



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 4, 2023

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: CCN: 245316
Cycle Start Date: May 18, 2023

Dear Administrator:

On August 1, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 4, 2023

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

Re: Reinspection Results
Event ID: M3F712

Dear Administrator:

On August 1, 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 May 18, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 2, 2023

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

RE: CCN: 245316
Cycle Start Date: June 2, 2023

Dear Administrator:

On May 18, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

New Richland Care Center

June 2, 2023

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 18, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 18, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

New Richland Care Center

June 2, 2023

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Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 2, 2023

Administrator
New Richland Care Center
312 Northeast 1st Street
New Richland, MN 56072

Re: State Nursing Home Licensing Orders
Event ID: M3F711

Dear Administrator:

The above facility was surveyed on May 16, 2023, through May 18, 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.

New Richland Care Center

June 2, 2023

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.

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

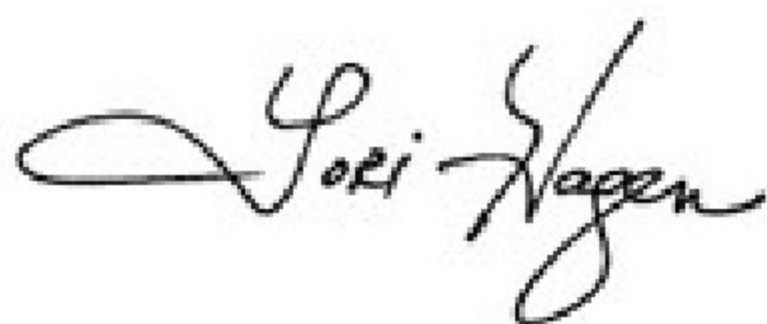
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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

PRINTED: 07/28/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/18/2023
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(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 5/16/23 through 5/18/23, 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. The following complaint was reviewed. H53162067C (MN00093055) with a deficiency issued at F689, F725, and F838. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete	F 689			7/28/23
			1: Residents R4 and R5 fall incidents reviewed by DON/NM and completed an		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/08/2023

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 comprehensive fall analysis to determine accurate causal factors and implement care plan interventions to prevent or mitigate the risk of falls for 2 of 3 residents (R4, R5) reviewed for falls. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/7/23 identified R4 did not have cognitive impairment. R4's diagnoses included dementia, epilepsy, hypertension, and overactive bladder. R4 was frequently incontinent of bladder and always continent of bowel. R4 had one fall with no injury and one fall with injury since the last assessment. R4's care plan, dated 12/7/21, identified R4 was incontinent of bladder at times due to overactive bladder with interventions that included limited assist of one staff with toileting with morning cares, before and after meals, at night, and as needed. R4's activities of daily living care plan identified R4 had decreased mobility and required extensive assist of one staff with lower body dressing and R4 required a four wheeled walker with limited assist from one staff for ambulation and transfers. R4's progress note dated 4/2/2023, indicated R4 had an unwitnessed fall around 9:50 a.m. R4 was found on floor at the foot of her bed, laying on her right side. R4 was unable to recall what happened or provide a description of what happened prior to fall. In review of R4's progress notes, assessments, and incident reports, it was not evident a comprehensive assessment and analysis had been completed that included root cause analysis	F 689	analysis of the situation. IDT met and discussed interventions for each resident to prevent further incidents and documented in notes section of the risk management on PCC. Changes communicated to floor staff at shift change and care plans updated. 2: To prevent similar situations in the future, DON/NM will look at the fall risk assessment of all residents to identify those residents that are at high risk of falls. Will review care plans and fall interventions of residents identified to be high risk weekly x4 weeks and with each fall there after ongoing. The fall scene investigation report will be done on the current shift in which the fall occurred. Nurses will put immediate intervention under risk management after completing the fall scene investigation with staff working with residents and finding out what was the cause of the fall. DON/NM will review any falls with IDT and determine the next course of action on the next business day. IDT will discuss immediate intervention that was put in place and if acceptable for long term intervention will add to care plan. Intervention will be noted in PCC-> Risk Mgmt-> Note section. Communication with nursing staff at change of shift. 3: Measures to ensure the problem does not recur include, general orientation manual, to assist all staff on the standard procedure and expectations of our community as well as a falls binder to walk through the proper steps in what to do in the event of a fall and all the paperwork to complete. In the binder		

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F 689	Continued From page 2 of causal factors in order to remove modifiable risk factors that would prevent and/or reduce the risk of falls. Further not evident R4's fall care plan had been reviewed or revised for appropriateness or new fall interventions after the 4/2/23 fall. R4's progress note dated 4/19/23 at 9:31 p.m., indicated R4 was calling out for help and was found on floor.R4's walker was not within her reach at time of fall. R4 stated that she had just used the bathroom and was not incontinent. R4's fall incident report dated 4/19/23, at 9:15 p.m. identified R4 had an unwitnessed fall. Causal factors included clutter, furniture, impaired memory, and not using a walker. Immediate intervention was R4 transferred back to bed. Despite the root cause that identified as "R4 was working more with therapy, questioning if walking down long hallway is making her more tired and weaker" it was not evident a comprehensive mobility assessment was completed and care plan reviewed for appropriateness. Further not evident interventions were developed and implemented to prevent or negate R4's risk for recurrent falls. R4's fall incident report dated 5/16/23 at 4:35 p.m. indicated R4 had an unwitnessed fall and hit her head. She was found on floor with only compression socks on and incontinent brief. The report indicated R4 was independent (conflicted with care plan dated 12/7/21) R4's call light pendent and gripper socks were on the tray table. Root cause indicated was R4 had taken her shoes off in the bathroom when she was transferring from the toilet seat to the wheelchair. R4's care plan revisions included, encourage R4 to keep her shoes on, encourage to use call light	F 689	there is the fall scene investigation in which they perform and can assist them in coming up with an immediate intervention. The immediate intervention will be implemented by the nurse in charge on that shift and will be reported to the other staff verbally, placed on shift report and in the incident report in the notes section. This will reduce the immediate risk and will remove any risk factor that may be present. 4: The facility will monitor its performance by having the DON/NM do audits weekly x4 weeks and then with each fall there after ongoing, to ensure that all fall scene investigation is complete, and an immediate intervention is implemented. All falls will be reviewed the next business day by IDT to make sure the solutions are sustained and if audits need to be continued after the 4 weeks. Education was given to staff about expectations of fall and fall prevention verbally and through written materials in the falls binder at each nurses station 6/9/2023.		

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F 689	Continued From page 3 for assistance, and silent alarm for bed and wheelchair. During an interview on 5/17/23 2:01 p.m. with family member (FM)-B and family member (FM)-C both indicated concerns for safety and responsiveness to R4's needs. FM-C reported another family member was in R4's room on the evening of 5/16/23 at around 8:00 p.m. R4 had to wait for 20 minutes for staff to come in. When staff did respond, they shut off the call light without attending to R4's needs and reported they would come back to assist R4. After staff let the room, R4 tried to take herself, family had to stop her, and encourage her to wait for assistance. The staff eventually came back into the room to take R4 to the bathroom. FM-B reported staff did not anticipate R4's needs, staff did not check on her frequently enough, staff were not aware of how often she was incontinent bowel or bladder, and when R4 tried to change her own clothes. FM-C indicated that R4 needed more help and should not be doing these things on her own because of her risk for falling. In review of R4's call light logs on 5/16/23, at 7:24 p.m. R4's call light was on for 20 minutes and 57 seconds, and at 8:08 p.m. R4's call light was on for 9 minutes, During Interview on 5/18/23 at 10:17 a.m., RN-A indicated it was the facilities standard of care to implement something right away to mitigate risk for falls with serious injury. RN-A reviewed R4's 4/2/23 fall record, stated the cause of the fall was unknown. The facility and family believed R4 may have been furniture surfing (using environmental/furniture surfaces for balance). RN-A could not locate any interventions in her	F 689			

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F 689	Continued From page 4 care plan following the 4/2/23 fall. During interview on 5/18/23 at 12:02 p.m., DON acknowledged R4 had a fall on 4/2/23, and stated the causal analysis was not completed and should have been. DON explained the facility should have identified concerns with R4's falls, there should have been interventions to prevent falls from reoccurring. If there had been appropriate interventions in place it could have prevented a secondary fall. At the time of the fall on 5/16/23, R4 was independent with transfers, however, if staff would have been with R4, the fall could have been prevented. During interview on 5/17/23 at 2:55 p.m., administrator indicated therapy reassessed R4's mobility and functional ability the morning of 5/17/23. Therapy made the determination and recommendation R4 was to be transferred with one staff assist. Therapy found R4 was unable to put on her slipper socks or TED hose (compression stockings) independently even with adaptive equipment and requires help to do so. R5's Minimum Data Set quarterly, (MDS) dated 5/2/23 indicated R5 did not have cognitive impairment. R5's diagnoses included Parkinson's Disease and overactive bladder. In addition, R5 had one fall with injury and required assist of one staff for transfers, toileting and dressing. R5 was frequently incontinent of bladder and always continent of bowels. R5's care plan dated 11/28/22, identified R5 required extensive assist of one staff for toileting, limited one staff assist for ambulation with four wheeled walker, and extensive assist of one staff	F 689			

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F 689	Continued From page 5 for lower body dressing. R5's progress note dated 5/8/23, indicated R5's roommate came to the nurse's station to inform staff R5 had fallen. R5 was located with her back to the wall facing the toilet. R5 stated she had stood up, turned, and lost her balance. She was found to have on TED hose (compression socks) and no shoes. Incident report dated 5/8/23 at 8:30 indicated that the immediate action taken was a full body assessment, and the resident was transferred with assist of two via mechanical lift into her wheelchair. There were no injuries observed at the time of the incident. Predisposing physiological factors included gait imbalance. Predisposing situational factors included improper footwear. In review of R5's progress notes, assessments, and incident reports, it was not evident a comprehensive assessment and analysis had been completed that included root causes analysis of causal factors in order to remove modifiable risk factors that would prevent and/or reduce the risk of falls. Further not evident R5's fall care plan had been reviewed or revised for appropriateness or new fall interventions. During an interview on 5/18/23 at 11:53 a.m., License practical nurse (LPN)-A, indicated R5 required assist of one for transfers, but sometimes would take herself to the bathroom. R5 should not be taking herself to the bathroom and staff would assist her if they saw her self-transferring. LPN-A indicated R5 was impulsive and if left alone would attempt to get up by herself.	F 689			

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F 689	Continued From page 6 During interview on 5/18/23 at 10:17 a.m., RN-A indicated awareness of R5's fall on 5/8/23. According to the risk management report dated 5/9/23, staff encouraged R5 to have shoes on. There were no changes in R5's care plan following the fall and no new interventions were put in place for recurrent falls. Risk management note was requested from the facility, however not received. During an interview on 5/17/23 at 1:09 p.m., RN-B indicated R5 required reminders to use the call light, frequent checks to see if she needed to use the bathroom, and staff were to anticipate her needs. R5 required extensive assist for transfers and staff needed to stay with R5 while she was in the bathroom. RN-B stated R5 should not have been left alone in the bathroom on 5/8/23. R5's fall could have been prevented had staff stayed with her. RN-B reviewed R5's care plan and reported the care plan did not direct staff to not leave R5 alone in the bathroom. During interview on 5/17/23 at 1:50 p.m., DON indicated R5's fall was still being reviewed by the facility. The interdisciplinary team (IDT) reviewed usually reviewed falls on Tuesdays and new interventions would be put into place after the IDT review. R5's fall should have been reviewed by IDT on 5/16/23. During a subsequent interview on 5/18/23 at 12:02 p.m., DON acknowledged a lack of causal analysis of why R5 fell on 5/8/23, and no immediate interventions put into place. Upon reviewing R5's care plan, DON stated there was only the transfer status in the care plan for R5. The care plan did not direct staff to not leave R5 alone in the bathroom.	F 689			

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F 689	Continued From page 7 Fall policy entitled, "Incident Reports-Completion and Initial Investigation," revised 6/12/18, did not include directives to complete a root cause analysis and lacked guidance on developing/implementing interventions to prevent or mitigate fall risks. The policy included 1. The nurse manager will promptly initiate an investigation and document information about the incident in the Risk Management tab. The following will be included: a. the date and time of the accident or incident took place, b. the nature of the injury; c. the circumstances surrounding the accident or incident; d. where the incident took place, e. the name and witnesses and their accounts of the accident or the incident; f. the residents account of accident or incident; g. the time the attending physician was notified, as well as the time the physician responded and his or her instructions, h. the time the administrator was notified; i. the date/time the resident's family was notified and by whom; j. the condition of the injured person, including vital signs, k. the disposition of the resident, l. results of the investigation, m. follow up information, including any corrective action, n. other pertinent data as necessary or required, and o. the signature and title of the person completing the report.	F 689			
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725			7/28/23

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F 725	Continued From page 8 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure adequate staffing levels to ensure residents needs were met timely to receive care and assistance as needed for 9 of 9 residents (R1, R2, R3, R6, R7, R8, R9, R10, and R11). This had the potential to affect all 35 residents who resided in the facility. Findings Include: R1's admission record dated 5/18/23, identified R1 had diagnoses of inflammatory polyarthropathy (inflammation of the joints), osteoarthritis, pain in left ankle and joints of left foot, and difficulty walking. R1's quarterly Minimum Data Set (MDS) dated 1/14/23 indicated R1 did not have cognitive	F 725	1. The Facility will correct this by having the nurse manager (NM) do audits of care plans and revising of care plan if applicable of the specific needs of the residents in question during survey. If there are certain times in which the resident uses the call light, can we anticipate what the need is at that time and add an intervention into the care plan for the said resident to prevent the use of call light at specific times. We can accomplish this by doing a call light audit and interviews of specific residents and adding toileting times to the care plan if applicable. The NM will follow up with residents needs according to the care plan and provide timely changes as they arise.		

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F 725	Continued From page 9 impairment. R1 required supervision with toileting, transfers, and all dressing needs. R1 was continent of bowel and bladder. R1's admission baseline care plan dated 12/16/22, identified he required assist of one for bed mobility, R1 was a fall risk. Transfer and locomotion assistance were not completed on this assessment. The pain care plan directed to administer scheduled and as needed (PRN) medications. R1's nursing progress notes dated 12/18/22, indicated R1 had expressed frustrations about call light times prior to needing to call the police for assistance. R1's call light records identified the following call light response times: On 12/17/22, at 10:30 a.m. 17 minutes (min) and 26 seconds (sec), and again at 11:12 a.m. for 19 min. and 46 sec. On 12/18/23, at 9:15 p.m. 30 min. and 48 sec. During interview on 5/16/23 at 2:38 p.m., R1 stated he was admitted to the facility on 12/16/22, and discharged on 12/18/23 because it would take staff up to an hour or more to provide care to meet his needs. R1 stated because of the delays it would cause increased pain and discomfort. R1 explained he waited 30 minutes on 12/18/23, for his call light to be answered. R1 called the police to be removed from the facility because he was frustrated, in pain, and did not feel safe because staff were not responsive. On 5/16/23, the following was observed: Room 112's call light was on from 12:51 p.m. and turned off at 1:09 p.m. for a total of 18 minutes.	F 725	2. To protect residents from similar situations in the future. - Verbal education will be provided to staff regarding the facilities overall staffing plan expectations for normal staffing levels; including workload efficiency, how to properly prioritize tasks, working together across units as a team when needs change due to staffing levels, residents need, or other daily changes. Will have a nursing meeting before 7/28/23 to go over education. -The facility will look into the purchase of new radios/walkies that will identify the room number to improve response times. - Schedules will be based on acuity level in accordance with the facility assessment which was completed 6/2/2023; taking acuity levels into consideration (based on RUG scores) and a minimum staffing level to meet all resident needs in accordance with the comprehensive assessment and care plan was established. Acuity was looked at from a general standpoint then allocated based on unit acuity levels. - DON/NM will review call light logs each business day and if we identify a trend with residents will review said residents care plan and modify care plan to reflect what specific needs are needed at that time. -Administrator and IDT will review staffing hours are appropriate to resident acuity levels per the facility assessment tool weekly or as needed by change in resident census/level of care. -Facility will make use of a staffing tool to show direct care hours per shift per area		

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F 725	Continued From page 10 Room 115's call light was on from 12:54 p.m. and turned off at 1:11 p.m. for a total of 17 minutes. Room 106's call light was on from 12:49 p.m. and turned off at 1:12 p.m. for a total of 23 minutes. R2's admission record dated 05/4/23, identified R2 had diagnoses of fracture of left pubis, fracture of left femur and chronic kidney disease. R2's quarterly Minimum Data Set (MDS) dated 5/19/23, indicated R2 had moderate cognitive impairment. R2's care plan dated 5/5/23, indicated R2 required extensive assist of one with a walker for ambulation, extensive assist for lower body dressing, and used a walker for transfers. During interview on 5/16/23, at 1:41 p.m. R2 stated the timeliness of care was terrible. This morning he had both his bedroom and bathroom call lights on, he knew both were on because the red light was on. R2 saw two staff members walk past his room. R2 stated he just got himself up and got dressed but was not supposed to do that because therapy has told him he required help. R2 explained he liked to get up early but has had to wait to get up until after 8:00 a.m. because there was not enough staff to help him. During a subsequent interview on 5/17/23, at 10:51 a.m. R2 stated there were issues with long call lights every morning and everynight, he would get cold waiting for staff to help him to go to the bathroom and get dressed. R2 felt bad because he needed help putting on his shoes to be safe. Per call light log on 5/16/23 at 7:02 a.m. R2's call light was on for 41 min. and 59 sec.	F 725	per day as it relates to the current census/acuity level on the facility assessment. 3. Measures put in to place to ensure that the problem does not recur: - Facility procedures for mandating staff when call-ins occur, and the on-call schedule was reviewed and found to be appropriate; protocols were reiterated to managers and staff. - Scheduler and NM/DON will audit the schedule making sure all spots are filled to the best of the facilities ability per the census/acuity level of the facility. - NM/DON/SS will complete 5 resident interviews weekly for 7 weeks to be able to interview all residents by 7/28/23 and then quarterly at care conferences. Call light/schedules and resident interviews will be reviewed at QA X3 months. 4. The facility will continue to monitor all residents and resident care plans as necessary to ensure that residents are getting the proper care that they need according to their acuity level. Facility will make sure staffing is staffed to the acuity level/census of the building. We will have all audits completed by 7/28/23.		

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F 725	Continued From page 11 R3's quarterly Minimum Data Set (MDS) dated 4/11/23, indicated R3 did not have cognitive impairment. R3's was dependent on two staff for bed mobility and dependent on two or more staff for all transfers. R3's care plan dated 06/09/2020, identified R3 was a fall risk related to impulsive behaviors. The care plan directed staff to keep the call light within reach and encourage resident to use the call light for assistance as needed. Care plan also indicated R3 required assist of two staff for toileting on commode every 2-3 hours and assist of 1-2 staff for bed pan use. During an interview on 5/16/23 at 4:14 p.m., R3 indicated that it took a long time to get help. R3 was left on the commode for 40 minutes with her call light on; she needed to call her sisters to get the attention of the staff to transfer her off the commode. R3 stated it was very uncomfortable waiting on the commode for that long. During an interview on 5/16/23 at 3:55 p.m., family member (FM)-A stated there were long wait times to get the help R3 required. Call light times were excessive because R3 required two staff to transfer her. FM-A reported that R3 sometimes waited thirty minutes to just get on the commode, then would have to wait again to get off the commode. R3 would get uncomfortable waiting on the commode. FM-A explained on several occasions she has received calls from R3 when staff would not not answer her call light; FM-A would have to call the facility to inform them R3 needed assistance. FM-A expressed concerns regarding limited cares due to lack of staffing such as oral hygiene, toileting, and cleanliness.	F 725			

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F 725	Continued From page 12 R6 quarterly Minimum Data Set (MDS) dated 5/12/23 indicated R6 did not have cognitive impairment. R6 required assist of one staff for toileting, transfers, and all dressing needs. R6 was occasionally incontinent of urine and always continent of bowel. During an interview on 5/16/23 at 1:23 p.m., R6 stated staff were slow to respond to her needs and the response times have been inconsistent. R6 explained she has been incontinent because she has had to wait for 20 minutes before someone would come into help her. R6 could hear staff at the nursing station discussing personal situations when her call light was on; it was frustrating to know staff were talking about personal situations instead of helping residents with call lights on. R7 quarterly Minimum Data Set (MDS) dated 5/5/23 indicated R7 did not have cognitive impairment. R7 required assist of one person for toileting, transfers, and all dressing needs. R7 was frequently incontinent of bowl and bladder. During an interview on 5/16/23 at 2:19 p.m., R7 indicated it took quite awhile for staff to answer call lights, it all depended on the day, which staff were working, and how many staff were working. Sometimes R7 would choose not to use her call light so she did not have to wait for staff to help her. R8's quarterly Minimum Data Set (MDS) dated 4/20/23 indicated R8 had severely impaired cognition. R8 required assist of two person for toileting, transfers, and all dressing needs. R8	F 725			

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F 725	Continued From page 13 was always incontinent of bowel and bladder. During interview on 5/16/23 at 3:35 p.m., R8 stated when she put her call light on it took awhile, but staff would eventually come in. R8 stated when she used to put her call light on it would take staff 10-15 minutes to answer, but now it was taking longer. On 5/17/23, the following was observed: Room 112's call light was on at 8:30 a.m. At 8:56 a.m. there was noted to be yelling coming from that room using the words "help". At 9:10 a.m. an unidentified nursing assistant (NA) entered the room and turned off the call light that had been on for a total of 40 minutes. Room 106's call light was on from 8:41 a.m. and turned off at 9:02 a.m. for a total of 21 minutes. Room 108's call light was on at 8:49 a.m. and off at 9:00 a.m. for a total of 11 minutes. Room 115's call light was on at 8:51 a.m. and off at 9:03 a.m. for a total of 12 minutes. During this time, R3 had her call light in her hand while seated in the hallway in her wheelchair waiting and looking for help. R9's quarterly Minimum Data Set (MDS) dated 4/21/23 indicated R9 did not have cognitive impairment. R9 required assist of one person for toileting, transfers, and all dressing needs. R9 was frequently incontinent of bowel and bladder. During and interview on 5/17/23 at 11:00 a.m., R9 stated there was a wait for call lights in the facility, he had to wait awhile this morning. R9 explained call light response times were dependent on how many staff were there to help. The longest he has had to wait was 45 minutes. R9 indicated he has been incontinent waiting for staff.	F 725			

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F 725	Continued From page 14 R9's call light record identified on 5/17/23, at 8:56 a.m. the call light was on for 16 min. and 45 sec. R10's quarterly Minimum Data Set (MDS) dated 3/7/23 indicated R10 did not have cognitive impairment. R10 required assist of one person for toileting, transfers, and all dressing needs. R10 was always incontinent of bowel and bladder. During an interview on 5/17/23 at 11:45 a.m., R10 explained she needed staff to help her because she could not do basic tasks such as toiling herself or getting up for meals. R10 stated she has waited up to two hours before receiving assistance from staff. R10 was frustrated because the long response times have caused her to her to be incontinent several times and has had to wait 20 minutes or longer to get changed out of a wet incontinent pad. R10 felt that her needs were not important to the staff because she has seen staff walk right past her call light. R11's quarterly Minimum Data Set (MDS) dated 5/5/23 indicated R11 did not have cognitive impairment. R11 required assist of two people for toileting, transfers, and one person assist for all dressing needs. R11 was frequently incontinent of bowel and bladder. During an interview on 5/18/23 at 9:55 a.m.,R11 indicated that call light response varied on whether or not staff were timely. R11 stated 20 minutes was the average, however when there was not enough staff it was an hour. R11 explained he was unable to get up on his own and required a standing mechanical lift to get up. He had no other choice but to wait for staff.	F 725			

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F 725	Continued From page 15 Facility call light records reviewed between 5/10/23 to 5/17/23, identified excessive call light times with the longest response time of 84 min and 14 sec. The review identified the following: -9 call light times that exceeded 1 hour -70 call lights that exceeded 30 minutes -414 call lights that exceeded 10 minutes A review of call light records for the last month between 4/18/23 and 5/18/23, identified long call light response times had been ongoing with the longest recorded on 4/23/23, when it took staff over two hours to respond. The record also identified the following excessive response times: -On 4/22/23, 85 minutes 57 seconds -On 4/25/23, 89 minutes 19 seconds -On 4/30/23, 72 minutes 12 seconds -On 5/3/23, 82 minutes 49 seconds -On 5/5/23, 88 minutes 41 seconds, -On 5/15/23, 85 minutes 14 seconds -On 5/17/23 69 minutes and 11 seconds During interview on 5/18/23 at 9:32 a.m., nursing assistant (NA)-A indicated that she has had residents complain about call light response times. NA-A explained response times over 10 minutes would be considered long wait times and was a safety concerns. Response times over 40 minutes was extremely long. NA-A indicated long call light response times put residents at risk for falls. During interview on 5/18/23 at 9:37 a.m., NA-B indicated that she has had residents complain about call light response times. NA-B has had resident call lights on for more then 10 minutes. Call lights on for 30 or 40 minutes was excessive and a safety concern because residents could get inpatient, try to self-transfer and fall. NA-B stated	F 725			

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F 725	Continued From page 16 nobody should have to wait that long. During an interview on 5/18/23 10:06 a.m., NA-C stated residents complain about call light times when the facility was short staffed. NA-C felt the facility was short staffed at times. NA-C considered call light response times over 10 minutes would be long because it put residents at risk to self-transfer that should not. NA-C indicated that anything over 30 minutes would cause resident frustration, agitation, and high potential for self-transferring/self-toileting. During an interview on 5/18/23 at 10:17 a.m., registered nurse (RN)-A indicated that an acceptable call light time for the facility would be 5 minutes and 30 minutes would be considered an excessive time to wait. A response time over 30 minutes would pose risk for self-transfer and higher potential for falls. RN-A indicated she did not have concerns with staffing levels but was not aware of the resident's call light response time concerns. RN-A reviewed the last week of call light response times that identified call lights were on for over 60 minutes. RN-A stated that was "absolutely not an acceptable standard of care". RN-A indicated she expected staff to answer call lights within 10 minutes and changes needed to be made. During interview on 5/18/23 at 12:02 p.m., the director of nursing (DON) indicated anything over 30 minutes for a call light would be excessive for the facility because it could lead to safety concerns and a high risk for falls and patient safety issues. Anything over 60 minutes was a significant safety concern and would be considered an unacceptable standard. DON was she was unaware any resident concerns with call	F 725			

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F 838	Continued From page 18 physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.	F 838			

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F 838	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to ensure that the facility assessment was reviewed and updated annually that included and identified the facility's staffing needs based on the care needs of the resident population. This had the potential to affect all 35 residents who resided in the facility. Findings include: SEE F725 Based on observation, interview, and document review the facility failed to ensure adequate staffing levels to ensure residents needs were met timely to receive care and assistance as needed for 8/8 residents R1,R2,R3,R6,R8,R9,R10 and R11. These deficient practices had the potential to affect all 35 residents who resided in the facility. Review of the facility assessment dated 8/5/2021 identified there was no indication that the facility assessment was revised and updated annually or as necessary to determine what resources were required to care for its residents competently and with appropriate staffing during both day-to-day operation and emergencies. There is no evidence it had been reviewed in the last 21 months. In addition, the facility assessment did not differentiate direct care resident population staffing requirements for shifts nor assigned wings. Facility call light records reviewed for the last week 5/10/23 to 5/17/23, identified excessive call light times with the longest response time of 84 min and 14 sec. The review identified the	F 838	1. Facility administrator and IDT reviewed/updated the facility assessment in its entirety on 6/2/2023 to ensure accurate and current information is reported. 2. To protect all the residents from similar situations in the future, administrator and IDT will review and update facility assessment with changes in census and acuity of residents. The facility will make sure it reflects the status of the facility in a timely manner. 3. The facility administrator/schedular will make use of a staffing tool to measure direct care hours per shift. Per area, per day as it relates to the current census/acuity level on the facility assessment. 4. The facility administration and IDT will monitor the accuracy of the facility assessment by doing weekly audits until completion of audits on 7/28/2023.		

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F 838	Continued From page 20 following: -9 call light times that exceeded 1 hour -70 call lights that exceeded 30 minutes -414 call lights that exceeded 10 minutes A review of call light records for the last month between 4/18/23 and 5/18/23, identified long call light response times had been ongoing with the longest recorded on 4/23/23, when it took staff over two hours to respond. The record also identified the following excessive response times: -On 4/22/23, 85 minutes 57 seconds -On 4/25/23, 89 minutes 19 seconds -On 4/30/23, 72 minutes 12 seconds -On 5/3/23, 82 minutes 49 seconds -On 5/5/23, 88 minutes 41 seconds, -On 5/15/23, 85 minutes 14 seconds -On 5/17/23 69 minutes and 11 seconds During interview on 5/16/23 at 2:38 p.m., R1 stated he was admitted to the facility on 12/16/22, and discharged on 12/18/23, because it would take staff up to an hour or more to provide care to meet his needs. R1 stated because of the delays he would have increased pain and discomfort. R1 explained he waited 30 minutes on 12/18/23, for his call light to be answered. R1 called the police to be removed from the facility because he was frustrated, in pain, and did not feel safe because staff were not responsive During interview on 5/16/23, at 1:41 p.m. R2 indicated the timeliness of care was terrible. This morning he had both his bedroom and bathroom call lights on, he knew both were on because the red light was on. R2 saw two staff members walk past his room. R2 stated he just got himself up and got dressed but was not supposed to do that because therapy had told him he required help.	F 838			

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F 838	Continued From page 21 R2 explained he liked to get up early but has had to wait to get up until after 8:00 a.m. because there was not enough staff. During a subsequent interview on 5/17/23, at 10:51 a.m. R2 stated there were issues with long call lights every morning and every night, he would get cold while waiting for staff to help him go to the bathroom and get dressed. R2 felt bad because he needed help putting on his shoes to be safe. During an interview on 5/16/23 at 4:14 p.m., R3 indicated that it took a long time to get help. She was left on the commode for 40 minutes with her call light on and needed to call her sister to get the attention of the staff to transfer her off the commode. R3 stated it was very uncomfortable waiting on the commode for that long. During an interview on 5/16/23 at 1:23 p.m., R6 stated staff were slow to respond to her needs. R6 explained she has been incontinent because she has had to wait for 20 minutes before someone would come into help her. R6 could hear staff at the nursing station discussing personal situations when her call light was on which frustrating to know staff were talking about personal situations instead of helping residents with call lights on. During interview on 5/16/23 at 3:35 p.m., R8 stated when she put her call light on it took awhile, but staff would eventually come in. R8 stated when she used to put her call light on it would take staff 10-15 minutes, but now it was taking longer. During and interview on 5/17/23 at 11:00 a.m., R9 stated there was a wait for call lights in the facility, he had to wait awhile this morning. R9 explained	F 838			

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F 838	Continued From page 22 call light response times were dependent on how many staff were there to help. The longest he has had to wait was 45 minutes. R9 indicated he has been incontinent waiting for staff. During an interview on 5/17/23 at 11:45 a.m., R10 explained she needed staff to help her because she could not do basic tasks such as toileting herself or getting up for meals. R10 stated she has waited up to two hours before receiving assistance from staff. R10 was frustrated because the long response times have caused her to be incontinent several times. She has had to wait 20 minutes or longer to get changed out of a wet incontinent pad. R10 felt that her needs were not important to the staff because she has seen staff walk right past her call light. During an interview on 5/18/23 at 9:55 a.m.,R11 indicated call light response varies on weather or not staff were timely. R11 stated 20 minutes was the average, however when there was not enough staff the average was an hour. R11 explained he was unable to get up on his own and required a standing mechanical lift to get up. He had no other choice than to wait for staff to get his needs met. During interview on 5/18/23 at 9:32 a.m., nursing assistant (NA)-A indicated that she has had residents complain about call light response times. NA-A indicated long call light response times put residents at risk for falls. During interview on 5/18/23 at 9:37 a.m., NA-B indicated that she has had residents complain about call light response times. Call lights on for 30 or 40 minutes was excessive and a safety concern because residents could get inpatient, try	F 838			

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F 838	Continued From page 23 to self-transfer and fall. NA-B stated nobody should have to wait that long. During interview on 5/18/23 at 12:02 p.m., director of nursing (DON) indicated anything over 30 minutes for a call light would be excessive for the facility because it could lead to safety concerns and a high risk for falls and patient safety issues. Anything over 60 minutes was a significant safety concern and would be considered an unacceptable standard. DON was unaware any resident concerns with call light response times. DON reviewed the last week of call light times and indicated that the frequency of the excessive wait times was not expectable. During interview on 5/18/23 at 1:00 p.m., upon request of the facility assessment administrator was unsure of what the facility assessment was or where it was located in the facility. Administrator was able to locate a facility assessment, however with assessment dated 8/5/2021.	F 838			

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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 5/16/23 through 5/18/23, 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 correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/08/23

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H53162067C (MN00093055) with a licensing order issued at 0800 and 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	2 000			

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure adequate staffing levels to ensure residents needs were met timely to receive care and assistance as needed for 9 of 9 residents (R1, R2, R3, R6, R7, R8, R9, R10, and R11). This had the potential to affect all 35 residents who resided in the facility. Findings Include: R1's admission record dated 5/18/23, identified R1 had diagnoses of inflammatory polyarthropathy (inflammation of the joints), osteoarthritis, pain in left ankle and joints of left foot, and difficulty walking.	2 800	corrected		6/14/23

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2 800	Continued From page 3 R1's quarterly Minimum Data Set (MDS) dated 1/14/23 indicated R1 did not have cognitive impairment. R1 required supervision with toileting, transfers, and all dressing needs. R1 was continent of bowel and bladder. R1's admission baseline care plan dated 12/16/22, identified he required assist of one for bed mobility, R1 was a fall risk. Transfer and locomotion assistance were not completed on this assessment. The pain care plan directed to administer scheduled and as needed (PRN) medications. R1's nursing progress notes dated 12/18/22, indicated R1 had expressed frustrations about call light times prior to needing to call the police for assistance. R1's call light records identified the following call light response times: On 12/17/22, at 10:30 a.m. 17 minutes (min) and 26 seconds (sec), and again at 11:12 a.m. for 19 min. and 46 sec. On 12/18/23, at 9:15 p.m. 30 min. and 48 sec. During interview on 5/16/23 at 2:38 p.m., R1 stated he was admitted to the facility on 12/16/22, and discharged on 12/18/23 because it would take staff up to an hour or more to provide care to meet his needs. R1 stated because of the delays it would cause increased pain and discomfort. R1 explained he waited 30 minutes on 12/18/23, for his call light to be answered. R1 called the police to be removed from the facility because he was frustrated, in pain, and did not feel safe because staff were not responsive. On 5/16/23, the following was observed:	2 800			

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2 800	Continued From page 4 Room 112's call light was on from 12:51 p.m. and turned off at 1:09 p.m. for a total of 18 minutes. Room 115's call light was on from 12:54 p.m. and turned off at 1:11 p.m. for a total of 17 minutes. Room 106's call light was on from 12:49 p.m. and turned off at 1:12 p.m. for a total of 23 minutes. R2's admission record dated 05/4/23, identified R2 had diagnoses of fracture of left pubis, fracture of left femur and chronic kidney disease. R2's quarterly Minimum Data Set (MDS) dated 5/19/23, indicated R2 had moderate cognitive impairment. R2's care plan dated 5/5/23, indicated R2 required extensive assist of one with a walker for ambulation, extensive assist for lower body dressing, and used a walker for transfers. During interview on 5/16/23, at 1:41 p.m. R2 stated the timeliness of care was terrible. This morning he had both his bedroom and bathroom call lights on, he knew both were on because the red light was on. R2 saw two staff members walk past his room. R2 stated he just got himself up and got dressed but was not supposed to do that because therapy has told him he required help. R2 explained he liked to get up early but has had to wait to get up until after 8:00 a.m. because there was not enough staff to help him. During a subsequent interview on 5/17/23, at 10:51 a.m. R2 stated there were issues with long call lights every morning and everynight, he would get cold waiting for staff to help him to go to the bathroom and get dressed. R2 felt bad because he needed help putting on his shoes to be safe. Per call light log on 5/16/23 at 7:02 a.m. R2's call light was on for 41 min. and 59 sec.	2 800			

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2 800	Continued From page 5 R3's quarterly Minimum Data Set (MDS) dated 4/11/23, indicated R3 did not have cognitive impairment. R3's was dependent on two staff for bed mobility and dependent on two or more staff for all transfers. R3's care plan dated 06/09/2020, identified R3 was a fall risk related to impulsive behaviors. The care plan directed staff to keep the call light within reach and encourage resident to use the call light for assistance as needed. Care plan also indicated R3 required assist of two staff for toileting on commode every 2-3 hours and assist of 1-2 staff for bed pan use. During an interview on 5/16/23 at 4:14 p.m., R3 indicated that it took a long time to get help. R3 was left on the commode for 40 minutes with her call light on; she needed to call her sisters to get the attention of the staff to transfer her off the commode. R3 stated it was very uncomfortable waiting on the commode for that long. During an interview on 5/16/23 at 3:55 p.m., family member (FM)-A stated there were long wait times to get the help R3 required. Call light times were excessive because R3 required two staff to transfer her. FM-A reported that R3 sometimes waited thirty minutes to just get on the commode, then would have to wait again to get off the commode. R3 would get uncomfortable waiting on the commode. FM-A explained on several occasions she has received calls from R3 when staff would not not answer her call light; FM-A would have to call the facility to inform them R3 needed assistance. FM-A expressed concerns regarding limited cares due to lack of staffing such as oral hygiene, toileting, and cleanliness.	2 800			

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2 800	Continued From page 6 R6 quarterly Minimum Data Set (MDS) dated 5/12/23 indicated R6 did not have cognitive impairment. R6 required assist of one staff for toileting, transfers, and all dressing needs. R6 was occasionally incontinent of urine and always continent of bowel. During an interview on 5/16/23 at 1:23 p.m., R6 stated staff were slow to respond to her needs and the response times have been inconsistent. R6 explained she has been incontinent because she has had to wait for 20 minutes before someone would come into help her. R6 could hear staff at the nursing station discussing personal situations when her call light was on; it was frustrating to know staff were talking about personal situations instead of helping residents with call lights on. R7 quarterly Minimum Data Set (MDS) dated 5/5/23 indicated R7 did not have cognitive impairment. R7 required assist of one person for toileting, transfers, and all dressing needs. R7 was frequently incontinent of bowl and bladder. During an interview on 5/16/23 at 2:19 p.m., R7 indicated it took quite awhile for staff to answer call lights, it all depended on the day, which staff were working, and how many staff were working. Sometimes R7 would choose not to use her call light so she did not have to wait for staff to help her. R8's quarterly Minimum Data Set (MDS) dated 4/20/23 indicated R8 had severely impaired cognition. R8 required assist of two person for toileting, transfers, and all dressing needs. R8 was always incontinent of bowel and bladder.	2 800			

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2 800	Continued From page 7 During interview on 5/16/23 at 3:35 p.m., R8 stated when she put her call light on it took awhile, but staff would eventually come in. R8 stated when she used to put her call light on it would take staff 10-15 minutes to answer, but now it was taking longer. On 5/17/23, the following was observed: Room 112's call light was on at 8:30 a.m. At 8:56 a.m. there was noted to be yelling coming from that room using the words "help". At 9:10 a.m. an unidentified nursing assistant (NA) entered the room and turned off the call light that had been on for a total of 40 minutes. Room 106's call light was on from 8:41 a.m. and turned off at 9:02 a.m. for a total of 21 minutes. Room 108's call light was on at 8:49 a.m. and off at 9:00 a.m. for a total of 11 minutes. Room 115's call light was on at 8:51 a.m. and off at 9:03 a.m. for a total of 12 minutes. During this time, R3 had her call light in her hand while seated in the hallway in her wheelchair waiting and looking for help. R9's quarterly Minimum Data Set (MDS) dated 4/21/23 indicated R9 did not have cognitive impairment. R9 required assist of one person for toileting, transfers, and all dressing needs. R9 was frequently incontinent of bowel and bladder. During and interview on 5/17/23 at 11:00 a.m., R9 stated there was a wait for call lights in the facility, he had to wait awhile this morning. R9 explained call light response times were dependent on how many staff were there to help. The longest he has had to wait was 45 minutes. R9 indicated he has been incontinent waiting for staff. R9's call light record identified on 5/17/23, at 8:56	2 800			

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2 800	Continued From page 8 a.m. the call light was on for 16 min. and 45 sec. R10's quarterly Minimum Data Set (MDS) dated 3/7/23 indicated R10 did not have cognitive impairment. R10 required assist of one person for toileting, transfers, and all dressing needs. R10 was always incontinent of bowel and bladder. During an interview on 5/17/23 at 11:45 a.m., R10 explained she needed staff to help her because she could not do basic tasks such as toiling herself or getting up for meals. R10 stated she has waited up to two hours before receiving assistance from staff. R10 was frustrated because the long response times have caused her to her to be incontinent several times and has had to wait 20 minutes or longer to get changed out of a wet incontinent pad. R10 felt that her needs were not important to the staff because she has seen staff walk right past her call light. R11's quarterly Minimum Data Set (MDS) dated 5/5/23 indicated R11 did not have cognitive impairment. R11 required assist of two people for toileting, transfers, and one person assist for all dressing needs. R11 was frequently incontinent of bowel and bladder. During an interview on 5/18/23 at 9:55 a.m.,R11 indicated that call light response varied on whether or not staff were timely. R11 stated 20 minutes was the average, however when there was not enough staff it was an hour. R11 explained he was unable to get up on his own and required a standing mechanical lift to get up. He had no other choice but to wait for staff. Facility call light records reviewed between 5/10/23 to 5/17/23, identified excessive call light times with the longest response time of 84 min	2 800			

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2 800	Continued From page 9 and 14 sec. The review identified the following: -9 call light times that exceeded 1 hour -70 call lights that exceeded 30 minutes -414 call lights that exceeded 10 minutes A review of call light records for the last month between 4/18/23 and 5/18/23, identified long call light response times had been ongoing with the longest recorded on 4/23/23, when it took staff over two hours to respond. The record also identified the following excessive response times: -On 4/22/23, 85 minutes 57 seconds -On 4/25/23, 89 minutes 19 seconds -On 4/30/23, 72 minutes 12 seconds -On 5/3/23, 82 minutes 49 seconds -On 5/5/23, 88 minutes 41 seconds, -On 5/15/23, 85 minutes 14 seconds -On 5/17/23 69 minutes and 11 seconds During interview on 5/18/23 at 9:32 a.m., nursing assistant (NA)-A indicated that she has had residents complain about call light response times. NA-A explained response times over 10 minutes would be considered long wait times and was a safety concerns. Response times over 40 minutes was extremely long. NA-A indicated long call light response times put residents at risk for falls. During interview on 5/18/23 at 9:37 a.m., NA-B indicated that she has had residents complain about call light response times. NA-B has had resident call lights on for more then 10 minutes. Call lights on for 30 or 40 minutes was excessive and a safety concern because residents could get inpatient, try to self-transfer and fall. NA-B stated nobody should have to wait that long. During an interview on 5/18/23 10:06 a.m., NA-C stated residents complain about call light times	2 800			

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2 800	Continued From page 10 when the facility was short staffed. NA-C felt the facility was short staffed at times. NA-C considered call light response times over 10 minutes would be long because it put residents at risk to self-transfer that should not. NA-C indicated that anything over 30 minutes would cause resident frustration, agitation, and high potential for self-transferring/self-toileting. During an interview on 5/18/23 at 10:17 a.m., registered nurse (RN)-A indicated that an acceptable call light time for the facility would be 5 minutes and 30 minutes would be considered an excessive time to wait. A response time over 30 minutes would pose risk for self-transfer and higher potential for falls. RN-A indicated she did not have concerns with staffing levels but was not aware of the resident's call light response time concerns. RN-A reviewed the last week of call light response times that identified call lights were on for over 60 minutes. RN-A stated that was "absolutely not an acceptable standard of care". RN-A indicated she expected staff to answer call lights within 10 minutes and changes needed to be made. During interview on 5/18/23 at 12:02 p.m., the director of nursing (DON) indicated anything over 30 minutes for a call light would be excessive for the facility because it could lead to safety concerns and a high risk for falls and patient safety issues. Anything over 60 minutes was a significant safety concern and would be considered an unacceptable standard. DON was she was unaware any resident concerns with call light response times. DON reviewed the last week of call light times and indicated that the frequency of the excessive wait times was not expectable.	2 800			

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2 800	Continued From page 11 The Facility Assessment that identified the facility's resident population and acuity levels in conjunction with staffing levels had not been reviewed or updated since 8/5/21. At the time of the survey, it could not be determined if the data was accurate to determine necessary staffing levels. Call light and staffing policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, medication administration, meals, and eating assistance. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830			6/14/23

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2 830	Continued From page 12 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive fall analysis to determine accurate causal factors and implement care plan interventions to prevent or mitigate the risk of falls for 2 of 3 residents (R4, R5) reviewed for falls. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/7/23 identified R4 did not have cognitive impairment. R4's diagnoses included dementia, epilepsy, hypertension, and overactive bladder. R4 was frequently incontinent of bladder and always continent of bowel. R4 had one fall with no injury and one fall with injury since the last assessment. R4's care plan, dated 12/7/21, identified R4 was incontinent of bladder at times due to overactive bladder with interventions that included limited assist of one staff with toileting with morning cares, before and after meals, at night, and as needed. R4's activities of daily living care plan	2 830	corrected		

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2 830	Continued From page 13 identified R4 had decreased mobility and required extensive assist of one staff with lower body dressing and R4 required a four wheeled walker with limited assist from one staff for ambulation and transfers. R4's progress note dated 4/2/2023, indicated R4 had an unwitnessed fall around 9:50 a.m. R4 was found on floor at the foot of her bed, laying on her right side. R4 was unable to recall what happened or provide a description of what happened prior to fall. In review of R4's progress notes, assessments, and incident reports, it was not evident a comprehensive assessment and analysis had been completed that included root cause analysis of causal factors in order to remove modifiable risk factors that would prevent and/or reduce the risk of falls. Further not evident R4's fall care plan had been reviewed or revised for appropriateness or new fall interventions after the 4/2/23 fall. R4's progress note dated 4/19/23 at 9:31 p.m., indicated R4 was calling out for help and was found on floor. R4's walker was not within her reach at time of fall. R4 stated that she had just used the bathroom and was not incontinent. R4's fall incident report dated 4/19/23, at 9:15 p.m. identified R4 had an unwitnessed fall. Causal factors included clutter, furniture, impaired memory, and not using a walker. Immediate intervention was R4 transferred back to bed. Despite the root cause that identified as "R4 was working more with therapy, questioning if walking down long hallway is making her more tired and weaker" it was not evident a comprehensive mobility assessment was completed and care plan reviewed for appropriateness. Further not	2 830			

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2 830	Continued From page 14 evident interventions were developed and implemented to prevent or negate R4's risk for recurrent falls. R4's fall incident report dated 5/16/23 at 4:35 p.m. indicated R4 had an unwitnessed fall and hit her head. She was found on floor with only compression socks on and incontinent brief. The report indicated R4 was independent (conflicted with care plan dated 12/7/21) R4's call light pendent and gripper socks were on the tray table. Root cause indicated was R4 had taken her shoes off in the bathroom when she was transferring from the toilet seat to the wheelchair. R4's care plan revisions included, encourage R4 to keep her shoes on, encourage to use call light for assistance, and silent alarm for bed and wheelchair. During an interview on 5/17/23 2:01 p.m. with family member (FM)-B and family member (FM)-C both indicated concerns for safety and responsiveness to R4's needs. FM-C reported another family member was in R4's room on the evening of 5/16/23 at around 8:00 p.m. R4 had to wait for 20 minutes for staff to come in. When staff did respond, they shut off the call light without attending to R4's needs and reported they would come back to assist R4. After staff let the room, R4 tried to take herself, family had to stop her, and encourage her to wait for assistance. The staff eventually came back into the room to take R4 to the bathroom. FM-B reported staff did not anticipate R4's needs, staff did not check on her frequently enough, staff were not aware of how often she was incontinent bowel or bladder, and when R4 tried to change her own clothes. FM-C indicated that R4 needed more help and should not be doing these things on her own because of her risk for falling.	2 830			

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2 830	Continued From page 15 In review of R4's call light logs on 5/16/23, at 7:24 p.m. R4's call light was on for 20 minutes and 57 seconds, and at 8:08 p.m. R4's call light was on for 9 minutes, During Interview on 5/18/23 at 10:17 a.m., RN-A indicated it was the facilities standard of care to implement something right away to mitigate risk for falls with serious injury. RN-A reviewed R4's 4/2/23 fall record, stated the cause of the fall was unknown. The facility and family believed R4 may have been furniture surfing (using environmental/furniture surfaces for balance). RN-A could not locate any interventions in her care plan following the 4/2/23 fall. During interview on 5/18/23 at 12:02 p.m., DON acknowledged R4 had a fall on 4/2/23, and stated the causal analysis was not completed and should have been. DON explained the facility should have identified concerns with R4's falls, there should have been interventions to prevent falls from reoccurring. If there had been appropriate interventions in place it could have prevented a secondary fall. At the time of the fall on 5/16/23, R4 was independent with transfers, however, if staff would have been with R4, the fall could have been prevented. During interview on 5/17/23 at 2:55 p.m., administrator indicated therapy reassessed R4's mobility and functional ability the morning of 5/17/23. Therapy made the determination and recommendation R4 was to be transferred with one staff assist. Therapy found R4 was unable to put on her slipper socks or TED hose (compression stockings) independently even with adaptive equipment and requires help to do so.	2 830			

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2 830	Continued From page 16 R5's Minimum Data Set quarterly, (MDS) dated 5/2/23 indicated R5 did not have cognitive impairment. R5's diagnoses included Parkinson's Disease and overactive bladder. In addition, R5 had one fall with injury and required assist of one staff for transfers, toileting and dressing. R5 was frequently incontinent of bladder and always continent of bowels. R5's care plan dated 11/28/22, identified R5 required extensive assist of one staff for toileting, limited one staff assist for ambulation with four wheeled walker, and extensive assist of one staff for lower body dressing. R5's progress note dated 5/8/23, indicated R5's roommate came to the nurse's station to inform staff R5 had fallen. R5 was located with her back to the wall facing the toilet. R5 stated she had stood up, turned, and lost her balance. She was found to have on TED hose (compression socks) and no shoes. Incident report dated 5/8/23 at 8:30 indicated that the immediate action taken was a full body assessment, and the resident was transferred with assist of two via mechanical lift into her wheelchair. There were no injuries observed at the time of the incident. Predisposing physiological factors included gait imbalance. Predisposing situational factors included improper footwear. In review of R5's progress notes, assessments, and incident reports, it was not evident a comprehensive assessment and analysis had been completed that included root causes analysis of causal factors in order to remove modifiable risk factors that would prevent and/or	2 830			

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2 830	Continued From page 17 reduce the risk of falls. Further not evident R5's fall care plan had been reviewed or revised for appropriateness or new fall interventions. During an interview on 5/18/23 at 11:53 a.m., License practical nurse (LPN)-A, indicated R5 required assist of one for transfers, but sometimes would take herself to the bathroom. R5 should not be taking herself to the bathroom and staff would assist her if they saw her self-transferring. LPN-A indicated R5 was impulsive and if left alone would attempt to get up by herself. During interview on 5/18/23 at 10:17 a.m., RN-A indicated awareness of R5's fall on 5/8/23. According to the risk management report dated 5/9/23, staff encouraged R5 to have shoes on. There were no changes in R5's care plan following the fall and no new interventions were put in place for recurrent falls. Risk management note was requested from the facility, however not received. During an interview on 5/17/23 at 1:09 p.m., RN-B indicated R5 required reminders to use the call light, frequent checks to see if she needed to use the bathroom, and staff were to anticipate her needs. R5 required extensive assist for transfers and staff needed to stay with R5 while she was in the bathroom. RN-B stated R5 should not have been left alone in the bathroom on 5/8/23. R5's fall could have been prevented had staff stayed with her. RN-B reviewed R5's care plan and reported the care plan did not direct staff to not leave R5 alone in the bathroom. During interview on 5/17/23 at 1:50 p.m., DON indicated R5's fall was still being reviewed by the facility. The interdisciplinary team (IDT) reviewed	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00748	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/18/2023
NAME OF PROVIDER OR SUPPLIER NEW RICHLAND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 312 NORTHEAST 1ST STREET NEW RICHLAND, MN 56072		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From page 18 usually reviewed falls on Tuesdays and new interventions would be put into place after the IDT review. R5's fall should have been reviewed by IDT on 5/16/23. During a subsequent interview on 5/18/23 at 12:02 p.m., DON acknowledged a lack of causal analysis of why R5 fell on 5/8/23, and no immediate interventions put into place. Upon reviewing R5's care plan, DON stated there was only the transfer status in the care plan for R5. The care plan did not direct staff to not leave R5 alone in the bathroom. Fall policy entitled, "Incident Reports-Completion and Initial Investigation," revised 6/12/18, did not include directives to complete a root cause analysis and lacked guidance on developing/implementing interventions to prevent or mitigate fall risks. The policy included 1. The nurse manager will promptly initiate an investigation and document information about the incident in the Risk Management tab. The following will be included: a. the date and time of the accident or incident took place, b. the nature of the injury; c. the circumstances surrounding the accident or incident; d. where the incident took place, e. the name and witnesses and their accounts of the accident or the incident; f. the residents account of accident or incident; g. the time the attending physician was notified, as well as the time the physician responded and his or her instructions, h. the time the administrator was notified; i. the date/time the resident's family was notified and by whom; j. the condition of the injured person, including vital signs, k. the disposition of the resident, l. results of the investigation, m. follow up information, including any corrective action, n. other pertinent data as necessary or required, and o. the signature and title of the person completing the report.	2 830			

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2 830	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and 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			