DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 16, 2021

Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: CCN: 245350
Cycle Start Date: November 3, 2021

Dear Administrator:

On November 19, 2021, we notified you a remedy was imposed. On December 6, 2021 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 November 29, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 4, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 19, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 4, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 29, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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December 16, 2021

Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

Re: Reinspection Results
Event ID: J8I812

Dear Administrator:

On December 6, 2021 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 December 6, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 19, 2021

Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: CCN: 245350
Cycle Start Date: November 3, 2021

Dear Administrator:

On November 3, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 4, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 4, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 4, 2021.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 4, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Benedicts Senior Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 4, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 May 3, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental

Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(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 10/29/21 through 11/3/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5350145C (MN77825), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		11/29/21

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

Electronically Signed | 11/24/2021

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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to prevent reoccurring falls for 3 of 4 residents (R5, R2, R3) reviewed who resided in the Gardens Gate Unit. This resulted in harm for R5 when she sustained a right lower extremity fracture after an unwitnessed fall on 10/21/21, and was admitted to hospital for surgical intervention. Findings Include: R5's admission Minimal Data Set (MDS) dated 7/26/21, indicated R5 had diagnoses which included stroke, hemiplegia and no cognitive impairment. Further review of MDS, indicated R5 required limited assistance of one staff member for all activities of daily living (ADLS). R5's care plan dated 7/19/21, indicated R5 was at risk for injury related to impaired mobility, narcotic medication, history of falls, impulsive, does not consistently ask for assistance or use call light, poor safety awareness, self-transfers, self-toilets, self ambulates, and right-side hemiplegia. Interventions for R5's falls included: auto-lock brakes on wheelchair, call staff for items out of reach, Dycem on wheelchair seat, encourage resident to wear appropriate footwear, monthly pharmacy review, observe for adverse side effects, obtain lab work as indicated, referrals to physical, occupation and speech therapy as indicated, reposition per tissue tolerance, and risk and consequences of not reporting falls discussed on 7/19/21. R5's Fall Risk Evaluation dated 8/27/21, indicated	F 689	R5 – R5's plan of care was updated with the following interventions on 11/2/21 prior to the resident's return from the hospital: a room change closer to the nurse's desk as well as a wider bed with scoop mattress. A comprehensive review of R5's falls was completed with the IDT. R2 – R2's plan of care was updated with the following interventions: On 11/1/21, R2's plan of care was updated to reflect the presence and use of a soft touch call light (to better facilitate resident activating her call light) as well as to reflect the presence of "(R2) has a note from daughter on her tray table reminding (R2) to use her call light when she wants to get up." On 11/2/21, R2's plan of care was updated to reflect the addition of Dycem (a non-slip material) which was placed between the wheelchair and the (wheelchair) cushion. A comprehensive review of R2's falls was completed with the IDT. R3 – R3's plan of care was updated with the following interventions: On 11/1/21, R3's plan of care was updated to reflect the addition of Dycem (a non-slip material) which was placed between the cushion and recliner to prevent cushion movement. A comprehensive review of R3's falls was completed with the IDT. On 11/2/21, re-education was initiated for all staff for falls, which included documenting information to the circumstances of the fall, identifying causative factors, identifying interventions,	

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F 689	Continued From page 2 a pattern of falls was the reason for the evaluation and interventions listed as above in care plan in addition to pain management involvement, pressure reduction cushion in wheelchair, scoop mattress on bed, risk and consequences for self-transferring, self- toileting and refusing assistive devices with ambulation in room, refusal of pull ups, and refusal of gripper socks. R5 has had 10 recent falls which resulted in minor injuries and a fracture. The following falls were reviewed and lacked evidence of a post fall root cause analysis and implementation of appropriate interventions to reduce likelihood of future falls. -8/12/21: R5 had an unwitnessed fall from wheelchair while reaching for an item on the floor and no injuries were noted at time of fall. The interdisciplinary team (IDT) reviewed fall on 8/19/21, and no patterns were noted, and no new interventions added following the fall. -8/26/21: R5 had an unwitnessed fall from toilet stating she fell asleep and slipped off. There were no injuries noted. The IDT reviewed the fall on 8/26/21, determined self-transferring to be the pattern for R5's falls and no new interventions were added following the fall. -8/30/21: R5 had an unwitnessed fall outside when she slid out of the wheelchair and sustained an abrasion on her right knee which was cleaned, and a band aide was applied. The IDT reviewed fall on 8/30/21, determined self-transferring to be the pattern for R5's falls and no new interventions were added following the fall.	F 689	and updating the plan of care. A further review with nursing leadership was also completed for review of documentation and comprehensive assessment of the incident, interventions in place and reviewing the residents' plan of care. Facility fall policy was reviewed. A checklist was developed and implemented to facilitate completion of necessary documentation and follow-up by nursing staff in response to a resident fall. Random chart audits will be completed throughout the units within facility to ensure the checklist is utilized, a comprehensive assessment of the incident is completed, and interventions are in place and identified within the residents' plan of care. The Audits will be completed weekly for one month, then monthly until reviewed at quarterly Quality Assurance committee. The Director of Nursing and/or designee will report the findings of the audits at the quarterly "Quality Assurance" committee and determine if further interventions are warranted as well as to determine the frequency for ongoing audits.	

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F 689	Continued From page 3	F 689		

-9/3/21: R5 had an unwitnessed fall while attempting to transfer from wheelchair to her bed. There were no injuries noted at the time of R5's fall. The IDT reviewed the fall on 9/3/21, determined self-transferring to be the pattern and no new interventions were added following the fall.

-9/4/21: R5 had an unwitnessed fall in resident's bathroom on 9/4/21, at 7:45 a.m. when she slipped from the wheelchair. R5's wheelchair cushion was removed from wheelchair "as it extends beyond wheelchair seat giving resident false sense of security as to where actual seat of wheelchair ends." R5's medical record lacked evidence a post fall assessment was completed following R5's fall on 9/4/21.

-9/13/21: R5 had an unwitnessed fall from bed attempting to transfer to the toilet and no injuries were noted. The IDT reviewed the fall on 9/13/21, determined self-transferring to be the pattern and no new interventions were added following the fall.

-10/15/21: R5 had an unwitnessed fall in room while attempting to pull pants up and no injuries were noted. Post Fall lacked evidence IDT reviewed fall and no new interventions were added following the fall.

-10/17/21: R5 had an unwitnessed fall from bed while attempting to transfer into wheelchair to use the bathroom and R5 reported she hit the back of her head. Post Fall lacked evidence the IDT reviewed the fall, and no new interventions were added following the fall.

-10/19/21: R5 had an unwitnessed fall near the

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F 689	Continued From page 4	F 689		

bed in her room and no injuries were noted at the time of the fall. Post Fall lacked evidence IDT reviewed the fall and no new interventions were added following the fall.

-10/21/21: R5 had an unwitnessed fall in room while attempting to pull up pants and reported discomfort and pain to right knee. R5 was reminded to call for assistance "with these tasks" and an ice pack was applied to knee and an oxycodone was given related to knee pain.

R5's progress note dated 10/21/21, at 11:55 a.m. an order from doctor for an x-ray of right knee for increased pain after fall and direct trauma to right knee. On 10/21/21, at 9:24 p.m. doctor was updated on x-ray results showing R5 had a "comminuted distal femoral fracture displaced medially." Further review of R5's progress notes dated 10/22/21, R5 was sent to the orthopedics for evaluation of surgical intervention for right lower extremity fracture. R5 was scheduled to return to the facility on 11/2/21.

On 11/2/21, at 10:36 a.m. nursing assistant (NA)-A indicated R5 was "unstable and super high fall risk and she does not use her call light and will self-transfer all the time." NA-A indicated R5's fall interventions included Dycem to wheelchair, pendant call light, not leaving her on the toilet or during cares, and room changes.

On 11/2/21, at 1:47 p.m. NA-B indicated R5 was at risk for falls, however, likes to be independent and will not utilize call light for staff assistance. NA-B indicated interventions included assist with transferring and toileting, room changes, utilizing a reacher and education to use call light.

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F 689	Continued From page 5	F 689		

On 11/2/21, at 10:56 a.m. dirctor of nursing (DON) indicated the facility knew R5 was a high fall risk on admission and immediately discussed the risk and consequences of self-transferring on admission with resident. Further, DON indicated R5 was "unstable" and was known to not consistently call for assistance from staff. DON confirmed R5's record lacked evidence of interventions implemented following R5's 10 most recent falls.

R2's significant change MDS dated 9/29/21, indicated R2 had diagnosis which included Parkinson's Disease and moderately impaired cognition. Further review of MDS, indicated R2 required total assistance of two staff members for bed mobility, transfers, ambulating in room, toileting, and hygiene.

R2's admission Fall Risk Evaluation dated 8/26/21, identified R2 at risk for falls.

R2's care plan dated 8/26/21, indicated R2 was at risk for injury related to impaired mobility, history of falls, has limited range of motion to bilateral hands, impulsive, does not consistently ask for help or use call light, poor safety awareness, self-transfers, and self-toilets. Interventions for R2's falls included encourage appropriate footwear, monthly medication regime pharmacy review, observe resident for adverse effects of medications in drug regime; obtain lab work as indicated, referrals to physical, occupational and speech therapy, reposition per tissue tolerance, toileting per elimination plan of care, and risk and consequences of self-transfers discussed on 8/26/21 which include falls, minor injuries, fractures, head injuries, up to and including death.

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F 689	Continued From page 6	F 689		

Since admission, R2 has had 4 falls which have resulted in minor injuries. The following falls were reviewed and lacked evidence of a post fall root cause analysis and implementation of appropriate interventions to reduce likelihood of future falls. Review of R2's Post Fall Follow- Up included:

-9/9/21: R2 had an unwitnessed fall from bed when she slipped while "trying to get up". R2 was not wearing socks and was not using her assistive device. R2 reported she "hit her left shoulder and landed on buttocks. Resident also stated she hit her pinkie and ring finger on right hand. Ice pack was given." Further review of Post Fall indicated the IDT met on 9/14/21, determined cognitive loss and Parkinson's diagnoses were the patterns noted to falls and no new interventions were added following the fall.

- 9/18/21: R2 had an unwitnessed fall from her bed while self-transferring. R2 was noted to have a small bump on the left side of her head with a small amount of blood and abrasions were noted to bilateral knees. Further review of Post Fall indicated the IDT met on 9/20/21, determined self-transferring as the pattern noted to R2's falls and no new interventions were added following the fall.

- 9/23/21: R2 had an unwitnessed fall from bed when R2 lost her balance while self-transferring. No injuries were noted and R2 was reminded to use call light for assistance. Further review of Post Fall indicated the IDT met on 9/24/21, determined self-transferring as the pattern noted to R2's falls and no new interventions were added following the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

- 10/9/21: R2 had an unwitnessed fall from bed while self-transferring. R2 reported hitting head "slightly". Further review of Post Fall indicated the IDT met on 10/15/21, determined self-transferring as the pattern noted to R2's falls and intervention was try to re-educate R2 on need for staff to assist her with transfers.

On 10/29/21, at 12:57 p.m. R2 was observed sitting in her transport wheelchair in the dining room and had a pair of shoes on her feet. Further, at 1:23 p.m. R2 was observed in her room lying in bed on her back, bed was at knee height, wearing TED socks, and a soft touch call light on the right side of her bed. On 11/2/21, at 1:54 p.m. R2 was observed in her room lying on her back in bed, bed was low to the floor and resident had gripper socks on feet.

On 10/29/21, at 1:23 p.m. R2 indicated she has had several falls related to "trying to pick something up off the floor and losing balance" and further stated "I am petrified of what can happen to me if I fall face first and land on my face."

On 10/29/21, at 2:04 p.m. registered nurse (RN)-A indicated R2 is at risk for falls and will self-transfer. RN-A was not aware if R2 required the use of gripper socks while in bed, however stated during transfers staff were to ensure R2 had "transferable shoes on".

On 10/29/21, at 2:32 p.m. (NA)-A indicated R2 was "impulsive" and has fallen related to self-transferring. NA-A indicated R2 had impaired cognition at times. When asked about fall interventions, NA-A checked R2's Kardex and confirmed there were no interventions for falls. In

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addition, NA-A indicated R2 should have gripper socks on in bed and shoes on when up in wheelchair.

On 10/29/21, at 3:01 p.m. registered nurse (RN)-B indicated R2 was noted to self-transfer and her cognition may vary. Further, RN-B indicated R2 was a fall risk and interventions included wearing shoes when she is out of bed, observing for side effects, toileting as requests, moved rooms and "that is all I see for her".

On 11/1/21, at 9:53 a.m. Director of Nursing (DON) indicated R2 had impaired cognition and "she is mobile and gets up and moves around a lot." DON confirmed following the 4 falls there were no interventions documented.

On 11/2/21, at 1:47 p.m. NA-B indicated R2 was at risk for falls and interventions included using a transfer belt while transferring, assist of two staff for transferring, always lower the bed to the floor and wear gripper socks due to R3 self-transferring.

R3's quarterly MDS dated 8/26/21, indicated R3 had diagnosis which included dementia and severely impaired cognition. Further review of MDS, indicated R3 required supervision with set up only for most ADLs and limited assist of one staff member for dressing and hygiene.

R3's Fall Risk Evaluation dated 12/1/20, identified R3 for being at risk for falls.

R3's care plan dated 11/18/19, indicated R3 was at risk for injury related to impaired mobility, impaired cognition, diabetic with fluctuating blood sugars, history of falls, impulsive, does not

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consistently ask for assistance or use call light, and poor safety awareness. Interventions for R3's falls included: encourage resident to wear appropriate footwear, monthly medication pharmacy review, observe resident for adverse effects of medication, obtain lab work as indicated, referral to physical, occupational and speech therapies as indicated, reposition per tissue tolerance, toileting per elimination plan of care, risk and consequences of self-transfers discussed on 11/18/19, and offer assistance with transfers and ambulation on overnight 7/20/20.

R3 has had two recent falls which resulted in minor injuries. The following falls were reviewed and lacked evidence of a post fall root cause analysis and implementation of appropriate interventions to reduce likelihood of future falls. Review of R3's Post Fall Follow- Up included:

- 10/23/21: R3 had an unwitnessed fall in his room from the recliner. On 10/29/21, the post fall follow up was not completed and there was no root cause analysis or new interventions added following the fall.
-10/24/21: On 10/29/21, R3's electronic medical record lacked evidence a post fall follow up was completed for R3's fall that occurred on 10/24/21.

R3's progress notes were reviewed:

-10/24/21: Fall occurred on 10/23/21, at 6:15 p.m. when R3 fell by his recliner while he attempted to ambulate to the restroom. R3 was noted to sustain a skin tear on left elbow and Mepilex was applied. Progress note lacked evidence an intervention was added following R3's fall.

-10/24/21: Fall occurred on 10/24/21, at 7:15 p.m.

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when R3 fell near his recliner and R3 indicated he stood to boost himself back in his recliner and slid out. Further, R3 reports "discomfort in ribs" on right side. Progress note lack evidence an intervention was added following R3's fall.

On 10/29/21, at 1:40 p.m. R3 was observed sitting in his room in his recliner. R3 had on shoes and walker was next to recliner.

On 10/29/21, at 1:23 p.m. RN-A indicated R3 "generally has a level of confusion." RN-A indicated she was aware of a recent fall however was not aware of any interventions implemented other than "making sure he is being checked on and needs are being met."

On 10/29/21, at 1:40 p.m. R3 stated that he has not had any falls at the facility.

On 10/29/21, at 2:32 p.m. NA-A indicated R3 was not a fall risk, however was aware of a recent fall and confirmed there were no interventions in place on R3's Kardex other than offering assistance as needed for transfers.

On 10/29/21, at 3:01 p.m. RN-B indicated R3 was at risk for falls and interventions included in R3's care plan was encouraging to wear appropriate shoe, offering assistance with transfers overnight shift, monitoring medications, therapy referrals and "mostly assisting him when he asks for assistance." RN-B confirmed R3's record lacked evidence of interventions added following two recent falls. Following R3's fall on 10/23/21 the post fall is not completed and further stated "there are a couple of residents that have not been completed" and there was not a post fall completed following R3's fall on 10/24/21. In

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addition, RN-B stated "looks like both had to do with the recliner. So, it looks like we need to take a look at his recliner. There were no interventions added for either of those."

On 11/1/21, at 9:53 a.m. DON indicated R3 had cognitive impairments and is a fall risk. DON confirmed that R3's record lacked evidence of implementation of interventions following his two recent falls. Further, DON indicated the reports lack documentation on what caused R3 to fall.

On 11/1/21, at 9:53 a.m. DON indicated staff were expected to follow the fall policy and determine a root cause to implement an appropriate intervention. Further, DON stated there had been leadership changes for the Garden Gate unit that may be a contributing factor to the lack of documentation on the post fall assessments. In addition, DON stated "it is not clearly and concisely documented. I am disappointed and seeing an opportunity to improve."

On 11/2/21, at 3:35 p.m. Administrator indicated the facility's fall policy was to implement an intervention following a fall "as soon after the fall as possible" and the IDT will meet weekly regarding all falls on the unit.

Review of facility policy titled Falls- Long Term Care revised 8/21, indicated "Based on evaluations and current data, the interdisciplinary team will collaborate to identify and implement appropriate interventions related to the resident's specific risk factors and factors contributing to resident's fall history in attempt to prevent the resident from falling, reduce the occurrence of falls and/or minimize complications from falling."

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F 689	Continued From page 12 Further review of facility policy indicated the staff will monitor and document the resident's response to interventions intended to reduce falling or the risks of falling and if the interventions have been successful in preventing falls the staff will continue the interventions, however if the "falls occur despite initial interventions, staff will implement additional or different interventions as applicable or may indicate why the current approach remains relevant."	F 689		

Electronically delivered
November 19, 2021

Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders
Event ID: J8I811

Dear Administrator:

The above facility was surveyed on October 29, 2021 through November 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	C 11/03/2021

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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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 10/29/21 through 11/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5350145C (MN77825) 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,	2 000		

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2 000	Continued From page 2 the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to prevent reoccurring falls for 3 of 4 residents (R5, R2, R3) reviewed who resided in the Gardens Gate Unit. This resulted in harm for R5 when she sustained a right lower extremity fracture after an	2 830	Corrected.	11/29/21

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2 830	Continued From page 3 unwitnessed fall on 10/21/21, and was admitted to hospital for surgical intervention. Findings Include: R5's admission Minimal Data Set (MDS) dated 7/26/21, indicated R5 had diagnoses which included stroke, hemiplegia and no cognitive impairment. Further review of MDS, indicated R5 required limited assistance of one staff member for all activities of daily living (ADLS). R5's care plan dated 7/19/21, indicated R5 was at risk for injury related to impaired mobility, narcotic medication, history of falls, impulsive, does not consistently ask for assistance or use call light, poor safety awareness, self-transfers, self-toilets, self ambulates, and right-side hemiplegia. Interventions for R5's falls included: auto-lock brakes on wheelchair, call staff for items out of reach, Dycem on wheelchair seat, encourage resident to wear appropriate footwear, monthly pharmacy review, observe for adverse side effects, obtain lab work as indicated, referrals to physical, occupation and speech therapy as indicated, reposition per tissue tolerance, and risk and consequences of not reporting falls discussed on 7/19/21. R5's Fall Risk Evaluation dated 8/27/21, indicated a pattern of falls was the reason for the evaluation and interventions listed as above in care plan in addition to pain management involvement, pressure reduction cushion in wheelchair, scoop mattress on bed, risk and consequences for self-transferring, self- toileting and refusing assistive devices with ambulation in room, refusal of pull ups, and refusal of gripper socks.	2 830		

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2 830	Continued From page 4 R5 has had 10 recent falls which resulted in minor injuries and a fracture. The following falls were reviewed and lacked evidence of a post fall root cause analysis and implementation of appropriate interventions to reduce likelihood of future falls. -8/12/21: R5 had an unwitnessed fall from wheelchair while reaching for an item on the floor and no injuries were noted at time of fall. The interdisciplinary team (IDT) reviewed fall on 8/19/21, and no patterns were noted, and no new interventions added following the fall. -8/26/21: R5 had an unwitnessed fall from toilet stating she fell asleep and slipped off. There were no injuries noted. The IDT reviewed the fall on 8/26/21, determined self-transferring to be the pattern for R5's falls and no new interventions were added following the fall. -8/30/21: R5 had an unwitnessed fall outside when she slid out of the wheelchair and sustained an abrasion on her right knee which was cleaned, and a band aide was applied. The IDT reviewed fall on 8/30/21, determined self-transferring to be the pattern for R5's falls and no new interventions were added following the fall. -9/3/21: R5 had an unwitnessed fall while attempting to transfer from wheelchair to her bed. There were no injuries noted at the time of R5's fall. The IDT reviewed the fall on 9/3/21, determined self-transferring to be the pattern and no new interventions were added following the fall. -9/4/21: R5 had an unwitnessed fall in resident's bathroom on 9/4/21, at 7:45 a.m. when she slipped from the wheelchair. R5's wheelchair	2 830		

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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2 830	Continued From page 5 cushion was removed from wheelchair "as it extends beyond wheelchair seat giving resident false sense of security as to where actual seat of wheelchair ends." R5's medical record lacked evidence a post fall assessment was completed following R5's fall on 9/4/21. -9/13/21: R5 had an unwitnessed fall from bed attempting to transfer to the toilet and no injuries were noted. The IDT reviewed the fall on 9/13/21, determined self-transferring to be the pattern and no new interventions were added following the fall. -10/15/21: R5 had an unwitnessed fall in room while attempting to pull pants up and no injuries were noted. Post Fall lacked evidence IDT reviewed fall and no new interventions were added following the fall. -10/17/21: R5 had an unwitnessed fall from bed while attempting to transfer into wheelchair to use the bathroom and R5 reported she hit the back of her head. Post Fall lacked evidence the IDT reviewed the fall, and no new interventions were added following the fall. -10/19/21: R5 had an unwitnessed fall near the bed in her room and no injuries were noted at the time of the fall. Post Fall lacked evidence IDT reviewed the fall and no new interventions were added following the fall. -10/21/21: R5 had an unwitnessed fall in room while attempting to pull up pants and reported discomfort and pain to right knee. R5 was reminded to call for assistance "with these tasks" and an ice pack was applied to knee and an oxycodone was given related to knee pain.	2 830		

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2 830	Continued From page 6 R5's progress note dated 10/21/21, at 11:55 a.m. an order from doctor for an x-ray of right knee for increased pain after fall and direct trauma to right knee. On 10/21/21, at 9:24 p.m. doctor was updated on x-ray results showing R5 had a "comminuted distal femoral fracture displaced medially." Further review of R5's progress notes dated 10/22/21, R5 was sent to the orthopedics for evaluation of surgical intervention for right lower extremity fracture. R5 was scheduled to return to the facility on 11/2/21. On 11/2/21, at 10:36 a.m. nursing assistant (NA)-A indicated R5 was "unstable and super high fall risk and she does not use her call light and will self-transfer all the time." NA-A indicated R5's fall interventions included Dycem to wheelchair, pendant call light, not leaving her on the toilet or during cares, and room changes. On 11/2/21, at 1:47 p.m. NA-B indicated R5 was at risk for falls, however, likes to be independent and will not utilize call light for staff assistance. NA-B indicated interventions included assist with transferring and toileting, room changes, utilizing a reacher and education to use call light. On 11/2/21, at 10:56 a.m. dirctor of nursing (DON) indicated the facility knew R5 was a high fall risk on admission and immediately discussed the risk and consequences of self-transferring on admission with resident. Further, DON indicated R5 was "unstable" and was known to not consistently call for assistance from staff. DON confirmed R5's record lacked evidence of interventions implemented following R5's 10 most recent falls. R2's significant change MDS dated 9/29/21, indicated R2 had diagnosis which included	2 830		

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2 830	Continued From page 7 Parkinson's Disease and moderately impaired cognition. Further review of MDS, indicated R2 required total assistance of two staff members for bed mobility, transfers, ambulating in room, toileting, and hygiene. R2's admission Fall Risk Evaluation dated 8/26/21, identified R2 at risk for falls. R2's care plan dated 8/26/21, indicated R2 was at risk for injury related to impaired mobility, history of falls, has limited range of motion to bilateral hands, impulsive, does not consistently ask for help or use call light, poor safety awareness, self-transfers, and self-toilets. Interventions for R2's falls included encourage appropriate footwear, monthly medication regime pharmacy review, observe resident for adverse effects of medications in drug regime; obtain lab work as indicated, referrals to physical, occupational and speech therapy, reposition per tissue tolerance, toileting per elimination plan of care, and risk and consequences of self-transfers discussed on 8/26/21 which include falls, minor injuries, fractures, head injuries, up to and including death. Since admission, R2 has had 4 falls which have resulted in minor injuries. The following falls were reviewed and lacked evidence of a post fall root cause analysis and implementation of appropriate interventions to reduce likelihood of future falls. Review of R2's Post Fall Follow- Up included: -9/9/21: R2 had an unwitnessed fall from bed when she slipped while "trying to get up". R2 was not wearing socks and was not using her assistive device. R2 reported she "hit her left shoulder and landed on buttocks. Resident also stated she hit her pinkie and ring finger on right	2 830		

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2 830	Continued From page 8	2 830		

hand. Ice pack was given." Further review of Post Fall indicated the IDT met on 9/14/21, determined cognitive loss and Parkinson's diagnoses were the patterns noted to falls and no new interventions were added following the fall.

- 9/18/21: R2 had an unwitnessed fall from her bed while self-transferring. R2 was noted to have a small bump on the left side of her head with a small amount of blood and abrasions were noted to bilateral knees. Further review of Post Fall indicated the IDT met on 9/20/21, determined self-transferring as the pattern noted to R2's falls and no new interventions were added following the fall.

- 9/23/21: R2 had an unwitnessed fall from bed when R2 lost her balance while self-transferring. No injuries were noted and R2 was reminded to use call light for assistance. Further review of Post Fall indicated the IDT met on 9/24/21, determined self-transferring as the pattern noted to R2's falls and no new interventions were added following the fall.

- 10/9/21: R2 had an unwitnessed fall from bed while self-transferring. R2 reported hitting head "slightly". Further review of Post Fall indicated the IDT met on 10/15/21, determined self-transferring as the pattern noted to R2's falls and intervention was try to re-educate R2 on need for staff to assist her with transfers.

On 10/29/21, at 12:57 p.m. R2 was observed sitting in her transport wheelchair in the dining room and had a pair of shoes on her feet. Further, at 1:23 p.m. R2 was observed in her room lying in bed on her back, bed was at knee height, wearing TED socks, and a soft touch call light on the right side of her bed. On 11/2/21, at

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2 830	Continued From page 9 1:54 p.m. R2 was observed in her room lying on her back in bed, bed was low to the floor and resident had gripper socks on feet. On 10/29/21, at 1:23 p.m. R2 indicated she has had several falls related to "trying to pick something up off the floor and losing balance" and further stated "I am petrified of what can happen to me if I fall face first and land on my face." On 10/29/21, at 2:04 p.m. registered nurse (RN)-A indicated R2 is at risk for falls and will self-transfer. RN-A was not aware if R2 required the use of gripper socks while in bed, however stated during transfers staff were to ensure R2 had "transferable shoes on". On 10/29/21, at 2:32 p.m. (NA)-A indicated R2 was "impulsive" and has fallen related to self-transferring. NA-A indicated R2 had impaired cognition at times. When asked about fall interventions, NA-A checked R2's Kardex and confirmed there were no interventions for falls. In addition, NA-A indicated R2 should have gripper socks on in bed and shoes on when up in wheelchair. On 10/29/21, at 3:01 p.m. registered nurse (RN)-B indicated R2 was noted to self-transfer and her cognition may vary. Further, RN-B indicated R2 was a fall risk and interventions included wearing shoes when she is out of bed, observing for side effects, toileting as requests, moved rooms and "that is all I see for her". On 11/1/21, at 9:53 a.m. Director of Nursing (DON) indicated R2 had impaired cognition and "she is mobile and gets up and moves around a lot." DON confirmed following the 4 falls there	2 830		

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2 830	Continued From page 10 were no interventions documented. On 11/2/21, at 1:47 p.m. NA-B indicated R2 was at risk for falls and interventions included using a transfer belt while transferring, assist of two staff for transferring, always lower the bed to the floor and wear gripper socks due to R3 self-transferring. R3's quarterly MDS dated 8/26/21, indicated R3 had diagnosis which included dementia and severely impaired cognition. Further review of MDS, indicated R3 required supervision with set up only for most ADLs and limited assist of one staff member for dressing and hygiene. R3's Fall Risk Evaluation dated 12/1/20, identified R3 for being at risk for falls. R3's care plan dated 11/18/19, indicated R3 was at risk for injury related to impaired mobility, impaired cognition, diabetic with fluctuating blood sugars, history of falls, impulsive, does not consistently ask for assistance or use call light, and poor safety awareness. Interventions for R3's falls included: encourage resident to wear appropriate footwear, monthly medication pharmacy review, observe resident for adverse effects of medication, obtain lab work as indicated, referral to physical, occupational and speech therapies as indicated, reposition per tissue tolerance, toileting per elimination plan of care, risk and consequences of self-transfers discussed on 11/18/19, and offer assistance with transfers and ambulation on overnight 7/20/20. R3 has had two recent falls which resulted in minor injuries. The following falls were reviewed and lacked evidence of a post fall root cause analysis and implementation of appropriate	2 830		

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2 830	Continued From page 11 interventions to reduce likelihood of future falls. Review of R3's Post Fall Follow- Up included: - 10/23/21: R3 had an unwitnessed fall in his room from the recliner. On 10/29/21, the post fall follow up was not completed and there was no root cause analysis or new interventions added following the fall. -10/24/21: On 10/29/21, R3's electronic medical record lacked evidence a post fall follow up was completed for R3's fall that occurred on 10/24/21. R3's progress notes were reviewed: -10/24/21: Fall occurred on 10/23/21, at 6:15 p.m. when R3 fell by his recliner while he attempted to ambulate to the restroom. R3 was noted to sustain a skin tear on left elbow and Mepilex was applied. Progress note lacked evidence an intervention was added following R3's fall. -10/24/21: Fall occurred on 10/24/21, at 7:15 p.m. when R3 fell near his recliner and R3 indicated he stood to boost himself back in his recliner and slid out. Further, R3 reports "discomfort in ribs" on right side. Progress note lack evidence an intervention was added following R3's fall. On 10/29/21, at 1:40 p.m. R3 was observed sitting in his room in his recliner. R3 had on shoes and walker was next to recliner. On 10/29/21, at 1:23 p.m. RN-A indicated R3 "generally has a level of confusion." RN-A indicated she was aware of a recent fall however was not aware of any interventions implemented other than "making sure he is being checked on and needs are being met." On 10/29/21, at 1:40 p.m. R3 stated that he has	2 830		

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2 830	Continued From page 12 not had any falls at the facility. On 10/29/21, at 2:32 p.m. NA-A indicated R3 was not a fall risk, however was aware of a recent fall and confirmed there were no interventions in place on R3's Kardex other than offering assistance as needed for transfers. On 10/29/21, at 3:01 p.m. RN-B indicated R3 was at risk for falls and interventions included in R3's care plan was encouraging to wear appropriate shoe, offering assistance with transfers overnight shift, monitoring medications, therapy referrals and "mostly assisting him when he asks for assistance." RN-B confirmed R3's record lacked evidence of interventions added following two recent falls. Following R3's fall on 10/23/21 the post fall is not completed and further stated "there are a couple of residents that have not been completed" and there was not a post fall completed following R3's fall on 10/24/21. In addition, RN-B stated "looks like both had to do with the recliner. So, it looks like we need to take a look at his recliner. There were no interventions added for either of those." On 11/1/21, at 9:53 a.m. DON indicated R3 had cognitive impairments and is a fall risk. DON confirmed that R3's record lacked evidence of implementation of interventions following his two recent falls. Further, DON indicated the reports lack documentation on what caused R3 to fall. On 11/1/21, at 9:53 a.m. DON indicated staff were expected to follow the fall policy and determine a root cause to implement an appropriate intervention. Further, DON stated there had been leadership changes for the Garden Gate unit that may be a contributing factor to the lack of documentation on the post	2 830		

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2 830	Continued From page 13 fall assessments. In addition, DON stated "it is not clearly and concisely documented. I am disappointed and seeing an opportunity to improve." On 11/2/21, at 3:35 p.m. Administrator indicated the facility's fall policy was to implement an intervention following a fall "as soon after the fall as possible" and the IDT will meet weekly regarding all falls on the unit. Review of facility policy titled Falls- Long Term Care revised 8/21, indicated "Based on evaluations and current data, the interdisciplinary team will collaborate to identify and implement appropriate interventions related to the resident's specific risk factors and factors contributing to resident's fall history in attempt to prevent the resident from falling, reduce the occurrence of falls and/or minimize complications from falling." Further review of facility policy indicated the staff will monitor and document the resident's response to interventions intended to reduce falling or the risks of falling and if the interventions have been successful in preventing falls the staff will continue the interventions, however if the "falls occur despite initial interventions, staff will implement additional or different interventions as applicable or may indicate why the current approach remains relevant." 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. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of	2 830		

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2 830	Continued From page 14 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		