P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 22, 2022

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

RE: CCN: 245359
Cycle Start Date: July 21, 2022

Dear Administrator:

On August 1, 2022, we notified you a remedy was imposed. On August 18, 2022 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 August 17, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 16, 2022 be discontinued as of August 17, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 1, 2022, 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 July 21, 2022. 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

August 22, 2022

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

Re: Reinspection Results
Event ID: 84Q012 and 3E9S12

Dear Administrator:

On August 18, 2022 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 surveys completed on July 21, 2022 and August 2, 2022. 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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Submitted
August 1, 2022

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

RE: CCN: 245359
Cycle Start Date: July 21, 2022

Dear Administrator:

On July 21, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 21, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 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 August 16, 2022.

This Department is also recommending 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 August 16, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 16, 2022 (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pine Haven Care Center Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 21, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 "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, Licensing and Certification Program 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 January 21, 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. BUILDING ______ B. WING ______	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN CARE CENTER INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/18/22, 7/19/22, 7/20/22, and 7/21/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ for F689 began on 4/8/2022, when the facility failed to ensure falls were comprehensively assessed for causal factors/root and failed to implement immediate interventions to prevent and/or mitigate fall risk. The interim administrator, and interim director of nursing (IDON) were notified of the IJ on 7/20/22, at 5:19 p.m. The IJ was removed on 7/21/22, at 4:20 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 7/21/22. The following complaints was found to be SUBSTANTIATED: H53593054C (MN00084809) and H5359088C (MN00082766). The following complaints were found to be unsubstantiated without deficiency: H53593076C (MN00084843), H53593234C (MN00085048), and H53593284C (MN00083493). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed — 08/09/2022

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 000	Continued From page 1 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 substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=K	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 comprehensive fall assessments with root cause analysis, identify patterns of falls, and failed to consistently implement immediate individualized appropriate interventions to prevent additional falls for 3 of 25 residents (R8, R5, R4), who were at high risk for falls. This deficient practice resulted in an immediate jeopardy (IJ) when R8 sustained a fractured neck and ultimate death, R5 who sustained degloving of the hand and a facial laceration requiring emergency room visit, and R4 who sustained a fall with a pelvic fracture. In addition to the resident(s) in immediate jeopardy, the facility failed to comprehensively	F 689	Plan of Correction PINE HAVEN CARE CENTER INC Provider Number: 245359 Survey End Date: 7/21/22 This plan of correction and the responses to each F-tag are submitted to maintain certification in the Medicare Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an	8/17/22

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PINE HAVEN CARE CENTER INC	210 NORTHWEST 3RD STREET PINE ISLAND, MN 55963

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F 689	Continued From page 2 assess each fall for R6 and failed to provide prevention interventions to decrease future falls resulting in the potential for harm to R6. The IJ began on 4/8/22, when R8 had not been comprehensively assessed and individualized apropriate interventions were implemented. The interim administrator and interim director of nursing (IDON), were notified of the IJ on 7/20/22, at 5:19 p.m. The IJ was removed on 7/21/22, at 4:20 p.m. but noncompliance remained at the lower scope and severity level 2 at an E which indicates a pattern and no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings included: R8's, hospital, After Visit Summary (AVS) dated 4/7/22, identified R8 was hospitalized from 3/29/22, until 4/7/22, for increased falls with orthostatic hypotension, new medications to start are midodrine (medication to help with low blood pressure that can cause severe dizziness or fainting), and was not able to walk due to hypotension. R8's admission record, identified R8 was admitted on 4/7/22, with diagnoses that included history of falling, Parkinson's disease, Lewy bodies dementia, restless leg syndrome, abnormalities of gait and mobility, and long term use of anticoagulants. R8's Fall Risk Evaluation, dated 4/7/22, identified R8 was a moderate risk for falls, and indicated interventions of rubber soled shoes for walking and utilize a toileting plan.	F 689	independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F 689 Free of Accident Hazards/Supervision/Devices SS=E Resident #R8 has expired. Resident #R6 no longer resides in the facility due to planned discharge to new location closer to family. Resident #R5 has been reassessed for fall risk. Identified history of falls and trends based upon record review. Completed a historical post-fall assessment which provides detailed summation of contributing factors and potential root cause. Based upon findings, the IDON, Clinical Consultant and IDT have reviewed and updated the care plan to reflect fall prevention strategies. The physician and resident representative have been notified. Resident #R4 has been reassessed for fall risk. Identified history of falls and trends based upon record review. Completed a historical post-fall assessment which provides detailed summation of contributing factors and potential root cause. Based upon findings, the IDON, Clinical Consultant and IDT have reviewed and updated the care plan to reflect fall prevention strategies. The physician and resident representative have been notified. The facility has reviewed all resident records with nursing staff to identify residents who are at high risk for falls. This was completed on 7/19/2022 as part	

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F 689	Continued From page 3 R8's admission, minimum data set (MDS), dated 4/14/22, identified moderate cognitive impairment, exhibited delusions and other behaviors for 1-3 days that significantly interfered with his care and activities. R8 required extensive assistance with activities of daily living (ADL)'s and used a wheelchair for mobility. R8 was occasionally incontinent of bowel and bladder. Further identified R8 had a fall 1 month prior to admit, 1 fall without injury and 1 fall with major injury. R8's, "Physical Therapy (PT) Treatment Encounter Note," dated 4/8/22, identified that R8 reported weakness upon standing for short periods of time. R8's blood pressure was taken in a seated position with a reading of 105/51, upon standing his blood pressure reading was 64/34, after 3 minutes of standing blood pressure rechecked with a reading of 94/49. (Normal blood pressure reading is 120/80). R8's medical record between 4/7/22 to 4/16/22, identified R8 had sustained three falls. Dates of the falls were 4/8/22, which resulted a lumbar spinal fracture, 4/15/22, and 4/16/22. After each fall event, R8's record lacked a comprehensive assessment for causal factors, identification of probable root cause, and immediate appropriate interventions to prevent and/or mitigate risk of recurrent falls. In addition, it was not evident the care plan and/or interventions were evaluated for effectiveness, nor evident the care plan was reviewed or revised after the fall. Following R8's fall on 4/15/22, there was no indication R8 had been assessed for injuries nor evidence the physician was notified. R8's fall on 4/16/22, resulted in death according to his death certifcate.	F 689	of a past non-compliance plan which identified fall prevention program improvement. All residents identified as high risk for falls have had comprehensive fall risk assessments completed by 7/19/2022. Individualized appropriate fall interventions have been added to the care plan as indicated. Staff providing care for those residents have received education on the individual resident fall prevention interventions. The Director of Nursing, responsible for the oversight of the clinical direction and clinical systems of the facility is no longer employed at the facility effective 7/14/2022. The Managing Agent has placed an IDON in the facility. Identified in the SOD as RN – A no longer works at the facility. The facility has reviewed and revised the fall prevention program policies and procedures including comprehensive fall risk assessment, roles and responsibilities to fall response by nursing staff, post fall assessment including that determination of root cause and appropriate immediate interventions to be included on the care plan. The facility Medical Director has reviewed and approved the above policies. On July 18th, the facility initiated a revised daily clinical meeting which includes the review of incidents of falls, root cause(s), interventions, and care plan revisions. A weekly comprehensive fall prevention meeting was initiated by the IDON the	

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F 689	Continued From page 4 R8's Fall Report, dated 4/8/22, at 6:30 a.m. identified R8 had an unwitnessed fall in the bathroom and was found to be incontinent, immediate action taken was R8 was reoriented to the call light usage and hourly safety checks were started. R8's incident report identified the aforementioned information. Despite R8 being found in the bathroom and incontinent, it was not evident R8's toileting plan was assessed or revised. R8's Physician Progress note, dated 4/8/22, identified that prior to admit that R8 had been hospitalized for recurrent falls and had hematuria (blood in the urine) following a transurethral resection of bladder tumor. R8 had several episodes of bilateral limb shaking and decreased level of consciousness and was found to have significant positive orthostatic hypotension. Additionally, describes that R8 had a fall overnight with some back pain this morning that is congruent with findings of sacral and S4 fractures seen back in early March. R8 had reported he needed to use the restroom, could not find his call button, he attempted to get up on his own, and fell from standing height landing on hips without injury. Physician orders were updated to include staff to complete hourly safety checks, due to high risk for falls and history (of falls). R8's fall care plan, dated 4/8/22, identified R8 was at high risk for falls related to confusion, deconditioning, and hypotension. Corresponding interventions included the following: anticipate and meet R8's needs, be sure the call light is within reach and encourage to use it for assist as needed, waist high compression stockings on in	F 689	week of July 18th to include a review of residents at high risk of falls, individual interventions, and trends identified. Upon notification of the immediate jeopardy, education for all nursing staff was initiated immediately related to respective roles and responsibilities for fall prevention (i.e., fall risk assessments, fall response, post fall assessment including investigations, root cause determination, and appropriate immediate interventions including to be placed on the care plan). The facility has configured the POC kiosks on 7/21/2022 so that nursing assistants can access the resident care plan (read only). The facility has set an alert on the system so that the nursing assistants can see when a change was made to the resident's care plan. All resident specific fall interventions have been added to the nursing assistant Kardex. Education to nursing assistants is being provided to nursing staff on the above changes. The facility provided education to licensed nursing staff on accessing and revising the care plan in the electronic health record. The facility has revised the new hire orientation and agency staff orientation to include the falls prevention education in alignment with the facility policies indicated above. An audit of all incidents of falls will be completed by the IDON and/or designee to assure that a comprehensive assessment was completed, determination of root cause, immediate	

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F 689	Continued From page 5 AM and off at HS (bedtime), and hourly checks for safety. R8's progress noted dated 4/9/22, at 9:50 p.m. identified that R8 had increased confusion and staff had to do a 1:1 with R8 since 9:00 p.m. because R8 was caught self-transferring and ambulating in his room three times after supper and had complained of chest pain, increased respirations, shaking and acting non-sensible at times. At 10:30 p.m. R8 was sent to the emergency department (ED) for a change in condition. R8 returned to facility at 3:50 a.m. R8's AVS included an order for CT Pelvis Lumbar Spine on 4/12/22. R8's physician progress note dated 4/13/22, indicated that R8 had an emergency room visit over the weekend related to increased confusion after a fall, imaging was negative for an intracranial bleed, there was a new L1 (lumbar region of the spine) compression fracture and some interval healing at S4 (sacral region of the spine). R8's Sinemet (antiparkinsonian drug) was decreased with thoughts that this could be causing R8's orthostatic hypotension. R8's care plan was not revised to address the new lumbar fracture. R8's progress note dated 4/15/22, at 11:59 p.m. identified that shortly before supper R8 had been fidgety and busy, was self-transferring, pulling his call light out of the wall and trying to "fix" things. R8 was also noted to be dragging his furniture around the room, could not explain to staff why he needed to move these things stating it just needed to be done, was also found walking while holding onto his curtain. R8 was found on the	F 689	individualized interventions were implemented, care plan was updated to reflect changes and staff were communicated with of the changes via the POC system and report process. This audit will be conducted 5 days per week for 2 weeks, weekly for two weeks and monthly until compliance is achieved. The DON and/or designee will conduct random observation audits of care plan fall prevention interventions for those individuals identified as high risk 2 times per week for 4 weeks. Action will be taken immediately as issues are identified and staff education and coaching will be provided. Audit results and actions taken will be reported to the QAPI Committee and the Committees recommendations will be followed. The IDON is responsible for compliance. Date of Alleged Compliance is August 17, 2022.	

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F 689	Continued From page 6 floor in his room seated on his bottom. R8's record did not include any other additional information pertaining to the fall, nor evident the physician was notified. R8's rogress note dated 4/16/22, identified that at 8:45 a.m. R8 was found by a nurse on the floor in his bathroom. R8 was bleeding from a laceration to his left forehead and had a small laceration under his right eye, R8 complained of back pain and was unable to answer questions per his baseline, staff stayed with R8 until emergency services arrived for transport by ambulance to the ED. R8's Minnesota Document of Death was reviewed, and indicated that R8 died at the hospital on 4/20/22, at 5:42 p.m., causes for death indicated, complications of Lewy Body Dementia and blunt force injury to the head and spine from a fall. Date of injury was 4/16/22, at 8:50 a.m. Injury occurred from a fall at standing height. During an interview on 7/20/22, at 1:25 p.m. with the clinical manager (CM) and interim director of nursing (IDON) present, CM verified that R8 had 3 falls during his stay from 4/7/22, to 4/16/22, with no root cause analysis, and no prevention interventions were put in place. CM was not aware of the second fall that occurred until it was brought to her attention by the surveyor. CM further verified R8 was not assessed for injury, no comprehensive assessment was completed and failed to root cause or place prevention interventions for future falls. CM was aware that R8's last fall had resulted in a neck fracture and had passed away.	F 689		

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F 689	Continued From page 7 R5's admission record, identified R5 had diagnoses of psychophysical visual disturbances (visual disturbance in which a person with partial or severe blindness experiences visual hallucinations), polymyositis (inflammatory disease that causes muscle pain and stiffness), osteoarthritis, macular degeneration (eye condition that distorts or causes loss of central vision), glaucoma (eye diseases that can cause vision loss and blindness), and insomnia. R5's significant change, MDS, dated 7/1/22, identified R8 had significant cognitive impairment, exhibited delusions, did not walk, and required extensive assistance of 1-2 staff with ADL's and used a wheelchair for mobility. R5 was occasionally incontinent of bowel and bladder and had 1 fall with injury. R5's fall care plan dated 4/5/21, identified R5 was at risk for falls characterized by history of falls/injury, with multiple risk factors related to diagnoses of hypertension, history of fractures, glaucoma, medication use, required assist with ADL's and the use of an assistive device. Interventions were to: anticipate and meet R5's needs, be sure the call light is within reach, transfer and change positions slowly, wear proper and non-slip footwear, reinforce need to call for assistance, have commonly used articles within easy reach and check R5 frequently to ensure safety. R5's care plan did not identify additional and/or revisions to fall interventions after 4/4/21. R5's fall record was reviewed between 3/1/22, to 7/20/22. R5's record identified R5 had falls on 3/4/22, and 6/19/22, in which both caused injury. R5's record lacked a comprehensive assessment for causal factors/root cause, was not evident	F 689		

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immediate interventions were developed or implemented.

R5's Fall Report dated 3/4/22, at 7:40 a.m. identified R5 was being transferred with an EZ-stand (a type of mechanical lift to assist a patient to and from one area to another) with the help of a nursing assistant (NA) to get to the bathroom. NA stated when she lifted R5 up, R5 lifted her feet up causing her to fall to her knees on the EZ-stand foot plate. This fall resulted in a skin tear to her right lower leg.

R5's record did not include a comprehensive transfer assessment before or after the fall to ensure safety during transfers with a standing mechanical lift.

R5's physician note dated 5/25/22, identified that R5 has had ongoing decline since her COVID diagnosis in April 2022, there was noted functional decline prior to this but has since increased. R5 has gone from the use of an EZ-stand for transfers to a Hoyer lift (full body lift).

R5's Incident Audit Report, dated 6/19/22, identified that R5 was found at 3:30 p.m. on the floor lying against the tray table with the power lift chair tipped on top of her, pressure dressing applied to right wrist and 911 was called R5 was transported to the ER. Injury was a skin tear to the back of the right hand and unable to determine the laceration to the face.

R5's June 2022 treatment administration record (TAR) identified an order for hourly checks while in the recliner from 6/20/22, to 6/29/22. On 6/29/22, the order was changed to hourly checks for safety. The record did not identify why the

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order was changed or identify when the recliner was removed.

R5's progress note dated 6/27/22, identified that the fall from 6/19/22, at 3:30 p.m. identified R5 sustained a degloving (happens when a large piece of skin and the layer of soft tissue right under it partially or completely ripped from your body) injury to her right hand and an injury to the right side of her face and scalp. Root cause of fall was R5 did not use her call light for assistance and improper use of the lift chair. The intervention that was identified was to remove the recliner and use only the Broda chair, care plan updated.

R5's care plan was not updated per the progress note and according to the June TAR documentation, R5 used the recliner on 6/27/22, 6/28/22, and 6/29/22.

During an observation and interview on 7/20/22, at 3:09 p.m., R5 was seated in her Broda chair in her room. A large L-shaped reddened scar was observed on the top of R5's right hand. R5 stated, "Oh, I think it got squashed in something, then they had to wrap it." R5 put her right hand out in front of her and stated, maybe they should rewrap it. R5 indicated she had not had any falls, "I have been pretty lucky". R5 stated she did not have pain, but had a problem with her eyes, "I am going blind, it's been really hard to deal with and has been going on for a couple of years now, there is nothing they can do about it."

During interview on 7/20/22, at 11:59 a.m. with CM and IDON present. CM verified that R5 had 2 falls that were not appropriately root caused, prevention interventions were inappropriate and

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not updated to the care plan. CM stated R5 had impaired cognition and sounded like the first fall R5 did not have the leg strap used for the EZ-stand transfer and that may have contributed to the fall. CM indicated R5 was not reassessed by therapy to determine if the leg strap should be used after the fall. R5 was eventually changed to a Hoyer lift for transfers, and thought the date was maybe 5/20/22. In regard to R5's second fall on 6/27/22, CM indicated R5 may have had access to the remote in her recliner which may have caused her last fall and was not sure if the recliner had been removed from R5's room as it was not updated on the care plan.

R4's admission record, identified R4 was admitted on 9/24/21, with diagnoses of history of falling and right femur fracture, dementia with Lewy bodies, bilateral hearing loss, extrapyramidal and movement disorder (involuntary or uncontrollable movements such as tremors or muscle contractions caused by side effects from certain medications), and abnormal involuntary movements.

R4's significant change, MDS, dated 7/1/22, identified R4 had moderate cognitive impairment, and required extensive assistance of one staff with ADL's and used a walker and wheelchair for mobility. R4 was frequently incontinent of bowel and bladder and had 2 or more falls with no injury.

Review of R4's, fall risk assessments, identified they were done on the follow dates, 9/24/21, 5/24/22, and 7/11/22, identified R4 was at risk for falls and the clinical suggestions were to utilize a toileting plan.

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R4's care plan, dated 4/4/21, identified R4 was at high risk for falls characterized by history pf falls/injury, multiple risk factors that include history of fractures, glaucoma, medication use, required assist with ADL's and use of an assistive device. Interventions were to: anticipate and meet R4's needs, be sure the call light is within reach, transfer and change positions slowly, wear proper and non-slip footwear, reinforce need to call for assistance, have commonly used articles within easy reach and check R4 frequently to ensure safety.

Review of R4's TAR's from March 2022, to July 14, 2022, identified hourly safety checks.

Review of R4's care plan identified no new interventions added since 4/4/21, which was PT/OT consult if needed.

R4's record reviewed from 3/11/22, to 7/19/22, identified R4 had five falls. Every fall lacked a comprehensive assessment to determine identification of root cause/causal factors for implementation of appropriate immediate interventions to prevent falls and/or mitigate the risk. The last fall on 7/2/22, resulted in a right pubic fracture, five day hospitalization and a decline in her ADL's with significant pain requiring narcotic medication to keep pain under control.

R4's progress note dated 3/11/22, identified at 7:00 p.m. R4 was found lying on her left side facing the bedroom door with her head towards the bathroom, R4 stated she was trying to get into her wheelchair, lost her balance and fell, intervention was reminder to use her call light.

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R4's progress note dated 5/10/22, identified at 3:30 a.m. R4 was found lying on the floor just in front of her door entry, R4 was assessed, brought to the bathroom and assisted back to bed.

R4's Fall Follow Up Notation dated 5/19/22, (follow up fall from 5/10/22) identified a root cause of not asking for assistance.

R4's Falls Initial Notation dated 5/27/22, R4 was found on the floor in her room at 10:15 p.m., no root cause identified, prevention intervention was to place her wheelchair next to her bed (intervention was not identified in the care plan).

R4's progress note dated 6/4/22, at 8:00 p.m. identified that R8 fell attempting to get out of her wheelchair.

R4's progress note dated 6/13/22, identified a follow-up for a fall on 5/27/22, root cause identified as not using her call light for assist.

R4's care conference note dated 6/14/22, identified R4 to have moderate cognitive impairment with noted delusions. R4 liked to be up at 6:00 a.m. and in bed by 10:00 p.m.

R4's progress note dated 6/28/22, identified R4 experienced a bit of dizziness after breakfast and was assisted to lay down in bed.

R4's progress note dated 7/2/22, identified that at 1:30 p.m. R4 was found flat on her back leaning towards the left side of the door. R4 had 9/10 pain in her head, left hip, lower back and spine. R4 was oriented to self only. At 2:00 p.m. paramedics arrived to transport to the hospital. At 10:55 p.m. the hospital notified the facility that

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R4 had a pelvic fracture.

R4's Incident Audit Report dated 7/2/22, identified that R4 tripped when she was trying to go to her bed from her wheelchair, (does not identify what R4 tripped over), prevention intervention was to maintain a clear pathway in her room.

R4's progress note dated 7/7/22, identified R4 returned from the hospital on a stretcher at 3:45 p.m. with a pain rating of 8/10 with movement.
.
R4's care conference note dated 7/8/22, identified that R4 is now a Hoyer lift for transfers, takes dilaudid for her pain, and on occasion will experience delusions and hallucinations. Will start PT and OT.

During an observation on 7/18/22, at 4:10 p.m. R4 was noted to be lying on her back in bed, covered with a light quilt with her eyes closed. Bed is in low position and had grip tape strips on the floor in front of the bed. R4's soft touch call light was noted to be lying at the bottom of the bed on R4's left hand side out of her reach.

During an observation and interview on 7/20/22, at 3:18 p.m. R4 was noted to be lying in a low bed with the head of the bed slightly elevated. R4 stated she had pain fromy falling; her elbows both ached, her heels both ached, and this all started when her hips started hurting. R4 indicated her hips hurt from the fall, she hurt her pelvis, and her pain was managed pretty well.

During an interview on 7/20/22, at 10:40 a.m. licensed practical nurse (LPN)-A stated the reason for R4's falls was mostly because she self-transferred, she liked to try and get herself

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into bed, and they try to keep her involved in activities. Her cognition has declined, especially her short-term memory, sometimes she will put her call light on and forget why she put it on. She does not utilize her call light very often since her memory had declined.

During an interview on 7/20/22, at 10:44 a.m. nursing assistant (NA)-A stated R4 was more confused than she used to be. NA-A explained R4 would fall because she self-transferred especially if she has to go to the bathroom or when she tries to get to her bed. For interventions we try and get her in her bed, offer toileting every 2 hours. NA-A indicated an unawareness if scheduled safety checks were in place, stated she would have been notified by a nurse if there was safety checks. As far as R4's cognition goes I would say she is more confused.

During an interview on 7/20/22, at 3:26 p.m. NA-B stated he has worked at the facility for 2 months, was assigned to work as a "float" (not assigned a specific group of residents) and would assist with R4 as needed. NA-B stated R4 had at least one fall and thought her fall interventions were to make sure her floor was not slippery, keep the bed in low position and do every 15 minute checks. NA-B indicated this was done for all residents who had falls (15-minute checks could not be verified as completed in R4's record).

During an interview on 7/20/22, at 3:27 p.m. registered nurse (RN)-A verified he was the nurse for R4 for the evening shift today and was the nurse working on 7/2/22, when R4 last fell. RN-A stated R4 was a high fall risk, her fall intervention was every one hour checks which nurses and NA's were responsible for. RN-A was unable to

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figure out how to access R4's care plan in order to verify the fall interventions in the electronic health record (EHR). RN-A stated R4 was confused and thought staff had to keep reminding R4 to use her call light.

During an interview on 7/20/22, at 3:36 p.m. NA-C stated this was his second day working the floor and was scheduled to work the floor that R4 resided on for the evening shift. NA-C was not aware if R4 ever had any falls and was not able to articulate any of R4's fall interventions. NA-C was able to state R4 was currently upgraded from a Hoyer lift to an EZ-stand for transfers, NA-C thought that R4 maybe had a broken hip.

During an interview on 7/20/22 at 11:37 a.m. CM verified R4 had falls on 3/11/22, 5/10/22, 5/27/22, 6/4/22, and 7/2/22. CM stated R4's fall on 7/2/22, resulted in a right pubic fracture resulting in hospitalization for 4 days, the falls were not appropriately root caused and interventions were not put in place, or updated to the care plan. IDON verified R4's care plan interventions had not been updated since 10/1/21, and stated, we will be having some education on making sure the nurses are more knowledgeable on how to update a care plan.

R6's admission record, identified R6 had diagnoses of history of falling, repeated falls, dementia with behavioral disturbance, hydrocephalus, ataxic gait, syncope and collapse, mixed receptive-expressive language disorder, and collapsed vertebra in lumbar region.

R6's significant change MDS, dated 5/20/22, identified moderate cognitive impairment,

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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) COMPLETION DATE

F 689

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required supervision with eating, limited assist of 1 with bed mobility, walking and locomotion, required extensive assist of 1 with transfers, dressing, toileting and hygiene. Balance during transitions and walking identified that R6 is not steady but able to stabilize without human assistance with the following: moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfer, used a walker for mobility. R6 was frequently incontinent of bowel and bladder and has had 2 or more falls without injury.

R6's discharge assessment, dated 7/6/22, identified R6 had 2 or more falls without injury and had a planned discharge to another nursing home.

R6's care plan for 3/1/22, to 7/6/22, with accurate revision dates was requested and not received by the facility after multiple requests. The care plan that was provided identified interventions with a revision date of 7/20/22, after the resident had been discharged. The care plan identified R6 was at high risk for falls related to gait/balance problems due to a history of falls prior to admission, hypertension, history of TIA's, syncope, insomnia, diabetes, dementia, depression, weakness, and ataxic gait, in addition R6 had a history of falls with a lumbar fracture, will frequently self-transfer without walker and frequently does not use call light or ask for assist. Interventions dated 7/20/22 included anticipate and meet needs, assist to keep clutter off the floor in the bathroom, be sure call light is in use and remind R6 to use it, ensure to wear gripper socks when in bed, ensure shoes are within, reach grip strips in front of recliner and on the

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	245359	A. BUILDING _______ B. WING _______	C 07/21/2022

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floor next to bed
Intervention that included a discernable implementation date included the following:
-Dycem in recliner (start date 11/13/2020)
-Hourly safety checks (start date 6/4/21)
-half-hour checks (start date 7/8/21)
-Toilet plan identified to check and change for incontinence every 2 hours, offer to go to the bathroom (start 9/13/21)

R6's physician visit dated 3/4/22, was reviewed and indicated that R6 had fallen at least 7 times in 2021, and again on 2/20/22.

Review of R6's fall risk assessments indicated R6 was at risk for falls and were completed on the following dates, 3/17/22, 5/11/22, 5/12/22, 5/14/22, 5/17/22, 5/18/22, 6/11/22, 6/20/22, and 6/27/22. The clinical suggestions were to utilize, personal/pressure sensor alarms and nonskid footwear for use with ambulation.

Review of R6's medical record identified, R6 had seven falls between 3/15/22, to 6/27/22. All falls were unwitnessed and in her room. All falls lacked a comprehensive assessment, lacked identification of accurate root cause/causal factors, was not evident immediate interventions were implemented, and the care plan was not revised. R6 did not sustain any significant injuries.

R6's fall record documentation included the following:

-3/17/22, at 5:56 a.m. R6 was found on her right side on the floor in her room, bump noted to the back of her head and R6 refused to go to the ER, did not have shoes on and stated she was trying to get into the recliner. Root cause was R6 failed

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to have gripper socks on and failed to use her call light, and no new intervention was provided.

-5/11/22, at 8:00 p.m. R6 was found on the floor in her bathroom, had told staff she was feeling ill and had an emesis. Root cause identified as R6 failed to use her call light, no intervention provided.

-5/14/22, at 4:37 p.m. R6 was found on the floor between her bed and recliner. Root cause identified as R6 failed to use her call light, no intervention provided.

-6/9/22, at 9:00 p.m. R6 was found lying in the middle of her floor, complained of level 7/10 pain to her right upper arm. R6 was walking from her bathroocm to her closet carrying long pajamas. Root cause identified as R6 failed to use her call light, no intervention provided.

-6/11/22, at 10:45 p.m. R6 was found on the floor in front of her recliner, R6 stated she slid out of her chair, does not identify if Dycem was used per her care plan. R6 was noted to be incontinent at the time. Root cause identified as R6 failed to use her call light, no intervention provided.

-6/20/22, at 8:30 p.m. R6 found sitting on the floor of her room in between the closet and her recliner with her back against the wall, stated she was trying to grab something out of the closet. R6 was noted to be oriented to person and situation only per her baseline. Root cause identified as R6 did not ask for assist and was trying to get something out of the closet, no new prevention intervention was identified.

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-6/27/22, at 5:47 p.m. R6 could be heard from the hallway calling for help, was found in her room on the doorway of the bathroom floor, R6 complained of pain in her right upper arm. Root cause identified as R6 failed to use her call light, no intervention provided.

During interview on 7/20/22, at 11:06, a.m. with CM and IDON present. CM indicated after a resident would have a fall, the floor nurse would immediately assess the resident for injury, when safe the resident would be transferred with a Hoyer lift to either the chair or the bed. The floor nurse would be responsible for the documentation in the record, which would include assessment, identification of root cause, and the new intervention. The care plan would then be updated to reflect the new intervention. All department heads meet every morning Monday through Friday to discuss incidents in risk management, this would include falls. CM further stated we don't really discuss the root cause of falls, there is not a section in risk management for that, we never really discuss that. The floor nurse is responsible for that.

During an interview on 7/20/22, at 1:51 p.m. with the CM and IDON present, CM verified that R6 had 7 falls during her stay from 3/17/22, to 6/27/22, with no root cause analysis, and no prevention interventions that were put into place. CM further verified this by looking at the dates on R6's care plan with no new interventions noted. CM stated that R6 had a planned discharge to another nursing home that happened on 7/6/22.

The immediate jeopardy that began on 4/8/22 was removed on 7/21/22, at 4:20 p.m. when the facility educated their staff on the policy and

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procedures related to the fall process, R4 and R5's falls were comprehensively assess and care plans were reviewed and revised with appropriate interventions. In addition residents were identified that were at high risk for falls and assessments were completed with necessary care plan revisions. Noncompliance remained at the lower scope and severity level 2, an E-scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Facility Policy, "Fall Prevention and Reduction," reviewed 7/2022, indicated, Individual fall precautions and interventions will be developed for all residents who admit to a facility. All falls will be reviewed, and preventative measures will be taken to decrease falls whenever possible to prevent injury. Interventions will be identified related to the residents' specific risks and causes in order to reduce falling and to try to minimize complications from falling. All residents are assessed for fall risk. All falls will be analyzed to determine the root cause of the fall.

Procedure for Resident Fall:
1. A licensed nurse will evaluate resident's pain, range of motion and level on consciousness or change in cognition level before moving or assisting resident to a safer position.
2. Keep resident comfortable and avoid moving if there is suspected fracture.
3. A resident on the floor should not be "lifted" from the floor. Mechanical lift equipment is to be used to lift a resident to a chair or a bed.
4. Vital signs will be completed after all fall events; if possible, complete orthostatic blood pressure comparison.
5. If resident is diabetic, blood glucose levels

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should be determined.
6. Perform a skin and wound check.
7. If on anticoagulant and head strike suspected, or falls unwitnessed, note last INR reading and current dose.
8. If fall is unwitnessed or resident hits head, neurological checks will be initiated.
9. Complete post fall huddle with staff working on the unit where the resident fell.
10. Seek immediate medical care if needed: notify provider and seek orders or call 911 if the situation demands the need.
11. Notify the provider immediately for all resident falls.
12. Notify the administrator and DN immediately if the resident has a change in condition after a fall or resident hit their head.
13. Notify the administrator and the DON by office phone and leave message if no injury from the fall, no head strike.
14. Notify the administrator and the DON immediately if the resident requires transport to the hospital within 72 hours of a fall. Includes evenings, nights and weekends.
15. Contact the resident representative on same shift for all resident falls.
16. Document the fall in risk management using appropriate fall progress note.
17. Determine the root cause as to why the resident fell and implement intervention specific to the cause of the fall.
18. Start immediate intervention to attempt to prevent further falls. (See fall intervention list.)
19. Update the care plan and the Kardex with the fall intervention.
20. Hall nurse to complete the fall risk assessment after the fall to identify the new or changing risk factors for resident fall.
21. Hall nurses begin documentation for Falls

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F 689	Continued From page 22 Follow up Notation a minimum of once per shift for 72 hours. Complete VS ROM, neurological checks (if required). 22. Nurse Manager for designee is responsible to ensure the completion of the Risk Management for a fall. Procedure for Fall Risk Assessment: 1. A fall risk assessment will be completed at the following times: upon admission, prior to annual MDS, quarterly (reviewed), significant change and following a resident fall. 2. Implement appropriate interventions/precautions. All member of the interdisciplinary team will participate and contribute to the plan of care with resident specifics fall reduction efforts. 3. The resident representative will be notified of the residents falls as appropriate. 4. Provider will be notified as appropriate.	F 689		

Electronically delivered
August 1, 2022

Administrator
Pine Haven Care Center Inc
210 Northwest 3rd Street
Pine Island, MN 55963

Re: State Nursing Home Licensing Orders
Event ID: 84Q011

Dear Administrator:

The above facility was surveyed on July 18, 2022 through July 21, 2022 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00148	A. BUILDING: ______ B. WING ______	C 07/21/2022

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 7/18/22, 7/19/22, 7/20/22 and 7/21/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H53593054C (MN84809) and H5359088C (MN 82766) with a licensing order issued at 0830. The following complaints were found to be UNSUBSTANTIATED: H53593076C (MN84843), H53593234C (MN85048), and H53593284C (MN83493) with no licensing orders issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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 assessments with root cause analysis, identify patterns of falls, and failed to consistently implement immediate individualized	2 830	Corrected	8/15/22

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appropriate interventions to prevent additional falls for 3 of 25 residents (R8, R5, R4), who were at high risk for falls. This deficient practice resulted in an immediate jeopardy (IJ) when R8 sustained a fractured neck and ultimate death, R5 who sustained degloving of the hand and a facial laceration requiring emergency room visit, and R4 who sustained a fall with a pelvic fracture. In addition to the resident(s) in immediate jeopardy, the facility failed to comprehensively assess each fall for R6 and failed to provide prevention interventions to decrease future falls resulting in the potential for harm to R6.

The IJ began on 4/8/22, when R8 had not been comprehensively assessed and individualized apropriate interventions were implemented. The interim administrator and interim director of nursing (IDON), were notified of the IJ on 7/20/22, at 5:19 p.m. The IJ was removed on 7/21/22, at 4:20 p.m. but noncompliance remained at the lower scope and severity level 2 at an E which indicates a pattern and no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings included:

R8's, hospital, After Visit Summary (AVS) dated 4/7/22, identified R8 was hospitalized from 3/29/22, until 4/7/22, for increased falls with orthostatic hypotension, new medications to start are midodrine (medication to help with low blood pressure that can cause severe dizziness or fainting), and was not able to walk due to hypotension.

R8's admission record, identified R8 was admitted on 4/7/22, with diagnoses that included

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2 830	Continued From page 4	2 830		

history of falling, Parkinson's disease, Lewy bodies dementia, restless leg syndrome, abnormalities of gait and mobility, and long term use of anticoagulants.

R8's Fall Risk Evaluation, dated 4/7/22, identified R8 was a moderate risk for falls, and indicated interventions of rubber soled shoes for walking and utilize a toileting plan.

R8's admission, minimum data set (MDS), dated 4/14/22, identified moderate cognitive impairment, exhibited delusions and other behaviors for 1-3 days that significantly interfered with his care and activities. R8 required extensive assistance with activities of daily living (ADL)'s and used a wheelchair for mobility. R8 was occasionally incontinent of bowel and bladder. Further identified R8 had a fall 1 month prior to admit, 1 fall without injury and 1 fall with major injury.

R8's, "Physical Therapy (PT) Treatment Encounter Note," dated 4/8/22, identified that R8 reported weakness upon standing for short periods of time. R8's blood pressure was taken in a seated position with a reading of 105/51, upon standing his blood pressure reading was 64/34, after 3 minutes of standing blood pressure rechecked with a reading of 94/49. (Normal blood pressure reading is 120/80).

R8's medical record between 4/7/22 to 4/16/22, identified R8 had sustained three falls. Dates of the falls were 4/8/22, which resulted a lumbar spinal fracture, 4/15/22, and 4/16/22. After each fall event, R8's record lacked a comprehensive assessment for causal factors, identification of probable root cause, and immediate appropriate interventions to prevent and/or mitigate risk of

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recurrent falls. In addition, it was not evident the care plan and/or interventions were evaluated for effectiveness, nor evident the care plan was reviewed or revised after the fall. Following R8's fall on 4/15/22, there was no indication R8 had been assessed for injuries nor evidence the physician was notified. R8's fall on 4/16/22, resulted in death according to his death certifcate.

R8's Fall Report, dated 4/8/22, at 6:30 a.m. identified R8 had an unwitnessed fall in the bathroom and was found to be incontinent, immediate action taken was R8 was reoriented to the call light usage and hourly safety checks were started. R8's incident report identified the aforementioned information. Despite R8 being found in the bathroom and incontinent, it was not evident R8's toileting plan was assessed or revised.

R8's Physician Progress note, dated 4/8/22, identified that prior to admit that R8 had been hospitalized for recurrent falls and had hematuria (blood in the urine) following a transurethral resection of bladder tumor. R8 had several episodes of bilateral limb shaking and decreased level of consciousness and was found to have significant positive orthostatic hypotension. Additionally, describes that R8 had a fall overnight with some back pain this morning that is congruent with findings of sacral and S4 fractures seen back in early March. R8 had reported he needed to use the restroom, could not find his call button, he attempted to get up on his own, and fell from standing height landing on hips without injury. Physician orders were updated to include staff to complete hourly safety checks, due to high risk for falls and history (of falls).

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2 830	Continued From page 6 R8's fall care plan, dated 4/8/22, identified R8 was at high risk for falls related to confusion, deconditioning, and hypotension. Corresponding interventions included the following: anticipate and meet R8's needs, be sure the call light is within reach and encourage to use it for assist as needed, waist high compression stockings on in AM and off at HS (bedtime), and hourly checks for safety. R8's progress noted dated 4/9/22, at 9:50 p.m. identified that R8 had increased confusion and staff had to do a 1:1 with R8 since 9:00 p.m. because R8 was caught self-transferring and ambulating in his room three times after supper and had complained of chest pain, increased respirations, shaking and acting non-sensible at times. At 10:30 p.m. R8 was sent to the emergency department (ED) for a change in condition. R8 returned to facility at 3:50 a.m. R8's AVS included an order for CT Pelvis Lumbar Spine on 4/12/22. R8's physician progress note dated 4/13/22, indicated that R8 had an emergency room visit over the weekend related to increased confusion after a fall, imaging was negative for an intracranial bleed, there was a new L1 (lumbar region of the spine) compression fracture and some interval healing at S4 (sacral region of the spine). R8's Sinemet (antiparkinsonian drug) was decreased with thoughts that this could be causing R8's orthostatic hypotension. R8's care plan was not revised to address the new lumbar fracture. R8's progress note dated 4/15/22, at 11:59 p.m. identified that shortly before supper R8 had been fidgety and busy, was self-transferring, pulling his	2 830		

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call light out of the wall and trying to "fix" things. R8 was also noted to be dragging his furniture around the room, could not explain to staff why he needed to move these things stating it just needed to be done, was also found walking while holding onto his curtain. R8 was found on the floor in his room seated on his bottom. R8's record did not include any other additional information pertaining to the fall, nor evident the physician was notified.

R8's rogress note dated 4/16/22, identified that at 8:45 a.m. R8 was found by a nurse on the floor in his bathroom. R8 was bleeding from a laceration to his left forehead and had a small laceration under his right eye, R8 complained of back pain and was unable to answer questions per his baseline, staff stayed with R8 until emergency services arrived for transport by ambulance to the ED.

R8's Minnesota Document of Death was reviewed, and indicated that R8 died at the hospital on 4/20/22, at 5:42 p.m., causes for death indicated, complications of Lewy Body Dementia and blunt force injury to the head and spine from a fall. Date of injury was 4/16/22, at 8:50 a.m. Injury occurred from a fall at standing height.

During an interview on 7/20/22, at 1:25 p.m. with the clinical manager (CM) and interim director of nursing (IDON) present, CM verified that R8 had 3 falls during his stay from 4/7/22, to 4/16/22, with no root cause analysis, and no prevention interventions were put in place. CM was not aware of the second fall that occurred until it was brought to her attention by the surveyor. CM further verified R8 was not assessed for injury, no comprehensive assessment was completed and

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failed to root cause or place prevention interventions for future falls. CM was aware that R8's last fall had resulted in a neck fracture and had passed away.

R5's admission record, identified R5 had diagnoses of psychophysical visual disturbances (visual disturbance in which a person with partial or severe blindness experiences visual hallucinations), polymyositis (inflammatory disease that causes muscle pain and stiffness), osteoarthritis, macular degeneration (eye condition that distorts or causes loss of central vision), glaucoma (eye diseases that can cause vision loss and blindness), and insomnia.

R5's significant change, MDS, dated 7/1/22, identified R8 had significant cognitive impairment, exhibited delusions, did not walk, and required extensive assistance of 1-2 staff with ADL's and used a wheelchair for mobility. R5 was occasionally incontinent of bowel and bladder and had 1 fall with injury.

R5's fall care plan dated 4/5/21, identified R5 was at risk for falls characterized by history of falls/injury, with multiple risk factors related to diagnoses of hypertension, history of fractures, glaucoma, medication use, required assist with ADL's and the use of an assistive device. Interventions were to: anticipate and meet R5's needs, be sure the call light is within reach, transfer and change positions slowly, wear proper and non-slip footwear, reinforce need to call for assistance, have commonly used articles within easy reach and check R5 frequently to ensure safety. R5's care plan did not identify additional and/or revisions to fall interventions after 4/4/21.

R5's fall record was reviewed between 3/1/22, to

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7/20/22. R5's record identified R5 had falls on 3/4/22, and 6/19/22, in which both caused injury. R5's record lacked a comprehensive assessment for causal factors/root cause, was not evident immediate interventions were developed or implemented.

R5's Fall Report dated 3/4/22, at 7:40 a.m. identified R5 was being transferred with an EZ-stand (a type of mechanical lift to assist a patient to and from one area to another) with the help of a nursing assistant (NA) to get to the bathroom. NA stated when she lifted R5 up, R5 lifted her feet up causing her to fall to her knees on the EZ-stand foot plate. This fall resulted in a skin tear to her right lower leg.

R5's record did not include a comprehensive transfer assessment before or after the fall to ensure safety during transfers with a standing mechanical lift.

R5's physician note dated 5/25/22, identified that R5 has had ongoing decline since her COVID diagnosis in April 2022, there was noted functional decline prior to this but has since increased. R5 has gone from the use of an EZ-stand for transfers to a Hoyer lift (full body lift).

R5's Incident Audit Report, dated 6/19/22, identified that R5 was found at 3:30 p.m. on the floor lying against the tray table with the power lift chair tipped on top of her, pressure dressing applied to right wrist and 911 was called R5 was transported to the ER. Injury was a skin tear to the back of the right hand and unable to determine the laceration to the face.

R5's June 2022 treatment administration record (TAR) identified an order for hourly checks while

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in the recliner from 6/20/22, to 6/29/22. On 6/29/22, the order was changed to hourly checks for safety. The record did not identify why the order was changed or identify when the recliner was removed.

R5's progress note dated 6/27/22, identified that the fall from 6/19/22, at 3:30 p.m. identified R5 sustained a degloving (happens when a large piece of skin and the layer of soft tissue right under it partially or completely ripped from your body) injury to her right hand and an injury to the right side of her face and scalp. Root cause of fall was R5 did not use her call light for assistance and improper use of the lift chair. The intervention that was identified was to remove the recliner and use only the Broda chair, care plan updated.

R5's care plan was not updated per the progress note and according to the June TAR documentation, R5 used the recliner on 6/27/22, 6/28/22, and 6/29/22.

During an observation and interview on 7/20/22, at 3:09 p.m., R5 was seated in her Broda chair in her room. A large L-shaped reddened scar was observed on the top of R5's right hand. R5 stated, "Oh, I think it got squashed in something, then they had to wrap it." R5 put her right hand out in front of her and stated, maybe they should rewrap it. R5 indicated she had not had any falls, "I have been pretty lucky". R5 stated she did not have pain, but had a problem with her eyes, "I am going blind, it's been really hard to deal with and has been going on for a couple of years now, there is nothing they can do about it."

During interview on 7/20/22, at 11:59 a.m. with CM and IDON present. CM verified that R5 had 2

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falls that were not appropriately root caused, prevention interventions were inappropriate and not updated to the care plan. CM stated R5 had impaired cognition and sounded like the first fall R5 did not have the leg strap used for the EZ-stand transfer and that may have contributed to the fall. CM indicated R5 was not reassessed by therapy to determine if the leg strap should be used after the fall. R5 was eventually changed to a Hoyer lift for transfers, and thought the date was maybe 5/20/22. In regard to R5's second fall on 6/27/22, CM indicated R5 may have had access to the remote in her recliner which may have caused her last fall and was not sure if the recliner had been removed from R5's room as it was not updated on the care plan.

R4's admission record, identified R4 was admitted on 9/24/21, with diagnoses of history of falling and right femur fracture, dementia with Lewy bodies, bilateral hearing loss, extrapyramidal and movement disorder (involuntary or uncontrollable movements such as tremors or muscle contractions caused by side effects from certain medications), and abnormal involuntary movements.

R4's significant change, MDS, dated 7/1/22, identified R4 had moderate cognitive impairment, and required extensive assistance of one staff with ADL's and used a walker and wheelchair for mobility. R4 was frequently incontinent of bowel and bladder and had 2 or more falls with no injury.

Review of R4's, fall risk assessments, identified they were done on the follow dates, 9/24/21, 5/24/22, and 7/11/22, identified R4 was at risk for falls and the clinical suggestions were to utilize a

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2 830	Continued From page 12 toileting plan. R4's care plan, dated 4/4/21, identified R4 was at high risk for falls characterized by history pf falls/injury, multiple risk factors that include history of fractures, glaucoma, medication use, required assist with ADL's and use of an assistive device. Interventions were to: anticipate and meet R4's needs, be sure the call light is within reach, transfer and change positions slowly, wear proper and non-slip footwear, reinforce need to call for assistance, have commonly used articles within easy reach and check R4 frequently to ensure safety. Review of R4's TAR's from March 2022, to July 14, 2022, identified hourly safety checks. Review of R4's care plan identified no new interventions added since 4/4/21, which was PT/OT consult if needed. R4's record reviewed from 3/11/22, to 7/19/22, identified R4 had five falls. Every fall lacked a comprehensive assessment to determine identification of root cause/causal factors for implementation of appropriate immediate interventions to prevent falls and/or mitigate the risk. The last fall on 7/2/22, resulted in a right pubic fracture, five day hospitalization and a decline in her ADL's with significant pain requiring narcotic medication to keep pain under control. R4's progress note dated 3/11/22, identified at 7:00 p.m. R4 was found lying on her left side facing the bedroom door with her head towards the bathroom, R4 stated she was trying to get into her wheelchair, lost her balance and fell, intervention was reminder to use her call light.	2 830		

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2 830	Continued From page 13 R4's progress note dated 5/10/22, identified at 3:30 a.m. R4 was found lying on the floor just in front of her door entry, R4 was assessed, brought to the bathroom and assisted back to bed. R4's Fall Follow Up Notation dated 5/19/22, (follow up fall from 5/10/22) identified a root cause of not asking for assistance. R4's Falls Initial Notation dated 5/27/22, R4 was found on the floor in her room at 10:15 p.m., no root cause identified, prevention intervention was to place her wheelchair next to her bed (intervention was not identified in the care plan). R4's progress note dated 6/4/22, at 8:00 p.m. identified that R8 fell attempting to get out of her wheelchair. R4's progress note dated 6/13/22, identified a follow-up for a fall on 5/27/22, root cause identified as not using her call light for assist. R4's care conference note dated 6/14/22, identified R4 to have moderate cognitive impairment with noted delusions. R4 liked to be up at 6:00 a.m. and in bed by 10:00 p.m. R4's progress note dated 6/28/22, identified R4 experienced a bit of dizziness after breakfast and was assisted to lay down in bed. R4's progress note dated 7/2/22, identified that at 1:30 p.m. R4 was found flat on her back leaning towards the left side of the door. R4 had 9/10 pain in her head, left hip, lower back and spine. R4 was oriented to self only. At 2:00 p.m. paramedics arrived to transport to the hospital. At 10:55 p.m. the hospital notified the facility that R4 had a pelvic fracture.	2 830		

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2 830	Continued From page 14 R4's Incident Audit Report dated 7/2/22, identified that R4 tripped when she was trying to go to her bed from her wheelchair, (does not identify what R4 tripped over), prevention intervention was to maintain a clear pathway in her room. R4's progress note dated 7/7/22, identified R4 returned from the hospital on a stretcher at 3:45 p.m. with a pain rating of 8/10 with movement. . R4's care conference note dated 7/8/22, identified that R4 is now a Hoyer lift for transfers, takes dilaudid for her pain, and on occasion will experience delusions and hallucinations. Will start PT and OT. During an observation on 7/18/22, at 4:10 p.m. R4 was noted to be lying on her back in bed, covered with a light quilt with her eyes closed. Bed is in low position and had grip tape strips on the floor in front of the bed. R4's soft touch call light was noted to be lying at the bottom of the bed on R4's left hand side out of her reach. During an observation and interview on 7/20/22, at 3:18 p.m. R4 was noted to be lying in a low bed with the head of the bed slightly elevated. R4 stated she had pain fromy falling; her elbows both ached, her heels both ached, and this all started when her hips started hurting. R4 indicated her hips hurt from the fall, she hurt her pelvis, and her pain was managed pretty well. During an interview on 7/20/22, at 10:40 a.m. licensed practical nurse (LPN)-A stated the reason for R4's falls was mostly because she self-transferred, she liked to try and get herself into bed, and they try to keep her involved in activities. Her cognition has declined, especially	2 830		

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her short-term memory, sometimes she will put her call light on and forget why she put it on. She does not utilize her call light very often since her memory had declined.

During an interview on 7/20/22, at 10:44 a.m. nursing assistant (NA)-A stated R4 was more confused than she used to be. NA-A explained R4 would fall because she self-transferred especially if she has to go to the bathroom or when she tries to get to her bed. For interventions we try and get her in her bed, offer toileting every 2 hours. NA-A indicated an unawareness if scheduled safety checks were in place, stated she would have been notified by a nurse if there was safety checks. As far as R4's cognition goes I would say she is more confused.

During an interview on 7/20/22, at 3:26 p.m. NA-B stated he has worked at the facility for 2 months, was assigned to work as a "float" (not assigned a specific group of residents) and would assist with R4 as needed. NA-B stated R4 had at least one fall and thought her fall interventions were to make sure her floor was not slippery, keep the bed in low position and do every 15 minute checks. NA-B indicated this was done for all residents who had falls (15-minute checks could not be verified as completed in R4's record).

During an interview on 7/20/22, at 3:27 p.m. registered nurse (RN)-A verified he was the nurse for R4 for the evening shift today and was the nurse working on 7/2/22, when R4 last fell. RN-A stated R4 was a high fall risk, her fall intervention was every one hour checks which nurses and NA's were responsible for. RN-A was unable to figure out how to access R4's care plan in order to verify the fall interventions in the electronic health record (EHR). RN-A stated R4 was

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confused and thought staff had to keep reminding R4 to use her call light.

During an interview on 7/20/22, at 3:36 p.m. NA-C stated this was his second day working the floor and was scheduled to work the floor that R4 resided on for the evening shift. NA-C was not aware if R4 ever had any falls and was not able to articulate any of R4's fall interventions. NA-C was able to state R4 was currently upgraded from a Hoyer lift to an EZ-stand for transfers, NA-C thought that R4 maybe had a broken hip.

During an interview on 7/20/22 at 11:37 a.m. CM verified R4 had falls on 3/11/22, 5/10/22, 5/27/22, 6/4/22, and 7/2/22. CM stated R4's fall on 7/2/22, resulted in a right pubic fracture resulting in hospitalization for 4 days, the falls were not appropriately root caused and interventions were not put in place, or updated to the care plan. IDON verified R4's care plan interventions had not been updated since 10/1/21, and stated, we will be having some education on making sure the nurses are more knowledgeable on how to update a care plan.

R6's admission record, identified R6 had diagnoses of history of falling, repeated falls, dementia with behavioral disturbance, hydrocephalus, ataxic gait, syncope and collapse, mixed receptive-expressive language disorder, and collapsed vertebra in lumbar region.

R6's significant change MDS, dated 5/20/22, identified moderate cognitive impairment, required supervision with eating, limited assist of 1 with bed mobility, walking and locomotion, required extensive assist of 1 with transfers, dressing, toileting and hygiene. Balance during

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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 17 transitions and walking identified that R6 is not steady but able to stabilize without human assistance with the following: moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfer, used a walker for mobility. R6 was frequently incontinent of bowel and bladder and has had 2 or more falls without injury. R6's discharge assessment, dated 7/6/22, identified R6 had 2 or more falls without injury and had a planned discharge to another nursing home. R6's care plan for 3/1/22, to 7/6/22, with accurate revision dates was requested and not received by the facility after multiple requests. The care plan that was provided identified interventions with a revision date of 7/20/22, after the resident had been discharged. The care plan identified R6 was at high risk for falls related to gait/balance problems due to a history of falls prior to admission, hypertension, history of TIA's, syncope, insomnia, diabetes, dementia, depression, weakness, and ataxic gait, in addition R6 had a history of falls with a lumbar fracture, will frequently self-transfer without walker and frequently does not use call light or ask for assist. Interventions dated 7/20/22 included anticipate and meet needs, assist to keep clutter off the floor in the bathroom, be sure call light is in use and remind R6 to use it, ensure to wear gripper socks when in bed, ensure shoes are within, reach grip strips in front of recliner and on the floor next to bed Intervention that included a discernable implementation date included the following: -Dycem in recliner (start date 11/13/2020) -Hourly safety checks (start date 6/4/21)	2 830		

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2 830	Continued From page 18 -half-hour checks (start date 7/8/21) -Toilet plan identified to check and change for incontinence every 2 hours, offer to go to the bathroom (start 9/13/21) R6's physician visit dated 3/4/22, was reviewed and indicated that R6 had fallen at least 7 times in 2021, and again on 2/20/22. Review of R6's fall risk assessments indicated R6 was at risk for falls and were completed on the following dates, 3/17/22, 5/11/22, 5/12/22, 5/14/22, 5/17/22, 5/18/22, 6/11/22, 6/20/22, and 6/27/22. The clinical suggestions were to utilize, personal/pressure sensor alarms and nonskid footwear for use with ambulation. Review of R6's medical record identified, R6 had seven falls between 3/15/22, to 6/27/22. All falls were unwitnessed and in her room. All falls lacked a comprehensive assessment, lacked identification of accurate root cause/causal factors, was not evident immediate interventions were implemented, and the care plan was not revised. R6 did not sustain any significant injuries. R6's fall record documentation included the following: -3/17/22, at 5:56 a.m. R6 was found on her right side on the floor in her room, bump noted to the back of her head and R6 refused to go to the ER, did not have shoes on and stated she was trying to get into the recliner. Root cause was R6 failed to have gripper socks on and failed to use her call light, and no new intervention was provided. -5/11/22, at 8:00 p.m. R6 was found on the floor in her bathroom, had told staff she was feeling ill and had an emesis. Root cause identified as R6	2 830		

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2 830	Continued From page 19	2 830		

failed to use her call light, no intervention provided.

-5/14/22, at 4:37 p.m. R6 was found on the floor between her bed and recliner. Root cause identified as R6 failed to use her call light, no intervention provided.

-6/9/22, at 9:00 p.m. R6 was found lying in the middle of her floor, complained of level 7/10 pain to her right upper arm. R6 was walking from her bathroocm to her closet carrying long pajamas. Root cause identified as R6 failed to use her call light, no intervention provided.

-6/11/22, at 10:45 p.m. R6 was found on the floor in front of her recliner, R6 stated she slid out of her chair, does not identify if Dycem was used per her care plan. R6 was noted to be incontinent at the time. Root cause identified as R6 failed to use her call light, no intervention provided.

-6/20/22, at 8:30 p.m. R6 found sitting on the floor of her room in between the closet and her recliner with her back against the wall, stated she was trying to grab something out of the closet. R6 was noted to be oriented to person and situation only per her baseline. Root cause identified as R6 did not ask for assist and was trying to get something out of the closet, no new prevention intervention was identified.

-6/27/22, at 5:47 p.m. R6 could be heard from the hallway calling for help, was found in her room on the doorway of the bathroom floor, R6 complained of pain in her right upper arm. Root cause identified as R6 failed to use her call light, no intervention provided.

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2 830	Continued From page 20 During interview on 7/20/22, at 11:06, a.m. with CM and IDON present. CM indicated after a resident would have a fall, the floor nurse would immediately assess the resident for injury, when safe the resident would be transferred with a Hoyer lift to either the chair or the bed. The floor nurse would be responsible for the documentation in the record, which would include assessment, identification of root cause, and the new intervention. The care plan would then be updated to reflect the new intervention. All department heads meet every morning Monday through Friday to discuss incidents in risk management, this would include falls. CM further stated we don't really discuss the root cause of falls, there is not a section in risk management for that, we never really discuss that. The floor nurse is responsible for that. During an interview on 7/20/22, at 1:51 p.m. with the CM and IDON present, CM verified that R6 had 7 falls during her stay from 3/17/22, to 6/27/22, with no root cause analysis, and no prevention interventions that were put into place. CM further verified this by looking at the dates on R6's care plan with no new interventions noted. CM stated that R6 had a planned discharge to another nursing home that happened on 7/6/22. The immediate jeopardy that began on 4/8/22 was removed on 7/21/22, at 4:20 p.m. when the facility educated their staff on the policy and procedures related to the fall process, R4 and R5's falls were comprehensively assess and care plans were reviewed and revised with appropriate interventions. In addition residents were identified that were at high risk for falls and assessments were completed with necessary care plan revisions. Noncompliance remained at the lower scope and severity level 2, an E-scope and	2 830		

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severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Facility Policy, "Fall Prevention and Reduction," reviewed 7/2022, indicated, Individual fall precautions and interventions will be developed for all residents who admit to a facility. All falls will be reviewed, and preventative measures will be taken to decrease falls whenever possible to prevent injury. Interventions will be identified related to the residents' specific risks and causes in order to reduce falling and to try to minimize complications from falling. All residents are assessed for fall risk. All falls will be analyzed to determine the root cause of the fall.

Procedure for Resident Fall:
1. A licensed nurse will evaluate resident's pain, range of motion and level on consciousness or change in cognition level before moving or assisting resident to a safer position.
2. Keep resident comfortable and avoid moving if there is suspected fracture.
3. A resident on the floor should not be "lifted" from the floor. Mechanical lift equipment is to be used to lift a resident to a chair or a bed.
4. Vital signs will be completed after all fall events; if possible, complete orthostatic blood pressure comparison.
5. If resident is diabetic, blood glucose levels should be determined.
6. Perform a skin and wound check.
7. If on anticoagulant and head strike suspected, or falls unwitnessed, note last INR reading and current dose.
8. If fall is unwitnessed or resident hits head, neurological checks will be initiated.
9. Complete post fall huddle with staff working on the unit where the resident fell.

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2 830	Continued From page 22 10. Seek immediate medical care if needed: notify provider and seek orders or call 911 if the situation demands the need. 11. Notify the provider immediately for all resident falls. 12. Notify the administrator and DN immediately if the resident has a change in condition after a fall or resident hit their head. 13. Notify the administrator and the DON by office phone and leave message if no injury from the fall, no head strike. 14. Notify the administrator and the DON immediately if the resident requires transport to the hospital within 72 hours of a fall. Includes evenings, nights and weekends. 15. Contact the resident representative on same shift for all resident falls. 16. Document the fall in risk management using appropriate fall progress note. 17. Determine the root cause as to why the resident fell and implement intervention specific to the cause of the fall. 18. Start immediate intervention to attempt to prevent further falls. (See fall intervention list.) 19. Update the care plan and the Kardex with the fall intervention. 20. Hall nurse to complete the fall risk assessment after the fall to identify the new or changing risk factors for resident fall. 21. Hall nurses begin documentation for Falls Follow up Notation a minimum of once per shift for 72 hours. Complete VS ROM, neurological checks (if required). 22. Nurse Manager for designee is responsible to ensure the completion of the Risk Management for a fall. Procedure for Fall Risk Assessment: 1. A fall risk assessment will be completed at the following times: upon admission, prior to annual	2 830		

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2 830	Continued From page 23 MDS, quarterly (reviewed), significant change and following a resident fall. 2. Implement appropriate interventions/precautions. All member of the interdisciplinary team will participate and contribute to the plan of care with resident specifics fall reduction efforts. 3. The resident representative will be notified of the residents falls as appropriate. 4. Provider will be notified as appropriate. 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 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		