dated 10/14/21, identified R1 was admitted to the emergency room with complaint of left hip pain	2 830		

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after a fall. The note identified R1 had a small laceration to his head and some discomfort there as well. The ED course identified R1's small laceration to the back of his head was cleansed thoroughly and adhesive was placed over the wound for closure. R1 was on Hospice and R1 revoked his hospice care at the time. R1's X-ray of the hip demonstrated an intertrochanteric (hip) fracture.

R1's Hospital Discharge Summary dated 10/18/21, identified R1 was admitted from the facility where he was on hospice services. R1 had fallen with a left hip fracture. R1 was admitted and hospice was discontinued to surgically repair the hip for comfort measures. R1 was slow to mobilize with therapy and did not return to his pre-surgical condition mentally. R1 had some improvement, however, was noted to be choking on fluids yesterday, discussion held with family and agreed to have R1 transferred back to the facility on hospice. Hospice consulted with plans to admit R1 later today at the facility.

R1's Orthopedic Surgery Discharge Summary dated 10/18/21, identified R1 was admitted to hospital on 10/14/21, for a principle and pre-operative diagnoses of closed left intertrochanteric (hip) fracture. R1 had a surgical repair which consisted of a left trochanteric fixation and nailing.

R1's Documentation Of Death form, undated, identified R1 died on 10/20/21, of acute respiratory distress syndrome, and presumed aspiration pneumonia. The form identified other significant concerns contributing to death was the fall resulting in hip fracture 10/14/21, and R1 underwent surgery on 10/15/21.

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2 830	Continued From page 9 On 11/3/21, at 3:33 p.m. administrator indicated after R1's fall, the nurse assessed him and noted R1 had no pain, however, after a short time R1 developed pain and was transferred to the hospital. The facility received notification R1 had a fracture and had chosen surgery. Administrator indicated when R1 was re-admitted to the facility, R1 was placed back on hospice services. Administrator stated he completed the five day investigation after R1's fall which included interviewing NA-A who was present during R1's fall, LPN-A who assessed R1 after his fall and CM-A. Administrator confirmed he had not been aware R1's fall prevention interventions were not being followed, or any concerns with how NA assisted R1 in the bathroom or during his transfer, which resulted in R1's fall. Administrator confirmed he had not been aware it was identified on R1's IDT Post Fall Review R1 had been wearing regular socks instead of the gripper socks. Administrator confirmed the facility had not provided any education to the staff following R1's fall, as he believed at the time NA-A had followed the facility procedures. The facility policy titled Accidents/Falls-HDRG revised 5/20, identified the facility strived to promote safety, dignity, and overall quality of life for its residents by providing an environment that was free from any hazards for which the facility had control and by providing appropriate supervision and interventions to prevent avoidable accidents. The policy further identified a care plan for fall risk would be developed and communicated to all appropriate staff. The policy identified that each incident/accident or fall would be investigated and/or assessed to determine the cause of the episode to prevent any further injury and the interdisciplinary team would review all incident/accident reports whenever possible.	2 830		

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2 830	Continued From page 10 The facility policy titled Gait/Transfer Belt, revised 4/09, identified gait/transfer belts may be used to prevent injury to employees and the resident when transferring the resident. The policy procedures included applying the belt around the resident's waist over his/her clothing, allowing enough room between the belt and his/her clothing for a flat hand to be inserted and after the transfer removed the belt. The IJ which began on 10/14/21, was removed on 11/4/21, when the facility successfully implemented a removal plan which included: review of the policies for accidents and incidents, development of person-centered care plans, and gait belt for transfers, review of current residents' care plans and Kardex to determine fall interventions were appropriate and accurate, with observations made to assure appropriate interventions were in place. The facility provided education to nursing staff on proper use of transfer belts, transfers, following the care plan for interventions to prevent falls, and use of Kardex for location of fall interventions. The facility performed competency testing of staff for use of transfer belts as well. The facility provided education to the staffing director to ensure nursing staff were checked off on education list and to notify the DON/designee to educate staff prior to working their next shift. On 11/4/21, between 1:40 p.m. to 4:00 p.m. interviews with staffing director, nursing staff and management verified training on transfer belts, transfers, fall interventions and Kardex was completed, as well as all residents were reviewed to assure fall interventions were in place and accurate. The facility had a plan in place and check off system to assure all staff would be educated prior to working their next shift.	2 830		

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2 830	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls to assure proper interventions 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		