Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 18, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: August 14, 2023

Dear Administrator:

On October 11, 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,

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

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October 18, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

Re: Reinspection Results
Event ID: OUKD12

Dear Administrator:

On October 11, 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 August 14, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

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

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August 30, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: August 14, 2023

Dear Administrator:

On August 14, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 November 14, 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 February 14, 2024, (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.

Please contact me with any questions regarding this letter.

Sincerely,

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

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August 30, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

Re: State Nursing Home Licensing Orders
Event ID: OUKD11

Dear Administrator:

The above facility was surveyed on August 9, 2023, through August 14, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST DODGE CENTER, MN 55927

(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 8/9/23 to 8/14/23, 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 with no deficiency issued. H53444486C (MN00095801) The following complaints were reviewed. H53444422C (MN00095736) H53444411C (MN00091810) H53444412C (MN00088627) H53444416C(MN00095923) with a licensing order issued at F690 and F689 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	F 689		10/9/23

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

Electronically Signed | 09/07/2023

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 accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess for an individualized toileting schedule and failed to implement individualized interventions used to reduce the risk of fall for 1 of 5 residents (R1) who was reviewed for accidents. Findings include: R1's Admission Record identified R1 admitted on 9/8/22, had diagnoses of Parkinson's dementia, dysphagia, Chronic Obstructive Pulmonary Disease (COPD), contusion of the scalp, contusion of the abdominal wall, laceration of the liver, fracture of the first and third lumbar vertebra, fracture of multiple ribs. R1's quarterly Minimum Data Set (MDS) dated 6/30/23, identified R1 had adequate hearing and vision, clear speech, makes self-understood and understands others, had moderately impaired cognition and had no rejection of cares. MDS indicated R1 needed extensive assist of one staff, with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. MDS also indicated R1 had poor balance had a history of three or more falls and was frequently incontinent of bladder but always continent of bowels. R1's progress notes were reviewed from 1/1/23 through 8/13/23 indicated R1 had 14 falls related to mobility. Falls were documented on: -1/5/23 in front of his toilet in the bathroom at 9:50 p.m. Team decided all interventions were in place and no changes needed. Report stated resident had been toileted 1.5 hours before fall.	F 689	1. How corrective action will be accomplished for the resident(s) found to have been affected by the deficient practice: - Fairview's fall policy and procedure was updated on February 13, 2023. Education was completed by all nursing staff on fall policy and procedures. - Every morning (Monday through Friday) incidents will be reviewed by the incident intervention team. Root cause analysis and interventions will be determined and documented in the medical record. - Fall compliance will be monitored weekly at IDT meetings. - Resident R1's care plan was and will be updated to better reflect the resident's condition as well as individualized interventions and goals to help reduce the risk of falls and injury. - All Nursing staff were in-serviced on August 15, 2023 of the importance of following the care plan. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - New dining room seating chart was implemented to increase visualization of all	

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F 689	Continued From page 2 -1/7/23 fall found in room bare footed with pants around his ankles at 9:17 a.m. Root cause of self-transferring to the bathroom. Stated physical therapy to evaluate for therapy appropriateness and no further changes to care plan at this time. Report indicated resident had been toileted 2 hours before fall. Minor abrasions noted from this fall. -2/21/23 fall found in his room on the floor around 8:30 a.m., unable to say why he self-transferred. -2/23/23 fall found at 10:45 p.m. next to recliner in the room sitting on buttocks scooting along. Root cause of resident reported he was going to the bathroom. Team added alarms to bed and chair as well as he had a video monitor in room because he was in isolation for Covid. -2/27/23 at 4:10 a.m. found in his room holding on to a dining room chair kneeling on his knees. Dining room chair was removed from his room. Multiple knee abrasions noted. Stated he had been toileted 15 minutes before the fall. -3/18/23 at 5:00 a.m. fall resident found in the bathroom with walker straddling the toilet and buttocks against the wall. Root Cause of lost balance while toileting. Minor abrasions noted from fall. -4/29/23 fall at 4:30 a.m. R1 found in room with his walker in the bathroom tipped over. R1 told staff he went to the bathroom and fell so he crawled to recliner chair) Root Cause was resident needed to toilet and last fall was around 5:00 a.m. for toilet so added to toileting program to toilet at 4:00 a.m. rounds. -5/21/23 fall R1 ambulated himself to bathroom and fell. Intervention to have resident toilet at day/evening shift change and bring to front day room around 3:00 p.m. Skin tear and abrasions documented from fall. -6/21/23 6:15 a.m. fall at 6:15 a.m. a.m. resident	F 689	residents during meals. - A change of shift huddle was implemented to inform nursing staff of facility updates, resident updates and therapy changes. - A new face sheet was added to the CNA care guide to ensure that they are informed of important updates, those residents who are to attend AAA each evening, those residents that the night shift are to be getting up in the morning and any other important information that may be relevant. - A cheat sheet was put out for non-nursing staff to be aware of residents who are at high risk for falls, those residents who attend AAA each evening and those who are to be in the dayroom during the day for better visualization. - All resident's care plans will continue to be updated to better reflect each resident's condition as well as individualized interventions and goals to help avoid falls or injury. - All nursing staff were in-serviced on August 15, 2023 of the importance of following the care plan. - All falls with interventions will be	

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F 689	Continued From page 3 in the room in front of his recliner. Care plan toileting added at the change of shift from day to overnight shift and brought to the front day room to watch TV. Intervention on this was to remind staff to toilet at shift changes before the overnight staff leaves. -7/2/23 Fall resident found in the bathroom at around 12:45 p.m. Intervention of resident being toileted after lunch and brought to day room after lunch. -7/21/23 Fall at 3:52 a.m. indicated a NA heard a crash sound from R1's room and round R1 sitting on the floor in front of his recliner chair with his walker tipped over. Resident had socks on with call light within reach. R1 was assessed to have a red mark on the right side of his back and an abrasion on his chest. Intervention added to try to toilet R1 during night rounds. -7/28/23 fall reported at 7:00 a.m. resident found sitting in his room by recliner. Report of care plan not followed NA reminded to bring R1 to bathroom after waking and then to the day room, also to make sure gripper socks are on properly. Care plan indicated resident was to be toileted and brought to the living room at change of shift at around 6:00 a.m. DON and report indicated this had not been done. - 8/2/23 fall at 7:26 a.m. indicated R1 had fallen in his room at 12:48 a.m. R1 was observed to have head laceration and stated he was experiencing pain. R1 was sent to the hospital by ambulance. -8/13 fall reported nurse entered room at 7:00 a.m. and found the resident kneeling by his bed in the praying position. DON stated she had put in a nursing order on R1's treatment record to help remind staff to bring R1 to the dining room after being toileted and dressed in the morning on change of shift. DON indicated change of shift to be around 6:00 a.m. DON and Fall report	F 689	reviewed quarterly at the QAPI meeting. 3. The date that each deficiency will be corrected: - Deficiency Tag F-689 will be in compliance by October 9, 2023.	

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F 689	Continued From page 4 indicated this had not been done. R1's Mobility Care plan last care plan review completed 8/7/23 indicated R1 would be safe and secure with assistance of staff and avoid significant injury through next review. Care planned interventions identified and created: -9/8/22 instruct and remind resident to use call light when needing assistance. Monitor for steadiness when ambulating. -9/14/22 R1 attempts to self-transfer frequently, resident has sign in room to push call light and wait for help. -9/22/22 do not allow R1 to ambulate without assistance. -3/10/23 ambulation with the assistance of one staff with four wheeled walker and gait belt and was to have TLSO (a brace that limits movement in your spine from the thoracic area (mid back) to your sacrum (low back) on when out of bed. Anticipate R1's needs. Ensure nonskid socks and properly fitted shoes. Keep frequently used items within R1's reach. -3/16/23 do not leave R1 unattended in the bathroom. -3/21/23 R1 will be offered to toilet upon rising, before and after meals, at hour of sleep (HS) at 4:00 a.m. and then as he needs -5/22/23 resident would be toileted day/evening shift change and brought up to the day room to watch television as he allows. -06/21/23 at change of shift NOC/Day shift with toilet and bring R1 up to the living room to wait for breakfast as he will allow. -7/26/23 encourage R1 to toilet on rounds during night shift. R1's nursing assistant care guide dated 8/11/23, included assist of one to toilet with gait belt and	F 689		

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F 689	Continued From page 5 front wheeled walker, to not leave unattended in the bathroom, to offer toileting upon rising, before and after meals, at HS and as needed, added to toilet and 4:00 a.m. and every 2 hours. Sleep indicated R1 to be in bed at 11:30 p.m. and wake at 6:30 a.m. Night shift to get up and take to front day room. Special Cares instructions included high falls risk, resident to be toileted at day/evening shift change and brought to day room as R1 allows. At a.m. shift change bring up to living room as he allows, encourage R1 to toilet on rounds on night shift. During an interview on 8/10/23, at 2:22 p.m. director of nursing (DON) stated, most of R1's falls are related to him transferring to toilet himself. DON stated it appears that the staff did not follow the care plan on 6/21/23 fall at 6:15 a.m. when resident was supposed to be brought to the day room by the overnight staff and should not have been in his room, on 7/21/23 fall in his bathroom at when an intervention was to remind staff to bring R1 back to the dayroom after lunch, on 7/28/23 staff was to bring R1 to toilet and bring to the day room before the overnight staff left for the day. During an interview on 8/14/23, at 1:40 p.m. DON stated R1 had fallen again over the weekend and the care plan was not followed. DON stated the intervention to get R1 up in the morning and moved to the day room had been added the to the treatment administration record (TAR) to help the staff to remember but the order had not been followed. DON stated she and her team recognized that was a problem and have put new items in place to alert staff to new fall interventions and discuss residents daily that are high falls risks.	F 689		

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F 689	Continued From page 6 Review of Facility policy titled, Resident Fall, dated 2/13/23, indicated the policy of the facility is to ensure the safety of all residents after sustaining a fall.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		10/9/23

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	245344	A. BUILDING _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 7 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to complete comprehensive bowel/bladder assessments, failed to develop individualized toileting schedule/program, failed to follow the care plan for toileting to improve, maintain, or reduce the risk for worsening bowel/bladder function for 1 of 1 resident (R1) reviewed for incontinence. Findings include: R1's Admission Record identified R1 admitted on 9/8/22, had diagnoses of Parkinson's dementia, dysphagia, Chronic Obstructive Pulmonary Disease (COPD), contusion of the scalp, contusion of the abdominal wall, laceration of the liver, fracture of the first and third lumbar vertebra, fracture of multiple ribs. R1's quarterly Minimum Data Set (MDS) dated 6/30/23, identified R1 had adequate hearing and vision, clear speech, makes self-understood and understands others, had moderately impaired cognition and had no rejection of cares. MDS indicated R1 needed extensive assist of one staff, with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. MDS also indicated R1 had poor balance had a history of three or more falls and was frequently incontinent of bladder but always continent of bowels. R1's Mobility Care plan dated 9/8/22, revised on 8/7/23, indicated R1 will be offered to toilet upon	F 690	1. How corrective action will be accomplished for the resident(s) found to have been affected by the deficient practice: - A three day toileting diary was implemented on September 8, 2023 to evaluate and establish a pattern in order to individualized a toileting schedule for R1. - Resident R1's care plan will be updated to better reflect individualized interventions and goals for a toileting schedule. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - A toileting documentation record was implemented to document when each resident is actually toileted. - A three day toileting diary will be implemented for each resident over the next 30 days in order to evaluate and establish a pattern in order to individualized toileting schedules.	

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F 690	Continued From page 8 rising, before and after meals, at hour of sleep (HS) at 4:00 a.m. and then as he needs. R1 was to be transferred assist of one with front wheeled walker and gait belt and was to have TLSO (a brace that limits movement in your spine from the thoracic area (mid back) to your sacrum (low back) on when out of bed. To not allow R1 to ambulate without assistance. At change of shift NOC/Day shift with toilet and bring R1 up to the living room to wait for breakfast as he will allow. R1 was also to be toileted at day/evening shift change and brought up to the dayroom to watch TV as he allows and to be toileted on rounds during the night shift. Care plan also indicated to not allow resident to ambulate without assistant and to not leave R1 unattended in the bathroom. R1's Alteration in elimination related to immobility care plan dated 9/9/22, revised on 8/7/23, indicated R1 was to be toileted with assist of one with front wheeled walker and gait belt. R1 was to be toileted upon rising, before and after meals, at HS and then as needed. Elimination care plan lacked toileting scheduled at change of shift, overnight rounds and 4 a.m. toileting. R1's progress notes were reviewed from 1/1/23 through 8/14/23 and found that R1 had a fall on 1/5/23 in front of his toilet in the bathroom, on 1/7/23 fall found in room bare footed with pants around his ankles. Root cause of self-transferring to the bathroom), 2/21/23 fall found in his room (unable to say why he self-transferred), 2/22/23 fall found next to recliner in the room sitting on buttocks scooting along. (Root cause of resident reported he was going to the bathroom) 3/18/23 fall resident found in the bathroom with walker straddling the toilet and buttocks against the wall. (Root Cause of lost balance while toileting)	F 690	- A shift change huddle was implemented to inform nursing staff for facility updates, resident updates and therapy changes. - A new face sheet was added to the CNA care guide to ensure that they are informed of important updates, those residents who are to attend AAA each evening, those residents that the night shift are to be getting up in the morning and any other important information that may be relevant. - All resident's care plans will be updated to better reflect each resident's individualized interventions and goals who need toileting schedules. - All Nursing staff were in-serviced on August 15, 2023 of the importance of following the care plan. 3. The date that each deficiency will be corrected. - Deficiency tag F-690 will be in compliance by October 9, 2023	

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F 690	Continued From page 9 4/29/23 fall at 4:30 a.m. R1 found in room with his walker in the bathroom tipped over. (R1 told staff he went to the bathroom and fell so he crawled to recliner chair.) Root Cause was resident needed to toilet and last fall was around 5 am for toilet so added to toileting program to toilet at 4:00 a.m. rounds. 5/21/23 fall R1 ambulated himself to bathroom and fell. (Intervention to have resident toilet at day/evening shift change and bring to front day room. 6/21/23 6:15 a.m. fall resident in the room in front of his recliner. (care plan toileting added at the change of shift from day to overnight shift and brought to the front day room to watch TV.) 7/2/23 Fall resident found in the bathroom at around 11:45 a.m. (Intervention of resident being toileted after lunch and brought to day room) 7/21/23 fall NA stated R1 last toileted at 1:00 a.m. (Intervention added to toilet R1 on overnight rounds.) 7/28/23 fall reported at 7:00 a.m. resident found sitting in his room by recliner. (report of care plan not followed NA reminded to bring R1 to bathroom after waking and then to the day room, also to make sure gripper socks are on properly.) R1's nursing assistant care guide dated 8/11/23, included assist of one to toilet with gait belt and front wheeled walker, to not leave unattended in the bathroom, to offer toileting upon rising, before and after meals, at HS and as needed. Pull ups only and added to toilet and 4:00 a.m. and every 2 hours, Sleep must bed at 11:30 p.m. and wake at 6:30 a.m. Night shift to get up and take to front day room. Special Cares instructions included high falls risk, resident to be toileted at day/evening shift change and brought to day room as R1 allows. At a.m. shift change bring up to living room as he allows, encourage R1 to toilet on rounds on night shift.	F 690		

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F 690	Continued From page 10 R1's bowel and bladder elimination urinary continence diary dated 8/14/23 on his 30 days look back to 7/14/23, documentation indicated R1's 7/21/23 fall was at 1:00 a.m. and R1 was last toileted at 9:09 p.m. R1's 7/28/23 fall indicated he fell at 7:00 a.m. in his room. (R1's care plan indicates R1 is supposed to be toileted at 4:00 a.m. and brought to the day area). R1's diary indicated R1 was last toileted before the fall on 7/27/23 at 7:07 p.m. R1's next fall was on 8/2/23 at 12:45 a.m. documentation shows R1 was last toileted on 8/1/23 at 10:10 p.m. and resident had not gone and was dry at that time. R1 had a fall on 8/7/23 11:07 p.m. in his room. (Care plan indicates him to not go to bed till 11:30 p.m.) Resident was last toileted and only toileted at 1:33 p.m. per documentation. R1 had a fall on 8/13/23 at 7:00 a.m. in his room at 6:30 a.m. (care plan indicates R1 to be toileted every 2 hours on the overnight shift and to be gotten up at 4 a.m. for toileting and brought to the day room) R1's diary indicated R1 was last toileted at 1:25 a.m. During an interview on 8/10/23, at 10:31 a.m. with nursing assistant (NA)-A stated residents do not really have toileting plans, most residents are just toileted every 2 hours or a couple of times a shift. "We know when R1 needs to go he gets restless." During an interview on 8/10/23, at 2:06 p.m. with the director of nursing (DON) stated we have standardized toileting plans not individualized. DON stated the admission fall assessment is used to determine the interventions that have been put in place.	F 690		

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F 690	Continued From page 11 During an interview on 8/14/23, at 10:48 a.m. with registered nurse (RN)-A stated the facility does not use any multiday bowel and bladder assessments and the schedule for resident toileting is standard upon waking, before and after meals and at bedtime. RN-A stated she was not aware of individualized toileting plans. During an interview on 8/14/23, at 10:53 a.m. licensed practical nurse (LPN)-A stated most of R1's falls are related to him saying he needs to use the bathroom. During an interview on 8/14/23, at 11:01 a.m. DON stated we do not have individualized toileting plans, we do not have an assessment that look at patterns or frequencies. Policy on incontinence care was requested and not received.	F 690		

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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 8/9/23 to 8/14/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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

Electronically Signed | 09/07/23

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was reviewed with no deficiency issued. H53444486C (MN00095801) The following complaints were reviewed. H53444422C (MN00095736) H53444411C (MN00091810) H53444412C (MN00088627) H53444416C(MN00095923) with a licensing order issued at 0830 and 0915. 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	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess for an individualized toileting schedule and failed to implement individualized interventions used to reduce the risk of fall for 1 of 5 residents (R1) who was reviewed for accidents.	2 830	1. How corrective action will be accomplished for the resident(s) found to have been affected by the deficient practice: - Fairview's fall policy and procedure was	10/9/23

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2 830	Continued From page 3 Findings include: R1's Admission Record identified R1 admitted on 9/8/22, had diagnoses of Parkinson's dementia, dysphagia, Chronic Obstructive Pulmonary Disease (COPD), contusion of the scalp, contusion of the abdominal wall, laceration of the liver, fracture of the first and third lumbar vertebra, fracture of multiple ribs. R1's quarterly Minimum Data Set (MDS) dated 6/30/23, identified R1 had adequate hearing and vision, clear speech, makes self-understood and understands others, had moderately impaired cognition and had no rejection of cares. MDS indicated R1 needed extensive assist of one staff, with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. MDS also indicated R1 had poor balance had a history of three or more falls and was frequently incontinent of bladder but always continent of bowels. R1's progress notes were reviewed from 1/1/23 through 8/13/23 indicated R1 had 14 falls related to mobility. Falls were documented on: -1/5/23 in front of his toilet in the bathroom at 9:50 p.m. Team decided all interventions were in place and no changes needed. Report stated resident had been toileted 1.5 hours before fall. -1/7/23 fall found in room bare footed with pants around his ankles at 9:17 a.m. Root cause of self-transferring to the bathroom. Stated physical therapy to evaluate for therapy appropriateness and no further changes to care plan at this time. Report indicated resident had been toileted 2 hours before fall. Minor abrasions noted from this fall. -2/21/23 fall found in his room on the floor around 8:30 a.m., unable to say why he self-transferred.	2 830	updated on February 13, 2023. Education was completed by all nursing staff on fall policy and procedures. - Every morning (Monday through Friday) incidents will be reviewed by the incident intervention team. Root cause analysis and interventions will be determined and documented in the medical record. - Fall compliance will be monitored weekly at IDT meetings. - Resident R1's care plan was and will be updated to better reflect the resident's condition as well as individualized interventions and goals to help reduce the risk of falls and injury. - All Nursing staff were in-serviced on August 15, 2023 of the importance of following the care plan. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - New dining room seating chart was implemented to increase visualization of all residents during meals. - A change of shift huddle was implemented to inform nursing staff of facility updates, resident updates and therapy changes. - A new face sheet was added to the CNA care guide to ensure that they are	

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2 830	Continued From page 4 -2/23/23 fall found at 10:45 p.m. next to recliner in the room sitting on buttocks scooting along. Root cause of resident reported he was going to the bathroom. Team added alarms to bed and chair as well as he had a video monitor in room because he was in isolation for Covid. -2/27/23 at 4:10 a.m. found in his room holding on to a dining room chair kneeling on his knees. Dining room chair was removed from his room. Multiple knee abrasions noted. Stated he had been toileted 15 minutes before the fall. -3/18/23 at 5:00 a.m. fall resident found in the bathroom with walker straddling the toilet and buttocks against the wall. Root Cause of lost balance while toileting. Minor abrasions noted from fall. -4/29/23 fall at 4:30 a.m. R1 found in room with his walker in the bathroom tipped over. R1 told staff he went to the bathroom and fell so he crawled to recliner chair) Root Cause was resident needed to toilet and last fall was around 5:00 a.m. for toilet so added to toileting program to toilet at 4:00 a.m. rounds. -5/21/23 fall R1 ambulated himself to bathroom and fell. Intervention to have resident toilet at day/evening shift change and bring to front day room around 3:00 p.m. Skin tear and abrasions documented from fall. -6/21/23 6:15 a.m. fall at 6:15 a.m. a.m. resident in the room in front of his recliner. Care plan toileting added at the change of shift from day to overnight shift and brought to the front day room to watch TV. Intervention on this was to remind staff to toilet at shift changes before the overnight staff leaves. -7/2/23 Fall resident found in the bathroom at around 12:45 p.m. Intervention of resident being toileted after lunch and brought to day room after lunch. -7/21/23 Fall at 3:52 a.m. indicated a NA heard a	2 830	informed of important updates, those residents who are to attend AAA each evening, those residents that the night shift are to be getting up in the morning and any other important information that may be relevant. - A cheat sheet was put out for non-nursing staff to be aware of residents who are at high risk for falls, those residents who attend AAA each evening and those who are to be in the dayroom during the day for better visualization. - All resident's care plans will continue to be updated to better reflect each resident's condition as well as individualized interventions and goals to help avoid falls or injury. - All nursing staff were in-serviced on August 15, 2023 of the importance of following the care plan. - All falls with interventions will be reviewed quarterly at the QAPI meeting. 3. The date that each deficiency will be corrected: - Deficiency Tag F-830 will be in compliance by October 9, 2023.	

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2 830	Continued From page 5 crash sound from R1's room and round R1 sitting on the floor in front of his recliner chair with his walker tipped over. Resident had socks on with call light within reach. R1 was assessed to have a red mark on the right side of his back and an abrasion on his chest. Intervention added to try to toilet R1 during night rounds. -7/28/23 fall reported at 7:00 a.m. resident found sitting in his room by recliner. Report of care plan not followed NA reminded to bring R1 to bathroom after waking and then to the day room, also to make sure gripper socks are on properly. Care plan indicated resident was to be toileted and brought to the living room at change of shift at around 6:00 a.m. DON and report indicated this had not been done. - 8/2/23 fall at 7:26 a.m. indicated R1 had fallen in his room at 12:48 a.m. R1 was observed to have head laceration and stated he was experiencing pain. R1 was sent to the hospital by ambulance. -8/13 fall reported nurse entered room at 7:00 a.m. and found the resident kneeling by his bed in the praying position. DON stated she had put in a nursing order on R1's treatment record to help remind staff to bring R1 to the dining room after being toileted and dressed in the morning on change of shift. DON indicated change of shift to be around 6:00 a.m. DON and Fall report indicated this had not been done. R1's Mobility Care plan last care plan review completed 8/7/23 indicated R1 would be safe and secure with assistance of staff and avoid significant injury through next review. Care planned interventions identified and created: -9/8/22 instruct and remind resident to use call light when needing assistance. Monitor for steadiness when ambulating. -9/14/22 R1 attempts to self-transfer frequently, resident has sign in room to push call light and	2 830		

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	00103	A. BUILDING: _____ B. WING _____	C 08/14/2023

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2 830	Continued From page 6 wait for help. -9/22/22 do not allow R1 to ambulate without assistance. -3/10/23 ambulation with the assistance of one staff with four wheeled walker and gait belt and was to have TLSO (a brace that limits movement in your spine from the thoracic area (mid back) to your sacrum (low back) on when out of bed. Anticipate R1's needs. Ensure nonskid socks and properly fitted shoes. Keep frequently used items within R1's reach. -3/16/23 do not leave R1 unattended in the bathroom. -3/21/23 R1 will be offered to toilet upon rising, before and after meals, at hour of sleep (HS) at 4:00 a.m. and then as he needs -5/22/23 resident would be toileted day/evening shift change and brought up to the day room to watch television as he allows. -06/21/23 at change of shift NOC/Day shift with toilet and bring R1 up to the living room to wait for breakfast as he will allow. -7/26/23 encourage R1 to toilet on rounds during night shift. R1's nursing assistant care guide dated 8/11/23, included assist of one to toilet with gait belt and front wheeled walker, to not leave unattended in the bathroom, to offer toileting upon rising, before and after meals, at HS and as needed, added to toilet and 4:00 a.m. and every 2 hours. Sleep indicated R1 to be in bed at 11:30 p.m. and wake at 6:30 a.m. Night shift to get up and take to front day room. Special Cares instructions included high falls risk, resident to be toileted at day/evening shift change and brought to day room as R1 allows. At a.m. shift change bring up to living room as he allows, encourage R1 to toilet on rounds on night shift.	2 830		

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2 830	Continued From page 7 During an interview on 8/10/23, at 2:22 p.m. director of nursing (DON) stated, most of R1's falls are related to him transferring to toilet himself. DON stated it appears that the staff did not follow the care plan on 6/21/23 fall at 6:15 a.m. when resident was supposed to be brought to the day room by the overnight staff and should not have been in his room, on 7/21/23 fall in his bathroom at when an intervention was to remind staff to bring R1 back to the dayroom after lunch, on 7/28/23 staff was to bring R1 to toilet and bring to the day room before the overnight staff left for the day. During an interview on 8/14/23, at 1:40 p.m. DON stated R1 had fallen again over the weekend and the care plan was not followed. DON stated the intervention to get R1 up in the morning and moved to the day room had been added the to the treatment administration record (TAR) to help the staff to remember but the order had not been followed. DON stated she and her team recognized that was a problem and have put new items in place to alert staff to new fall interventions and discuss residents daily that are high falls risks. Review of Facility policy titled, Resident Fall, dated 2/13/23, indicated the policy of the facility is to ensure the safety of all residents after sustaining a fall. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of	2 830		

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2 830	Continued From page 8 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		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to complete comprehensive bowel/bladder assessments, failed to develop individualized toileting schedule/program, failed to follow the care plan for toileting to improve, maintain, or reduce the risk for worsening bowel/bladder function for 1 of 1 resident (R1)	2 915	. How corrective action will be accomplished for the resident(s) found to have been affected by the deficient practice: - A three day toileting diary was implemented on September 8, 2023 to	10/9/23

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2 915	Continued From page 9 reviewed for incontinence. Findings include: R1's Admission Record identified R1 admitted on 9/8/22, had diagnoses of Parkinson's dementia, dysphagia, Chronic Obstructive Pulmonary Disease (COPD), contusion of the scalp, contusion of the abdominal wall, laceration of the liver, fracture of the first and third lumbar vertebra, fracture of multiple ribs. R1's quarterly Minimum Data Set (MDS) dated 6/30/23, identified R1 had adequate hearing and vision, clear speech, makes self-understood and understands others, had moderately impaired cognition and had no rejection of cares. MDS indicated R1 needed extensive assist of one staff, with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. MDS also indicated R1 had poor balance had a history of three or more falls and was frequently incontinent of bladder but always continent of bowels. R1's Mobility Care plan dated 9/8/22, revised on 8/7/23, indicated R1 will be offered to toilet upon rising, before and after meals, at hour of sleep (HS) at 4:00 a.m. and then as he needs. R1 was to be transferred assist of one with front wheeled walker and gait belt and was to have TLSO (a brace that limits movement in your spine from the thoracic area (mid back) to your sacrum (low back) on when out of bed. To not allow R1 to ambulate without assistance. At change of shift NOC/Day shift with toilet and bring R1 up to the living room to wait for breakfast as he will allow. R1 was also to be toileted at day/evening shift change and brought up to the dayroom to watch TV as he allows and to be toileted on rounds during the night shift. Care plan also indicated to	2 915	evaluate and establish a pattern in order to individualized a toileting schedule for R1. - Resident R1's care plan will be updated to better reflect individualized interventions and goals for a toileting schedule. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - A toileting documentation record was implemented to document when each resident is actually toileted. - A three day toileting diary will be implemented for each resident over the next 30 days in order to evaluate and establish a pattern in order to individualized toileting schedules. - A shift change huddle was implemented to inform nursing staff for facility updates, resident updates and therapy changes. - A new face sheet was added to the CNA care guide to ensure that they are informed of important updates, those residents who are to attend AAA each evening, those residents that the night shift are to be getting up in the morning and any other important information that may be	

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2 915	Continued From page 10 not allow resident to ambulate without assistant and to not leave R1 unattended in the bathroom. R1's Alteration in elimination related to immobility care plan dated 9/9/22, revised on 8/7/23, indicated R1 was to be toileted with assist of one with front wheeled walker and gait belt. R1 was to be toileted upon rising, before and after meals, at HS and then as needed. Elimination care plan lacked toileting scheduled at change of shift, overnight rounds and 4 a.m. toileting. R1's progress notes were reviewed from 1/1/23 through 8/14/23 and found that R1 had a fall on 1/5/23 in front of his toilet in the bathroom, on 1/7/23 fall found in room bare footed with pants around his ankles. Root cause of self-transferring to the bathroom), 2/21/23 fall found in his room (unable to say why he self-transferred), 2/22/23 fall found next to recliner in the room sitting on buttocks scooting along. (Root cause of resident reported he was going to the bathroom) 3/18/23 fall resident found in the bathroom with walker straddling the toilet and buttocks against the wall. (Root Cause of lost balance while toileting) 4/29/23 fall at 4:30 a.m. R1 found in room with his walker in the bathroom tipped over. (R1 told staff he went to the bathroom and fell so he crawled to recliner chair.) Root Cause was resident needed to toilet and last fall was around 5 am for toilet so added to toileting program to toilet at 4:00 a.m. rounds. 5/21/23 fall R1 ambulated himself to bathroom and fell. (Intervention to have resident toilet at day/evening shift change and bring to front day room. 6/21/23 6:15 a.m. fall resident in the room in front of his recliner. (care plan toileting added at the change of shift from day to overnight shift and brought to the front day room to watch TV.) 7/2/23 Fall resident found in the bathroom at around 11:45 a.m. (Intervention of	2 915	relevant. - All resident's care plans will be updated to better reflect each resident's individualized interventions and goals who need toileting schedules. - All Nursing staff were in-serviced on August 15, 2023 of the importance of following the care plan. 3. The date that each deficiency will be corrected. - Deficiency tag F-915 will be in compliance by October 9, 2023	

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2 915	Continued From page 11 resident being toileted after lunch and brought to day room) 7/21/23 fall NA stated R1 last toileted at 1:00 a.m. (Intervention added to toilet R1 on overnight rounds.) 7/28/23 fall reported at 7:00 a.m. resident found sitting in his room by recliner. (report of care plan not followed NA reminded to bring R1 to bathroom after waking and then to the day room, also to make sure gripper socks are on properly.) R1's nursing assistant care guide dated 8/11/23, included assist of one to toilet with gait belt and front wheeled walker, to not leave unattended in the bathroom, to offer toileting upon rising, before and after meals, at HS and as needed. Pull ups only and added to toilet and 4:00 a.m. and every 2 hours, Sleep must bed at 11:30 p.m. and wake at 6:30 a.m. Night shift to get up and take to front day room. Special Cares instructions included high falls risk, resident to be toileted at day/evening shift change and brought to day room as R1 allows. At a.m. shift change bring up to living room as he allows, encourage R1 to toilet on rounds on night shift. R1's bowel and bladder elimination urinary continence diary dated 8/14/23 on his 30 days look back to 7/14/23, documentation indicated R1's 7/21/23 fall was at 1:00 a.m. and R1 was last toileted at 9:09 p.m. R1's 7/28/23 fall indicated he fell at 7:00 a.m. in his room. (R1's care plan indicates R1 is supposed to be toileted at 4:00 a.m. and brought to the day area). R1's diary indicated R1 was last toileted before the fall on 7/27/23 at 7:07 p.m. R1's next fall was on 8/2/23 at 12:45 a.m. documentation shows R1 was last toileted on 8/1/23 at 10:10 p.m. and resident had not gone and was dry at that time. R1 had a fall on 8/7/23 11:07 p.m. in his room. (Care plan indicates him to not go to bed till 11:30	2 915		

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2 915	Continued From page 12 p.m.) Resident was last toileted and only toileted at 1:33 p.m. per documentation. R1 had a fall on 8/13/23 at 7:00 a.m. in his room at 6:30 a.m. (care plan indicates R1 to be toileted every 2 hours on the overnight shift and to be gotten up at 4 a.m. for toileting and brought to the day room) R1's diary indicated R1 was last toileted at 1:25 a.m. During an interview on 8/10/23, at 10:31 a.m. with nursing assistant (NA)-A stated residents do not really have toileting plans, most residents are just toileted every 2 hours or a couple of times a shift. "We know when R1 needs to go he gets restless." During an interview on 8/10/23, at 2:06 p.m. with the director of nursing (DON) stated we have standardized toileting plans not individualized. DON stated the admission fall assessment is used to determine the interventions that have been put in place. During an interview on 8/14/23, at 10:48 a.m. with registered nurse (RN)-A stated the facility does not use any multiday bowel and bladder assessments and the schedule for resident toileting is standard upon waking, before and after meals and at bedtime. RN-A stated she was not aware of individualized toileting plans. During an interview on 8/14/23, at 10:53 a.m. licensed practical nurse (LPN)-A stated most of R1's falls are related to him saying he needs to use the bathroom. During an interview on 8/14/23, at 11:01 a.m. DON stated we do not have individualized toileting plans, we do not have an assessment that look at patterns or frequencies.	2 915		

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2 915	Continued From page 13 Policy on incontinence care was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		