Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2026

Administrator
Benedictine Living Community | Mother of Mercy
230 Church Avenue, Box 676
Albany, MN 56307

RE: CCN: 245339

Cycle Start Date: April 12, 2026

Dear Administrator:

On April 12, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a

finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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)

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

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

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

Sincerely,

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

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230 Church Avenue, Box 676
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Re: Event ID: 231380-H1

Dear Administrator:

The above facility survey was completed on April12, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community | Mother of Mercy	**230 CHURCH AVENUE, BOX 676 , ALBANY, Minnesota, 56307**

(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
F0000	INITIAL COMMENTS On 5/7/26, 5/8/26, 5/11/26, and 5/12/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was reviewed. H53391560C (2989748) with a deficiency issued at F689 past noncompliance. The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess the independent use of an electric lift chair for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm when R1 attempted to self-transfer from the lift chair, fell, hit her head, and sustained a hematoma (a collection of blood in the tissues after an injury) and laceration of the forehead, sent to the emergency department (ED) for further evaluation, wound care, pain control, and received four stitches to the right forehead. R1 sustained an additional fall from a wheel chair, hit her head, sustained a	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0689 SS = G	Continued from page 1 hematoma to right lateral proximal (point of attachment) hip, sent to ED for further evaluation and pain control. The facility implemented corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's admission Minimum Data Set (MDS) dated 4/28/26, identified she was admitted on 4/15/26, from the hospital. R1 had difficulty heading in some environments (when a person spoke softly or setting was noisy), impaired vision (able to see large print, but not regular print in newspapers/books), severely impaired cognition with thinking and/or memory, and no behaviors. R1 was dependent upon staff for toileting, lower body dressing, substantial /maximal assistance needed with shower/bathes, personal hygiene, repositioning in bed, sit to stand, all transfers, and used manual wheelchair for mobility. She was always continent of bowel and bladder. Medical history included renal insufficiency, arthritis, osteoporosis (causes bones to become weak and brittle), macular degeneration (blurred or reduced central vision), and encephalopathy (is a change in how your brain function and/or dysfunction and can appear as confusion, disorientation, memory loss, personality changes, agitation or irritability, and can be temporary or permanent), and kyphosis (excessive rounding of the upper back and can cause back pain and stiffness). R1's provider orders from 4/15/26, through 4/21/26, identified: -Order date 4/15/26, Physical therapy (PT) and Occupational therapy (OT) to evaluate and treat. -Order date: 4/21/26, OT to perform cognitive testing. -Order date 4/21/26, Acetaminophen oral tablet 500 milligrams (mg). Give 1000 mg by mouth three times a day related to wedge compression fracture (a spinal fracture where the front of the vertebra collapses while the back stays intact, giving the bones a wedge or triangular shape with weakened bones from osteoporosis). -Order date 4/21/26, Acetaminophen oral tablet 500 mg. Give 500 mg by mouth every 24 hours as needed for pain. R1's Fall risk evaluation completed on 4/15/26 at 12:33 p.m., identified short term memory loss. Poor safety awareness (i.e. self-transfers, forget to lock	F0689		

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F0689 SS = G	Continued from page 2 wheelchair brakes), moderately impaired vision, unable to ambulate to chair, required assist of two to transfer, and had three or more health conditions and medications that would increase her risk factors. R1 was identified as a risk for falls. Nursing interventions/approaches: discussed with family/R1 importance and reminders to use call light prior to any transfers and help with activities of daily living (ADLs) to prevent falls. R1's care plan dated 4/28/26, identified: -R1 was deemed vulnerable due to risk for falls, history of falls, cognitive deficits, and poor impulsive control, and required assist with ADLs. Staff were expected to encourage resident/responsible part to address questions/concerns to staff and interdisciplinary team to discuss resident's status, well-being, and observe and document changes in mood, behavior, and routine. Date initiated 4/14/26. -R1 had potential for injury related osteoarthritis and wedge compression fracture to spine. He was ok to have power lift chair in room but without power function intact. Therapy deemed inappropriate to have full power function. Daughter gave verbal consent 4/20/26. Date initiated: 4/20/26. -R1 had self-care deficit related to encephalopathy (a broad term for any disease, damage, or malfunction of the brain that alters its function or structure and occurs when the brain is deprived of oxygen, exposed to toxins, or affected by an underlying illness and causes a change in mental state and/or behavior). Staff were instructed to transfer with physical assist of two staff and EZ aide and stay with her while on toilet. Date initiated 4/15/26. -R1 had potential for injury related to impaired mobility, incontinence of bowel and bladder, impaired cognition, antipsychotic/antianxiety/narcotic/diuretic medications, impaired vision/hearing, history of falls, fluctuating blood sugars, and limited range of motion (ROM). She was impulsive as evidenced by (AEB) did not consistently ask for help or use call light, poor safety awareness, self-transferred, self-toileted, and refused to wear shoes with transfers. Staff were directed to keep call light within reach and encourage to use it, lift recliner use not recommended, deemed inappropriate to have power lift chair function, remained in neutral position, and continue to monitor appropriateness. Date initiated: 4/15/26. Date revised 4/20/26.	F0689		

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F0689 SS = G	Continued from page 3 - R1 had impaired cognitive function related to difficulty making decisions, disorientation, forgetfulness, impaired decision making, periods of confusion, and unable to make safe decisions. Staff were directed to explain cares/procedures prior to beginning it in simple and few words, provide cues, reorientation, and reminders as needed. Date initiated 4/14/26. -R1 had a communication problem related to a hearing deficit and impaired (very poor) vision related to macular degeneration. Staff were directed to anticipate needs, allow adequate time to respond, and use simple, brief, consistent words/cues, and keep call light within reach. Date initiated 4/15/26. R1's care sheet dated 5/6/26, identified Ambulation: not at this time, pivot only, assist of one with two wheeled walker and gait belt for transfers. Had glasses, very poor vision, hard of hearing, and stay with resident while on toilet. Lift recliner not recommended. Do not prop feet in recliner, on chair/stool, place in be to elevate feet. R1's progress notes from 4/15/26 through 5/5/26, identified: -4/15/26 at 10:49 a.m., BIMS completed and showed cognitive impairment. Patient Health Questionnaire (PHQ9) (assessment for mental health/depression) completed with score of 3/30 (0-4 minimal depression/mood concerns). She stated had difficulty concentrating at times. -4/15/26 at 11:06 a.m., R1 was admitted to facility from a local hospital for weakness and encephalopathy, not ambulating at this time, transferred with assist of two, pivots with walker and gait belt. R1 was able to demonstrate success in using the bed remote, television remote, and call light to make needs known. She was oriented to person only and noted weakness to bilateral upper extremities upon admission. -4/15/26, and 4/16/26, Orientated to person only, impaired short-term memory, decision making, and confused. -4/17/26, at 11:51 a.m., Alert and orientated to situation only, impaired short-term memory/decision making, and confused. Pleasant but anxious mood. -4/17/26 at 11:56 a.m., Reported by daughter she became more confused and restless in the evenings. She refused medications last evening. Was reported she was up multiple times during the night, in and	F0689		

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F0689 SS = G	Continued from page 4 out of her recliner, bed, and unable to get comfortable. -4/18/26 at 9:03 a.m., Orientated to situation only, impaired decision-making ability/short term memory, and confused. She required assist of staff and EZ stand with transfers. Changes in mood, behaviors noted, and some anxiety. -4/18/26 at 3:41p.m., R1 was found on floor laying on right side beside recliner with legs and arms curled. Injuries: open skin tear to superior area of right temporal region with moderate to severe bleeding. Severe pain noted to right temporal area, she was unable to place numerical value of pain, increased with touch. Open area cleansed with normal saline (NS), active bleeding contained after application of 4 x 4 gauze sponge dressing applied. Stretch gauze wrapped around injury and secured with surgical tape. Provider and daughter notified. Non emergent emergency medical services (EMS) notified for transfer. -4/19/26 at 9:26 a.m., Fall follow-up (FU): laceration with stitches noted above right eyebrow, clean, dry and intact with no signs of bleeding or infection. Denied pain. She was lethargic but arousable. Monitored closely for safety at least every 30 minutes while in her room. -4/19/26 at 7:38 p.m., R1 remained pleasantly confused throughout shift. -4/20/26 at 9:26 a.m., Orientated to situation only, impaired short-term memory and decision-making ability, and confused. Unsteady gait, impaired balance and weakness, required supervision. Self-transfer resulted in a fall on 4/18/26. -4/20/26 at 1:31p.m., Writer called and updated daughter. Power cord taken out of R1's room due to PT and OT noted increased confusion. Daughter stated ok to have recliner remain in her room without power cord intact. -4/21/26 at 8:51 p.m., IDT reviewed fall on 4/20/26. Noted she had used a power lift chair at home prior to admission. She had a power lift chair in place and the surface she sat on prior to attempting to self-transfer. She used non-skid footwear, and her left knee gave out, sent to hospital, had laceration sutured, and no fractures were identified. R1 was noted to have increased confusion and decreased cognitive impairment during PT session today. Therapy and nursing decided R1 was not to have full function of the power to lift chair at this time. Writer	F0689		

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F0689 SS = G	Continued from page 5 removed power cord and updated daughter. No, as needed (PRN) medication use within 24 hours of fall and no acute changes in resident's condition prior to the fall. -4/21/26 at 9:15 p.m., New order from Nurse Practitioner (NP): Occupational therapy (OT) perform Saint Louis University Mental Status (SLUMS) (a cognitive assessment tool designed to screen for signs of cognitive impairment in older adults, including various types of dementia, like Alzheimer's disease) for cognitive testing. -4/26/26 at 1:15 a.m., R1 anxious throughout shift, reported difficulty falling asleep and frequently activating her call light. -4/26/26 at 2:30 a.m., Writer followed up with continued anxiety and repeated call light use. Was determined R1 wanted her clothing to be placed back on. -4/27/26 at 10:11 a.m., Provider noted increased insomnia and anxiety concerns in the evenings/night. -4/27/26 at 7:59 p.m., New order Trazadone 25 milligrams (mg) by mouth at bedtime related to insomnia -4/28/26 at 9:56 a.m., Changes to mood and behavior noted. Lethargic due to little to no sleep. -5/1/26 at 1:35 a.m., R1 observed to be anxious during routine rounding. Refused to return to bed. Placed R1 in wheelchair and positioned her at nursing station at 1:00 a.m. and appeared calmer. Sent message to provider requested evaluation for possible anxiety medication. -5/1/26 at 12: 13 p.m., New orders: Hydroxyzine (antihistamine primarily used to treat short-term anxiety) 25 mg every 6 hours PRN times 14 days for anxiety and increased Trazadone to 50 mg every HS. -5/2/26 at 12:52 p.m., Changes in mood/behavior noted, lethargic due to poor sleep. -5/3/26 at 5:30 a.m., R1 went to sleep at about 10:15 p.m. and appeared to sleep through most of the night. -5/5/26 at 11:14 a.m., R1 complained of upper left thigh pain 10/10, holding/guarding it while tearful. Left extremity if more swollen with 2+ edema and when tried to extend it she quickly reacted in pain.	F0689		

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F0689 SS = G	Continued from page 6 Updated provider. -5/5/26 at 10:21 p.m., R1 returned from local hospital ED via ambulance. No evidence of bone injury or intracranial hemorrhage. Instructions: ice thigh, acetaminophen, and rest. -5/6/26 at 9:39 a.m., IDT reviewed fall and interviewed floor nurse that was present at time of fall. R1 was noted to have feet elevated in room due to her cognitive decline she may have attempted to use bedside tray table to assist with standing. New intervention: lay resident in bed to elevate feet versus using a stationary item and leaving in wheelchair. Physical therapy (PT) visits dated 4/15/27, through 5/8/26, identified: -4/15/26 at 5:30 p.m., PT Evaluation and Plan of Treatment identified: referral for PT was made due to recent hospital stay for acute encephalopathy and increased confusion. R1's prior living environment: she lived at home with others and reported she slept on the couch, lifting her legs into bed was difficult. R1's fall risk assessment identified that she felt unsteady when standing, walking, and afraid of falling. She had a fall 4/2025, with a fracture of the left pelvis and a fall 5/19/25, sustained first lumbar (the first bone at the top of the back) compression (vertebra in the spine collapses due to trauma, weakened bone density, or osteoporosis) fracture. R1 required skilled therapy to address lower extremity core strength, transfers, and ambulation, improve balance, and decrease risk for falls. Without skilled therapy R1 was at greater risk for falls, resulting in injury or hospitalization. -4/17/26, R1 was pleasant and cooperative. She reported pain and weakness in left lower extremity (LLE). -4/20/26, Nursing reported R1 fell out of her lift chair this morning and bumped her head. Good participation and motivation for transfers, exercises, balance and gait training. -4/21/26, R1 required a prolonged knee extension stretch due to tight hamstrings. She required frequent cueing and rest breaks throughout the session due to fatigue. -4/22/26, Good participation and motivation with transfers, exercise, balance, and gait training. She required rest breaks due to fatigue.	F0689		

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F0689 SS = G	Continued from page 7 -4/23/26, Required step by step extensive direction for mobility. -4/24/26, R1 started to have heavy eyelids and required cues for keeping eyes open and awake. Attempted gait training ambulation with FWW put unable to awaken. -4/30/26, R1 had limited strength and weakness in her bilaterally lower extremities (BLE) and limited knee extension left greater than right. -5/1/26, R1 was able to ambulate with two wheeled walker 8 feet and 15 feet contact guide assistance (CGA) (the caregiver must keep continuous, hands-on physical contact with the patient, usually on their gait belt or back, to provide physical support, maintain balance, and assist with coordination if they stumble). Complained of some left thigh pain followed by wheelchair at a slow pace with shuffling steps. -5/6/24, Attended care conference. R1 had a recent fall, likely due to self-transferring, went to ER, no fractures. -5/7/26, R1 was drowsy and did not sleep well last night. She had increased pain in her lower right extremity (RLE) due to recent fall. Staff nurse confirmed she had a large hematoma on right lateral thigh. R1 complained of increased pain, took small steps, and was very cautious due to fall. Tylenol given and bio freeze applied to right thigh for pain prior to therapy session with relief. -5/8/26, R1 reported right thigh pain where hematoma was, restricted movement, and unable to provide a pain scale number. OT visits from 4/16/26, through 5/7/26, identified: -4/16/26, OT Evaluation and Plan of Treatment, identified R1 was alert however oriented to person only and increased confusion noted from her baseline. She was able to follow directions with simple cueing. Stand pivot transfer (SPT) wheelchair to toilet with front wheeled walker (FWW) she required moderate assist of one to stand and cues for sequencing. Dependent on clothing management and peri cares. Barriers likely to impact discharge to next level: exacerbation of cognitive impairment. Patient characteristics that may impact treatment: lacked capacity for chronic disease management. R1 had a fall history in the past year with an injury: sacral fracture and lumbar compression fractures.	F0689		

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F0689 SS = G	Continued from page 8 She felt unsteady when standing and worried about falling. Lacked insight into condition and risk factors. Multiple medical conditions/history, and multiple medications. Followed one step directions usually with cues/prompts. Decision making ability for routine activities was severely impaired. Problem solving new situations, dependent. Memory: dependent. Safety awareness: lacked awareness/impaired. Upper extremity strength impaired bilaterally. Self-care function score 2 (score 0 to 12; 12 being the highest function). She required substantial/maximal assistance with toilet transfers. -4/16/26, R1 was alert and oriented to person only, increased confusion noted from her baseline and followed directions with simple cueing. Barrier impacting treatment: mental status. Required treatment modifications to overcome barriers: required maximum cues for sequencing tasks and orientation. -4/17/26, R1 required verbal and tactile cues/input throughout session to stay awake, alert, and for correct sequencing. -4/20/26 at 11:29 a.m., R1 was generally restless lying in bed upon arrival. Assisted to bathroom with moderate assist with maximum cues, and gait belt. She was somewhat limited by low vision and confusion. Changes identified: R1 required maximum cues for sequencing tasks, in combination with orientation times person only, and prompted concerns with use of power lift chair. Recommendations at this time was removal of power lift option and utilized adjustable angle bed for periods of rest versus power lift chair. Due to her short stature, her feet need to be elevated or else they will dangle risking sliding forward from chair. Collaborated with director of nursing (DON) and provided written communication of recommendations. -4/21/26, R1 participated with verbal and tactile cues for directions and placement possibly due to eyesight. -4/22/26, improved ADL engagement, able to ambulate 10 steps to toilet with maximum cues and rests/breaks due to fatigue. -4/23/26, R1 was pleasantly confused and willing to participate. R1 was administered SLUMS, identified a score of 4/30, and indicated dementia. Allen Cognitive Scale (ACL) (a standard measure of cognitive functioning) with a score of 3.6 (scores between 3.0 and 3.8 meant a person required someone to look after them and help with ADLs). It	F0689		

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F0689 SS = G	Continued from page 9 was recommended 24-hour supervision was provided and remove access to dangerous objects. -4/24/26, Worked to progress from EZ aid with two person assist to pivot transfers with FWW. Required step by step cues for technique with transfers. Recommendation: one assist with EZ aid transfers. -4/27/26, R1 required several rest periods due to maximum fatigue and frequent cueing. -5/2/26, R1 required cues to turn feet and process of completing stand pivot transfer (SPT). -5/4/26, R1 assisted to gym in wheelchair, falling asleep, attempted to arouse several minutes without success. Unable to complete OT due to sleepiness and decreased alertness when woken up. -5/5/26, R1 alert today and required extra time to process directives. -5/5/26, R1 had fall self-transferring yesterday, sent to emergency room (ER) for imaging, no fracture. Applied elevating footrests due to complaints of right/shortened hamstring/calve was tight due to increased sitting with knees at 90 degrees. -5/7/26, R1 trialed a lightweight manual wheelchair with low seat to the floor and was able to reach floor with feet to propel herself while in wheelchair. Facility 5-day report submitted on 4/24/26 at 3:04 p.m., identified R1 was placed in power lift recliner chair after lunch in full reclined position. She attempted to stand up and her leg gave out. She fell, hit her head, and cried out for help. Nursing assistance entered R1's room found a large pool of blood and recliner in a fully reclined position. The call light was found on the same side as the recliner R1 had fallen from, within reach. Licensed practical nurse (LPN) attempted to slow the bleeding, applied pressure, ice, while she called EMS. R1 required evaluation in ER and received four sutures. Clinical manager, registered nurse (RN) felt that R1 was appropriate to have the full power function at the time of admission, but the assessment was omitted during the admission process. Maintenance director (MD) was interviewed and noted the power lift chairs are standard items provided in resident rooms at time of admission. The morning after the fall RN completed the adaptive equipment assessment and deemed R1 as appropriate and updated care plan. That afternoon therapy was working with resident deemed her inappropriate due to level of cognition at the time of the assessment being completed. This	F0689		

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F0689 SS = G	Continued from page 10 report (allegation) was not verified as R1 had a power lift chair at home and the care plan was being followed at the time of the fall. R1's ED provider notes dated 4/18/26 at 3:54 p.m., identified: Chief complaint fall injury. She presented the ED via EMS from nursing home memory care unit for further evaluation of a head injury after a fall. Just shortly prior to arrival she attempted to get up out of her chair without assistance when she stated her left leg gave out causing her to fall to the ground. She did not lose consciousness. She had a right sided headache near the area of injury and bleeding was controlled. No changes in vision or hearing. Physical exam identified a frail elderly female with a laceration. Through secondary assessment a hematoma (a collection of blood trapped underneath the skin due to a blow to the head) to the right forehead was identified. Ofirmev (acetaminophen) 1 gram (g) administered via intravenously (IV) for pain and NS 0.9% 500 milligrams (ml) IV for dry mucus membranes. Family felt like her confusion might have been a little bit worse today than usual. The following tests were ordered: chest and pelvic x-rays (unchanged no acute findings), computed tomography (CT) (imagining that used x-ray techniques to create detailed images of the body) of the head/cervical/lumbar spine/thoracic (no acute abnormalities found), and urinalysis (negative results), and urine culture. Forehead laceration was repaired with four sutures (see separate procedure note). History suggests mechanical cause of the fall. Discharged in stable condition back to nursing home via EMS. R1's right forehead laceration repair document dated 4/18/26 at 6:47 p.m., identified laceration length 2.5 centimeters (cm), anesthesia lidocaine topical application and local infiltration (Lidocaine 1% with epinephrine) 1 ml subcutaneously (SQ) were administered. Laceration was irrigated with normal saline and four nylon sutures and three steri strip were used to repair the site. Antibiotic ointment and non- adherent dressing were applied. Estimated blood loss 1 ml. R1's Physical Device Evaluation dated 4/20/26 at 10:16 a.m., identified device being assessed, power lift recliner. Current applicable medical conditions: cognitive deficit and arthritis. R1's specific medical symptoms that required use of device: [R1] used lift power recliner for limited mobility and elevate legs when sitting. This device was a therapeutic intervention to achieve proper body position, balance or alignment: yes. The resident's level of	F0689		

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F0689 SS = G	Continued from page 11 independence with device: [R1] was being assessed by therapy for independence with device and assisted by staff to transfer. This device was not for bed mobility. By checking the box (box checked), as the nurse, you attest to reviewing the risks and benefits with the resident/representative. Verbal consent was given by R1's daughter upon admission. The care plan addressed this device and the need to review the use of this device: yes. Skin Evaluation dated 4/22/26, identified new skin impairment: -Right face temple wound bruising 5 centimeters (cm) x 3.5 cm). -Other: right face temple wound 3 cm. Steri strips dry and intact. No signs and symptoms of infection noted. R1's SLUMS examination dated 4/22/26, identified a score of 4/30 (scoring: 25 -30 normal, 20 to 26 mild neurocognitive disorder, and 1 to 20 Dementia). Rehabilitation Communication document dated 4/20/26, identified: Subject: [R1]. Comments/Recommendations: Discontinue use of powerlift chair controls at this time due to cognitive decline and variability from her baseline. Recommending patient rest in adjustable bed to reduce fall risk. Contact Rehab Department with questions/concerns Facility incident report dated 5/5/26 at 2:23 p.m., identified resident hollering out, staff walked in with resident lying on her side with head towards door, beside table between her legs, unable to move due to hollering in pain. She complained of pain in back and legs. R1 had an unwitnessed fall and complained of head and back excruciating pain. Contributing factors: wet floor, furniture, gait imbalance, impaired memory, drowsy, confused, lethargic, weak, ambulation status: assist of two with device, agitation, restlessness, sleepiness, complained of dizziness/lightheadedness and headache. Sent to ED for evaluation. R1's ED provider notes dated 5/5/26 at 3:54 p.m. identified EMS reported she fell while transferring from her chair today, sustained injury with obvious deformity to left hip. EMS administered 50 micrograms (mcg) of Fentanyl (a narcotic analgesic used for serve pain) in route. Physical exam identified swelling over right lateral proximal hip consistent with a hematoma with painful ROM. She presented with multiple complaints of pain in	F0689		

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F0689 SS = G	Continued from page 12 multiple areas without significant traumatic injury other than the right thigh hematoma. X-ray of right/left femur, pelvis, and spine, no definite acute fracture and soft tissue swelling lateral to the proximal femur. MRI would be recommended to further evaluate nondisplaced femoral neck fracture give R1's degree of osteopenia and if unable to bear weight. CT of head was negative for hemorrhage. Normal Saline (sodium chloride 0.9%) was administered 1000 mg via IV (hydration), acetaminophen 650 mg, and tramadol 50 mg (pain management). Clinical impression and primary diagnosis: Confusion related to dehydration and constipation. Discharged back to facility at 8:57 p.m. During an observation on 5/7/26 at 1:25 p.m. nursing assistant (NA)-A knocked on the door, entered her room and stated he came to assist her to the bathroom. NA-A sanitized hands placed a transfer belt around her waist and pulled it snug. He pushed her wheelchair into the bathroom, removed her footrests from wheelchair, pushed her up to the toilet, and instructed her to grab a hold of the bar, and counted to three. NA-A grabbed ahold of the transfer belt with his right hand and assisted her up to stand. R1 grunted when she stood up and stated not sure I could do this, unable to move her feet, pivoted, pants were pulled down by NA-A, and lowered herself down onto the toilet. R1 pointed at a large bruise located on her right outer thigh, color was black and blue with a small amount of yellow discoloration approximately six inches in diameter. NA-A assisted her up to stand, completed peri cares, and R1 pivoted until she was in front of the WC. NA-A pulled up her pants, lowered herself down onto the wheelchair and pushed her back over to the side of her bed. NA-A sanitized hands and exited the room. R1's recliner was placed approximately three feet away from the bed, no power cord was visible, the remote was located on the floor still attached to the chair. During an interview on 5/7/26 at 1:13 p.m., R1 sat in a low wheelchair in the doorway of her room, fully dressed with gripper socks and her feet on the footrests. She had a fading bruise located underneath her right eye and healed laceration located on right side of her forehead. R1 pushed the wheels on her wheelchair with her hands and backed herself up into her room. R1 stated she had fallen two times since she arrived at this facility, one time from the recliner and another time just recently She stated unsure how she fell, received a big bump and it hurt, pointed to under her right eye, pointed to left thigh, and the right upper outer thigh. R1 stated she did not sit in the recliner anymore was	F0689		

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F0689 SS = G	Continued from page 13 afraid of falling again, scared her when she hit her head quite hard, was bleeding and was taken to the hospital. During an interview on 5/7/26 at 2:27 p.m., NA-E stated R1 was forgetful and confused, would not have been safe to use a lift chair remote, unable to remember how to use it, tended to self-transfer, placed her at a high risk for falls. During an interview on 5/7/26 at 2:43 p.m., LPN-B stated R1 had impaired cognition and had not changed since admission. The admitting nurse and therapy would have been expected to assess R1 upon admission for safe use of the lift recliner prior to use. We do not know if the resident understands what the buttons are used for and could have placed them at risk for injuries/falls. R1 would have not been safe to use the remote to operate the lift chair safely due to impaired cognition. The remote should have been removed until assessment was completed. R1 self-transferred and not safe alone in room with the lift recliner electric remote or manual and placed her at risk for another fall/injury. The other day R1's daughter came to visit in the morning and asked if R1's feet could be elevated. The daughter placed R1's feet on a chair on top of a pillow while she sat in her wheelchair in her room and everything was fine. At 1:45 p.m. R1 was toileted, and feet placed back up on a chair in her room. At about 2:10 p.m. we heard someone hollering out and found R1 laying on the floor. LPN-B entered R1's room and noted the chair her feet were placed on was pushed across the floor and she was scared. R1 stated after fall she may have moved that chair, possibly grabbed the bedside table and fell onto the floor. R1 substantiated a large hematoma on the right outer thigh. Prior to this fall she complained about left leg could have been due to previous left hip replacement surgery. LPN-B stated she sent R1 to ER via ambulance, diagnosed her with a hematoma to right thigh and no fractures. During an interview on 5/8/26 at 8:40 a.m., family member (FM) stated R1's cognition/memory was poor when admitted to the facility from the hospital. Her memory varied from one day to the next and some days it was better than others. There was an electric lift chair in her room when admitted. R1 had an electric lift chair at home she used but someone was there with her most of the time with her. R1 was kind of out of it and needed cues to push the buttons. FM had bought a call light button off Amazon, and R1 used it most of the time, but there were times she forgot. R1 used the control for the lift chair, to use the call light, pushed the lift chair	F0689		

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F0689 SS = G	Continued from page 14 all the way up and FM thought she was going to fall out of it and another time she forgot to use call light again, was almost standing up by herself without assistance, really concerned her. FM stated she did not share that information with staff and was unaware if an assessment was completed on R1 upon admission regarding safe use of lift chair. FM stated she assumed therapy would determine if R1 would be safe in the lift recliner with a remote. Follow- up interview on 5/12/26 at 8:53 a.m., FM stated she did not remember being asked if she felt comfortable and safe with R1 using the remote to her lift recliner at the facility upon admission or after that. Risks and benefits were not explained for use of the lift chair independently. FM stated on 5/5/26, R1 was scared to be placed into the recliner after her fall. FM stated around 9:00 a.m. she placed R1's feet on a chair while she sat in her wheelchair about two feet away from her bed, the bedside table was placed between her and the bed, and call placed light on table or pinned to her. FM informed nurse working prior to leaving the facility that morning how she had left her mother in her room and nurse verbally acknowledged what she had said. After lunch that same day she received a phone call and informed R1 had fallen from her wheelchair and was currently on the floor. FM immediately went to facility, only lived a short distance away, arrived before paramedics got there. R1laid on the floor with head behind the door to her room and legs in front of the recliner. R1 was in pain crying and screaming. Staff had informed her the bedside table had been tipped over and laid over R1's legs when they found her. FM pointed out a bruise on R1's face more noticeable on the left outer forehead, purple in color approximately two inches by ½ inch, and stated she hit her head during this fall. R1 was sent into ER via ambulance. During an interview on 5/8/26 at 10:45 a.m., with maintenance director (MD) stated the lift chair recliners located in resident rooms have a power system to recline them back, forward, upwards, and elevate/lower the footrest. The recliners were a standard item provided to residents upon admission. MD stated the resident should be assessed prior to using the electric lift chair for safe use and ability to operate it safely to avoid falls or injury. The power cords have been removed from the lift chairs, stored in the unit managers' office, until an admission assessment is completed so that residents are deemed safe to use the lift chair safely. MD verified R1's power cord had been removed from the lift	F0689		

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F0689 SS = G	Continued from page 15 chair, unable to use footrest or recline/lift chair, it was a chair now, nothing more. During an interview on 5/8/26 at 11:14 a.m., NA-B stated she worked the day R1 was admitted, she was confused and long and short-term memory were not the best but mostly short-term memory was affected, she was forgetful. When unable to sleep at night, R1 was more confused during the day. NA-B stated she noticed in the past two weeks R1's cognition had gotten worse since admission. She had forgotten she had gone to the bathroom right after she was taken. R1's impulsiveness had increased, forgot to use call light and had found her sitting on edge of the bed. She had a fall out of the recliner since admission, unsure how that happened and sustained a large bruise on the right hip. R1 would not be safe in her room along with her feet elevated in the recliner with the remote or on a chair due to poor cognition, memory and poor safety awareness, and could have resulted in a fall. During an interview on 5/8/26 at 11:40 a.m., NA-E stated she had worked with R1 right after her admission to the facility and was confused and forgetful. NA-E stated two weeks ago she noticed a change in cognition and her memory was worse and self-transferred, kept her out of her room so she could be monitored closer. NA-E stated R1 had a hard time sleeping/laying in her bed, tried to lay her down, up within five minutes trying to self-transfer, impulsive frequently, and tried to stand up if not monitored closely. R1 had told her she does not feel comfortable in recliner and scared of it since her fall. R1 was not safe to be left alone, lacked safety awareness, unaware she required assistance to walk, does not seem to understand, and wanted to get moving to take herself to bathroom at times. During an interview on 5/8/26 at 2:32 p.m., PT verified during her initial physical therapy evaluation and plan of treatment dated 5/15/26, she indicated prior level of function: needed some help. PT stated to clarify that documentation: she made her best judgement and R1 required cueing on where her hands were to be placed to get up, lacked safety awareness, not meant to be left alone to transfer, lacked cognition (identified when tested with OT on 4/23/26), and required minimal assist to get up. Prior to her fall she walked approximately130 feet at a slow paced with contact guide (held onto gait belt) and did well. R1 was able to follow basic instructions /cues. There were other therapists who indicated R1 was out of it and unable to follow directions at times.	F0689		

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F0689 SS = G	Continued from page 16 Follow-up interview on 5/11/26 at 4:42 p.m., PT stated she had tried placing R1's feet/legs up and unable to stretch them that far (example: onto a chair). PT recommended R1's feet be placed on a stool only if she sat at nurse's station where she was watched. R1 should have been supervised if they planned on placing her feet up to keep her safe. R1 had the capacity to push the stationary chair with her feet, chair was found pushed off into the corner when she fell onto the floor. PT stated placement of R1's feet on a stationary chair while in a wheelchair would not have been safe or an ideal situation with her cognitive issues, history of transfers, and increased her risk for a fall. During an interview on 5/11/26 at 10:47 a.m., OT stated first time he saw R1 was on 4/16/26 and completed the initial assessment. OT had seen R1 during her last stay at the facility from 7/10/25 to 8/11/25, and identified a definite cognitive change since the last admission. R1 was not at her baseline, confused, oriented times one to person only, severely impaired decision making, and required assist for all cares and transfers. R1's vision was very impaired and sat closer to the television and typically that would be important to be aware of. There was no policy or protocol for therapy to assess power lift chair safety specifically but rather nursing brought concerns to the therapist's attention and a more in-depth assessment including cognition and vision, ROM to grasp remote and the ability to manage it safely would be provided by rehab/therapy. If cognition was a concern, then most likely OT would have completed that assessment. She was not assessed for power lift chair use on the 4/16/26, not a standard protocol for therapy to assess for the safety use unless nursing indicated the need for use. The Physical Device Evaluation (PDE) completed by nursing indicated a consent was provided by daughter but did not indicate what for, would have made her believe that maybe she said the power lift chair would be ok. The PDE was more like a check list or an assessment used to determine which device they were using and what they would benefit from and not an assessment. There was indication on that form the nurse deferred the assessment to therapy, unable to speak to that. The determining factor regarding the use of the lift recliner would have been her cognition, see initial assessment completed by OT on 4/16/26. The control should have been removed from the room until the OT chair lift assessment was completed. During an interview on 5/11/27 at 12:15 p.m., primary provider and medical director (MD) stated he	F0689		

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F0689 SS = G	Continued from page 17 saw R1 on 4/22/26. R1 had been in the hospital with metabolic (triggered by systemic illness, nutritional deficiencies, or toxic exposure) encephalopathy due to dehydration. R1 had an ongoing cognitive decline and maybe delirium (a sudden, severe state of confusion and altered awareness that can develop over hours or days and fluctuate in intensity) due to cognitive impairment with memory concerns leading up to this last hospital admission. Delirium can last for weeks to months and take up to six to twelve weeks to recover. Typically, when 92 years old, they do not bounce back as quickly. R1's daughter had concerns based on cognition issues prior to her being hospitalized. People do recover and clear from delirium, she could be at baseline, hard to tell. Anyone who is only oriented to self-such as R1, meant they were having some ongoing delirium, forgetting to ask for help/call for assistance, poor safety awareness, and would get up by herself, and attempted to do it alone. This would have placed her at high risk for falls and injuries, hard for staff to intervene and modify things other than support a good sleep cycle, include her in activities, and provide closer observation. MD stated R1 was pretty confused when he saw her and could postulate (to assume or suggest that a statement, theory, or idea was true) given her delirium, decreased cognition (waxing and waning) there were more times of lucidity than clarity, therefore when more confused she would have had more of a problem using the lift chair remote, been identified as a safety risk which could have caused a situation for a fall or injury. Facility nursing staff would be expected to review hospital documentation, follow the facility policy, use good nursing judgement, and complete an initial assessment upon admission. Given all the changes in the system right now there could have been a discrepancy and if there was an acute concern regarding the safe use of the lift chair, contact therapy to complete a lift chair assessment, the sooner the better. MD stated he was unsure if the family had the option to choose whether the resident was safe to use the lift chair without an assessment completed by therapy. R1 substantiated an injury after she fell on 5/18/26, laceration and required four sutures. MD stated R1 fell again on 5/5/26, unaware of what happened, understood she had worsening pain and sent to ED to be evaluated. Unable to comment if she would have been safe with feet elevated on a stationary chair while in wheelchair. During an interview on 5/11/26 at 1:49 p.m., licensed practical nurse (LPN)-A stated R1 had memory loss, confusion and oriented to self and daughter only. On 4/18/26, right before 2:00 p.m.	F0689		

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F0689 SS = G	Continued from page 18 saw R1 alone in her room, in the lift recliner, with feet up on the footrest, slightly reclined back, with the chair remote, call light clipped to her clothing, water cup and bowl of Cheez-its were placed on bedside table located next to recliner. LPN-A stated she administered R1 medications at 1:30 p.m., she was calm, and at 1:45 p.m. R1 was toileted by NA (unsure which one) and placed in recliner. She stated worked again the following day and was informed R1 had fallen shortly after she had left for the day. LPN-A stated she was not interviewed after she fell. The remote for the lift chair had arrows on it and could have been confusing to R1. She had not seen R1 operate the lift chair, but due to her cognition, most likely not been safe using it. R1 had weakness with forgetfulness and would not be safe in her room alone with feet up on a chair. R1 may not have remembered to use the call light when she wanted her feet down and potentially lead to a fall or injury. A safer way to elevate R1's feet would be to have placed her in bed with pillows underneath them. During an interview on 5/11/26 at 2:30 p.m., NA-C stated R1 had a poor memory, used her call light occasionally but often forgot. R1 was frequently confused and impulsive. Co-workers had informed her they had seen R1 try and self-transfer at times, but she had not seen that until 4/18/26, around 2:20 p.m. passed linen and found R1 laying on the floor in her room on her right side, dentures and glasses were on the floor. There was a lot of blood, a big old puddle on the floor, and all over her hands, arms, shirt, neck and face. R1 laid between the recliner and the bed, awake stated "help me, help me", blood coming from her head and told me she was in the recliner prior to the fall. NA-C stated she noticed the footrest on chair was still in up position. NA-C stated she never placed R1 in the recliner, she did not ask to go in it, thought she would be safe in it, and unable to tell if she had access to the recliner remote on the day of the fall. R1 would have been able to use the remote for the recliner, was forgetful, unsure how safe it would have been. R1 would not have been safe with her feet propped up on a chair while she was in the wheelchair in her room alone, she was so fragile and could have fallen if she tried to get up. NA-C stated she would have placed R1 in bed instead or asked the nurse what to do and frequently checked on her. During an interview on 5/11/26 at 2:50 p.m., unit manager registered nurse (RN)-A stated staff noticed R1 had poor safety awareness, self-transferred and wondered if she had self-transferred from her wheelchair to the recliner. Overall R1 had a decline	F0689		

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F0689 SS = G	Continued from page 19 in cognition and daughter felt like it was dementia. R1 was at baseline upon admission after hospital stay, then a decline in cognition was noted around the time she fell from the recliner (4/18/26) and evaluated for lift chair use after the fall. R1 had was a little hard of hearing, refused to wear hearing aids and light sensitivity, and wore sunglasses inside. R1 demonstrated she was able to use remote safely when admission assessment was being completed on 4/15/26, and OT was in the room later in the day and talked to them, it was not documented. Unfortunately, R1's OT admission assessment was completed on 4/20/26, unfortunately it was documented that she used a physical device, and the device assessment was not completed until 4/20/26, after OT completed their assessment. The old process before R1's fall on 4/18/26, was to complete the lift chair assessment within two days of admission and the new process started shortly after R1's fall, the assessment was expected be completed on day of admission. RN-A completed her device assessment on 4/20/26 at 10:16 a.m., and felt through her assessment upon admission, daughter's feedback, and demonstrated she could safely use the lift chair with remote, she was ok in her room alone using the remote. OT completed their assessment that afternoon, same day, at 1:31 p.m., recommended the power cord be removed due to R1's increased confusion noted on 4/20/26, and potentially when she fluctuated in cognition, and short-term memory lacked. RN-A stated root cause analysis of R1's fall on 4/18/26, identified R1 was not appropriate or safe in lift recliner with control with cognition, restless, and potentially trying to self-transfer out of recliner. On 5/5/26, R1's daughter placed her feet up on a stationary chair while she sat in the wheelchair. R1 fell at 2:15 p.m. while daughter was still at facility due to attempting to self-transfer, unsure when her feet were placed up on the chair. Root cause of R1's fall on 5/5/26, was identified as due to decline in cognition and self-transfer was not safe to have feet elevated up on a stationary chair without supervision. R1 required more rest in bed when feet needed to be elevated rather than in recliner or wheelchair for safety. During an interview on 5/12/26 at 11:15 a.m., director of nursing (DON) stated the Adaptive Equipment Assessment was used to call out what the resident was using and if there was any type of risk for the use of that equipment. It was not a detailed, formal assessment, a general assessment using the grab bars. This assessment would have been expected to be completed by nursing as soon	F0689		

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F0689 SS = G	Continued from page 20 as possible before R1 was allowed to use the lift chair, could have caused injury, and should have been assessed prior to injury happening when she was in power lift chair got up and fell. Whether the assessment was done or not, R1 had a history of self-transferring, no matter if she was placed in wheelchair, bed, or recliner, she would attempt to self-transfer due to her delirium waxed and waned. The admitting nurse would have been expected to interview family if there were concerns regarding her history use of the lift chair at home, R1 was not the best historian. Nursing and therapy would be expected to work together to figure out who was responsible for completing the initial assessment regarding the use of the lift chair and there was a paper trail missing for R1. The prior process when she was admitted the Physical Device Evaluation was expected to be completed within three days of admission, which would have been 5/4/16, for R1. DON stated she was unable to speak to what was done with the lift chairs upon admission prior to the assessment completed within three days, need to talk with floor manager. There were two floor managers and neither of them indicated if the lift chairs were being used before the assessments were completed, never received a clear explanation, it fell off the radar, and we switched gears. We were currently working with maintenance to install stationary standard chairs in each room instead of recliner and unsure how soon that will take place. DON stated she interviewed maintenance director and the NA regarding R1's 4/18/26, fall from the recliner. NA informed her when she completed room checks on R1 the lift chair remote was reachable prior to her fall. From R1's admission to when the fall happened (5/15/26 to 5/18/26), documentation identified R1 had some good cognitive days, more cognitively intact in morning and afternoon she may not have been. R1 would have been able to use lift chair remote, deemed appropriate in her mind that would also be safe. DON stated there was no family consent signed or documentation in progress notes that identified consent was received for R1 to use the lift chair. Staff would have been expected to document it in the progress notes. R1's lift chair was not added to care plan at admission or time of fall and should have been after the assessment was completed to deem whether it was appropriate or not and identify if R1 had potential for injury. During a follow-up interview on 5/12/26 at 1:30 p.m., DON stated going forward all lift recliner power cords have been removed until new admissions to the facility are assessed by nursing. The power cords will be kept in the floor manager's office locked up. With the information she knew about R1	F0689		

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F0689 SS = G	Continued from page 21 now, she would not have been safe in the lift chair with a remote without an assessment. DON stated after review of R1's second fall that occurred on 5/5/26, her feet were placed up on something, got up, transferred and may have used the bedside table, tripped over it and fell. There was no indication placement of her feet on a chair was ok and she was not safe, would have placed her at a higher risk for a fall. R1 would have been able to remove her feet off the chair but unsure if it would have been done safely. DON stated she did not know who placed R1's feet up on the chair prior to the fall on 5/5/26. Facility document Gold IDT Intervention dated 5/5/26, posted on 3rd floor at nurse's station identified: Resident: [R1], incident type and date: 5/5/26, Fall, Intervention: Lay in bed to elevate feet and not up on stationary chair. Facility (new ownership) Interdisciplinary Team (IDT) Observation Guide updated on 2/17/26, identified name of Matrix Care Observation/Care Plan/Entry required: -Restraint/Adaptive Equipment Consent. -Department: Nursing -Reviews require the completion of a new assessment if changes are noted and if no changes, associate a review progress note to the observation reviewed. -Review to be completed: admission MDS within 8 hours, readmission (review), Quarterly MDS (review), Annual MDS completed by assessment reference date (ARD), Significant change MDS, and complete with initiation of new device. Facility policy Safety and Supervision of Residents dated 2018, identified purpose was to provide a safe environment for residents. The environment remained as free from accidents and hazards as possible accomplished through identifying/evaluating/analyzing hazards and risks. Implementing interventions to reduce the hazards and risks. Processes implemented include: -Identification of a resident's risk of potentially avoidable accident in the resident environment. -Implementation of individualized, resident-centered interventions, including adequate supervision and assistive devises, to reduce individual risk related to hazards in the environment.	F0689		

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F0689 SS = G	Continued from page 22 -Monitoring for effectiveness and modification of interventions when necessary. Facility policy Integrated Fall Management undated, identified: residents are assessed for their risk for falls upon admission (within 48 hours), significant change, quarterly, and thereafter. Resident interventions will be implemented through the resident centered care plan. Additional professionals maybe contacted to provide assessment and/or interventions regarding fall risk and prevention: attending physician/provider, pharmacist, PT, OT, and speech therapist (ST). A fall with an injury is when there are any resultant change in physical condition following a fall includes but not limited to lacerations, hematomas or related injury that caused the resident to complain of pain. The noncompliance started on 4/18/26 when staff transferred R1 to the lift recliner and elevated her legs without R1 being assessed for ability to use the device independently. R1's attempt to self transfer, with the foot rest still elevated, resulted in R1 falling and sustaining a hematoma (a collection of blood in the tissues after an injury) and laceration of the forehead, sent to the emergency department (ED) for further evaluation, wound care, pain control, and received four stitches to the right forehead. The noncompliance was corrected on 4/21/26 when the below steps were actions were implemented: Facility Stand up document located in the staff communication book on 3rd floor dates 4/21/26, 4/22/26, and 4/28/26, (same information on all 3 dated) identified: -Reminders: Residents need to have an assessment and be care-planned for having the full function of a power function of the recliner in their rooms. Some residents will have the power cord removed because the resident has been deemed not safe to have it intact and will stay in the room in a neutral position. If there are concerns with residents change in condition, please alert the unit RN to reassess them with their power lift chair. A full house audit was completed 4/20/26, through 4/21/26, on residents who had power lift chairs in their rooms to ensure their assessments were completed and care plan updated. If residents were deemed not safe with power lift chair in room the lift chair remained in a neutral position in the room without power function.	F0689		

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F0689 SS = G	Continued from page 23 Systemic actions/change identified: Facility is changing to Matrix electronic medication administration record (EMAR) that will trigger this observation (appropriateness to use the power lift recliner) based on census line changing to admission so that it will be present on dashboard to complete on admission. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.	F0689		

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20000	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 5/7/26, 5/8/26, 5/11/26, and 5/12/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaint was reviewed during the survey H53391560C (2989748). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		

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

Minnesota Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		