Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2023

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

RE: CCN: 245349
Cycle Start Date: January 30, 2023

Dear Administrator:

On February 16, 2023, we notified you a remedy was imposed. On March 8, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 3, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 16, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 30, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 14, 2023

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

Re: Reinspection Results
Event ID: MH4Q11 and RW0K12

Dear Administrator:

On March 3, 2023 and March 8, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on Februrary 2, 2023 and February 16, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

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

RE: CCN: 245349
Cycle Start Date: January 30, 2023

Dear Administrator:

On February 16, 2023, we informed you of imposed enforcement remedies.

On February 16, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 3, 2023, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 3, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 3, 2023.

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

As we notified you in our letter of February 16, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 30, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 30, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: RW0K11

Dear Administrator:

The above facility was surveyed on February 16, 2023 through February 16, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	C 02/16/2023

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 2/16/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H53498027C (MN00090615) with a deficiency issued 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 complete	F 689	Stewartville Care Center has policies and procedures to ensure that the residents□	3/3/23

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

Electronically Signed | 03/03/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 comprehensive fall analysis to determine accurate causal factors and implement care plan interventions to prevent or mitigate the risk of recurrent falls for 3 of 3 residents (R2, R1, R3) reviewed for falls. Findings include: R2's face sheet printed 1/26/23, identified R2 had a diagnoses of acute on chronic congestive heart failure and abnormalities of gait and mobility. R2's annual MDS dated 11/9/22, identified R2 did not have cognitive impairment. R2 required limited assistance of one staff for transfers and extensive assistance of one staff for toilet use. R2 was always incontinent of bladder and frequently incontinent of bowel. R2 had one fall with no injury since last MDS assessment. R2's fall care plan dated 7/29/20, identified R2 was at risk for falls related to poor safety judgement, muscle weakness, mild cognitive impairment, and confusion related to frequent urinary tract infections. Interventions included: analyze residents falls to determine pattern/trend, encourage resident to assume standing position slowly, encourage resident to use environmental devices such as hand grips, grab bars, and reachers, give verbal reminders to not ambulate or transfer without assistance. R2's record identified R2 had three falls between 11/17/22 to 2/2/23. R2's fall record documentation for 11/18/22, identified R2 had a witnessed fall when nursing assistant (NA) transferred R1 off the toilet, R1 lost her balance and fell between the toilet and	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 residents' safety needs/risks are reassessed quarterly and whenever there is a change in the residents' 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. A Neurological Assessment Policy and Procedure has been drafted and the fall related policies and procedures were reviewed and revised. The fall investigation and intervention documentation/tracking tools were assessed for efficiency and efficacy. The review of the resident□s fall risk factors and the root cause analysis of falls will now be incorporated into the resident□s	

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F 689	Continued From page 2 wall. NA had not used a gait assistive device. Interventions included: fall prevention program, gait belt and or consider a stand for all transfers related to resident's inability to support or balance own weight safely (sic) incurring injuries. R2's fall care plan was updated to include: staff to assist for all mobility and transfers using a front wheeled walker (FWW), ambulate short distances with staff- may need wheelchair to follow due to fatigue and low endurance. "ALWAYS use gait belt for transferring resident!" Consider assist of two or mobility transfer device upon approval by primary care provider. R2's progress note dated 11/18/22, identified R2 had a fall in her bathroom and landed on her left hip, she had no complaints of pain. Progress note at 1:13 p.m. indicated nurse felt left hip bone protruding. R2 reported left hip was painful to touch. Physician was notified and R2 was transferred to to the ED. Progress note at 6:23 p.m. indicated ED informed facility R2 did not have a hip fracture but was diagnosed with hematoma (abnormal collection of blood outside of a blood vessel) on left hip, trauma surgery would assess R2 and communicate to the facility whether R2 would be admitted to the hospital. Progress note at 11:29 p.m. identified R2 had been admitted to the hospital for "bleeding into the hip", hemarthrosis. R2's hospital After Visit Summary (AVS) identified R2 was admitted to the hospital on 11/18/22, with primary diagnosis of "Contusion (Hematoma) Thigh Initial Left". R2 required Eliquis (anticoagulant-blood thinning medication) for atrial fibrillation (heart arrhythmia). R2 sustained a contusion from a ground level fall after standing	F 689	electronic event report which allows/prompts for comprehensive documentation of the residents' vital signs, circumstances of the incident, follow-up, and other fall-related information. Information regarding falls continues to be filed by month in notebooks to facilitate the tracking data such as incidence of falls, each residents' fall history as well as trends such as time of day and location of falls. The licensed nurses have been made aware of the revisions to the Falls Prevention and Management Policy and Procedures. The nurses have been reinstructed on the need to 1) make a comprehensive nursing note at the time of the fall/incident 2) document immediate intervention(s) implemented to reduce the risk of fall recurrence 3) initiate an electronic fall event report and 4) complete all sections of the Fall Scene Investigation report at the time of the fall. All nursing staff have been educated on safe resident transfer techniques. The nursing staff completed a post-test and signed to verify receipt and understanding of the fall information. Recent falls will be reviewed by the interdisciplinary team (IDT) which meets five times per week. The IDT investigates the circumstances of the fall, analyzes causal factors, assesses current interventions for effectiveness, and determines if additional safety interventions are indicated.	

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F 689	Continued From page 3 up from the toilet while in the bathroom at 7:00 a.m. Over the course of the day R2 developed significant swelling over the left hip. Hospital course included monitoring of hemoglobin, pelvic binder placed for compression, and R2 was given medication that reversed the anticoagulation medication, and was administered intravenous (IV) Fentanyl 25 micrograms (narcotic medication) for pain control. Additionally R2 was administered Tylenol, Lidoderm patches (transdermal pain patch), oxycodone and hydromorphone (narcotic pain medications) for pain control. R2 was discharged back to the facility on 12/1/22. R2's fall record documentation for 1/17/23, indicated R2 had a witnessed fall in her room next to her bed after staff had walked her back from the bathroom to her bed. R2 became weak and slid to the floor. Staff had not used the gait belt. After the fall R2 complained of left elbow pain and red mark on lower back (did not include measurements). Fall interventions included: Initiate Fall Prevention Program. Consider assist of 2 or mobilization transfer device with approval of primary care provider, monitor status for 72 hours for bruising, change in mental status, pain, or other injuries related to the fall. Additional interventions included "transfer belts to be used [with] all transfers." R2's fall record documentation for 2/2/23, identified R2 had a fall at 3:30 p.m. when staff assisted R2 with a gait belt to transfer. Staff had to lower R2 to the floor because she became weak. Interventions included: 1) Fall Prevention Program, utilize stand aide or mechanical standing lift related to R2's weakness/muscle atrophy continued. 2) primary care provider	F 689	New upgraded motion detectors were put into use January 2023. All motion sensors have been tested and found in working order. Motion detector function will be tested monthly. Resident number 1 - The 95-year-old resident was admitted to the facility May 18, 2021 and was receiving hospice services when she died peacefully in her sleep January 18, 2023. The Director of Nursing reviewed the fall-related forms, care plan interventions, assessments, and nurses' notes; the findings will be referenced as part of the facilitys' quality improvement process. Resident number 2 - The resident was admitted to the facility November 19, 2019. The residents' current diagnoses include diabetes mellitus, chronic kidney disease, pulmonary edema, depressive disorder, hypertensive heart disease with heart failure, peripheral vascular disease, cognitive impairment and obesity. Hemodialysis was initiated December 12, 2022 due to kidney failure. The residents' fall-related plan of care was reviewed and revised March 3, 2023. The direct care givers are aware of the need for gait belt use with pivot transfers and when using the White Stand mechanical transfer device as well as other safety-related interventions. The safety plan of care will be reviewed quarterly and more often with changes in condition. Resident number 3 - The 99-year-old resident was admitted to the facility	

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 689	Continued From page 4 notified to change transfer device from only gait belt to either stand-aide/mechanical standing lift 3) medication and care plan updated with interventions of the event. Additional interventions directed staff to remind R2 to lift right foot that gets stuck and use mechanical standing lift if R2 was tired. During an observation and interview on 2/16/23, at 9:51 a.m., R2 was sitting in her wheelchair in her room. NA-A brought in the white stand aid and pushed it in front of the wheelchair and provided R2 with verbal cues during the transfer from the wheelchair to the bed. NA-A did not put gait belt on prior to the transfer. R2 completed the transfer safely with no signs of weakness. NA-A indicated after R2's most recent hospitalization, R2 had needed to use the stand-aide. NA-A confirmed she had not used the gait belt during the transfer and the gait belt should be used with all transfers including when the stand-aide was used. R1's face sheet printed 1/26/23, identified R1's diagnoses included: cerebral infarction (stroke) and osteoarthritis (arthritis in joint spaces). R1's quarterly minimum data set (MDS) dated 12/8/22, identified R1 was cognitively impaired. R1 required limited assistance of one staff with most activities of daily living (ADLs), extensive assist of one staff with mobility and dressing, R1 did not walk during the assessment period. R1 required one staff assist for toileting and was always continent of bowel and occasionally incontinent of bladder. R1 did not have any falls since admission or last assessment and no falls before admission.	F 689	October 19, 2022. Her diagnoses include chronic pain syndrome, chronic respiratory failure, history of falling, degenerative joint disease, compression fractures, metabolic encephalopathy, and functional debility/decline. The resident□s safety/fall-related care plan was reviewed and updated by the Director of Nursing March 3, 2023. The staff are aware of the need to use the White Stand mechanical transfer device and have been educated on correct use of the stand. The resident has had no falls since December 28, 2022. In the event of future falls, the staff will implement immediate interventions to reduce the risk of recurrence; the interdisciplinary team will identify root causes of falls and analyze the effectiveness of the current safety interventions and the need for additional safety interventions. Compliance will be monitored for the next three weeks by the Director of Nursing/designee through record audits of all residents who fall. Record reviews will include monitoring whether 1) there was a nurses' note made at the time of the falls 2) immediate interventions were taken to reduce the risk of recurrent fall 3) that neurological checks were completed according to facility policy 4) the Fall Investigation form was completed 5) the IDT investigated the circumstances of the fall, analyzed causal factors, assessed current interventions for effectiveness, and determined if additional safety interventions were indicated 6) an electronic event report was initiated and 7)	

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F 689	Continued From page 5 R1's fall Care Plan dated 6/3/21, identified R1 was at increased risk for falls related to recent fall on 1/7/23. R1 attempts to self-transfer and required assist of one staff with mobility. R1's fall interventions included: staff should walk with resident 2-3 times a day with front wheeled walker (FWW) and assist. R1 was independent with toileting and able to ambulate in her room with her walker. R1 required one staff to assist with transfer to and from chair and bed using FWW. R1's fall record identified R1 had three falls between 1/3/23 to 1/7/23. For all three falls, it was not evident the facility completed comprehensive fall assessments/analysis that identified root cause so that appropriate interventions were implemented to prevent and/or mitigate the risk of re-current falls. R1's event report dated 1/3/23, at 1:38 p.m., indicated R1 had an unwitnessed fall in her bathroom at 9:45 p.m. when she self-transferred. R1 sustained a small bruise by her elbow and forming bruise on the same arm. The immediate intervention was placement of personal alarm. Report indicated fall prevention program started on 1/4/23-1/11/23. Neurological assessment (includes: mental status, cranial nerves, motor and sensory function, pupillary response, reflexes, the cerebellum, and vital signs) flow sheet was started with normal findings. There was no indication R1's care plan was updated to identify the personal alarm. R1's progress note dated 1/4/23, at 11:54 a.m. indicated the physician was notified R1 had a fall on 1/2/23 with no injuries, however R1's record did not identify a fall that had occurred on 1/2/23.	F 689	the care plan was updated. Monthly for three months the Medical Record/Quality Assurance Consultant will audit records of resident with recent fall to ensure that related documentation is in compliance with facility policy and regulatory expectations. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed during the March and June Quality Assessment and Performance Improvement Committee meeting.	

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F 689	Continued From page 6 R1's progress note dated 1/4/23, at 2:29 p.m. indicated R1 was confused and continued to yell when she needed help going to the bathroom. R1 required two staff assist because R1 refused to open her eyes to help with transfers. There was no indication R1's transfer ability was reassessed in order to ascertain if R1 had a decline in mobility. R1's fall record documentation for 1/4/23, identified R1 had an unwitnessed fall, she was found sitting next to her bed, and had gotten up to use the bathroom. R1 reported she had hit her head. R1 had a recent decline in ADL abilities and interventions had been effective (did not identify which intervention were effective) R1's motion sensor had not alarmed. Neurological assessments were initiated but not completed; one assessment was completed on 1/4/23, at 9:15 p.m. resulted in normal findings. Interventions included implemented were alarms for mattress and floor. There was no indication R1's care plan was updated to include interventions of the mattress and floor alarms. R1's care plan was updated on 1/5/23, with the following intervention: consider utilization of visual monitor/camera kept at nurse station to observe R1 attempts at self-transferring, discuss with family. It was not evident the visual monitor/camera was implemented. R1's fall record documentation for 1/7/23, identified R1 had a witnessed fall out of her wheelchair after breakfast at 8:50 a.m. R1 had a "goose egg" on the left side of her forehead and was lethargic/drowsy. R1 had recent change in	F 689		

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F 689	Continued From page 7 medications (fall documentation did not specify the change) and recent decline in ADL's. The record identified immediate interventions were 15-minute checks, 1. Assist of 1-2 with all transfers and gait belt. 2. Fall precautions 24/7 times two weeks. 3. Hospice. 4. Light on in room p.m. -call light accessible. R1's record included an incomplete post fall Neurological Assessment flow sheet. Neurological assessments were completed on 1/7/21 at 8:55 a.m., 9:10 a.m., 9:25 a.m., 9:45 a.m. and 12:30 p.m. with normal findings. There was no indication R1's care plan was was revised to include the aforementioned interventions. During an interview on 2/16/23, at 1:18 p.m. ADON reviewed R1's fall record; ADON indicated comprehensive fall assessments that included causal analysis were not completed for any of the falls and the care plan was not updated with interventions identified on the reports. However, stated the mattress alarm was implemented but could not recall what if any other interventions had been implemented for R1 after the falls. ADON had indicated it was a standard of care that all staff use gait belts when assisting residents to transfer and or ambulate. R3's face sheet printed 1/26/23, identified R3 had a diagnoses that included history of falling, osteoarthritis, and chronic respiratory failure. R3's quarterly MDS dated 2/2/23, identified R3 did not have cognitive impairment. R3 required extensive assistance of one staff with transfers and toileting R3 was frequently incontinent of bladder and occasionally incontinent of bowel. R3 had two or more falls with no injury and one fall with injury since last MDS assessment.	F 689		

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F 689	Continued From page 8 R3's pain care plan dated 11/3/22 identified R3 had a history of falls with injury prior to admission. The care plan directed staff to encourage and assist R3 with mobility as tolerated. Fall prevention: assess resident's strength when using stand-aide and be aware she becomes weak not able tot maintain grip. R3's mobility care plan dated 11/3/22, identified R3 was total assist with mobility related to generalized weakness. The care plan directed staff to use the standing mechanical lift (EZ stand) for transfers which was inconsistent with the pain care plan directive. R3's progress note dated 12/21/22, at 3:00 p.m. indicated R3 required assistance from two staff with the EZ stand for all transfers. R3's progress note dated 12/22/22, at 10:40 a.m. indicated R3 transferred with assist of one staff with the stand-aide. R3's progress note dated 12/22/22, at 5:58 p.m. indicated R3 required assistance from two staff using the EZ stand for all transfers. R3's progress note dated 12/28/22, at 4:22 p.m. indicated R3 had let go of the stand-aide while being transferred at 3:30 p.m. that resulted in a skin tear on her right forearm and a large bruise on her left hand above her thumb. In review of R3's record it was not evident a comprehensive fall assessment and analysis was completed, no indication R3's care plan was revised, and not evident immediate interventions were implemented to mitigate risk of re-current falls.	F 689		

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F 689	Continued From page 9 During an interview on 2/16/23, at 1:18 p.m. ADON explained he was the person who was responsible for the fall program. ADON had indicated it was a standard of care that all staff use gait belts when assisting residents to transfer and or ambulate. ADON explained nurses were supposed to complete the fall scene investigation (FSI) checklist at the time of the fall, then complete a progress note, which triggered an event report to be completed. The electronic health record system would initiate "fall program" focus to alert staff. ADON indicated nurses would not develop or initiate immediate fall interventions. Nurses monitored the resident throughout the shift and would give report to the next shift. ADON indicated the facility was not completing comprehensive assessments after falls and consistently updating the care plan with new fall interventions. The facility's fall program needed to be changed because it was not working. During a subsequent interview at 3:23 p.m. further explained if residents had physical changes he expected NA's to notify the nurse and the nurse document the change. To his knowledge there was not a comprehensive mobility assessment when residents demonstrated changes. Therapy would complete comprehensive mobility assessments upon admission and if the resident had therapy days available to use under their insurance. During an interview with the DON on 2/16/23 at 3:53 p.m., director of nursing (DON) indicated the facility was in the process of reviewing their fall program, however, had not developed and/or revised the program. DON indicated fall assessments were completed upon admission but was not sure when subsequent assessments would be completed.	F 689		

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F 689	Continued From page 10 Facility policy/protocol for neurological assessments was requested and not received. Facility policy Standard Procedure Fall Assessment dated 8/2018, included fall assessments would be completed on admission, readmission and with significant changes. Post fall event forms would be completed after each fall on Matrix followed by a post-fall observation. Nursing administration and interdisciplinary team would review the fall event for interventions, safety devices and environmental factors and update the care plan and monitor for ongoing evaluation of interventions.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/16/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H53498027C (MN00090615) 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	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive fall analysis to determine accurate causal factors and implement care plan interventions to prevent or mitigate the risk of recurrent falls for 3 of 3 residents (R2, R1, R3) reviewed for falls. The facility's failures resulted in actual harm when R2's care plan was not followed resulting in hemarthrosis (bleeding into hip joint) that required hospitalization.	2 830	Acknowledged and corrected.	3/3/23

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2 830	Continued From page 3 Findings include: R2's face sheet printed 1/26/23, identified R2 had a diagnoses of acute on chronic congestive heart failure and abnormalities of gait and mobility. R2's annual MDS dated 11/9/22, identified R2 did not have cognitive impairment. R2 required limited assistance of one staff for transfers and extensive assistance of one staff for toilet use. R2 was always incontinent of bladder and frequently incontinent of bowel. R2 had one fall with no injury since last MDS assessment. R2's fall care plan dated 7/29/20, identified R2 was at risk for falls related to poor safety judgement, muscle weakness, mild cognitive impairment, and confusion related to frequent urinary tract infections. Interventions included: analyze residents falls to determine pattern/trend, encourage resident to assume standing position slowly, encourage resident to use environmental devices such as hand grips, grab bars, and reachers, give verbal reminders to not ambulate or transfer without assistance. R2's record identified R2 had three falls between 11/17/22 to 2/2/23, in which staff did not utilize a gait belt or appropriate transfer equipment. R2's fall record documentation for 11/17/22, indicated R2 had a witnessed fall in her room next to her bed after staff had walked her back from the bathroom to her bed. R2 became weak and slid to the floor. Staff had not used the gait belt. After the fall R2 complained of left elbow pain and red mark on lower back (did not include measurements). Fall interventions included: Initiate Fall Prevention Program. Consider assist of 2 or mobilization transfer device with approval	2 830		

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2 830	Continued From page 4 of primary care provider, monitor status for 72 hours for bruising, change in mental status, pain, or other injuries related to the fall. Additional interventions included "transfer belts to be used [with] all transfers." R2's fall care plan was updated to include: staff to assist for all mobility and transfers using a front wheeled walker (FWW), ambulate short distances with staff- may need wheelchair to follow due to fatigue and low endurance. "ALWAYS use gait belt for transferring resident!" Consider assist of two or mobility transfer device upon approval by primary care provider. R2's fall record documentation for 11/18/22, identified R2 had a witnessed fall when nursing assistant (NA) transferred R1 off the toilet, R1 lost her balance and fell between the toilet and wall. NA had not used a gait assistive device. Interventions included: fall prevention program, gait belt and or consider stand for all transfers related to resident's inability to support or balance own weight safely (sic) incurring injuries. R2's progress note dated 11/18/23, identified R2 had a fall in her bathroom and landed on her left hip, she had no complaints of pain. Progress note at 1:13 p.m. indicated nurse felt left hip bone protruding. R2 reported left hip was painful to touch. Physician was notified and R2 was transferred to to the ED. Progress note at 6:23 p.m. indicated ED informed facility R2 did not have a hip fracture but was diagnosed with hematoma (abnormal collection of blood outside of a blood vessel) on left hip, trauma surgery would assess R2 and communicate to the facility whether R2 would be admitted to the hospital. Progress note at 11:29 p.m. identified R2 had been admitted to the hospital for "bleeding into	2 830		

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2 830	Continued From page 5 the hip", hemarthrosis. R2's hospital After Visit Summary (AVS) identified R2 was admitted to the hospital on 11/18/22, with primary diagnosis of "Contusion (Hematoma) Thigh Initial Left". R2 required Eliquis (anticoagulant-blood thinning medication) for atrial fibrillation (heart arrhythmia). R2 sustained a contusion from a ground level fall after standing up from the toilet while in the bathroom at 7:00 a.m. Over the course of the day R2 developed significant swelling over the left hip. Hospital course included monitoring of hemoglobin, pelvic binder placed for compression, and R2 was given medication that reversed the anticoagulation medication, and was administered intravenous (IV) Fentanyl 25 micrograms (narcotic medication) for pain control. Additionally R2 was administered Tylenol, Lidoderm patches (transdermal pain patch), oxycodone and hydromorphone (narcotic pain medications) for pain control. R2 was discharged back to the facility on 12/1/22. R2's fall record documentation for 2/2/23, identified R2 had a fall at 3:30 p.m. when staff assisted R2 with a gait belt to transfer. Staff had to lower R2 to the floor because she became weak. Interventions included: 1) Fall Prevention Program, utilize stand aide or mechanical standing lift related to R2's weakness/muscle atrophy continued. 2) primary care provider notified to change transfer device from only gait belt to either stand-aide/mechanical standing lift 3) medication and care plan updated with interventions of the event. Additional interventions directed staff to remind R2 to lift right foot that gets stuck and use mechanical standing lift if R2 was tired.	2 830		

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(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
2 830	Continued From page 6 During an observation and interview on 2/16/23, at 9:51 a.m., R2 was sitting in her wheelchair in her room. NA-A brought in the white stand aid and pushed it in front of the wheelchair and provided R2 with verbal cues during the transfer from the wheelchair to the bed. NA-A did not put gait belt on prior to the transfer. R2 completed the transfer safely with no signs of weakness. NA-A indicated after R2's most recent hospition on 2/2/23, R2 had needed to use the stand-aide. NA-A confirmed she had not used the gait belt during the transfer and the gait belt should be used with all transfers including when the stand-aide was used. R1's face sheet printed 1/26/23, identified R1's diagnoses included: cerebral infarction (stroke) and osteoarthritis (arthritis in joint spaces). R1's quarterly minimum data set (MDS) dated 12/8/22, identified R1 was cognitively impaired. R1 required limited assistance of one staff with most activities of daily living (ADLs), extensive assist of one staff with mobility and dressing, R1 did not walk during the assessment period. R1 required one staff assist for toileting and was always continent of bowel and occasionally incontinent of bladder. R1 did not have any falls since admission or last assessment and no falls before admission. R1's fall Care Plan dated 6/3/21, identified R1 was at increased risk for falls related to recent fall on 1/7/23. R1 attempts to self-transfer and required assist of one staff with mobility. R1's fall interventions included: staff should walk with resident 2-3 times a day with front wheeled walker (FWW) and assist. R1 was independent with toileting and able to ambulate in her room with her walker. R1 required one staff to assist	2 830		

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	00429	A. BUILDING: _____ B. WING _____	02/16/2023

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2 830	Continued From page 7 with transfer to and from chair and bed using FWW. R1's fall record identified R1 had three falls between 1/3/23 to 1/7/23. For all three falls, it was not evident the facility completed comprehensive fall assessments/analysis that identified root cause so that appropriate interventions were implemented to prevent and/or mitigate the risk of re-current falls. R1's event report dated 1/3/23, at 1:38 p.m., indicated R1 had an unwitnessed fall in her bathroom at 9:45 p.m. when she self-transferred. R1 sustained a small bruise by her elbow and forming bruise on the same arm. The immediate intervention was placement of personal alarm. Report indicated fall prevention program started on 1/4/23-1/11/23. Neurological assessment (includes: mental status, cranial nerves, motor and sensory function, pupillary response, reflexes, the cerebellum, and vital signs) flow sheet was started with normal findings. There was no indication R1's care plan was updated to identify the personal alarm. R1's progress note dated 1/4/23, at 11:54 a.m. indicated the physician was notified R1 had a fall on 1/2/23 with no injuries, however R1's record did not identify a fall that had occurred on 1/2/23. R1's progress note dated 1/4/23, at 2:29 p.m. indicated R1 was confused and continued to yell when she needed help going to the bathroom. R1 required two staff assist because R1 refused to open her eyes to help with transfers. There was no indication R1's transfer ability was reassessed in order to ascertain if R1 had a decline in mobility.	2 830		

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2 830	Continued From page 8 R1's fall record documentation for 1/4/23, identified R1 had an unwitnessed fall, she was found sitting next to her bed, and had gotten up to use the bathroom. R1 reported she had hit her head. R1 had a recent decline in ADL abilities and interventions had been effective (did not identify which intervention were effective) R1's motion sensor had not alarmed. Neurological assessments were initiated but not completed; one assessment was completed on 1/4/23, at 9:15 p.m. resulted in normal findings. Interventions included implemented were alarms for mattress and floor. There was no indication R1's care plan was updated to include interventions of the mattress and floor alarms. R1's care plan was updated on 1/5/23, with the following intervention: consider utilization of visual monitor/camera kept at nurse station to observe R1 attempts at self-transferring, discuss with family. It was not evident the visual monitor/camera was implemented. R1's fall record documentation for 1/7/23, identified R1 had a witnessed fall out of her wheelchair after breakfast at 8:50 a.m. R1 had a "goose egg" on the left side of her forehead and was lethargic/drowsy. R1 had recent change in medications (fall documentation did not specify the change) and recent decline in ADL's. The record identified immediate interventions were 15-minute checks, 1. Assist of 1-2 with all transfers and gait belt. 2. Fall precautions 24/7 times two weeks. 3. Hospice. 4. Light on in room p.m. -call light accessible. R1's record included an incomplete post fall Neurological Assessment flow sheet. Neurological assessments were completed on 1/7/21 at 8:55 a.m., 9:10 a.m., 9:25 a.m., 9:45 a.m. and 12:30 p.m. with normal	2 830		

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2 830	Continued From page 9 findings. There was no indication R1's care plan was was revised to include the aforementioned interventions. During an interview on 2/16/23, at 1:18 p.m. ADON reviewed R1's fall record; ADON indicated comprehensive fall assessments that included causal analysis were not completed for any of the falls and the care plan was not updated with interventions identified on the reports. However, stated the mattress alarm was implemented but could not recall what if any other interventions had been implemented for R1 after the falls. ADON had indicated it was a standard of care that all staff use gait belts when assisting residents to transfer and or ambulate. R3's face sheet printed 1/26/23, identified R3 had a diagnoses that included history of falling, osteoarthritis, and chronic respiratory failure. R3's quarterly MDS dated 2/2/23, identified R3 did not have cognitive impairment. R3 required extensive assistance of one staff with transfers and toileting R3 was frequently incontinent of bladder and occasionally incontinent of bowel. R3 had two or more falls with no injury and one fall with injury since last MDS assessment. R3's pain care plan dated 11/3/22 identified R3 had a history of falls with injury prior to admission. The care plan directed staff to encourage and assist R3 with mobility as tolerated. Fall prevention: assess resident's strength when using stand-aide and be aware she becomes weak not able tot maintain grip. R3's mobility care plan dated 11/3/22, identified R3 was total assist with mobility related to generalized weakness. The care plan directed staff to use the standing mechanical lift (EZ stand) for transfers which was	2 830		

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2 830	Continued From page 10 inconsistent with the pain care plan directive. R3's progress note dated 12/21/22, at 3:00 p.m. indicated R3 required assistance from two staff with the EZ stand for all transfers. R3's progress note dated 12/22/22, at 10:40 a.m. indicated R3 transferred with assist of one staff with the stand-aide. R3's progress note dated 12/22/22, at 5:58 p.m. indicated R3 required assistance from two staff using the EZ stand for all transfers. R3's progress note dated 12/28/22, at 4:22 p.m. indicated R3 had let go of the stand-aide while being transferred at 3:30 p.m. that resulted in a skin tear on her right forearm and a large bruise on her left hand above her thumb. In review of R3's record it was not evident a comprehensive fall assessment and analysis was completed, no indication R3's care plan was revised, and not evident immediate interventions were implemented to mitigate risk of re-current falls. During an interview on 2/16/23, at 1:18 p.m. ADON explained he was the person who was responsible for the fall program. ADON explained nurses were supposed to complete the fall scene investigation (FSI) checklist at the time of the fall, then complete a progress note, which triggered an event report to be completed. The electronic health record system would initiate "fall program" focus to alert staff. ADON indicated nurses would not develop or initiate immediate fall interventions. Nurses monitored the resident throughout the shift and would give report to the next shift. ADON indicated the facility was not	2 830		

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2 830	Continued From page 11 completing comprehensive assessments after falls and consistently updating the care plan with new fall interventions. The facility's fall program needed to be changed because it was not working. During a subsequent interview at 3:23 p.m. further explained if residents had physical changes he expected NA's to notify the nurse and the nurse document the change. To his knowledge there was not a comprehensive mobility assessment when residents demonstrated changes. Therapy would complete comprehensive mobility assessments upon admission and if the resident had therapy days available to use under their insurance. During an interview with the DON on 2/16/23 at 3:53 p.m., director of nursing (DON) indicated the facility was in the process of reviewing their fall program, however, had not developed and/or revised the program. DON indicated fall assessments were completed upon admission but was not sure when subsequent assessments would be completed. Facility policy/protocol for neurological assessments was requested and not received. Facility policy Standard Procedure Fall Assessment dated 8/2018, included fall assessments would be completed on admission, readmission and with significant changes. Post fall event forms would be completed after each fall on Matrix followed by a post-fall observation. Nursing administration and interdisciplinary team would review the fall event for interventions, safety devices and environmental factors and update the care plan and monitor for ongoing evaluation of interventions. Suggested Method of Correction: The Directior of	2 830		

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2 830	Continued From page 12 Nursing or designee could review policies and procedures, fall investigations and interventions, care plan updates, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		