Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2023

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

RE: CCN: 245344
Cycle Start Date: February 7, 2023

Dear Administrator:

On February 28, 2023, we notified you a remedy was imposed. On March 17, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 9, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 15, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 28, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 9, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 23, 2023

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

Re: Reinspection Results
Event ID: MO3D12

Dear Administrator:

On March 17, 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 February 7, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

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

RE: CCN: 245344
Cycle Start Date: February 27, 2023

Dear Administrator:

On February 7, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 15, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 15, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 15, 2023.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 15, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fairview Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 7, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 02/07/2023

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 2/7/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be not in compliance: H 53447955C (MN 90496), and H53448143C (MN 90386), with a deficiency cited at (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=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	F 689	These corrective actions will be	3/9/23

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

Electronically Signed | 03/03/2023

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 review, the facility failed to complete a thorough analysis of resident falls to determine root cause, failed to implement appropriate patient-centered interventions, and evaluate the effectiveness of those interventions to minimize and/or prevent future falls with injury for 2 of 2 residents (R1 and R2) reviewed for falls. The facility's failure resulted in harm to R1 when after 3 prior falls R1 fell a fourth time and sustained a cervical (neck) fracture. Findings include: R1's 12/20/22, admission Minimum Date Set (MDS) assessment identified R1 had severe cognitive impairment, and exhibited behaviors which included physical behavior 1-3 days, verbal behaviors 1-3 days, other behaviors 1-3 days, rejection of care 1-3 days, and wandering 1-3 days. R1 had diagnosis of multiple myeloma, congestive heart failure, hypertension, cerebral vascular accident, urinary tract infection and arthritis. R1's record review of Fall Incident reports from admission on 12/20/22 through 1/22/23 included 4 falls with the fourth resulting in a significant injury requiring hospitalization. 1.) R1's fall incident report dated 1/2/23, at 3:00 p.m., indicated R1 had fallen out of his wheelchair while in the living room and was found sitting on his buttocks in front of his wheelchair (w/c). Nursing assessment identified no injuries and the Root Cause Analysis completed by the nurse on duty was listed as impulsive. Immediate interventions were listed as assessed for injuries, returned to wheelchair. R1's medical record lacked additional review to determine a cause for	F 689	accomplished for those residents found to have been affected by the deficient practice: 1. Fairview Care Center's fall policy and procedure was updated on February 13, 2023. Education will be completed by all nursing staff on fall policy and procedures by March 9, 2023. 2. 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. 3. Fall compliance will be monitored weekly at IDT meetings. 4. R1 and R2 care plans will be updated to better reflect each resident's condition as well as individualized interventions and goals to help reduce the risk of falls and injury. Following the Incident Intervention Policy and the completion of the PDSA worksheet daily, weekly IDT meeting and monthly QAPI meetings will provide the comprehensive continuity needed to analyze better ways of managing falls and other incidents for the concerned residents in this POC and all other residents moving forward. During the PDSA, an educator will be assigned to ensure any items that require staff education will be the responsibility of that educator. Any education provided will be recorded, signed off, and kept in a binder with the DON.	

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F 689	Continued From page 2 the fall and the 1/3/23, at 11:24 a.m., interdisciplinary team (IDT) meeting note listed the Root Cause Analysis: confused and attempted to self-transfer. No new interventions were implemented or the care plan updated following the fall. 2.) R1's fall incident report dated 1/4/23, at 3:45 a.m., indicated R1 had been found sitting on the floor of his room in front of his recliner. The report identified R1's call light was on with time documented as 4:45 a.m. When an unidentified nursing assistant (NA) found R1, he had been incontinent, and the footrest of the recliner chair was extended. The incident report listed the conclusion as R1 had slid off the footrest of the recliner causing the chair to tip forward. There was no injury noted and the immediate intervention was R1 was not to use the electric recliner unless the family was in attendance. The root cause completed by the nurse completing the report of the fall listed R1 had attempted to self-transfer from the recliner with the chair reclined. (R1 had been sleeping in his recliner according to interviews). The 1/4/23, at 10:50 a.m., IDT note listed the cause of the fall as R1 was attempting to self-toilet and the intervention was to assist R1 to bed after checking and to use the captain's chair instead of the recliner in his room. There was no further investigation or discussion documented as to the cause of R1's fall and no interventions were added to R1's plan of care. 3.) R1's fall incident report dated 1/20/23, at 1:45 p.m., identified R1 had been found sitting on the floor of his room with his back against the wall by an unidentified therapy staff who passed by R1's room. The report identified R1 had been more	F 689	We are also in contact with our representative for Point Click Care to have the risk management feature added to our software package. This will allow us to enter the incident, provide the interventions, and be signed off electronically by the Director of Nursing and the Administrator giving better control of the details involved in each situation. Moving forward, we have those details available to follow up and make sure the PDSA worksheet is being followed. In addition, the staff has already been trained on the updated Fall Policy on February 14, 2023, with signatures obtained of their understanding. Those who couldn't make it to the training are being trained in person by the DON and will get this training by March 8, 2023 Deficiency tag F-689 will be in compliance by March 9, 2023.	

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F 689	Continued From page 3 confused and had chronic Clostridium difficile (C-diff) (inflammation of the colon caused by bacteria and often caused by use of antibiotics. It can be transmitted from person to person by spores and can cause severe damage to the colon and even be fatal). The medical record contained no documentation on either the incident report or medical record as to what R1 had been doing prior to fall. R1's medical record lacked documentation of a IDT meeting review of the fall and the root cause listed by the nurse completing the report was confusion with a urinary tract infection (UTI). There were no further investigation documented or interventions added to R1's plan of care. 4.) R1's fall incident report dated 1/22/23, at 8:40 p.m., identified R1 was observed lying on the floor at the foot of his bed with an abrasion to his forehead, a second abrasion above the first one, a bruise to his right knee, a laceration on the top of his left thumb, and a laceration on the bridge of his nose. R1 refused to allow vital signs (VS) and became combative when staff went to assist him. The root cause documented on the incident report by the nurse was self-transfer, and attempt to ambulate without a walker. Notification was listed as completed but no time was documented as when family members were notified of R1's fall and that R1 needed to be sent to Emergency department for evaluation. The incident report identified R1 had been resistive and did not want staff to touch him as they were attempting to stop the bleeding. The report identified R1 was lifted from the floor with a Hoyer sling after checking his extremities (no additional assessment, or precautions for a potential head/neck injury were identified). R1 was seated in a wheelchair when family members and the ambulance arrived, and	F 689		

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F 689	Continued From page 4 he was transferred to the ambulance and to the emergency department. R1 was assessed at the emergency department and had diagnosis of left-sided frontal sinus and inferior wall of the right maxillary sinus fracture, small left anterior parafalcine subdural hematoma, (brain bleed), and acute fracture of the ring of his first cervical vertebrae. R1 was admitted to the acute care hospital from the emergency department. R1's medical record lacked documentation of an IDT meeting review of the incident, potential cause of the fall, review of interventions in place to keep R1 safe, and a review of actions taken by facility staff following discovery of R1 with a head injury. R1's current undated care plan identified R1 had been admitted from an acute care hospital following a change in mental status and Clostridium Difficile. R1's goal was for a short term stay with therapy for strengthening and conditioning and return to his previous living situation. R1 had also been diagnosed with Vancomycin-resistant Enterococci (VRE) and placed on contract isolation with cares. R1 was identified as at risk for falls with the intervention to remind to use his call light when he needed assistance and had been moved to a room closer to the nursing station following his 1/22/23 fall with fracture. The care plan failed to include safety measures that had been put into place which included the need for increased supervision, not to be in his room unattended, and use of his wingback chair if he wanted to transfer from his wheelchair. The care plan failed to identify R1's desire to return to an independent status with ambulation and lack of understanding of the need for assistance. R1 returned to the facility on 1/31/23 with signed	F 689		

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F 689	Continued From page 5	F 689		

physician orders for a cervical collar to be worn at all times and a shower collar to be used when showering. Must have 2 staff persons present when going into his room every shift.

R1's nursing assistant (NA) care sheet identified 2 staff were to be present when going into his room, he required the assist of 2 staff with a four wheeled walker and gait belt for all transfers and ambulation, he was to be repositioned every (Q) 3 hours. R1 had a cervical collar that was to be worn at all times, unless showering and then a shower collar was to be used. The NA care sheet identified R1 was to use the wing back chair in his room when he wanted to be out of his wheelchair and not the electric recliner.

R1's 1/23/23 at 12:25 a.m., Emergency Room (ED) report identified he had orders for aspirin and Plavix (a medication that decreases blood clots), had a history of stroke, recent urinary tract infection treated with Macrobid, C-diff treated with oral Vancomycin and he had been transferred to the ED after a fall with altered mental status. The record identified it was not known if R1 had lost consciousness, but he had hit his head. R1 had discoloration beneath his left eye, and multiple abrasions of his face. Evaluation in the ED identified R1 had a left-sided frontal sinus and inferior wall of the right maxillary sinus fracture, small left anterior parafalcine subdural hematoma, (brain bleed), and acute fracture of the ring of his first cervical vertebrae. R1 was admitted to acute care following the ED evaluation.

Interview on 2/7/23 at 9:00 a.m., with NA- A reported R1 had been hospitalized following a fall on 1/22/23 at 8:40 p.m. and returned to the facility

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F 689	Continued From page 6 on 1/31/23. She reported R1 required 2 staff persons to assist with personal cares and activities of daily living (ADL's). NA-A reported R1 required supervision due to attempts to self-transfer and was not supposed to be in his room without staff or family in attendance. NA-A reported R1 was positioned in the living room area to allow for close supervision by staff and was encouraged to attend activities to keep him busy. NA-A reported R1 had behaviors of hitting out, yelling and became agitated when staff attempted to redirect him when he attempted to self-transfer. She reported R1 did not understand he needed to have assistance for transfers and prior to his last fall R1 had been able to walk with therapy and the assistance of one staff person in his room. Interview on 2/7/23 at 11:36 a.m. with family members (FM)-A and B, reported R1 had fallen 4 times since his admission to the facility. FM-A reported the first fall on 1/2/23 had occurred due to R1 being left unattended in the living room area, and he had needed to go to the bathroom. The second fall took place on 1/4/23 and was due to R1 being left in his recliner with the footrest elevated, and he had attempted to climb out of the chair without the footrest lowered and had fallen. The third fall occurred on 1/20/23 when R1 was discovered seated on the floor of his room by therapy and he had been attempting to get something from his nightstand and could not reach it. The fourth fall was 1/22/23 and they were told R1 had fallen out of bed and had injuries to his face, arm, and hand. FM-A reported she was told R1 was being transferred to the ED for evaluation, and upon her arrival he was seated in his wheelchair in the living room area. Both FM-A and B reported they were	F 689		

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	245344	A. BUILDING _____ B. WING _____	C 02/07/2023

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F 689	Continued From page 7 concerned R1 had been transferred from the floor with a sling lift after his fall and no immobilization of his head and neck had been implemented. In addition, when the ambulance arrived, they also failed to provide head and neck immobilization for R1, and he had been transferred from his wheelchair to the ambulance stretcher. FM-A and B reported when R1 had arrived at the ED the doctor had also expressed concern that R1 had been transferred with no head and neck immobilization when he had an obvious head injury. Interview on 2/7/23 at 4:25 p.m., with the medical director (MD) reported his expectation for a resident that experienced a fall with a suspected head injury the provider would be notified, and the resident would not be moved until the ambulance arrived and immobilized the resident to prevent the risk of further injury prior to transfer to the ED. He also reported his expectation for the facility to investigate the potential root cause analysis of a fall and develop appropriate patient specific interventions which were included in the care plan. The MD reported he was not aware the facility was not following through with appropriate investigation into the potential cause of a fall and adding resident specific interventions to address the areas identified. R2's 11/11/22, admission MDS identified moderate cognitive impairment, extensive physical assistance of 1 staff for transfers, locomotion on/off the unit, dressing and toileting. R2 required limited physical assistance of one staff for bed mobility, ambulation in his room, and personal hygiene. R2 was occasionally incontinent of bladder and frequently incontinent of bowel. R2 had a history of falls prior to	F 689		

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F 689	Continued From page 8	F 689		

admission and diagnosis of type 1 diabetes, hemiplegia, and hemiparesis (paralysis of left side) following a cerebral infarction (stroke), hypertension, epilepsy, major depressive disorder, and history of a Myocardial infarction (heart attack).

R2's record review of fall incident reports dated 1/1/23 through 2/6/23 identified R2 had experienced 6 falls during that period with minor injuries.

1.) R2's fall incident report dated 1/1/23 at 7:45 p.m., identified R2 had attempted to self-transfer and was found on his back on the floor. The root cause listed on the incident report by the nurse was impulsive and self-transferred. R2's medical record lacked documentation of IDT review and analysis of the fall and the only intervention was signage posted in his room to use his call light as a reminder.

2.) R2's fall incident report dated 1/4/23 at 4:30 a.m., identified R2 had reported he had fallen, but it was not able to be determined if the fall occurred in his bedroom or the bathroom. The report noted R2 had been incontinent of stool and had scraped his knee which R2 reported had occurred when he had climbed into his recliner. The medical record lacked documentation of a root cause analysis or an IDT meeting review of his fall. There were no interventions added to the care plan.

3.) R2's fall incident report dated 1/9/23 at 8:30 a.m., identified R2 had fallen in the bathroom, the fall was unwitnessed and he was found sitting on the bathroom floor. The report identified R2 reported he had walked into the bathroom with

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F 689	Continued From page 9 his walker and fell. R2 had no injuries identified and the root cause analysis reported by the nurse completing the report was listed as self-transfer and weakness. No new interventions were added and the medical record lacked documentation of IDT review and analysis of R2's fall. 4.) R2's fall incident report dated 1/13/23 at 9:00 a.m., identified R2 was found leaning over Bed A and the call light was on, (R2 used Bed B). The report identified R2 had reported he was reaching for the call light and fell out of his wheelchair. The immediate intervention was listed as Dycem (non-slip surface) placed in his wheelchair. The IDT meeting note in the medical record dated 1/16/23 listed the intervention of Dycem in wheelchair, to offer to move to a room closer to the nursing station, but R2 declined, and no root was cause identified. 5.) R2's fall incident report dated 2/6/23 at 9:50 a.m., identified R2 had been found lying on the floor by his bed, and reported he had self-transferred from his recliner, attempted to walk behind his wheelchair to the bathroom, had fallen and then crawled to his room to turn on the call light. R2 reported he had turned on his call light prior to his fall but no light was on according to the report. The medical record lacked documentation of a root cause analysis or an IDT meeting review of his fall. 6.) R2's fall incident report dated 2/6/23 at 5:30 p.m., identified R2 was found lying on floor on his belly. The root cause listed by the nurse completing the report noted the resident wants to go home and thinks he can self-transfer. The medical record identified the fall was discussed on 2/7/23 at the IDT meeting with the note that	F 689		

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F 689	Continued From page 10 R2 had forgotten he had 2 falls on 2/6/23, and no injury was noted. The intervention was for the nurse practitioner to be updated on the two recent falls and the plan to perform a medication reconciliation on her visit on 2/8/23. There was no interventions added to provide for R2's safety in the care plan. Observation on 2/7/23 at 12:30 p.m., following his return from an appointment outside the facility. R2 was in a room located at the end of the hall next to a lounge area and farthest from the nursing station. R2 was seated in his wheelchair, in a darkened room watching TV. His lower body was positioned toward the front of his chair and upper body leaned back against the back of his chair. An over bed table was positioned in front of R2 with personal items within reach. R2 was noted to have his call light within reach and a sign posted in his room which was a reminder to use his call light. Interview on 2/7/23 at 1:58 p.m., with the director of nursing (DON) who reviewed the fall incident reports for both R1 and R2, identified the charge nurse on duty at the time of the fall was expected to complete the incident report and include the root cause analysis, and any immediate interventions were put into place. The DON reported the incident reports for R1 and R2 had missing details regarding the falls and actions had been implemented. During the interview the DON was uncertain of events or actions that had taken place and referred to the electronic documentation, but reported she was not able to explain or provide information other than what had been documented on the incident report. The DON reported R1 should not have been	F 689		

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F 689	Continued From page 11 transferred following his fall on 1/22/23, until the ambulance arrived and provided immobilization of his head and neck due to the potential of head and neck injury. She reported would need to provide additional education and review of the facility policy and procedure. The DON reported when staff went to check on R2 he became frustrated and didn't want staff to assist him because he believed he could do his own cares, including self -transfer and ambulation and did not need assistance. She reported R2 believed he was able to return home and resume his previous lifestyle which was not possible. The DON reported there needed to be ongoing discussion with the doctor and family members to determine a plan to provide for R2's safety and the development of reasonable goals for short and long term needs. Following review of the incidents for R2 the DON identified the incident reports did not contain complete information, appropriate root cause analysis of the potential cause of R2's falls, or individualized interventions implemented to keep R2 safe. The DON reported review and analysis of falls needed to be discussed at IDT meetings with the developed interventions included in the care plan. Interview on 2/8/23 at 6:30 p.m., with the DON reported in other facilities where she had worked previously, the process followed was for the initial incident report completed by the nurse on duty at the time of the fall, a follow up meeting/discussion was held with the IDT or management team on the following business day, and a Fall Committee was in place to review and determine any additional education or measures	F 689		

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F 689	Continued From page 12 indicated. The DON reported this process was not currently in place in the facility and needed to be developed to better determine the root cause of a fall and any appropriate interventions which could be added to the individualized care plan. Review of the 2/1/23, Resident Fall policy and procedure identified a nurse was to assess a resident before they were gotten up off the floor and if there was evidence of a significant injury and/or significant facial or head injury the provider was to be notified for guidance on steps to implement, and if the resident was to be moved from the floor or wait for the ambulance to arrive. Documentation of the fall was to include time the fall occurred, location of the fall, what the resident was doing prior to the fall, any environmental information that might have affected the fall, completion of pertinent information on the "Fall Scene Investigation" form with root cause of fall and immediate intervention. Document any injury and if the resident was receiving a blood thinning medication.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: MO3D11

Dear Administrator:

The above facility was surveyed on February 7, 2023 through February 7, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/7/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be not in compliance: H 53447955C (MN90496), and H53448143C (MN90386), with a licensing order issued at 830. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a thorough analysis of resident falls to determine root cause, failed to implement appropriate patient-centered interventions, and evaluate the effectiveness of those interventions to minimize and/or prevent future falls with injury for 2 of 2 residents (R1 and R2) reviewed for falls. The facility's failure resulted in harm to R1 when after 3 prior falls R1 fell a fourth time and sustained a cervical (neck) fracture.	2 830	Deficiency Tag F-2830 will be corrected. The facility will identify other residents having the potential to be affected by the same deficient practice. All resident's care plan will be updated to better reflect each resident's condition as well as individualized interventions and goals to help avoid falls or injury. Deficiency Tag F-2830 will be in compliance by March 9, 2023.	3/3/23

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2 830	Continued From page 3 Findings include: R1's 12/20/22, admission Minimum Date Set (MDS) assessment identified R1 had severe cognitive impairment, and exhibited behaviors which included physical behavior 1-3 days, verbal behaviors 1-3 days, other behaviors 1-3 days, rejection of care 1-3 days, and wandering 1-3 days. R1 had diagnosis of multiple myeloma, congestive heart failure, hypertension, cerebral vascular accident, urinary tract infection and arthritis. R1's record review of Fall Incident reports from admission on 12/20/22 through 1/22/23 included 4 falls with the fourth resulting in a significant injury requiring hospitalization. 1.) R1's fall incident report dated 1/2/23, at 3:00 p.m., indicated R1 had fallen out of his wheelchair while in the living room and was found sitting on his buttocks in front of his wheelchair (w/c). Nursing assessment identified no injuries and the Root Cause Analysis completed by the nurse on duty was listed as impulsive. Immediate interventions were listed as assessed for injuries, returned to wheelchair. R1's medical record lacked additional review to determine a cause for the fall and the 1/3/23, at 11:24 a.m., interdisciplinary team (IDT) meeting note listed the Root Cause Analysis: confused and attempted to self-transfer. No new interventions were implemented or the care plan updated following the fall. 2.) R1's fall incident report dated 1/4/23, at 3:45 a.m., indicated R1 had been found sitting on the floor of his room in front of his recliner. The report identified R1's call light was on with time documented as 4:45 a.m. When an unidentified	2 830		

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2 830	Continued From page 4 nursing assistant (NA) found R1, he had been incontinent, and the footrest of the recliner chair was extended. The incident report listed the conclusion as R1 had slid off the footrest of the recliner causing the chair to tip forward. There was no injury noted and the immediate intervention was R1 was not to use the electric recliner unless the family was in attendance. The root cause completed by the nurse completing the report of the fall listed R1 had attempted to self-transfer from the recliner with the chair reclined. (R1 had been sleeping in his recliner according to interviews). The 1/4/23, at 10:50 a.m., IDT note listed the cause of the fall as R1 was attempting to self-toilet and the intervention was to assist R1 to bed after checking and to use the captain's chair instead of the recliner in his room. There was no further investigation or discussion documented as to the cause of R1's fall and no interventions were added to R1's plan of care. 3.) R1's fall incident report dated 1/20/23, at 1:45 p.m., identified R1 had been found sitting on the floor of his room with his back against the wall by an unidentified therapy staff who passed by R1's room. The report identified R1 had been more confused and had chronic Clostridium difficile (C-diff) (inflammation of the colon caused by bacteria and often caused by use of antibiotics. It can be transmitted from person to person by spores and can cause severe damage to the colon and even be fatal). The medical record contained no documentation on either the incident report or medical record as to what R1 had been doing prior to fall. R1's medical record lacked documentation of a IDT meeting review of the fall and the root cause listed by the nurse completing the report was confusion with a urinary tract infection (UTI). There were no	2 830		

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2 830	Continued From page 5 further investigation documented or interventions added to R1's plan of care. 4.) R1's fall incident report dated 1/22/23, at 8:40 p.m., identified R1 was observed lying on the floor at the foot of his bed with an abrasion to his forehead, a second abrasion above the first one, a bruise to his right knee, a laceration on the top of his left thumb, and a laceration on the bridge of his nose. R1 refused to allow vital signs (VS) and became combative when staff went to assist him. The root cause documented on the incident report by the nurse was self-transfer, and attempt to ambulate without a walker. Notification was listed as completed but no time was documented as when family members were notified of R1's fall and that R1 needed to be sent to Emergency department for evaluation. The incident report identified R1 had been resistive and did not want staff to touch him as they were attempting to stop the bleeding. The report identified R1 was lifted from the floor with a Hoyer sling after checking his extremities (no additional assessment, or precautions for a potential head/neck injury were identified). R1 was seated in a wheelchair when family members and the ambulance arrived, and he was transferred to the ambulance and to the emergency department. R1 was assessed at the emergency department and had diagnosis of left-sided frontal sinus and inferior wall of the right maxillary sinus fracture, small left anterior parafalcine subdural hematoma, (brain bleed), and acute fracture of the ring of his first cervical vertebrae. R1 was admitted to the acute care hospital from the emergency department. R1's medical record lacked documentation of an IDT meeting review of the incident, potential cause of the fall, review of interventions in place to keep R1 safe, and a review of actions taken by facility staff following discovery of R1 with a head injury.	2 830		

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2 830	Continued From page 6 R1's current undated care plan identified R1 had been admitted from an acute care hospital following a change in mental status and Clostridium Difficile. R1's goal was for a short term stay with therapy for strengthening and conditioning and return to his previous living situation. R1 had also been diagnosed with Vancomycin-resistant Enterococci (VRE) and placed on contract isolation with cares. R1 was identified as at risk for falls with the intervention to remind to use his call light when he needed assistance and had been moved to a room closer to the nursing station following his 1/22/23 fall with fracture. The care plan failed to include safety measures that had been put into place which included the need for increased supervision, not to be in his room unattended, and use of his wingback chair if he wanted to transfer from his wheelchair. The care plan failed to identify R1's desire to return to an independent status with ambulation and lack of understanding of the need for assistance. R1 returned to the facility on 1/31/23 with signed physician orders for a cervical collar to be worn at all times and a shower collar to be used when showering. Must have 2 staff persons present when going into his room every shift. R1's nursing assistant (NA) care sheet identified 2 staff were to be present when going into his room, he required the assist of 2 staff with a four wheeled walker and gait belt for all transfers and ambulation, he was to be repositioned every (Q) 3 hours. R1 had a cervical collar that was to be worn at all times, unless showering and then a shower collar was to be used. The NA care sheet identified R1 was to use the wing back chair in his room when he wanted to be out of his wheelchair	2 830		

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2 830	Continued From page 7 and not the electric recliner. R1's 1/23/23 at 12:25 a.m., Emergency Room (ED) report identified he had orders for aspirin and Plavix (a medication that decreases blood clots), had a history of stroke, recent urinary tract infection treated with Macrobid, C-diff treated with oral Vancomycin and he had been transferred to the ED after a fall with altered mental status. The record identified it was not known if R1 had lost consciousness, but he had hit his head. R1 had discoloration beneath his left eye, and multiple abrasions of his face. Evaluation in the ED identified R1 had a left-sided frontal sinus and inferior wall of the right maxillary sinus fracture, small left anterior parafalcine subdural hematoma, (brain bleed), and acute fracture of the ring of his first cervical vertebrae. R1 was admitted to acute care following the ED evaluation. Interview on 2/7/23 at 9:00 a.m., with NA- A reported R1 had been hospitalized following a fall on 1/22/23 at 8:40 p.m. and returned to the facility on 1/31/23. She reported R1 required 2 staff persons to assist with personal cares and activities of daily living (ADL's). NA-A reported R1 required supervision due to attempts to self-transfer and was not supposed to be in his room without staff or family in attendance. NA-A reported R1 was positioned in the living room area to allow for close supervision by staff and was encouraged to attend activities to keep him busy. NA-A reported R1 had behaviors of hitting out, yelling and became agitated when staff attempted to redirect him when he attempted to self-transfer. She reported R1 did not understand he needed to have assistance for transfers and prior to his last fall R1 had been able to walk with therapy and the assistance of one staff person in	2 830		

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2 830	Continued From page 8 his room. Interview on 2/7/23 at 11:36 a.m. with family members (FM)-A and B, reported R1 had fallen 4 times since his admission to the facility. FM-A reported the first fall on 1/2/23 had occurred due to R1 being left unattended in the living room area, and he had needed to go to the bathroom. The second fall took place on 1/4/23 and was due to R1 being left in his recliner with the footrest elevated, and he had attempted to climb out of the chair without the footrest lowered and had fallen. The third fall occurred on 1/20/23 when R1 was discovered seated on the floor of his room by therapy and he had been attempting to get something from his nightstand and could not reach it. The fourth fall was 1/22/23 and they were told R1 had fallen out of bed and had injuries to his face, arm, and hand. FM-A reported she was told R1 was being transferred to the ED for evaluation, and upon her arrival he was seated in his wheelchair in the living room area. Both FM-A and B reported they were concerned R1 had been transferred from the floor with a sling lift after his fall and no immobilization of his head and neck had been implemented. In addition, when the ambulance arrived, they also failed to provide head and neck immobilization for R1, and he had been transferred from his wheelchair to the ambulance stretcher. FM-A and B reported when R1 had arrived at the ED the doctor had also expressed concern that R1 had been transferred with no head and neck immobilization when he had an obvious head injury. Interview on 2/7/23 at 4:25 p.m., with the medical director (MD) reported his expectation for a resident that experienced a fall with a suspected head injury the provider would be notified, and the	2 830		

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2 830	Continued From page 9 resident would not be moved until the ambulance arrived and immobilized the resident to prevent the risk of further injury prior to transfer to the ED. He also reported his expectation for the facility to investigate the potential root cause analysis of a fall and develop appropriate patient specific interventions which were included in the care plan. The MD reported he was not aware the facility was not following through with appropriate investigation into the potential cause of a fall and adding resident specific interventions to address the areas identified. R2's 11/11/22, admission MDS identified moderate cognitive impairment, extensive physical assistance of 1 staff for transfers, locomotion on/off the unit, dressing and toileting. R2 required limited physical assistance of one staff for bed mobility, ambulation in his room, and personal hygiene. R2 was occasionally incontinent of bladder and frequently incontinent of bowel. R2 had a history of falls prior to admission and diagnosis of type 1 diabetes, hemiplegia, and hemiparesis (paralysis of left side) following a cerebral infarction (stroke), hypertension, epilepsy, major depressive disorder, and history of a Myocardial infarction (heart attack). R2's record review of fall incident reports dated 1/1/23 through 2/6/23 identified R2 had experienced 6 falls during that period with minor injuries. 1.) R2's fall incident report dated 1/1/23 at 7:45 p.m., identified R2 had attempted to self-transfer and was found on his back on the floor. The root cause listed on the incident report by the nurse was impulsive and self-transferred. R2's medical record lacked documentation of IDT review and	2 830		

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2 830	Continued From page 10 analysis of the fall and the only intervention was signage posted in his room to use his call light as a reminder. 2.) R2's fall incident report dated 1/4/23 at 4:30 a.m., identified R2 had reported he had fallen, but it was not able to be determined if the fall occurred in his bedroom or the bathroom. The report noted R2 had been incontinent of stool and had scraped his knee which R2 reported had occurred when he had climbed into his recliner. The medical record lacked documentation of a root cause analysis or an IDT meeting review of his fall. There were no interventions added to the care plan. 3.) R2's fall incident report dated 1/9/23 at 8:30 a.m., identified R2 had fallen in the bathroom, the fall was unwitnessed and he was found sitting on the bathroom floor. The report identified R2 reported he had walked into the bathroom with his walker and fell. R2 had no injuries identified and the root cause analysis reported by the nurse completing the report was listed as self-transfer and weakness. No new interventions were added and the medical record lacked documentation of IDT review and analysis of R2's fall. 4.) R2's fall incident report dated 1/13/23 at 9:00 a.m., identified R2 was found leaning over Bed A and the call light was on, (R2 used Bed B). The report identified R2 had reported he was reaching for the call light and fell out of his wheelchair. The immediate intervention was listed as Dycem (non-slip surface) placed in his wheelchair. The IDT meeting note in the medical record dated 1/16/23 listed the intervention of Dycem in wheelchair, to offer to move to a room closer to the nursing station, but R2 declined, and no root was cause identified.	2 830		

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2 830	Continued From page 11 5.) R2's fall incident report dated 2/6/23 at 9:50 a.m., identified R2 had been found lying on the floor by his bed, and reported he had self-transferred from his recliner, attempted to walk behind his wheelchair to the bathroom, had fallen and then crawled to his room to turn on the call light. R2 reported he had turned on his call light prior to his fall but no light was on according to the report. The medical record lacked documentation of a root cause analysis or an IDT meeting review of his fall. 6.) R2's fall incident report dated 2/6/23 at 5:30 p.m., identified R2 was found lying on floor on his belly. The root cause listed by the nurse completing the report noted the resident wants to go home and thinks he can self-transfer. The medical record identified the fall was discussed on 2/7/23 at the IDT meeting with the note that R2 had forgotten he had 2 falls on 2/6/23, and no injury was noted. The intervention was for the nurse practitioner to be updated on the two recent falls and the plan to perform a medication reconciliation on her visit on 2/8/23. There was no interventions added to provide for R2's safety in the care plan. Observation on 2/7/23 at 12:30 p.m., following his return from an appointment outside the facility. R2 was in a room located at the end of the hall next to a lounge area and farthest from the nursing station. R2 was seated in his wheelchair, in a darkened room watching TV. His lower body was positioned toward the front of his chair and upper body leaned back against the back of his chair. An over bed table was positioned in front of R2 with personal items within reach. R2 was noted to have his call light within reach and a sign posted in his room which was a reminder to use	2 830		

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2 830	Continued From page 12 his call light. Interview on 2/7/23 at 1:58 p.m., with the director of nursing (DON) who reviewed the fall incident reports for both R1 and R2, identified the charge nurse on duty at the time of the fall was expected to complete the incident report and include the root cause analysis, and any immediate interventions were put into place. The DON reported the incident reports for R1 and R2 had missing details regarding the falls and actions had been implemented. During the interview the DON was uncertain of events or actions that had taken place and referred to the electronic documentation, but reported she was not able to explain or provide information other than what had been documented on the incident report. The DON reported R1 should not have been transferred following his fall on 1/22/23, until the ambulance arrived and provided immobilization of his head and neck due to the potential of head and neck injury. She reported would need to provide additional education and review of the facility policy and procedure. The DON reported when staff went to check on R2 he became frustrated and didn't want staff to assist him because he believed he could do his own cares, including self -transfer and ambulation and did not need assistance. She reported R2 believed he was able to return home and resume his previous lifestyle which was not possible. The DON reported there needed to be ongoing discussion with the doctor and family members to determine a plan to provide for R2's safety and the development of reasonable goals for short and long term needs. Following review of the incidents for R2 the DON	2 830		

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2 830	Continued From page 13 identified the incident reports did not contain complete information, appropriate root cause analysis of the potential cause of R2's falls, or individualized interventions implemented to keep R2 safe. The DON reported review and analysis of falls needed to be discussed at IDT meetings with the developed interventions included in the care plan. Interview on 2/8/23 at 6:30 p.m., with the DON reported in other facilities where she had worked previously, the process followed was for the initial incident report completed by the nurse on duty at the time of the fall, a follow up meeting/discussion was held with the IDT or management team on the following business day, and a Fall Committee was in place to review and determine any additional education or measures indicated. The DON reported this process was not currently in place in the facility and needed to be developed to better determine the root cause of a fall and any appropriate interventions which could be added to the individualized care plan. Review of the 2/1/23, Resident Fall policy and procedure identified a nurse was to assess a resident before they were gotten up off the floor and if there was evidence of a significant injury and/or significant facial or head injury the provider was to be notified for guidance on steps to implement, and if the resident was to be moved from the floor or wait for the ambulance to arrive. Documentation of the fall was to include time the fall occurred, location of the fall, what the resident was doing prior to the fall, any environmental information that might have affected the fall, completion of pertinent information on the "Fall Scene Investigation" form with root cause of fall and immediate intervention. Document any injury and if the resident was receiving a blood thinning	2 830		

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2 830	Continued From page 14 medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		