Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: July 25, 2024

Dear Administrator:

On September 25, 2024, we notified you a remedy was imposed. On October 9, 2024 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 October 1, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 25, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 25, 2024, 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 October 10, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 15, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

Re: Reinspection Results
Event ID: 8KRM12

Dear Administrator:

On September 12, 2024 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 July 25, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: July 25, 2024

Dear Administrator:

On July 25, 2024, a survey was completed at your facility by the Minnesota Departments 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 October 25, 2024 (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 January 25, 2025 (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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING ______ B. WING ______	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 7/24/24, and 7/25/24, 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: H53486185C (MN00105093), 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=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively	F 689	F689 Free of Accident Hazards/Supervision/Devices	9/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/15/2024

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 assess when a new fall risk was identified and failed to safely implement and maintain resident equipment for 1 of 3 residents (R1) who utilized an air mattress that was not maintained at the recommended pressure. Additionally, the facility failed to assess and immediately implement new interventions for 1 of 3 residents (R2) who had falls related to self-transfers. Findings include: R1: R1's significant change Minimum Data Set (MDS), dated 5/31/24, identified R1 was severely cognitively impaired and received total physical assist for most cares; however, extensive assist was provided for bed mobility. R1 was free of falls in the past quarter. Diagnoses included traumatic brain injury (TBI), sleep disorder, and muscle spasms. An Order Summary Report identified an order was entered on 6/5/23 for an air mattress to R1's bed. Staff were directed every shift to ensure proper function, inflation, and tie downs. A [comprehensive] Fall Review Evaluation form, locked 5/16/24, identified no history of falls in the past three months; however, R1 was at risk due to the following: medications administered, cognitive impairments, total bowel and bladder incontinence, wheelchair dependence with disorientation, and hands-on assistance to move from place to place. The Summary/Interventions section indicated R1 required dependence on a wheelchair for mobility as she was unable to walk. She was limited to only making slight changes to her extremities and required assistance with	F 689	Immediate Corrective Action: R2 is no longer at the facility. R1 air mattress inspected and evaluated immediately by facility to ensure proper settings and function. Air mattress manuals laminated, and zip tied to the air mattress. Orders placed to ensure proper function, inflation, and tie downs every shift. Education given to nursing department and maintenance regarding air mattress settings and function. Corrective Action as it applies to others: All residents placed on air mattresses will be reviewed to ensure proper settings and function. All residents will have orders in their chart to ensure proper function, inflation and tie downs every shift. Air mattress manuals will be placed on all air mattresses. Air mattress manuals reviewed to ensure facility is using per manufacturer guidelines. All residents at risk for falls due to self-transfers were identified and their care plan was assessed to ensure proper interventions were in place. All nurses were educated on immediate fall interventions. Interim DON and Nurse Manager were educated on identifying residents at risk for self-transfers and ensuring proper interventions are in place, as able. Fall Prevention and Management Policy	

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F 689	Continued From page 2 mobility. The evaluation lacked a fall analysis and information related to air mattress use, muscle spasms, chronic pain, or seizure activity, nor did it address any potential associated risks related to these. On 7/18/24, R1's weight was 145.8 pounds. R1's care plan identified an intervention for skin integrity that included a pressure redistribution mattress and for mobility she required two staff for bed mobility. The interventions were free of an assessed pressure setting identification or any additional mattress instructions. In addition, with a revision date of 3/17/22, R1 was a fall risk related to defined medication usage, impaired cognition and mobility, along with history of seizures. The goal was for her to be safe and free from falls. Interventions directed placement of foam side boards to her wheelchair for proper body alignment. Staff were directed to monitor and document on safety, review information on past falls and attempt to determine cause(s), record possible root causes of falls, and alter or remove any if possible. A Risk Management Found on Floor incident report, dated 7/20/24 at 10:40 p.m., indicated R1 was observed on the floor wrapped up in her bedding. She displayed intermitted confusion and she stated she tried to get up. R1 moaned and reported back, hip, and neck pain at a 10 when transferred to bed. She appeared still and refused to move when a skin assessment was attempted. An order was received for emergency department evaluation. Predisposing Environmental Factors identified "Other" and "Bed Position." Predisposing Situation Factors identified "Rolled out of bed." The form lacked intervention and/or	F 689	was reviewed and remains current. Dates of Compliance: 9/4/2024 Recurrence will be prevented by: Audits of all residents on air mattress will be completed weekly x4 then monthly x2 months to assure proper settings and function are being followed. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Audits of all residents at risk for falls due to self-transfers will be audited weekly x4 weeks, then monthly x2 months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or assigned designee	

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F 689	Continued From page 3	F 689		

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any investigatory information.

R1's progress notes identified the following:
-7/21/24 at 0:18 a.m.: the ambulance arrived at 12:10 a.m. and R1 was transported at 12:35 a.m. A copy of the incident report was placed in the director of nursing (DON)'s box.
-7/21/24 at 6:11 a.m.: hospital staff updated the facility R1 was assessed to have a C2 (cervical) fracture and was being transferred to another hospital.
-From 7/21/24 through 7/24/24, the progress notes lacked identification a 7/21/24 fall analysis and/or any interventions to mitigate a reoccurrence.

R1's hospital information identified the following:
-7/22/24, a neurosurgical consultation note identified R1 was seen at an outside hospital where imaging revealed a C2 fracture with possible widening of the disc space. "Fortunately, MRI [was] without disc injury, ligament injury or significant edema. There is a minimal fracture line at C2 - difficult to determine acuity."
-An MRI cervical spine final report identified an oblique fracture at the anterior-inferior corner of the C2 vertebral body without significant displacement. There was no overlying prevertebral soft tissue swelling or evidence of ligamentous injury or malalignment. There was minimal T2 hyperintense signal along the fracture. "Given the minimal associated marrow T2 hyperintensity, as well as the lack of prevertebral soft tissue swelling, this fracture is age indeterminate and could be hyperacute or subacute to chronic in nature."
-R1's hospital documentation lacked evidence of suspected head/cranial injury.

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F 689	Continued From page 4	F 689		

A progress note, dated 7/23/24 at 4:10 p.m., identified R1 returned to the facility at 1:30 p.m.

An Incident Review and Analysis form, dated 7/23/24 at 2:49 p.m., identified R1's 7/20/24 fall where R1 reported she potentially laid too close to the edge of the air mattress and pressed her call light after she fell. Her mattress was assessed and functioned properly "with the right weight." She was "potentially too close to the edge of the bed, causing her to slip out." An intervention section directed to "See Care Plan." Other interventions were identified as a foot cradle and a perimeter air mattress overlay. The form indicated that during the investigation, therapy reported R1 was unable to turn her body at all but was able to move her arms. She was not incontinent at the time of the fall and was checked on 40 minutes prior where she was left laying supine with no pillows used to offload her body and gripper socks on.

R1's care plan history identified fall risk interventions were created on 7/23/24 (three days later) to include a foot cradle and a perimeter air mattress overlay.

Resident group sheets were reviewed. R1 was identified as a fall risk, and she was to utilize nonskid footwear and to provide safety if a seizure occurred. Under bed mobility, staff were directed to ensure her air mattress functioned properly every shift. The group sheet lacked information related to R1's observed right sided leaning, perimeter overlay, bed cradle, mattress pump setting, bed height, and/or head elevation.

An Order Listing Report, printed 7/25/24, identified all orders entered for R1 since 7/20/24.

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F 689	Continued From page 5	F 689		

On 7/21/24, an order to send R1 to the ED for post-fall evaluation was entered. The orders lacked a fall batch order entry.

When interviewed on 7/24/24, at 10:27 a.m., R1 lacked signs and/or symptoms of distress. Her forehead/face was free of bruising or signs of injury. A neck collar was in place while she laid on an inflated air mattress that housed a head and foot sectioned perimeter overlay. A foot cradle was in place without concerns. She was centered within the bed with her head slightly elevated (approximately 20-30 degrees). She was questioned on her observed neck collar use. She explained she fell from bed a couple of weeks ago when she attempted to get out of bed as it was morning. R1 confirmed this was her first fall and she was able to move in bed. However, R1 was unable to move her lower extremities when cued by the surveyor, but she brought her arms to her forehead when asked to do so. She denied any staff concerns or fears while staff rolled her in bed. R1 identified she "rolled" off the bed, yelled for help, and staff came right away. She acknowledged this was the first time she attempted to get out of bed herself. R1 identified she went to the hospital after the fall to get checked out and she denied any injuries were found. R1 denied concerns with her air mattress.

On 7/24/24, at 10:46 a.m., immediately after R1's interview, her air mattress pump was examined. The pump identified it was a Custom Medical Solutions - Matrix ALAL Mattress System. The mattress pump identified the pump was on and lacked any lit warning identifications. The alternating cycle mode was set to every 15 minutes and the setting was set to "6." The Soft to Firm setting scale identified a setting of 6 was

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for a person who weighed an estimated 245 pounds.

On 7/24/24, at 2:27 p.m., R1's family member (FM)-A was interviewed via telephone. He stated he visited with R1 most evenings; however, missed the evening of her fall. He was concerned on how someone who was immobile for almost 40 months could flop themselves out of bed. FM-A informed him she remembered being on the floor, but she did not remember any overall details. He explained there were instances about three to four months ago when she pushed herself in her wheelchair with her left leg, and so maybe she pushed on the wall with her left leg enough to slide out of bed. "Sometimes she sits too straight" and may have slid a little also. He adjusted her in bed at times due to this. FM-A identified R1's head was often elevated at a 45-degree angle. He stated R1 thought she could stand and walk. "She is bullheaded." FM-A stated when R2's MRI/CT scan results came back, R1 had a C2 fracture; however, no one could figure out if this was new or old as there was no swelling of the ligaments and no indication it was an acute fracture. FM-A identified R1's air mattress was never to be static; it was always to be "rotating." He often checks this as he had found this on static in the past. FM-A was unaware of what the other pump settings should be.

During an interview on 7/24/24, at 3:40 p.m., TMA-B stated resident care plans identified their fall risk. She did not consider R1 a fall risk prior to the fall despite episodes where she witnessed R1 "leaning" while in bed. When this occurred, staff just helped reposition her. TMA-B explained R1 preferred to lay on her back, with her head elevated so she could watch TV, along with the

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F 689	Continued From page 7	F 689		

bed frame as close to the floor as it went to ensure overall safety. She indicated this was the position she left R1 in around 7:00 p.m. the evening relevant to her fall. TMA-B was unaware of R1's mattress pump settings and explained the monitoring on the TAR indicated she was to check the bed and make sure it was on and inflated: maintenance or management adjusted the beds as she was not allowed to touch any of the settings. TMA-B was unaware of any new or updated interventions to mitigate R1's fall risk. She was unaware if R1 had bumpers on her bed even though she previously worked with R1 this day.

R2:

R2's Face Sheet identified R2 admitted on 7/9/24, from the hospital, after he sustained multiple fractures of his right sided ribs. Additional diagnoses present on admission were history of a fall, muscle weakness, unsteadiness on his feet, aphasia, fracture of right femur, malnutrition, and history of TBI.

R2's Admission/Initial Data Collection form, dated 7/9/24, identified memory impairments, both short and long, assistance needed for mobility and toileting, ROM impairments on both upper and lower extremities right sides. In addition, R2 was frequently incontinent of bowel and bladder, had broken ribs and femur, and experienced falls in the past month and again in the past six months.

R2's 48 Hour Care Plan, dated 7/10/24, identified he was at risk for falls. No etiologies were identified. The goal was for him to remain safe and free from falls. Staff were directed to follow therapy instructions for mobility and to monitor

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F 689	Continued From page 8 and document on safety, review information on past falls and attempt to determine cause(s), record possible root causes of falls, and alter or remove any if possible. Staff were then to educate resident, family, caregivers, and the IDT (interdisciplinary team) on any findings. Resident group sheets were reviewed. R2's was identified a fall risk. There was no additional information under the safety heading. Toileting directions were provided for every two to three hours. A Leisure Act. - Rehab. - Restorative section identified he was to be offered to get up around 4:00 a.m. and 6:00 a.m., toilet, provide a cup of coffee, turn the news on, and offer to lay back down when coffee was finished. The group sheet lacked information related to his self-transfers, the use of a night light, or ensuring a Reacher was near him. R2's medical record identified the following entries and identified information: -7/10/24 progress note at 2:56 p.m.: R1 required one-on-one supervision with staff due to his high fall risk. The note lacked any additional details. -7/10/24 progress note at 10:53 p.m.: R1 attempted self-transfers and was restless. -7/11/24 progress note at 9:34 p.m.: R1 was observed standing next to his wheelchair. -7/12/24 provider progress note: R2 was assessed. The note lacked information related to the self-transfers. The plan of care was to be continued and there were no concerns from R2 or staff at that time. -7/15/24 Task behavioral documentation at 5:59 a.m.: one self-transfer attempt. Despite reassurance being provided, the behavior was unchanged. -7/15/24 progress note at 10:25 a.m.: after a	F 689		

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three-day bowel and bladder screen, R2 was incontinent of bowel and bladder and required assistance with toileting. A plan was initiated for him to be assisted with his toileting needs every two to three hours and as needed.
-7/15/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite reassurance being provided, the behavior was unchanged.
-7/15/24 progress note at 2:33 p.m.: R2 liked to self-transfer and wandered.
-7/15/24 progress note at 3:01 p.m.: R2 was found seated on the floor [at 6:00 a.m.]. No injuries were assessed. R2's only response was 'look at all of this' as he pointed at the room.
-7/15/24, an occupational therapy (OT) progress note at 3:01 p.m., identified OT approached R2 and found him on the floor. The note did not identify at what time R2 was found. No injuries were observed.
-7/15/24 order listing report identified fall batch orders to complete a post fall progress note every shift for 72 hours with directions to "Make sure to include any [signs/symptoms (s/s)] of injury and effectiveness of new fall interventions." The second order identified interventions for medication review request and call light reminder sign. There orders were discontinued 7/16/24.

A Risk Management Found on Floor incident report, dated 7/15/24 at 6:00 a.m., identified R2 was found seated on the floor. He was unable to identify what happened and he was injury free. He was returned to bed and "checked on frequently afterwards." Immediate actions identified staff placed a sign in his room to call for assistance and he was "frequently checked on throughout the day." "Lighting" concerns were identified, along with R2's confusion, history of

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falls, and not always able to realize his limitations in which R2 ambulated/transferred without assist. R2's medical provider was updated at 2:59 p.m., the DON at 3:00 p.m., and FM-B at 3:24 p.m.

An admission [comprehensive] Fall Review Evaluation form, dated 7/15/24 at 9:50 a.m., identified R2's history of multiple falls in the past month and past six months with risk factors related to psychotropic medication, memory impairments, impaired mobility, occasionally incontinent of bowel and bladder, and exhibited agitated, or wandering, behaviors in the past seven days. Environmental factors provided an option for "Lighting [as identified on the Risk Management 7/15/24 form];" however, this was blank. A summary identified R2 had potential risk for falls related to decreased mobility and listed medication and he was disoriented and required two staff for transfers. Fall interventions directed to see the care plan and staff would continue to monitor and update the plan of care as needed. The evaluation was free of information related to the 7/15/24, 6:00 a.m. fall.

An Incident Review and Analysis form, dated 7/15/24 at 10:20 a.m. and signed as complete on 7/18/24, identified the information from R2's 7/15/24 Found on Floor incident report. The form analysis indicated R2 was brought to the activity room after the incident. Contributing factors included inability to always realize his limitations, history of falls, lacked remembrance to use the call light, expressive aphasia, and the lack of room light. The form directed one to the care plan for interventions and indicated RN-C spoke to FM-B and was informed R2 enjoyed picking things up from the ground, such as sticks in the yard. In addition, he liked things tidy. The call do

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not fall sign was removed as R2 was severely cognitively impaired and he was provided with a grabber/Reacher.

An admission MDS driven Behavioral Symptoms CAA (Care Area Assessment), dated 7/16/24, identified R2 displayed three occurrences of self-transferring within a seven day look back period. The behaviors would be care planned to slow or minimize declines and risks. The CAA was free of information related to self-transfer mitigation.

An admission MDS driven Falls CAA, dated 7/16/24, identified R2's fall history with injury and that he fell once since admission. R2 displayed balance problems during surface transitions and transfers in which staff ensured his footwear prevented slipping, his room was set up to accommodate his needs, and his personal items were within his reach. The fall risk would be care planned to avoid complications and minimize risks. The CAA was free of information related to R2 footwear or room accommodation specifics. In addition, the CAA lacked details related to his 7/15/24 fall, his self-transfers, or any overall comprehensively assessed fall risk details and determined resident specific fall interventions.

R2's subsequent medical record identified the following entries and identified information:
-7/16/24 provider note identified R2 had "2 falls last night and 1 this morning." R2 continued to be forgetful and impulsive with self-transfers. A fall matt next to his bed was recommended.
-7/16/24 progress note at 6:52 a.m.: Fall Charting - vitals and neuros within R2's norm. No falls tonight on this shift. The note lacked effectiveness of interventions.

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F 689	Continued From page 12 -7/16/24 progress notes at 10:35 a.m.: R2 was seated on his bedroom floor [at 6:25 a.m.]. No injuries assessed. R2 unable to provide fall details. He was checked on frequently afterwards. -7/16/24 order listing report identified the fall batch orders were initiated with direction to monitor the effectiveness of a medication review request and call light reminder sign. A Risk Management Found on Floor incident report, dated 7/16/24 at 6:25 a.m., identified R2 was found seated on the floor without injury. He was unable to identify what happened. He was returned to bed and checked on frequently. An immediate intervention was a fall mat. "Poor Lighting" was identified, along with R2's incontinence, gait imbalance, and cognitive impairments. The medical provider was updated at 11:59 a.m., the DON at 12:01 p.m., and FM-B at 11:59 a.m. An Incident Review and Analysis form dated 7/16/24 at 4:08 p.m., and signed as completed on 7/18/24, identified the information from the 7/16/24 Found on Floor incident report. R2 was found incontinent, and the room was dark. He was cleaned up and new cloths donned. Current interventions directed one to the care plan. RN-C spoke with FM-B as the falls occurred at approximately the same time on two consecutive days. Based on FM-B's statements of R2's routines, interventions were implemented; however, the poor lighting concern and the fall matt from the incident report on 7/16/24 was not addressed. R2's subsequent medical record identified the following entries and identified information: -7/18/24 progress note at 5:44 a.m.: R2 remained	F 689		

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a fall follow up. He continued to self-transfer. The note lacked effectiveness of interventions.
-7/18/24 physical therapy (PT) progress note identified R2 continued to require two staff due to his fall risk and impulsive movements.
-[7/19/24 progress notes lacked documentation R2 fell at 5:00 a.m.]
-7/19/24 order listing report identified an order to cleanse above the right elbow skin tear, apply skin prep, and cover with non-adherent dressing. Change every three days.
-7/19/24 order listing report identified fall batch orders to complete a post fall progress note every shift for 72 hours with monitoring the effectiveness of a fall mat and night light interventions.
-7/19/24 provider note identified R2 was assessed for pain, fall, and blood pressure follow-up. He continued to have multiple falls, was impulsive, and had a fall matt in place. He was reminded to use the call light and was agreeable; however, he was forgetful. Blood pressure would continue to be monitored.

A Risk Management Found on Floor incident report, dated 7/19/24 at 5:00 a.m., identified R2 was found on the floor in which he was not on the fall mat. He and his bed were wet with urine. He was without socks and his bed was in the lowest position. He was unable to identify what happened and sustained a right elbow skin tear. He was changed into a new brief and gown, and socks were placed. An immediate intervention was a "a toileting plan." The form lacked specific toileting plan detailed adjustments to the 7/15/24 and 7/16/24 initiated toileting plans. "Lighting," "Noise," and "Poor Lighting" concerns were identified. The report lacked evidence FM-B was notified.

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An Incident Review and Analysis form dated 7/22/24 (three days after the fall), at 2:57 p.m., identified the information from the 7/19/24 Found on Floor incident report; however, did not identify R2 was found off the fall mat or there were lighting issues identified. Current interventions directed one to the care plan. Other intervention identified a toileting plan. The form lacked specific toileting plan detailed adjustments to the 7/15/24 and 7/16/24 initiated toileting plans.

R2's fall risk care plan identified he was at risk related to history of falls with injuries. He was to remain safe and free of falls. The following information was identified:
-On 7/18/24 [two days after a fall], a grabber or Reacher intervention was initiated.
-On 7/18/24 [two days after a fall], a 4:00 a.m. to 6:00 a.m. plan to offer R2 the opportunity to get out of bed, use the bathroom, have a cup of coffee, place channel 9 news on, and after done offer him to lay down for a nap was entered on the care plan.
-On 7/19/24, auto-lock brakes to the wheelchair were entered on the care plan. R2's chart lacked additional information on the brakes.

R2's subsequent medical record identified the following entries and identified information:
-7/19/24 progress note at 11:00 p.m.: R2 remained on fall follow up. Continued to attempt self-transfers but was easily redirectable. Confused per baseline. The note lacked effectiveness of interventions.
-7/20/24 Task behavioral documentation at 1:59 p.m.: five attempts at self-transfers. Despite redirection the behavior was unchanged.
-7/20/24 progress note at 3:06 a.m.: R2 was

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F 689	Continued From page 15 found seated on his bedroom floor [at 12:30 a.m.]. He was unable to state what happened. He was free of injury and toileted with his call light left within reach. Gripper socks were applied, and he was redirected to call for help instead of self-transferring. The incident report was placed in the DON's box. -7/20/24 order listing report lacked evidence fall batch orders were initiated related to R2's 7/20/24 fall. A Risk Management Found on Floor incident report, dated 7/20/24 at 12:30 a.m., identified R2 was found seated on the floor by the bathroom and was without injury. He was unable to identify what happened. R2 was toileted. "Other" and "Poor Lighting" were identified as concerns and he continued with previously identified risk factors. The report identified RN-C was notified at 3:04 a.m., but lacked evidence FM-B was notified, and/or the provider. An Incident Review and Analysis form, dated 7/20/24 at 1:51 p.m. and signed as completed on 7/23/24, identified the information from the 7/20/24 Found on Floor incident report. Contributing factors identified the room was dark when he was found. Current interventions directed one to the care plan. An implemented intervention was a night light to his room. R2's provider was updated; however, the Responsible Party incident review designation box was unchecked. R2's subsequent medical record identified the following entries and identified information: -7/20/24 progress note at 9:39 p.m.: R2 remained a fall follow up. He continued to demonstrate weakness and self-transfers. He was redirected	F 689		

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successfully. The note lacked effectiveness of interventions.
-7/21/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite a change in location the behavior was unchanged.
-7/22/24 PT progress note identified R2 was found self-transferring to the toilet upon therapy approach. The note lacked identification nursing was updated.
-7/22/24 OT progress note identified R2 stood alone in the bathroom upon approach. The note lacked identification nursing was updated.
-7/23/24 provider note identified R2 was assessed; however, the note lacked information related to his 7/20/24 fall, his continued fall risk, and self-transfers, or involved discussion related to fall interventions.
-7/23/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite redirection the behavior was unchanged.
-From 7/10/24 to 7/24/24, neither OT or PT progress notes identify R2 fell on 7/16/24, 7/19/24, or 7/20/24 and/or any involvement with nursing staff related to fall analysis and intervention discussions.

R2's fall risk care plan identified he was at risk related to history of falls with injuries. He was to remain safe and free of falls. The following information was identified:
-On 7/22/24 [two days after a fall], toilet R2 every two to three hours was entered on the care plan.
-On 7/23/24, [three days after a fall], night light to room was entered on the care plan.

R2's July 2024 TAR was reviewed. This identified 19 shift opportunities which directed staff to monitor injury and the effectiveness of designated fall interventions associated with orders initiated

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on 7/15/24, 7/16/24, and 7/19/24. The TAR lacked directions related to R2's 7/20/24 fall. All 19 opportunities were signed off by staff as completed. In relation, progress notes from 7/15/24 through 7/24/24, identified six progress notes for fall follow-up. Out of these six, none evaluated the effectiveness of the fall interventions.

During an initial tour on 7/24/24, at 10:18 a.m., R2 was not observed in his room. A red colored mat was on the floor. In addition, a soft-touched call light rested on the bed and the standard mattress was at an average bed height. Immediately after, TMA-A confirmed this was a fall mat.

When interviewed on 7/24/24, at 1:35 p.m., R2's room was free of the previously noted red fall mat and there were two signs within his room to remind him to put his call light on for help before getting out of his wheelchair and a sign on the bathroom door to please use call light for assistance. The bed height was at a standard height. Communication was more drawn out due to his expressive aphasia; however, with communication techniques, the interview progressed. He was good and agreed it was July. When asked where he was, he responded "I am not really sure." He confirmed falls since admission and these falls were from bed. When asked the reason for the falls, he stated, "I know the reason ...was trying to go to the bathroom." He denied injury from the falls. He was able to find his call light when cued and his Reacher when asked if he was able to use it. He acknowledged episodes where he had a hard time controlling his bladder and bowels and he felt staff toileted him to his liking. He denied

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concerns with his stay.

During an interview on 7/24/24, at 1:51 p.m., trained medication aide (TMA)-A stated resident fall risk was identified on the group sheets and within their charting system. He lacked the group sheets on him at that time. TMA-A thought fall interventions were identified on the group sheets but was not 100 percent sure. He did not feel R1 was a fall risk, and her recent fall surprised him. He stated R1 preferred to be in bed, on her back, and was not up for long periods of time. TMA-A explained R1 was able to move herself "a little bit" when in bed and she preferred her head elevated. R1 was overall dependent on staff but she helped feed herself at times. TMA-A indicated R1 utilized an air mattress and denied any noted concerns with it. He denied the facility educated him on air mattress expectations and/or what the manufacturer guidelines for use were. TMA-A denied he adjusted the pump settings as "It is there for a reason." He was unsure what R1's pump settings were expected to be set at. When he worked with her, he just checked to ensure the mattress was on and inflated. He was unable to identify when the perimeter overlay was placed.
-TMA-A stated he continued to monitor R2 "constantly," "somewhere where he needs to be in sight" as "he tries to jump out of his wheelchair." He identified R2 was much better when he was in bed and less likely to self-transfer. Fall interventions utilized on R2 were "the obvious ones" such as gait belt, making sure he had a steady rail in the bathroom, etc. He did not feel R2 had any specialized fall risk interventions. However, he explained basically every two to three hours they toileted him and attempted to keep him involved in as many

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activities he could for distraction purposes. Despite this, R2 continued to self-transfer and required his interception. The self-transfers varied per shift and depended on what R2 was doing at those moments. He denied nurses and/or management spoke to him about his insight into R2 and his fall risk for potential assist with intervention development and/or adjustments.

When interviewed on 7/24/24 at 2:58 p.m., registered nurse (RN)-A stated the nurse managers performed the fall risk assessments but explained all the residents were at risk for falls - some were just higher risk than others. After a resident fell, she was expected to enter an incident report into PointClickCare (PCC) which management then reviewed and who then developed intervention(s). RN-A explained if she were to initiate an intervention, this would be documented with her fall note. She expected all fall interventions to be entered in the care plan or on the group sheets. RN-A identified that on 7/20/24, she observed R1 on the floor wrapped up in her bedding. R1 informed RN-A that she attempted to get up. R1's call light was unplugged from the wall and her bed "was high" despite R1's need for a "low bed." RN-A clarified R1's bed was expected to be at "standard height" but "she was higher." She was unsure of R1's head elevation status as she was more concerned with getting R1 off the floor, but R1 preferred the head of her bed elevated about 30 to 45 degrees. The air mattress was inflated, and she did not feel she remembered any notable concerns. RN-A explained the NAs checked the air mattresses every shift to ensure they functioned properly and thus she did not personally check to ensure functionality: if staff did not approach her with any concerns, she initialed it off on the treatment

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F 689	Continued From page 20 administration record (TAR) that it was checked. R1's mattress setting(s) were unknown to her and she guessed the setting should be "maybe around 350." RN-A denied knowledge of previous R1 falls but within the past few months she had assisted R1 to reposition as she was closer to the edge of the bed with her head elevated, in which R1 had a tendency of doing when her head was elevated. RN-A explained the intervention put into place after R1's fall was her transfer to the hospital. She did not investigate any potential causes of the fall, or her concern related to the bed height. During the same interview, RN-A identified R2 required a low bed, a soft-touched call light, a fall mat, frequent checks, and gripper socks due to his self-transfers. RN-A explained R2 just get up when he felt the need but did not understand his weakness. She often had to tell R2 to use his call light. RN-A explained one-night R2 fell despite there already being a fall mat in place when he attempted to go to the bathroom. No intervention was initiated or adjusted that night. After the fall, staff toileted R2 and brought him to the nurse's station for a snack. Once finished, staff took him back to bed and just checked on him. She denied management spoketo her about her insight into R2 and his fall risk for potential assist with intervention development and/or adjustments. On 7/24/24, at 3:31 p.m., RN-A showed the surveyor, utilizing R1's bed, where she thought R1's bed height was after her fall. The top of the mattress was approximately 23 - 25 inches off the floor. When interviewed on 7/24/24, at 2:50 p.m., NA-A stated, on 7/20/24, he found R1 on the floor,	F 689		

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wrapped up in her blankets. R1 told him she was getting out of bed. He was unsure of any more details than that. NA-A did not remember anything overall that stood out; however, "the bed was quite high for her." He demonstrated an approximate height that was about 28-29 inches. He lacked memory on R1's head elevation but stated R1 preferred it raised up "a little bit." He also lacked memory of any air mattress concerns. NA-A identified, "Usually [R1] kind of leans over to the right." She can scoot to the right." This leaning was increased in intensity/frequency when R1 complained of increased "bottom" pain. Enough so, about a month ago she was closer to the edge and at risk for falling out of bed which required his assistance to reposition back to the middle. Other times when he witnessed this, he placed a pillow on her right side. Due to this leaning and scooting, NA-A kept R1's bed lowered to the floor. NA-A denied any recent education, or reeducation related to potential issues with R1's fall (bed height, mattress setting, etc.). During the same interview NA-A stated R2 was a fall risk - "every time you go out of his room he is trying to get out of bed." He indicated R2 self-transferred more during the day versus during the night. He was aware of the care planned interventions and reported R2 required a fall mat. He was here when R2 fell around 5:00 p.m. They dressed R2 and brought him to the nurse's station. NA-A was unsure about any additional interventions after that. He denied nurses and/or management spoke to him about his insight into R2 and his fall risk for potential assist with intervention development and/or adjustment.

During interview on 7/24/24, at 4:22 p.m., nurse manager (RN)-B identified floor nurses lacked the

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F 689	Continued From page 22 ability to adjust the care plan as this was a management responsibility. She explained, when a resident fell, staff were expected to follow steps indicated in a fall packet. These instructions included a "batch" order was entered into the order set, initiate a Risk Management incident report, initiate an investigation into the situation, and come up with an immediate intervention which was placed on the group sheets. After this, management reviewed all the information and adjusted as needed. When the batch order was entered, this allowed for the nurse to designate the immediate intervention which then prompted floor nurses to document each shift on the intervention. RN-B was unsure who completed the comprehensive fall assessment and/or when this was required to be completed. The nurses were provided a packet of information they were required to complete but she was unsure if this was part of the packet. If a resident were to have repeated falls, she was unsure what the process was and directed such questions for RN-C. She stated fall mats were to prevent injury and were not considered an intervention for fall mitigation. She was unsure without reviewing charts who utilized fall mats. RN-B explained R1 was unable to move in bed and required staff to reposition her. She expected her bed to be "low" as she would not want anyone to roll out of bed from a high height. She was unsure how R1 preferred the head of her bed. On 7/21/24, she was at the facility and was updated R1 rolled out of bed. That same day, the hospital updated her R1 "was hurt;" however, she reported she overall listened to the discussions around R1's fall but she was not really a part of them. She was unsure, in that moment, what interventions were put into place to mitigate falls for R1 and would have to review her care plan for details. During the same interview,	F 689		

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RN-B was questioned on R2's fall risk, she identified R2 was a fall risk based on his fall history. She was unsure about interventions for him and explained she would have to review his care plan.

When interviewed on 7/24/24, at 4:51 p.m., RN-C, a corporate nurse who filled the current interim director of nursing role, stated there was not a fall committee; however, the IDT meet every business day to discuss falls. After a fall the nurses initiated a Risk Management incident report, which she utilized to complete an incident analysis. RN-C explained she expected an immediate intervention to be put into place after a fall and added to the group sheets, given the nurses did not have access to edit the care plans. Group sheets were shredded after use. After she was updated about R1's fall on 7/21/24, a zoom call was initiated with management. The investigation "was a hard one." The best root cause determined was that R1 was possibly not positioned properly, slipped out of bed, and/or there was a potential default with her air mattress. In response, a perimeter overlay, and a bed cradle were initiated. She denied staff education related to any of her potential concerns, or additional follow-up with staff for more insight. RN-C R1's bed was checked that morning (7/24/24) by maintenance. No other audits were completed prior to that. After the surveyor entered the facility, she audits the air mattresses and identified R1's bed was at a six, which required an adjustment, as her setting should be a three based on her weight of 148. RN-C stated R1's bed setting of a six was too high for R1 as this setting was to be utilized when a weight was 240 pounds. Because of the incorrect settings, she felt staff needed education on how to program the

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F 689	Continued From page 24 pumps. She denied knowledge on prior staff education related to this. If R1's pump setting was too high, this indicated the mattress was overinflated for R1 and thus R1 was not able to "sink into the mattress as she should." This increased R1's risk of sliding out of bed, especially if R1 were not positioned in the middle. She was unaware of what R1's pump setting was at the time of her fall, or how R1 laid in bed prior to the fall. RN-C explained orders were placed on the TAR to routinely check on the air mattresses to ensure the pressure was set according to the resident's weight in PCC, and to ensure it was inflated, and lacked holes or leaks. She expected the nurses to perform this duty, and put eyes on the bed, as she was unsure if the NAs were trained. RN-C was aware R1 preferred her head elevated about 30 to 45 degrees. She was unaware of any bed positioning concerns for R1 until the husband was talked to this day and updated her R1's right sided lean appeared to be increased. She expected staff to update her, or other management staff, if acute changes were observed, such as increased leaning. During the same interview, RN-C stated the floor nurses were responsible for the initial comprehensive fall risk assessment, but she was unsure as to the completion timeframes of this. Any additional fall assessments were the responsibility of the MDS nurse which were completed quarterly and as needed, such as with a significant change in someone's status. She denied this was completed after a certain number of falls. After this answer, she responded, "You are talking about [R2]." If a resident was evaluated/assessed to be a high fall risk, she expected the care plan to be updated with the associated risk information; however, she explained the floor nurses lacked access to edit the care plan.	F 689		

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Instead, they are expected to update the group sheets. When questioned on R2's self-transfers, she denied knowledge of this but expected staff to notify her of such transfers to determine reasons and interventions to decrease them. She spoke to R2's "wife" after R2's first and second falls. This was when she learnt he loved to pick things up off the floor. She expected interventions in the care plan so that he does not fall. RN-C was questioned on R2's fall mat interventions. She explained this was an intervention a nurse had initiated; however, she removed this as it was not preventing falls or R2's getting out of bed. After she reviewed his care plan that day, she determined it was not supposed to be there. She was unsure how it ended back up in his room as she had previously removed it prior to today and thus she needed to follow up with staff related to this.

During a follow-up interview on 7/25/24, at 10:27 a.m., RN-C explained if a TMA worked and batch order fall documentation was required, the nurse was ultimately responsible to ensure this was completed. She expected to see documentation for every shift for the ordered 72 hours to ensure interventions are effective, there was not new pain, or any acute changes. In addition, this assisted in decreasing the risk of resident falls for the same reasons. R2's information was gone over, and she expected she would have noted R2 had the fall batch orders entered after his 7/20/24 fall for staff documentation.

During an interview on 7/25/24, at 11:41 a.m., NA-B stated she utilized the group sheets for fall information. If a resident self-transferred, or leaned, she was expected to let the nurse know. She was surprised R1 fell and explained the only

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thing that potentially caused R1's fall was her head was elevated too high. NA-B explained R1's head height was typically between 15 and 20 degrees and if it happened to be placed at 45 degrees, "she would have leaned over and fell." When she checked on R1, she ensured the bed was set at the lowest setting allowed. NA-B identified the facility had not trained her on air mattress expectations. She felt R1's setting was a three, but she was unsure as to R1's weight as she only accessed this information when she weighed her. NA-B was unable to identify the pump settings for any of the other four residents who used air mattresses.

When interviewed on 7/25/24, at 11:59 a.m., physical therapy assistant (PTA)-A stated she was involved in IDT fall discussions. Therapy then conducted a balance and/or gait assessment to determine if therapy was indicated. She lacked knowledge related to the air mattresses other than if concerns were present, she alerted nursing. She was unaware R1 leaned in bed or what R1's head elevation preference was prior to her fall but she acknowledged R1's bed should always be as low to the floor as the bed allowed due to R1's spasticity risk. PTA-A stated R1 now required head elevation related to the fracture and the associated collar use. She indicated there was no way R1 could have maneuvered herself close enough to the edge of the bed to get up as R1 only had a slight trace of upper and lower body activation; however, she explained there was a very slight possibility R1 could have a "bust of energy," episode of spasticity, or "wiggled" herself to the side if the head of the bed was too high, and thus she could have rolled out.
- PTA stated R2 was very impulsive. She identified R2 utilized a "light tap" call light, Dycem

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under his wheelchair cushion for anti-slip properties, and anti-roll back devices to his wheelchair. R2 frequently self-transferred since admission but which mainly occurred during the night hours. She denied remembrance of any conversations with nursing after his fall risk prior to his 7/15/24 initial fall. At that time, she adjusted his assist from one to two as his balance assessment showed an increased risk. She denied therapy initiated any additional interventions for fall mitigation.

During an interview on 7/25/24, at 12:43 p.m., RN-D stated all residents were at risk for falls, some were just more vulnerable than others. He indicated he had not worked when a resident fell and thus was not 100 percent sure of the nurse expectations; however, he would assess, investigate, and implement interventions. RN-D stated he felt he was unable to edit the care plan; however, he had never attempted such a task. He explained, after a resident fell, an order showed up on the TAR for fall follow-up. If a TMA worked on a side that required this documentation, he was expected to perform this process. When he signed off on this directive, it meant he conversed with the staff, and reviewed the effectiveness of the intervention identified was implemented. In addition, he indicated air mattress monitoring was on R1's TAR. Signing this off indicated he monitored the air mattress for proper air functioning in which he verified this by physically examining the mattress and ensuring the setting and weight match up. Despite this knowledge, he identified he does not complete this process every time he signed off the TAR monitoring as he just does routine visual monitoring of the bed when in rooms for such things as passing medications to ensure it is on and inflated. He

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does not cross reference the weight every time. RN-D stated R1 was overall immobile; however, R1 was able to move her torso back and forth slightly. He was unaware of her fall specifics, and he was unable to imagine how she moved herself out of bed. RN-D identified R1 preferred the head of her bed as flat as possible but often finds it to be about 30 degrees and when R1 sat in her wheelchair, she had a natural tendency to lean more to the right. After reviewing her pump settings and her weight, RN-D stated a setting of six would be hyperinflated for R1. This in turn would cause the bed to be a flatter surface which would increase the risk of slipping off: "It is squishier for a reason." In addition, he was concerned about R1 comfort if the mattress was also hyperinflated. Overall, "if there is not an importance, why have a weight designation."

On 7/25/24, at 1:21 p.m., an occupational therapist (OT)-A measured R1's head of the bed elevation when requested using a degree tool. R1 was elevated to 50 degrees.

When interviewed on 7/25/24, at 1:28 p.m., NA-C stated she would expect all fall interventions to be on the group sheet to help mitigate falls. She thought this information may be in the "charting system" but does not reference that information for interventions. She reported air mattress education that morning; however, no previous education was provided. NA-C explained she only had access to resident weights if she were the one who weighed them. NA-C explained R1 moved her arms and legs slightly and her head was normally elevated somewhere between flat and 90 degrees. R1 did not like it too high, and R1 did not like it flat: "midrange." She reported R1 leaned to the right

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maybe "twice or three times a week.". She had reported this in the past to nurses, but nothing was reported recently. NA-C stated if R1 was to have a spasm or a seizure, she would be at increased risk to roll out of bed. In addition, if the air mattress was inflated too high, because of an incorrect setting, this caused the mattress to be "bigger," "would raise her up more," and cause R1 to roll off. She was more concerned with overinflation as R1 utilized the alternating air setting. During the same interview, NA-C stated R2 was a "major" fall risk, mainly due to his confusion. She explained the care planned fall interventions, but she identified "distraction is needed" to help his fall risk. At times, she found him "messing" with his wheelchair legs/pedals. She observed this today. She utilized a snack which worked well for R2. She denied nurses and/or management spoke to her about her insight into R2 and his fall risk for potential assist with intervention development and/or adjustment.

On 7/25/24, at 2:12 p.m., a telephone interview was requested with R1 and R2's provider; however, no return call was provided.

When interviewed on 7/25/24, at 2:14 p.m., RN-E identified herself as a facility regional coordinator. She filled in doing MDSs as the position was currently vacant. She stated the admission comprehensive fall risk assessment was expected to be completed by the seventh day of stay, or the MDS reference date, by the DON or the nurse manager; however, "best practice" was to complete this as soon as possible. This was especially important if a resident admitted with a fall risk history: "We would not want them to wait" to complete the assessment. A comprehensive assessment was

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then completed annually thereafter or if there was a significant change in status. Any additional assessments would be referred to the clinical team. During the CAA process, she expected a fall risk analysis to help identify interventions and then the care plan was to be updated. If a comprehensive assessment were recently completed and the resident fell, there was not overall need to do another one as they already completed the risk analysis and updated the plan of care.

During a telephone interview on 7/25/24, at 2:29 p.m., FM-B stated R2 fell twice at the facility. When she asked if he had fallen more, and she was updated there were reports of four falls, she exclaimed, "What!" She expected she was updated about all falls he had while there. She did not understand why he continued to fall; however, she also explained his falls prior to facility admission and the interventions she was required to do to mitigate his falls at home. She identified he gets quite antsy when he had to use the bathroom and she always had to leave the bathroom light on for when he got up to go to the bathroom.

Air mattress education, prior to the survey, along with an air mattress policy were requested; however, none were provided.

A Matrix ALAL Mattress System, Custom Medical Solutions manufacturer, quick reference guide was provided. The guide directed the Firm/Soft setting was used to calibrate the mattress to the residents estimated body weight (35-pound increments). To check for correct inflation, the guide directed to slide a hand underneath the top cover to feel the base of the mattress and frame.

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Optimal firmness was to have a space of three to four fingers between the resident's coccyx or buttock area and the bed frame. If the resident was seated on the frame, the Fowler boost feature was to be activated to attain the desired space. If unsuccessful, continue to adjust the firmness in 35-pound increments until optimal space was reached between the resident's buttocks and the bed frame. When appropriate firmness achieved, close the top covers zipper, or secure the elastic banding underneath the mattress.

An Admission Checklist for Online Assessments - Floor Nurse, lacked identification the Fall Review Evaluation was part of the checklist.

A Fall Checklist packet revealed expected fall processes which included initiation of an immediate intervention and directed the nurse to a Fall Interventions Sheet. In addition, the nurse was to enter fall monitoring orders using the Monarch Fall Follow-up Order Set (batch update process). The checklist lacked direction on where the intervention was expected to be communicated to staff.

The Fall Information sheet instructed that an intervention was expected to be put into place immediately after a fall "per regulations" as this helped prevent falls from reoccurrence. Assisting a resident back into bed, or reminding the resident to use the call light, were not interventions. Forty-six interventions ideas were provided. One of them was floor mats. Additional directions reminded to ensure the interventions matched the reason for the incident.

A Nurse Manager/DON fall follow-up completion

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checklist identified expected steps. These included to review the falls with IDT, review the risk management and nurse checklist to ensure all steps completed such as intervention initiation, notifications, and documentation. If not completed, they were to provide education. Previous fall interventions were to be reviewed, along with the immediate intervention, to ensure appropriateness and to ensure the intervention was put into place. An Incident Review and Analysis was to be completed following provided instructions. Once completed, the care plan and care sheets were to be updated. The checklist lacked details on when this process was to be initiated and/or completed.

A Care Planning policy, dated 1/ 6/22, identified a baseline care plan was to be developed within 48 hours of admission to ensure the resident's immediate basic needs were met and maintained. The baseline care plan was to be utilized until the IDT conducted the comprehensive MDS assessment and developed a comprehensive individualized care plan.

A Fall Prevention and Management policy, dated 2/2024, identified its purpose was to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessment of a resident after a fall, and to assist staff with fall factor identification. The policy directed the Fall Risk Evaluation was to be conducted "upon admission," annually, with a significant change in condition, and as needed. If falls continued despite initial interventions, staff were to implement additional or different interventions or indicate why the current approach remains relevant. Staff were to monitor and document each resident's response to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING ______ B. WING ______	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 689	Continued From page 33 interventions intended to reduce falling or the risks of falling. After a fall, the provider and family were to be updated in an appropriate time frame. In addition, staff were to monitor and document the resident's response to and the effectiveness of interventions put into place to prevent further falls for 72 hours post fall. If a resident continued falling, staff were to re-evaluate the situation for possible adjustment of interventions. As needed, the provider was to assist staff to reconsider possible causes not previously identified.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2024

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

Re: State Nursing Home Licensing Orders
Event ID: 8KRM11

Dear Administrator:

The above facility was surveyed on July 24, 2024 through July 25, 2024 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00994	A. BUILDING: ______ B. WING ______	C 07/25/2024

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2 000	Initial Comments	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 7/24/24, and 7/25/24, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H53486185C (MN00105093), with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess when a new fall risk was identified and failed to safely implement and maintain resident equipment for 1 of 3 residents (R1) who utilized an air mattress that was not maintained at the recommended pressure. Additionally, the facility failed to assess and immediately implement new interventions for 1 of 3 residents (R2) who had falls related to self-transfers. Findings include:	2 830	Corrected	8/23/24

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2 830	Continued From page 3	2 830		

R1:

R1's significant change Minimum Data Set (MDS), dated 5/31/24, identified R1 was severely cognitively impaired and received total physical assist for most cares; however, extensive assist was provided for bed mobility. R1 was free of falls in the past quarter. Diagnoses included traumatic brain injury (TBI), sleep disorder, and muscle spasms.

An Order Summary Report identified an order was entered on 6/5/23 for an air mattress to R1's bed. Staff were directed every shift to ensure proper function, inflation, and tie downs.

A [comprehensive] Fall Review Evaluation form, locked 5/16/24, identified no history of falls in the past three months; however, R1 was at risk due to the following: medications administered, cognitive impairments, total bowel and bladder incontinence, wheelchair dependence with disorientation, and hands-on assistance to move from place to place. The Summary/Interventions section indicated R1 required dependence on a wheelchair for mobility as she was unable to walk. She was limited to only making slight changes to her extremities and required assistance with mobility. The evaluation lacked a fall analysis and information related to air mattress use, muscle spasms, chronic pain, or seizure activity, nor did it address any potential associated risks related to these.

On 7/18/24, R1's weight was 145.8 pounds.

R1's care plan identified an intervention for skin integrity that included a pressure redistribution mattress and for mobility she required two staff

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2 830	Continued From page 4	2 830		

for bed mobility. The interventions were free of an assessed pressure setting identification or any additional mattress instructions. In addition, with a revision date of 3/17/22, R1 was a fall risk related to defined medication usage, impaired cognition and mobility, along with history of seizures. The goal was for her to be safe and free from falls. Interventions directed placement of foam side boards to her wheelchair for proper body alignment. Staff were directed to monitor and document on safety, review information on past falls and attempt to determine cause(s), record possible root causes of falls, and alter or remove any if possible.

A Risk Management Found on Floor incident report, dated 7/20/24 at 10:40 p.m., indicated R1 was observed on the floor wrapped up in her bedding. She displayed intermitted confusion and she stated she tried to get up. R1 moaned and reported back, hip, and neck pain at a 10 when transferred to bed. She appeared still and refused to move when a skin assessment was attempted. An order was received for emergency department evaluation. Predisposing Environmental Factors identified "Other" and "Bed Position." Predisposing Situation Factors identified "Rolled out of bed." The form lacked intervention and/or any investigatory information.

R1's progress notes identified the following:
-7/21/24 at 0:18 a.m.: the ambulance arrived at 12:10 a.m. and R1 was transported at 12:35 a.m. A copy of the incident report was placed in the director of nursing (DON)'s box.
-7/21/24 at 6:11 a.m.: hospital staff updated the facility R1 was assessed to have a C2 (cervical) fracture and was being transferred to another hospital.
-From 7/21/24 through 7/24/24, the progress

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2 830	Continued From page 5	2 830		

Continued From page 5

notes lacked identification a 7/21/24 fall analysis and/or any interventions to mitigate a reoccurrence.

R1's hospital information identified the following:
-7/22/24, a neurosurgical consultation note identified R1 was seen at an outside hospital where imaging revealed a C2 fracture with possible widening of the disc space. "Fortunately, MRI [was] without disc injury, ligament injury or significant edema. There is a minimal fracture line at C2 - difficult to determine acuity."
-An MRI cervical spine final report identified an oblique fracture at the anterior-inferior corner of the C2 vertebral body without significant displacement. There was no overlying prevertebral soft tissue swelling or evidence of ligamentous injury or malalignment. There was minimal T2 hyperintense signal along the fracture. "Given the minimal associated marrow T2 hyperintensity, as well as the lack of prevertebral soft tissue swelling, this fracture is age indeterminate and could be hyperacute or subacute to chronic in nature."
-R1's hospital documentation lacked evidence of suspected head/cranial injury.

A progress note, dated 7/23/24 at 4:10 p.m., identified R1 returned to the facility at 1:30 p.m.

An Incident Review and Analysis form, dated 7/23/24 at 2:49 p.m., identified R1's 7/20/24 fall where R1 reported she potentially laid too close to the edge of the air mattress and pressed her call light after she fell. Her mattress was assessed and functioned properly "with the right weight." She was "potentially too close to the edge of the bed, causing her to slip out." An intervention section directed to "See Care Plan." Other interventions were identified as a foot

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2 830	Continued From page 6	2 830		

cradle and a perimeter air mattress overlay. The form indicated that during the investigation, therapy reported R1 was unable to turn her body at all but was able to move her arms. She was not incontinent at the time of the fall and was checked on 40 minutes prior where she was left laying supine with no pillows used to offload her body and gripper socks on.

R1's care plan history identified fall risk interventions were created on 7/23/24 (three days later) to include a foot cradle and a perimeter air mattress overlay.

Resident group sheets were reviewed. R1 was identified as a fall risk, and she was to utilize nonskid footwear and to provide safety if a seizure occurred. Under bed mobility, staff were directed to ensure her air mattress functioned properly every shift. The group sheet lacked information related to R1's observed right sided leaning, perimeter overlay, bed cradle, mattress pump setting, bed height, and/or head elevation.

An Order Listing Report, printed 7/25/24, identified all orders entered for R1 since 7/20/24. On 7/21/24, an order to send R1 to the ED for post-fall evaluation was entered. The orders lacked a fall batch order entry.

When interviewed on 7/24/24, at 10:27 a.m., R1 lacked signs and/or symptoms of distress. Her forehead/face was free of bruising or signs of injury. A neck collar was in place while she laid on an inflated air mattress that housed a head and foot sectioned perimeter overlay. A foot cradle was in place without concerns. She was centered within the bed with her head slightly elevated (approximately 20-30 degrees). She was questioned on her observed neck collar use. She

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explained she fell from bed a couple of weeks ago when she attempted to get out of bed as it was morning. R1 confirmed this was her first fall and she was able to move in bed. However, R1 was unable to move her lower extremities when cued by the surveyor, but she brought her arms to her forehead when asked to do so. She denied any staff concerns or fears while staff rolled her in bed. R1 identified she "rolled" off the bed, yelled for help, and staff came right away. She acknowledged this was the first time she attempted to get out of bed herself. R1 identified she went to the hospital after the fall to get checked out and she denied any injuries were found. R1 denied concerns with her air mattress.

On 7/24/24, at 10:46 a.m., immediately after R1's interview, her air mattress pump was examined. The pump identified it was a Custom Medical Solutions - Matrix ALAL Mattress System. The mattress pump identified the pump was on and lacked any lit warning identifications. The alternating cycle mode was set to every 15 minutes and the setting was set to "6." The Soft to Firm setting scale identified a setting of 6 was for a person who weighed an estimated 245 pounds.

On 7/24/24, at 2:27 p.m., R1's family member (FM)-A was interviewed via telephone. He stated he visited with R1 most evenings; however, missed the evening of her fall. He was concerned on how someone who was immobile for almost 40 months could flop themselves out of bed. FM-A informed him she remembered being on the floor, but she did not remember any overall details. He explained there were instances about three to four months ago when she pushed herself in her wheelchair with her left leg, and so maybe she pushed on the wall with her left leg

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2 830	Continued From page 8	2 830		

enough to slide out of bed. "Sometimes she sits too straight" and may have slid a little also. He adjusted her in bed at times due to this. FM-A identified R1's head was often elevated at a 45-degree angle. He stated R1 thought she could stand and walk. "She is bullheaded." FM-A stated when R2's MRI/CT scan results came back, R1 had a C2 fracture; however, no one could figure out if this was new or old as there was no swelling of the ligaments and no indication it was an acute fracture. FM-A identified R1's air mattress was never to be static; it was always to be "rotating." He often checks this as he had found this on static in the past. FM-A was unaware of what the other pump settings should be.

During an interview on 7/24/24, at 3:40 p.m., TMA-B stated resident care plans identified their fall risk. She did not consider R1 a fall risk prior to the fall despite episodes where she witnessed R1 "leaning" while in bed. When this occurred, staff just helped reposition her. TMA-B explained R1 preferred to lay on her back, with her head elevated so she could watch TV, along with the bed frame as close to the floor as it went to ensure overall safety. She indicated this was the position she left R1 in around 7:00 p.m. the evening relevant to her fall. TMA-B was unaware of R1's mattress pump settings and explained the monitoring on the TAR indicated she was to check the bed and make sure it was on and inflated: maintenance or management adjusted the beds as she was not allowed to touch any of the settings. TMA-B was unaware of any new or updated interventions to mitigate R1's fall risk. She was unaware if R1 had bumpers on her bed even though she previously worked with R1 this day.

R2:

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2 830	Continued From page 9	2 830		

R2's Face Sheet identified R2 admitted on 7/9/24, from the hospital, after he sustained multiple fractures of his right sided ribs. Additional diagnoses present on admission were history of a fall, muscle weakness, unsteadiness on his feet, aphasia, fracture of right femur, malnutrition, and history of TBI.

R2's Admission/Initial Data Collection form, dated 7/9/24, identified memory impairments, both short and long, assistance needed for mobility and toileting, ROM impairments on both upper and lower extremities right sides. In addition, R2 was frequently incontinent of bowel and bladder, had broken ribs and femur, and experienced falls in the past month and again in the past six months.

R2's 48 Hour Care Plan, dated 7/10/24, identified he was at risk for falls. No etiologies were identified. The goal was for him to remain safe and free from falls. Staff were directed to follow therapy instructions for mobility and to monitor and document on safety, review information on past falls and attempt to determine cause(s), record possible root causes of falls, and alter or remove any if possible. Staff were then to educate resident, family, caregivers, and the IDT (interdisciplinary team) on any findings.

Resident group sheets were reviewed. R2's was identified a fall risk. There was no additional information under the safety heading. Toileting directions were provided for every two to three hours. A Leisure Act. - Rehab. - Restorative section identified he was to be offered to get up around 4:00 a.m. and 6:00 a.m., toilet, provide a cup of coffee, turn the news on, and offer to lay back down when coffee was finished. The group sheet lacked information related to his

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2 830	Continued From page 10	2 830		

self-transfers, the use of a night light, or ensuring a Reacher was near him.

R2's medical record identified the following entries and identified information:
-7/10/24 progress note at 2:56 p.m.: R1 required one-on-one supervision with staff due to his high fall risk. The note lacked any additional details.
-7/10/24 progress note at 10:53 p.m.: R1 attempted self-transfers and was restless.
-7/11/24 progress note at 9:34 p.m.: R1 was observed standing next to his wheelchair.
-7/12/24 provider progress note: R2 was assessed. The note lacked information related to the self-transfers. The plan of care was to be continued and there were no concerns from R2 or staff at that time.
-7/15/24 Task behavioral documentation at 5:59 a.m.: one self-transfer attempt. Despite reassurance being provided, the behavior was unchanged.
-7/15/24 progress note at 10:25 a.m.: after a three-day bowel and bladder screen, R2 was incontinent of bowel and bladder and required assistance with toileting. A plan was initiated for him to be assisted with his toileting needs every two to three hours and as needed.
-7/15/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite reassurance being provided, the behavior was unchanged.
-7/15/24 progress note at 2:33 p.m.: R2 liked to self-transfer and wandered.
-7/15/24 progress note at 3:01 p.m.: R2 was found seated on the floor [at 6:00 a.m.]. No injuries were assessed. R2's only response was 'look at all of this' as he pointed at the room.
-7/15/24, an occupational therapy (OT) progress note at 3:01 p.m., identified OT approached R2 and found him on the floor. The note did not

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identify at what time R2 was found. No injuries were observed.
-7/15/24 order listing report identified fall batch orders to complete a post fall progress note every shift for 72 hours with directions to "Make sure to include any [signs/symptoms (s/s)] of injury and effectiveness of new fall interventions." The second order identified interventions for medication review request and call light reminder sign. There orders were discontinued 7/16/24.

A Risk Management Found on Floor incident report, dated 7/15/24 at 6:00 a.m., identified R2 was found seated on the floor. He was unable to identify what happened and he was injury free. He was returned to bed and "checked on frequently afterwards." Immediate actions identified staff placed a sign in his room to call for assistance and he was "frequently checked on throughout the day." "Lighting" concerns were identified, along with R2's confusion, history of falls, and not always able to realize his limitations in which R2 ambulated/transferred without assist. R2's medical provider was updated at 2:59 p.m., the DON at 3:00 p.m., and FM-B at 3:24 p.m.

An admission [comprehensive] Fall Review Evaluation form, dated 7/15/24 at 9:50 a.m., identified R2's history of multiple falls in the past month and past six months with risk factors related to psychotropic medication, memory impairments, impaired mobility, occasionally incontinent of bowel and bladder, and exhibited agitated, or wandering, behaviors in the past seven days. Environmental factors provided an option for "Lighting [as identified on the Risk Management 7/15/24 form];" however, this was blank. A summary identified R2 had potential risk for falls related to decreased mobility and listed medication and he was disoriented and required

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two staff for transfers. Fall interventions directed to see the care plan and staff would continue to monitor and update the plan of care as needed. The evaluation was free of information related to the 7/15/24, 6:00 a.m. fall.

An Incident Review and Analysis form, dated 7/15/24 at 10:20 a.m. and signed as complete on 7/18/24, identified the information from R2's 7/15/24 Found on Floor incident report. The form analysis indicated R2 was brought to the activity room after the incident. Contributing factors included inability to always realize his limitations, history of falls, lacked remembrance to use the call light, expressive aphasia, and the lack of room light. The form directed one to the care plan for interventions and indicated RN-C spoke to FM-B and was informed R2 enjoyed picking things up from the ground, such as sticks in the yard. In addition, he liked things tidy. The call do not fall sign was removed as R2 was severely cognitively impaired and he was provided with a grabber/Reacher.

An admission MDS driven Behavioral Symptoms CAA (Care Area Assessment), dated 7/16/24, identified R2 displayed three occurrences of self-transferring within a seven day look back period. The behaviors would be care planned to slow or minimize declines and risks. The CAA was free of information related to self-transfer mitigation.

An admission MDS driven Falls CAA, dated 7/16/24, identified R2's fall history with injury and that he fell once since admission. R2 displayed balance problems during surface transitions and transfers in which staff ensured his footwear prevented slipping, his room was set up to accommodate his needs, and his personal items

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2 830	Continued From page 13 were within his reach. The fall risk would be care planned to avoid complications and minimize risks. The CAA was free of information related to R2 footwear or room accommodation specifics. In addition, the CAA lacked details related to his 7/15/24 fall, his self-transfers, or any overall comprehensively assessed fall risk details and determined resident specific fall interventions. R2's subsequent medical record identified the following entries and identified information: -7/16/24 provider note identified R2 had "2 falls last night and 1 this morning." R2 continued to be forgetful and impulsive with self-transfers. A fall matt next to his bed was recommended. -7/16/24 progress note at 6:52 a.m.: Fall Charting - vitals and neuros within R2's norm. No falls tonight on this shift. The note lacked effectiveness of interventions. -7/16/24 progress notes at 10:35 a.m.: R2 was seated on his bedroom floor [at 6:25 a.m.]. No injuries assessed. R2 unable to provide fall details. He was checked on frequently afterwards. -7/16/24 order listing report identified the fall batch orders were initiated with direction to monitor the effectiveness of a medication review request and call light reminder sign. A Risk Management Found on Floor incident report, dated 7/16/24 at 6:25 a.m., identified R2 was found seated on the floor without injury. He was unable to identify what happened. He was returned to bed and checked on frequently. An immediate intervention was a fall mat. "Poor Lighting" was identified, along with R2's incontinence, gait imbalance, and cognitive impairments. The medical provider was updated at 11:59 a.m., the DON at 12:01 p.m., and FM-B at 11:59 a.m.	2 830		

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An Incident Review and Analysis form dated 7/16/24 at 4:08 p.m., and signed as completed on 7/18/24, identified the information from the 7/16/24 Found on Floor incident report. R2 was found incontinent, and the room was dark. He was cleaned up and new cloths donned. Current interventions directed one to the care plan. RN-C spoke with FM-B as the falls occurred at approximately the same time on two consecutive days. Based on FM-B's statements of R2's routines, interventions were implemented; however, the poor lighting concern and the fall matt from the incident report on 7/16/24 was not addressed.

R2's subsequent medical record identified the following entries and identified information:
-7/18/24 progress note at 5:44 a.m.: R2 remained a fall follow up. He continued to self-transfer. The note lacked effectiveness of interventions.
-7/18/24 physical therapy (PT) progress note identified R2 continued to require two staff due to his fall risk and impulsive movements.
-[7/19/24 progress notes lacked documentation R2 fell at 5:00 a.m.]
-7/19/24 order listing report identified an order to cleanse above the right elbow skin tear, apply skin prep, and cover with non-adherent dressing. Change every three days.
-7/19/24 order listing report identified fall batch orders to complete a post fall progress note every shift for 72 hours with monitoring the effectiveness of a fall mat and night light interventions.
-7/19/24 provider note identified R2 was assessed for pain, fall, and blood pressure follow-up. He continued to have multiple falls, was impulsive, and had a fall matt in place. He was reminded to use the call light and was agreeable; however, he was forgetful. Blood

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pressure would continue to be monitored.

A Risk Management Found on Floor incident report, dated 7/19/24 at 5:00 a.m., identified R2 was found on the floor in which he was not on the fall mat. He and his bed were wet with urine. He was without socks and his bed was in the lowest position. He was unable to identify what happened and sustained a right elbow skin tear. He was changed into a new brief and gown, and socks were placed. An immediate intervention was a "a toileting plan." The form lacked specific toileting plan detailed adjustments to the 7/15/24 and 7/16/24 initiated toileting plans. "Lighting," "Noise," and "Poor Lighting" concerns were identified. The report lacked evidence FM-B was notified.

An Incident Review and Analysis form dated 7/22/24 (three days after the fall), at 2:57 p.m., identified the information from the 7/19/24 Found on Floor incident report; however, did not identify R2 was found off the fall mat or there were lighting issues identified. Current interventions directed one to the care plan. Other intervention identified a toileting plan. The form lacked specific toileting plan detailed adjustments to the 7/15/24 and 7/16/24 initiated toileting plans.

R2's fall risk care plan identified he was at risk related to history of falls with injuries. He was to remain safe and free of falls. The following information was identified:
-On 7/18/24 [two days after a fall], a grabber or Reacher intervention was initiated.
-On 7/18/24 [two days after a fall], a 4:00 a.m. to 6:00 a.m. plan to offer R2 the opportunity to get out of bed, use the bathroom, have a cup of coffee, place channel 9 news on, and after done offer him to lay down for a nap was entered on

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the care plan.
-On 7/19/24, auto-lock brakes to the wheelchair were entered on the care plan. R2's chart lacked additional information on the brakes.

R2's subsequent medical record identified the following entries and identified information:
-7/19/24 progress note at 11:00 p.m.: R2 remained on fall follow up. Continued to attempt self-transfers but was easily redirectable. Confused per baseline. The note lacked effectiveness of interventions.
-7/20/24 Task behavioral documentation at 1:59 p.m.: five attempts at self-transfers. Despite redirection the behavior was unchanged.
-7/20/24 progress note at 3:06 a.m.: R2 was found seated on his bedroom floor [at 12:30 a.m.]. He was unable to state what happened. He was free of injury and toileted with his call light left within reach. Gripper socks were applied, and he was redirected to call for help instead of self-transferring. The incident report was placed in the DON's box.
-7/20/24 order listing report lacked evidence fall batch orders were initiated related to R2's 7/20/24 fall.

A Risk Management Found on Floor incident report, dated 7/20/24 at 12:30 a.m., identified R2 was found seated on the floor by the bathroom and was without injury. He was unable to identify what happened. R2 was toileted. "Other" and "Poor Lighting" were identified as concerns and he continued with previously identified risk factors. The report identified RN-C was notified at 3:04 a.m., but lacked evidence FM-B was notified, and/or the provider.

An Incident Review and Analysis form, dated 7/20/24 at 1:51 p.m. and signed as completed on

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2 830	Continued From page 17 7/23/24, identified the information from the 7/20/24 Found on Floor incident report. Contributing factors identified the room was dark when he was found. Current interventions directed one to the care plan. An implemented intervention was a night light to his room. R2's provider was updated; however, the Responsible Party incident review designation box was unchecked. R2's subsequent medical record identified the following entries and identified information: -7/20/24 progress note at 9:39 p.m.: R2 remained a fall follow up. He continued to demonstrate weakness and self-transfers. He was redirected successfully. The note lacked effectiveness of interventions. -7/21/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite a change in location the behavior was unchanged. -7/22/24 PT progress note identified R2 was found self-transferring to the toilet upon therapy approach. The note lacked identification nursing was updated. -7/22/24 OT progress note identified R2 stood alone in the bathroom upon approach. The note lacked identification nursing was updated. -7/23/24 provider note identified R2 was assessed; however, the note lacked information related to his 7/20/24 fall, his continued fall risk, and self-transfers, or involved discussion related to fall interventions. -7/23/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite redirection the behavior was unchanged. -From 7/10/24 to 7/24/24, neither OT or PT progress notes identify R2 fell on 7/16/24, 7/19/24, or 7/20/24 and/or any involvement with nursing staff related to fall analysis and intervention discussions.	2 830		

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R2's fall risk care plan identified he was at risk related to history of falls with injuries. He was to remain safe and free of falls. The following information was identified:
-On 7/22/24 [two days after a fall], toilet R2 every two to three hours was entered on the care plan.
-On 7/23/24, [three days after a fall], night light to room was entered on the care plan.

R2's July 2024 TAR was reviewed. This identified 19 shift opportunities which directed staff to monitor injury and the effectiveness of designated fall interventions associated with orders initiated on 7/15/24, 7/16/24, and 7/19/24. The TAR lacked directions related to R2's 7/20/24 fall. All 19 opportunities were signed off by staff as completed. In relation, progress notes from 7/15/24 through 7/24/24, identified six progress notes for fall follow-up. Out of these six, none evaluated the effectiveness of the fall interventions.

During an initial tour on 7/24/24, at 10:18 a.m., R2 was not observed in his room. A red colored mat was on the floor. In addition, a soft-touched call light rested on the bed and the standard mattress was at an average bed height. Immediately after, TMA-A confirmed this was a fall mat.

When interviewed on 7/24/24, at 1:35 p.m., R2's room was free of the previously noted red fall mat and there were two signs within his room to remind him to put his call light on for help before getting out of his wheelchair and a sign on the bathroom door to please use call light for assistance. The bed height was at a standard height. Communication was more drawn out due to his expressive aphasia; however, with

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2 830	Continued From page 19 communication techniques, the interview progressed. He was good and agreed it was July. When asked where he was, he responded "I am not really sure." He confirmed falls since admission and these falls were from bed. When asked the reason for the falls, he stated, "I know the reason ...was trying to go to the bathroom." He denied injury from the falls. He was able to find his call light when cued and his Reacher when asked if he was able to use it. He acknowledged episodes where he had a hard time controlling his bladder and bowels and he felt staff toileted him to his liking. He denied concerns with his stay. During an interview on 7/24/24, at 1:51 p.m., trained medication aide (TMA)-A stated resident fall risk was identified on the group sheets and within their charting system. He lacked the group sheets on him at that time. TMA-A thought fall interventions were identified on the group sheets but was not 100 percent sure. He did not feel R1 was a fall risk, and her recent fall surprised him. He stated R1 preferred to be in bed, on her back, and was not up for long periods of time. TMA-A explained R1 was able to move herself "a little bit" when in bed and she preferred her head elevated. R1 was overall dependent on staff but she helped feed herself at times. TMA-A indicated R1 utilized an air mattress and denied any noted concerns with it. He denied the facility educated him on air mattress expectations and/or what the manufacturer guidelines for use were. TMA-A denied he adjusted the pump settings as "It is there for a reason." He was unsure what R1's pump settings were expected to be set at. When he worked with her, he just checked to ensure the mattress was on and inflated. He was unable to identify when the perimeter overlay was placed.	2 830		

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2 830	Continued From page 20 -TMA-A stated he continued to monitor R2 "constantly," "somewhere where he needs to be in sight" as "he tries to jump out of his wheelchair." He identified R2 was much better when he was in bed and less likely to self-transfer. Fall interventions utilized on R2 were "the obvious ones" such as gait belt, making sure he had a steady rail in the bathroom, etc. He did not feel R2 had any specialized fall risk interventions. However, he explained basically every two to three hours they toileted him and attempted to keep him involved in as many activities he could for distraction purposes. Despite this, R2 continued to self-transfer and required his interception. The self-transfers varied per shift and depended on what R2 was doing at those moments. He denied nurses and/or management spoke to him about his insight into R2 and his fall risk for potential assist with intervention development and/or adjustments. When interviewed on 7/24/24 at 2:58 p.m., registered nurse (RN)-A stated the nurse managers performed the fall risk assessments but explained all the residents were at risk for falls - some were just higher risk than others. After a resident fell, she was expected to enter an incident report into PointClickCare (PCC) which management then reviewed and who then developed intervention(s). RN-A explained if she were to initiate an intervention, this would be documented with her fall note. She expected all fall interventions to be entered in the care plan or on the group sheets. RN-A identified that on 7/20/24, she observed R1 on the floor wrapped up in her bedding. R1 informed RN-A that she attempted to get up. R1's call light was unplugged from the wall and her bed "was high" despite R1's need for a "low bed." RN-A clarified R1's bed was expected to be at "standard height" but "she was	2 830		

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higher." She was unsure of R1's head elevation status as she was more concerned with getting R1 off the floor, but R1 preferred the head of her bed elevated about 30 to 45 degrees. The air mattress was inflated, and she did not feel she remembered any notable concerns. RN-A explained the NAs checked the air mattresses every shift to ensure they functioned properly and thus she did not personally check to ensure functionality: if staff did not approach her with any concerns, she initialed it off on the treatment administration record (TAR) that it was checked. R1's mattress setting(s) were unknown to her and she guessed the setting should be "maybe around 350." RN-A denied knowledge of previous R1 falls but within the past few months she had assisted R1 to reposition as she was closer to the edge of the bed with her head elevated, in which R1 had a tendency of doing when her head was elevated. RN-A explained the intervention put into place after R1's fall was her transfer to the hospital. She did not investigate any potential causes of the fall, or her concern related to the bed height. During the same interview, RN-A identified R2 required a low bed, a soft-touched call light, a fall mat, frequent checks, and gripper socks due to his self-transfers. RN-A explained R2 just get up when he felt the need but did not understand his weakness. She often had to tell R2 to use his call light. RN-A explained one-night R2 fell despite there already being a fall mat in place when he attempted to go to the bathroom. No intervention was initiated or adjusted that night. After the fall, staff toileted R2 and brought him to the nurse's station for a snack. Once finished, staff took him back to bed and just checked on him. She denied management spoketo her about her insight into R2 and his fall risk for potential assist with intervention development and/or adjustments.

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2 830	Continued From page 22 On 7/24/24, at 3:31 p.m., RN-A showed the surveyor, utilizing R1's bed, where she thought R1's bed height was after her fall. The top of the mattress was approximately 23 - 25 inches off the floor. When interviewed on 7/24/24, at 2:50 p.m., NA-A stated, on 7/20/24, he found R1 on the floor, wrapped up in her blankets. R1 told him she was getting out of bed. He was unsure of any more details than that. NA-A did not remember anything overall that stood out; however, "the bed was quite high for her." He demonstrated an approximate height that was about 28-29 inches. He lacked memory on R1's head elevation but stated R1 preferred it raised up "a little bit." He also lacked memory of any air mattress concerns. NA-A identified, "Usually [R1] kind of leans over to the right." She can scoot to the right." This leaning was increased in intensity/frequency when R1 complained of increased "bottom" pain. Enough so, about a month ago she was closer to the edge and at risk for falling out of bed which required his assistance to reposition back to the middle. Other times when he witnessed this, he placed a pillow on her right side. Due to this leaning and scooting, NA-A kept R1's bed lowered to the floor. NA-A denied any recent education, or reeducation related to potential issues with R1's fall (bed height, mattress setting, etc.). During the same interview NA-A stated R2 was a fall risk - "every time you go out of his room he is trying to get out of bed." He indicated R2 self-transferred more during the day versus during the night. He was aware of the care planned interventions and reported R2 required a fall mat. He was here when R2 fell around 5:00 p.m. They dressed R2 and brought him to the	2 830		

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2 830	Continued From page 23 nurse's station. NA-A was unsure about any additional interventions after that. He denied nurses and/or management spoke to him about his insight into R2 and his fall risk for potential assist with intervention development and/or adjustment. During interview on 7/24/24, at 4:22 p.m., nurse manager (RN)-B identified floor nurses lacked the ability to adjust the care plan as this was a management responsibility. She explained, when a resident fell, staff were expected to follow steps indicated in a fall packet. These instructions included a "batch" order was entered into the order set, initiate a Risk Management incident report, initiate an investigation into the situation, and come up with an immediate intervention which was placed on the group sheets. After this, management reviewed all the information and adjusted as needed. When the batch order was entered, this allowed for the nurse to designate the immediate intervention which then prompted floor nurses to document each shift on the intervention. RN-B was unsure who completed the comprehensive fall assessment and/or when this was required to be completed. The nurses were provided a packet of information they were required to complete but she was unsure if this was part of the packet. If a resident were to have repeated falls, she was unsure what the process was and directed such questions for RN-C. She stated fall mats were to prevent injury and were not considered an intervention for fall mitigation. She was unsure without reviewing charts who utilized fall mats. RN-B explained R1 was unable to move in bed and required staff to reposition her. She expected her bed to be "low" as she would not want anyone to roll out of bed from a high height. She was unsure how R1 preferred the head of her bed. On 7/21/24, she was at the	2 830		

2 830 | 2 830

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facility and was updated R1 rolled out of bed. That same day, the hospital updated her R1 "was hurt;" however, she reported she overall listened to the discussions around R1's fall but she was not really a part of them. She was unsure, in that moment, what interventions were put into place to mitigate falls for R1 and would have to review her care plan for details. During the same interview, RN-B was questioned on R2's fall risk, she identified R2 was a fall risk based on his fall history. She was unsure about interventions for him and explained she would have to review his care plan.

When interviewed on 7/24/24, at 4:51 p.m., RN-C, a corporate nurse who filled the current interim director of nursing role, stated there was not a fall committee; however, the IDT meet every business day to discuss falls. After a fall the nurses initiated a Risk Management incident report, which she utilized to complete an incident analysis. RN-C explained she expected an immediate intervention to be put into place after a fall and added to the group sheets, given the nurses did not have access to edit the care plans. Group sheets were shredded after use. After she was updated about R1's fall on 7/21/24, a zoom call was initiated with management. The investigation "was a hard one." The best root cause determined was that R1 was possibly not positioned properly, slipped out of bed, and/or there was a potential default with her air mattress. In response, a perimeter overlay, and a bed cradle were initiated. She denied staff education related to any of her potential concerns, or additional follow-up with staff for more insight. RN-C R1's bed was checked that morning (7/24/24) by maintenance. No other audits were completed prior to that. After the surveyor entered the facility, she audits the air mattresses and

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2 830	Continued From page 25 identified R1's bed was at a six, which required an adjustment, as her setting should be a three based on her weight of 148. RN-C stated R1's bed setting of a six was too high for R1 as this setting was to be utilized when a weight was 240 pounds. Because of the incorrect settings, she felt staff needed education on how to program the pumps. She denied knowledge on prior staff education related to this. If R1's pump setting was too high, this indicated the mattress was overinflated for R1 and thus R1 was not able to "sink into the mattress as she should." This increased R1's risk of sliding out of bed, especially if R1 were not positioned in the middle. She was unaware of what R1's pump setting was at the time of her fall, or how R1 laid in bed prior to the fall. RN-C explained orders were placed on the TAR to routinely check on the air mattresses to ensure the pressure was set according to the resident's weight in PCC, and to ensure it was inflated, and lacked holes or leaks. She expected the nurses to perform this duty, and put eyes on the bed, as she was unsure if the NAs were trained. RN-C was aware R1 preferred her head elevated about 30 to 45 degrees. She was unaware of any bed positioning concerns for R1 until the husband was talked to this day and updated her R1's right sided lean appeared to be increased. She expected staff to update her, or other management staff, if acute changes were observed, such as increased leaning. During the same interview, RN-C stated the floor nurses were responsible for the initial comprehensive fall risk assessment, but she was unsure as to the completion timeframes of this. Any additional fall assessments were the responsibility of the MDS nurse which were completed quarterly and as needed, such as with a significant change in someone's status. She denied this was completed after a certain number of falls. After	2 830		

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this answer, she responded, "You are talking about [R2]." If a resident was evaluated/assessed to be a high fall risk, she expected the care plan to be updated with the associated risk information; however, she explained the floor nurses lacked access to edit the care plan. Instead, they are expected to update the group sheets. When questioned on R2's self-transfers, she denied knowledge of this but expected staff to notify her of such transfers to determine reasons and interventions to decrease them. She spoke to R2's "wife" after R2's first and second falls. This was when she learnt he loved to pick things up off the floor. She expected interventions in the care plan so that he does not fall. RN-C was questioned on R2's fall mat interventions. She explained this was an intervention a nurse had initiated; however, she removed this as it was not preventing falls or R2's getting out of bed. After she reviewed his care plan that day, she determined it was not supposed to be there. She was unsure how it ended back up in his room as she had previously removed it prior to today and thus she needed to follow up with staff related to this.

During a follow-up interview on 7/25/24, at 10:27 a.m., RN-C explained if a TMA worked and batch order fall documentation was required, the nurse was ultimately responsible to ensure this was completed. She expected to see documentation for every shift for the ordered 72 hours to ensure interventions are effective, there was not new pain, or any acute changes. In addition, this assisted in decreasing the risk of resident falls for the same reasons. R2's information was gone over, and she expected she would have noted R2 had the fall batch orders entered after his 7/20/24 fall for staff documentation.

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During an interview on 7/25/24, at 11:41 a.m., NA-B stated she utilized the group sheets for fall information. If a resident self-transferred, or leaned, she was expected to let the nurse know. She was surprised R1 fell and explained the only thing that potentially caused R1's fall was her head was elevated too high. NA-B explained R1's head height was typically between 15 and 20 degrees and if it happened to be placed at 45 degrees, "she would have leaned over and fell." When she checked on R1, she ensured the bed was set at the lowest setting allowed. NA-B identified the facility had not trained her on air mattress expectations. She felt R1's setting was a three, but she was unsure as to R1's weight as she only accessed this information when she weighed her. NA-B was unable to identify the pump settings for any of the other four residents who used air mattresses.

When interviewed on 7/25/24, at 11:59 a.m., physical therapy assistant (PTA)-A stated she was involved in IDT fall discussions. Therapy then conducted a balance and/or gait assessment to determine if therapy was indicated. She lacked knowledge related to the air mattresses other than if concerns were present, she alerted nursing. She was unaware R1 leaned in bed or what R1's head elevation preference was prior to her fall but she acknowledged R1's bed should always be as low to the floor as the bed allowed due to R1's spasticity risk. PTA-A stated R1 now required head elevation related to the fracture and the associated collar use. She indicated there was no way R1 could have maneuvered herself close enough to the edge of the bed to get up as R1 only had a slight trace of upper and lower body activation; however, she explained there was a very slight possibility R1 could have a "bust of energy," episode of spasticity, or

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2 830	Continued From page 28 "wiggled" herself to the side if the head of the bed was too high, and thus she could have rolled out. - PTA stated R2 was very impulsive. She identified R2 utilized a "light tap" call light, Dycem under his wheelchair cushion for anti-slip properties, and anti-roll back devices to his wheelchair. R2 frequently self-transferred since admission but which mainly occurred during the night hours. She denied remembrance of any conversations with nursing after his fall risk prior to his 7/15/24 initial fall. At that time, she adjusted his assist from one to two as his balance assessment showed an increased risk. She denied therapy initiated any additional interventions for fall mitigation. During an interview on 7/25/24, at 12:43 p.m., RN-D stated all residents were at risk for falls, some were just more vulnerable than others. He indicated he had not worked when a resident fell and thus was not 100 percent sure of the nurse expectations; however, he would assess, investigate, and implement interventions. RN-D stated he felt he was unable to edit the care plan; however, he had never attempted such a task. He explained, after a resident fell, an order showed up on the TAR for fall follow-up. If a TMA worked on a side that required this documentation, he was expected to perform this process. When he signed off on this directive, it meant he conversed with the staff, and reviewed the effectiveness of the intervention identified was implemented. In addition, he indicated air mattress monitoring was on R1's TAR. Signing this off indicated he monitored the air mattress for proper air functioning in which he verified this by physically examining the mattress and ensuring the setting and weight match up. Despite this knowledge, he identified he does not complete this process every time he signed off the TAR monitoring as	2 830		

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2 830	Continued From page 29 he just does routine visual monitoring of the bed when in rooms for such things as passing medications to ensure it is on and inflated. He does not cross reference the weight every time. RN-D stated R1 was overall immobile; however, R1 was able to move her torso back and forth slightly. He was unaware of her fall specifics, and he was unable to imagine how she moved herself out of bed. RN-D identified R1 preferred the head of her bed as flat as possible but often finds it to be about 30 degrees and when R1 sat in her wheelchair, she had a natural tendency to lean more to the right. After reviewing her pump settings and her weight, RN-D stated a setting of six would be hyperinflated for R1. This in turn would cause the bed to be a flatter surface which would increase the risk of slipping off: "It is squishier for a reason." In addition, he was concerned about R1 comfort if the mattress was also hyperinflated. Overall, "if there is not an importance, why have a weight designation." On 7/25/24, at 1:21 p.m., an occupational therapist (OT)-A measured R1's head of the bed elevation when requested using a degree tool. R1 was elevated to 50 degrees. When interviewed on 7/25/24, at 1:28 p.m., NA-C stated she would expect all fall interventions to be on the group sheet to help mitigate falls. She thought this information may be in the "charting system" but does not reference that information for interventions. She reported air mattress education that morning; however, no previous education was provided. NA-C explained she only had access to resident weights if she were the one who weighed them. NA-C explained R1 moved her arms and legs slightly and her head was normally elevated somewhere between flat and 90 degrees. R1 did	2 830		

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not like it too high, and R1 did not like it flat: "midrange." She reported R1 leaned to the right maybe "twice or three times a week.". She had reported this in the past to nurses, but nothing was reported recently. NA-C stated if R1 was to have a spasm or a seizure, she would be at increased risk to roll out of bed. In addition, if the air mattress was inflated too high, because of an incorrect setting, this caused the mattress to be "bigger," "would raise her up more," and cause R1 to roll off. She was more concerned with overinflation as R1 utilized the alternating air setting. During the same interview, NA-C stated R2 was a "major" fall risk, mainly due to his confusion. She explained the care planned fall interventions, but she identified "distraction is needed" to help his fall risk. At times, she found him "messing" with his wheelchair legs/pedals. She observed this today. She utilized a snack which worked well for R2. She denied nurses and/or management spoke to her about her insight into R2 and his fall risk for potential assist with intervention development and/or adjustment.

On 7/25/24, at 2:12 p.m., a telephone interview was requested with R1 and R2's provider; however, no return call was provided.

When interviewed on 7/25/24, at 2:14 p.m., RN-E identified herself as a facility regional coordinator. She filled in doing MDSs as the position was currently vacant. She stated the admission comprehensive fall risk assessment was expected to be completed by the seventh day of stay, or the MDS reference date, by the DON or the nurse manager; however, "best practice" was to complete this as soon as possible. This was especially important if a resident admitted with a fall risk history: "We would not want them to wait" to complete the

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assessment. A comprehensive assessment was then completed annually thereafter or if there was a significant change in status. Any additional assessments would be referred to the clinical team. During the CAA process, she expected a fall risk analysis to help identify interventions and then the care plan was to be updated. If a comprehensive assessment were recently completed and the resident fell, there was not overall need to do another one as they already completed the risk analysis and updated the plan of care.

During a telephone interview on 7/25/24, at 2:29 p.m., FM-B stated R2 fell twice at the facility. When she asked if he had fallen more, and she was updated there were reports of four falls, she exclaimed, "What!" She expected she was updated about all falls he had while there. She did not understand why he continued to fall; however, she also explained his falls prior to facility admission and the interventions she was required to do to mitigate his falls at home. She identified he gets quite antsy when he had to use the bathroom and she always had to leave the bathroom light on for when he got up to go to the bathroom.

Air mattress education, prior to the survey, along with an air mattress policy were requested; however, none were provided.

A Matrix ALAL Mattress System, Custom Medical Solutions manufacturer, quick reference guide was provided. The guide directed the Firm/Soft setting was used to calibrate the mattress to the residents estimated body weight (35-pound increments). To check for correct inflation, the guide directed to slide a hand underneath the top cover to feel the base of the mattress and frame.

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Optimal firmness was to have a space of three to four fingers between the resident's coccyx or buttock area and the bed frame. If the resident was seated on the frame, the Fowler boost feature was to be activated to attain the desired space. If unsuccessful, continue to adjust the firmness in 35-pound increments until optimal space was reached between the resident's buttocks and the bed frame. When appropriate firmness achieved, close the top covers zipper, or secure the elastic banding underneath the mattress.

An Admission Checklist for Online Assessments - Floor Nurse, lacked identification the Fall Review Evaluation was part of the checklist.

A Fall Checklist packet revealed expected fall processes which included initiation of an immediate intervention and directed the nurse to a Fall Interventions Sheet. In addition, the nurse was to enter fall monitoring orders using the Monarch Fall Follow-up Order Set (batch update process). The checklist lacked direction on where the intervention was expected to be communicated to staff.

The Fall Information sheet instructed that an intervention was expected to be put into place immediately after a fall "per regulations" as this helped prevent falls from reoccurrence. Assisting a resident back into bed, or reminding the resident to use the call light, were not interventions. Forty-six interventions ideas were provided. One of them was floor mats. Additional directions reminded to ensure the interventions matched the reason for the incident.

A Nurse Manager/DON fall follow-up completion checklist identified expected steps. These

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included to review the falls with IDT, review the risk management and nurse checklist to ensure all steps completed such as intervention initiation, notifications, and documentation. If not completed, they were to provide education. Previous fall interventions were to be reviewed, along with the immediate intervention, to ensure appropriateness and to ensure the intervention was put into place. An Incident Review and Analysis was to be completed following provided instructions. Once completed, the care plan and care sheets were to be updated. The checklist lacked details on when this process was to be initiated and/or completed.

A Care Planning policy, dated 1/ 6/22, identified a baseline care plan was to be developed within 48 hours of admission to ensure the resident's immediate basic needs were met and maintained. The baseline care plan was to be utilized until the IDT conducted the comprehensive MDS assessment and developed a comprehensive individualized care plan.

A Fall Prevention and Management policy, dated 2/2024, identified its purpose was to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessment of a resident after a fall, and to assist staff with fall factor identification. The policy directed the Fall Risk Evaluation was to be conducted "upon admission," annually, with a significant change in condition, and as needed. If falls continued despite initial interventions, staff were to implement additional or different interventions or indicate why the current approach remains relevant. Staff were to monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. After a fall, the provider and family

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were to be updated in an appropriate time frame. In addition, staff were to monitor and document the resident's response to and the effectiveness of interventions put into place to prevent further falls for 72 hours post fall. If a resident continued falling, staff were to re-evaluate the situation for possible adjustment of interventions. As needed, the provider was to assist staff to reconsider possible causes not previously identified.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents, air mattress use, 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.