Electronically delivered
September 2, 2020

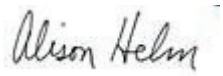
Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: July 13, 2020

Dear Administrator:

On August 26, 2020, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Electronically delivered
July 29, 2020

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: July 13, 2020

Dear Administrator:

On July 13, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2727

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 13, 2020 (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 13, 2021 (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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	C 07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(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 7/13/2020, abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5349038C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete post fall	F 689	Stewartville Care Center has policies and procedures to ensure that the residents□	8/21/20

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

Electronically Signed | 08/07/2020

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F 689	Continued From page 1 assessments and implement interventions following a fall for 2 of 2 residents (R1 and R2) reviewed for accidents. Findings include: R1's Face Sheet included diagnoses of repeated falls, dementia with behavioral disturbance with psychosis, and muscle wasting and atrophy. R1's quarterly Minimum Data Set (MDS) assessment dated 5/27/2020, indicated R1 had moderate cognitive impairment, and required extensive assistance from one staff member for transfers, toileting, and bed mobility. R1's Facility Investigation Form indicated R1 had an unwitnessed fall on 6/28/2020, at 8:30 p.m. in her room that caused a large bump on R1's head. The report indicated a nursing assistant had reported R1's fall to the nurse. However, when the nurse entered R1's room, R1 had already been transferred from the floor back to her wheelchair without a nursing assessment for further injury. During an interview on 7/13/2020, at 9:35 a.m. licensed practical nurse (LPN)-A stated, after a resident fall, the nurse was supposed to perform an assessment to make sure, whether there were injuries that could not be seen and to make sure the resident was safe to get back up. During an interview on 7/13/2020, at 10:48 p.m. director of nursing (DON) stated an unawareness R1 had been transferred back to her wheelchair prior to a completed nursing assessment. DON stated the assessment was important to rule out	F 689	environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a safety plan of care. The interdisciplinary care team comprehensively assesses each resident at the time of admission to identify safety risks and develops a resident-centered plan of care with interventions that enhance and promote safety. The resident□s safety needs/risks are reassessed quarterly and whenever there is a change in the resident□s mood/demeanor, physical condition, and/or cognition that impacts safety and functional status. The care plan is modified as necessary with the goal to attain maximum function with minimal risk of injury. The resident□s safety interventions are communicated to the direct care staff during shift reports and through the nursing assistant functional care plans which are routinely updated. The fall related policies and procedures were reviewed. The fall investigation and intervention documentation/tracking tools have been revised, expanded, and reorganized into an electronic file with forms that prompt the nurses to document the fall scene investigation details, safety-related interventions, and follow up. Use of the internal quality	

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F 689	Continued From page 2 a worsened injury and movement could make an injury worse. DON stated it was standard and it was expected that license nurses perform a post fall assessment to rule out further injury and to ensure the resident could transfer safely. R1's fall care plan dated 1/1/2020, indicated R1 was at risk for falls related to cognition and physical decline. "Resident has recently had multiple falls, with the last fall on 6/28/2020 ...Visual reminder on FWW [four wheeled walker] to ask for assistance before getting up." Corresponding interventions included, "Floor alarm and motion sensor to alert staff of unsafe transfers (start date 4/9/2020) and "Visual cues to remind resident to call for assistance (start date 2/6/2020)." During an observation on 7/13/2020, at 9:31 a.m. R1 laid in her bed with her eyes closed. Nursing assistant (NA)-A was in the room. When asked, NA-A said R1 was a fall risk, used a walker, and a motion sensor was in the room to alert staff when she was attempting self-transfers. NA-A stated before her move to this room, she used to have signs on her old walker that reminded her to ask for help, however, her new walker did not have any such signs. NA-A confirmed no signage was posted in R1's room that reminded her to call for help. NA-A then walked over to the motion sensor that sat on a shelf located near the foot of R1's bed that displayed a red. NA-A stated an alarm would not sound inside the room; it would sound in the adjacent room where the receiver box was at. During a continuous observation on 7/13/2020, from 9:35 a.m. to 10:18 a.m. R1 laid in her bed	F 689	improvement tool, Fall Analysis and Root Cause Summary, will continue to be utilized to assist the staff to better understand the causative circumstances prior to a resident□s fall and implement appropriate interventions to reduce the risk of subsequent falls. Information regarding falls is now filed by month in notebooks to facilitate the tracking data such as incidence of falls and each residents□ fall history as well as trends such as time of day and location of falls. The licensed nurses have been reeducated on the need 1) to perform neurological checks on all residents who have unwitnessed falls or who are observed hitting their head during a fall 2) to ensure that the safety/fall-related plan of care is assessed and implemented upon return from the hospital or other temporary absence including the use of safety equipment and signage and 3) to be alert for malfunctioning alarms and other staff notification devices. The nursing assistants have been instructed on the need to 1) call the nurse immediately when a resident has fallen 2) allow the licensed nurse to assess the resident before the resident is moved after a fall and 3) ensure that staff alerting devices are implemented according to the plan of care and are in working order. To minimize the risk of COVID-19 transmission, staff education was provided through one-on-one and small group training. Changes in procedures and compliance with policies will be	

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F 689	Continued From page 3 with her bedroom door slightly ajar. At 10:18 a.m. LPN-A stood at the nursing station desk; R1's motion sensor receiver box sat on the desk near LPN-A. LPN-A was asked how the motion sensor functioned. LPN-A grabbed the receiver, entered R1's room, and stated the motion sensor would not work because the red light on the sensor indicated the battery was dead. LPN-A then changed the battery and verified the device was functioning appropriately after the battery was changed. LPN-A was not aware of any routine maintenance or checks that were performed to ensure continuous working order. LPN-A stated she would expect staff to check the battery of the sensor with each interaction. LPN-A confirmed R1's walker and/or room did not have signage posted for reminders to ask for help per the care plan. During an interview on 7/13/2020, at 10:18 a.m. DON stated when R1 came back from the hospital she was assigned a different room, and her fall interventions had not yet been fully implemented and should have been. DON indicated fall devices were audited once a month and were supposed to be checked daily with cares to ensure the devices were functioning. R2 R2's Face Sheet included diagnoses of Parkinson's, dementia, urinary urgency, muscle weakness, abnormalities of gait, and macular degeneration in both eyes. R2's quarterly Minimum Data Set assessment dated 4/22/2020, indicated R2 did not have cognitive impairment, and required extensive	F 689	discussed with the licensed staff as they participate in the facility□s August 6, 2020 COVID-19 testing process. Resident number 1 - The 96-year-old resident was admitted to the facility January 20, 2018. Current diagnoses include dementia, anxiety, frailty related to age, metabolic encephalopathy, squamous cell carcinoma of the chest and repeated falls. The resident□s falls are routinely reviewed in the attempt to identify the root cause of falls and analyze the effectiveness of safety interventions. Related to the resident□s dementia, the resident has a short attention span and exhibits poor judgement with a lack of safety awareness. After a risk/benefit assessment, the use of alarms to alert staff to unsafe positioning was discontinued. The resident□s toileting program was reviewed and modified. Pain was reassessed. Prominently placed signs to remind the resident to call for assistance will be continued. A referral was made for physical therapy. On July 23, 2020, the physician increased the resident□s Seroquel dose (antipsychotic medication) due to hallucinations, delusions and increased paranoia. The resident□s plan of care was reviewed and updated accordingly. Resident number 2 - The 91-year-old resident was admitted to the facility December 27, 2016 with diagnoses to include Parkinson□s disease with major neurocognitive disorder, hallucinations,	

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F 689	Continued From page 4 assistance of one staff member for bed mobility, transfers, and toileting. R2's progress note dated 6/17/2020, indicated R2 had an unwitnessed fall in his room. The note included "Resident found lying on the floor, he had been self-transferring from the recliner to the wheelchair. Resident stated that he hit his head. No bumps or injuries noted. Able to move all extremities. Pupils equal. Hand grasps equal. Resident put into wheelchair. Resident stated, "I have the hardest head in Minnesota." During an interview on 7/13/2020, at 11:16 a.m. registered nurse (RN)-A said neurological assessments should be completed if the resident hit their head or if the resident was not able to say if they hit their head. RN-A indicated neurological assessments were to be completed in order to monitor for a change in condition. During an interview on 7/13/2020, at 2:40 p.m. RN-B stated neurological assessments and monitoring were supposed to be completed after a fall if the fall was unwitnessed and the resident was not a reliable reporter or if the resident hit their head. During a review of R2's record, continuous neurological assessments and monitoring for change in condition after the initial evaluation was not identified to have been completed. During an interview on 7/13/2020, at 3:03 p.m. director of nursing (DON) stated neurological assessments were supposed to be completed after an unwitnessed fall and the resident was not a reliable historian or when it was known that	F 689	agitation, frailty related to age, heart failure and kidney disease. Hospice services were started July 8, 2020. The resident now uses a Broda chair which allows him to self mobilize throughout the facility while increasing safety and comfort. The care plan has been updated accordingly. Neurochecks will be initiated for any future unwitnessed fall or any witnessed fall where the resident hit his head. Compliance will be monitored for the next two weeks by the Director of Nursing/designee through record audits of all residents who fall. Record reviews will include monitoring whether 1) the resident was assessed post fall by a licensed nurse before being assisted to the bed/chair 2) that appropriate signs and other safety/alerting interventions were in place 3) staff notification devices were in working order and 4) neurochecks were done according to facility policy. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the September Quality Assessment and Assurance Committee.	

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F 689	Continued From page 5 the resident hit their head. DON stated she expected nurses to complete the neurological evaluations per the protocol outlined on the facility form. Facility Fall Assessment Procedure dated 8/2018, indicated the designated staff member would complete a post fall event form after each fall, the fall would be reviewed by the interdisciplinary team for interventions, the care plan was then reviewed/revised, and the interventions were implemented for ongoing evaluation of interventions. The facility's neurological evaluation protocol was requested and not received.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 29, 2020

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Re: State Nursing Home Licensing Orders
Event ID: 5ON911

Dear Administrator:

The above facility was surveyed on July 13, 2020 through July 13, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2727

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00429	A. BUILDING: _____ B. WING _____	C 07/13/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/13/2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: H5349038C.	2 000		

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete post fall assessments and implement interventions following a fall for 2 of 2 residents (R1 and R2) reviewed for accidents. Findings include: R1's Face Sheet included diagnoses of repeated falls, dementia with behavioral disturbance with psychosis, and muscle wasting and atrophy.	2 830	Acknowledged and corrected.	8/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	C 07/13/2020

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2 830	Continued From page 2 R1's quarterly Minimum Data Set (MDS) assessment dated 5/27/2020, indicated R1 had moderate cognitive impairment, and required extensive assistance from one staff member for transfers, toileting, and bed mobility. R1's Facility Investigation Form indicated R1 had an unwitnessed fall on 6/28/2020, at 8:30 p.m. in her room that caused a large bump on R1's head. The report indicated a nursing assistant had reported R1's fall to the nurse. However, when the nurse entered R1's room, R1 had already been transferred from the floor back to her wheelchair without a nursing assessment for further injury. During an interview on 7/13/2020, at 9:35 a.m. licensed practical nurse (LPN)-A stated, after a resident fall, the nurse was supposed to perform an assessment to make sure, whether there were injuries that could not be seen and to make sure the resident was safe to get back up. During an interview on 7/13/2020, at 10:48 p.m. director of nursing (DON) stated an unawareness R1 had been transferred back to her wheelchair prior to a completed nursing assessment. DON stated the assessment was important to rule out a worsened injury and movement could make an injury worse. DON stated it was standard and it was expected that license nurses perform a post fall assessment to rule out further injury and to ensure the resident could transfer safely. R1's fall care plan dated 1/1/2020, indicated R1 was at risk for falls related to cognition and physical decline. "Resident has recently had multiple falls, with the last fall on 6/28/2020	2 830		

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2 830	Continued From page 3 ...Visual reminder on FWW [four wheeled walker] to ask for assistance before getting up." Corresponding interventions included, "Floor alarm and motion sensor to alert staff of unsafe transfers (start date 4/9/2020) and "Visual cues to remind resident to call for assistance (start date 2/6/2020)." During an observation on 7/13/2020, at 9:31 a.m. R1 laid in her bed with her eyes closed. Nursing assistant (NA)-A was in the room. When asked, NA-A said R1 was a fall risk, used a walker, and a motion sensor was in the room to alert staff when she was attempting self-transfers. NA-A stated before her move to this room, she used to have signs on her old walker that reminded her to ask for help, however, her new walker did not have any such signs. NA-A confirmed no signage was posted in R1's room that reminded her to call for help. NA-A then walked over to the motion sensor that sat on a shelf located near the foot of R1's bed that displayed a red. NA-A stated an alarm would not sound inside the room; it would sound in the adjacent room where the receiver box was at. During a continuous observation on 7/13/2020, from 9:35 a.m. to 10:18 a.m. R1 laid in her bed with her bedroom door slightly ajar. At 10:18 a.m. LPN-A stood at the nursing station desk; R1's motion sensor receiver box sat on the desk near LPN-A. LPN-A was asked how the motion sensor functioned. LPN-A grabbed the receiver, entered R1's room, and stated the motion sensor would not work because the red light on the sensor indicated the battery was dead. LPN-A then changed the battery and verified the device was functioning appropriately after the battery was changed. LPN-A was not aware of any routine	2 830		

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2 830	Continued From page 4 maintenance or checks that were performed to ensure continuous working order. LPN-A stated she would expect staff to check the battery of the sensor with each interaction. LPN-A confirmed R1's walker and/or room did not have signage posted for reminders to ask for help per the care plan. During an interview on 7/13/2020, at 10:18 a.m. DON stated when R1 came back from the hospital she was assigned a different room, and her fall interventions had not yet been fully implemented and should have been. DON indicated fall devices were audited once a month and were supposed to be checked daily with cares to ensure the devices were functioning. R2 R2's Face Sheet included diagnoses of Parkinson's, dementia, urinary urgency, muscle weakness, abnormalities of gait, and macular degeneration in both eyes. R2's quarterly Minimum Data Set assessment dated 4/22/2020, indicated R2 did not have cognitive impairment, and required extensive assistance of one staff member for bed mobility, transfers, and toileting. R2's progress note dated 6/17/2020, indicated R2 had an unwitnessed fall in his room. The note included "Resident found lying on the floor, he had been self-transferring from the recliner to the wheelchair. Resident stated that he hit his head. No bumps or injuries noted. Able to move all extremities. Pupils equal. Hand grasps equal. Resident put into wheelchair. Resident stated, "I have the hardest head in Minnesota."	2 830		

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2 830	Continued From page 5 During an interview on 7/13/2020, at 11:16 a.m. registered nurse (RN)-A said neurological assessments should be completed if the resident hit their head or if the resident was not able to say if they hit their head. RN-A indicated neurological assessments were to be completed in order to monitor for a change in condition. During an interview on 7/13/2020, at 2:40 p.m. RN-B stated neurological assessments and monitoring were supposed to be completed after a fall if the fall was unwitnessed and the resident was not a reliable reporter or if the resident hit their head. During a review of R2's record, continuous neurological assessments and monitoring for change in condition after the initial evaluation was not identified to have been completed. During an interview on 7/13/2020, at 3:03 p.m. director of nursing (DON) stated neurological assessments were supposed to be completed after an unwitnessed fall and the resident was not a reliable historian or when it was known that the resident hit their head. DON stated she expected nurses to complete the neurological evaluations per the protocol outlined on the facility form. Facility Fall Assessment Procedure dated 8/2018, indicated the designated staff member would complete a post fall event form after each fall, the fall would be reviewed by the interdisciplinary team for interventions, the care plan was then reviewed/revised, and the interventions were implemented for ongoing evaluation of interventions.	2 830		

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2 830	Continued From page 6 The facility's neurological evaluation protocol was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		