Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 9, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: August 22, 2024

Dear Administrator:

On September 6, 2024, we notified you a remedy was imposed. On September 25, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 16, 2024.

As authorized by CMS, the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 21, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 6, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 21, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 16, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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October 9, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: Reinspection Results
Event ID: GP5N12

Dear Administrator:

On September 25, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division, completed a reinspection of your facility to determine correction of orders found on the survey completed on August 22, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 6, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: August 22, 2024

Dear Administrator:

On August 22, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location 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 September 21, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 21, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 21, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 21, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Meadow Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 21, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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 an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 22, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

INFORMAL DISPUTE RESOLUTION (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://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING ______ B. WING ______	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	**210 EAST GRAND AVENUE GRAND MEADOW, MN 55936**

(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 8/20, 8/21, and 8/22/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H53676887C (MNMN00105692); H53676768C (MN00105571); H53676508C (MN00105358) with a deficiency cited at F689, F609, F610, and F657. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		9/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/16/2024

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

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a fall with serious injury with potential neglect was reported to the State Agency (SA) for 2 of 3 residents (R3 and R2) reviewed for falls. Findings include: R3 A Vulnerable Adult Maltreatment Report submitted to the State Agency on 7/30/24 at 5:45 p.m., alleged caregiver neglect for an incident that had occurred on 7/24/24 at approximately 5:00 a.m. The report indicated R3 fell on 7/18/24 and was sent to the emergency department (ED) for a broken finger and again, fell on 7/24/24 in the morning and was sent to the ED with injuries and died the next day. Further indicated R3 had COVID and was in his room with the door shut	F 609	F (609) PLAN OF CORRECTION Grand Meadow Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the	

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F 609	Continued From page 2 and needed staff assistance to transfer. In review of Facility Reported Incidents (FRI), it was not evident R3's fall was reported to the State Agency. R3's quarterly Minimum Data Set (MDS) dated 7/11/24, indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease. R3's fall report dated 7/18/24 at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell. Further indicates R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the ED for evaluation. A follow up noted dated 7/31/24, identified R3 was trying to get through a doorway when he went weak. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. R3's ED After Visit Summary dated 7/18/24, indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger.	F 609	requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 609, Reporting of Alleged Violations. Grand Meadow Senior Living corrected the deficiency by educating the Executive Director on reporting requirements by Accura Chief Operating Officer on 9/11/2024. 2. To correct the deficiency and to ensure the problem does not recur all leadership staff who complete state reports were educated on reporting requirements on 9/11/24 by Accura Chief Operating Officer. Executive Director and/or designee will audit resident allegations for appropriate reporting and thorough investigation weekly for 3 months and then randomly to ensure continued compliance. 3. As part of Grand Meadow Senior Living s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community s QA Process.	

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F 609	Continued From page 3	F 609		

R3's fall report dated 7/24/24 at 7 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have "open area to feet, toes, and a large hematoma to left upper eye". R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. A follow up note on 7/25/24 indicated R3 was deceased due to respiratory complications. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. factors.

R2
A Vulnerable Adult Maltreatment Report was submitted to the SA on 8/7/24 at 12:44 p.m., alleged caregiver neglect for an incident that occurred on 8/7/24. The report indicated R2 was sent to the hospital after "falling and busted eye open" due to having only one person assist with a transfer when it should have been two staff assisting.

In review of Facility Reported Incidents (FRI), it was not evident R2's fall was reported to the State Agency.

R2's admission Minimum Data Set (MDS) dated 5/26/24, indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2 diagnoses included progressive

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F 609	Continued From page 4	F 609		

supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling.

R2 Fall report dated 8/7/24 at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a laceration to the left eye and emergency medical services (EMS) were called for transport to the emergency department (ED). A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. R2's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R2's care plan had been followed at the time of the fall.

During observation and interview on 8/20/24 at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, "things aren't going very well here". Further clarified she fell "a few weeks ago", hit her head, and went to the hospital for stitches, Stated, "I usually transfer with two people but there was only one [staff] here".

During an interview on 8/21/24 at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but R2 had reported that when she fell and hit her head, there was only one person assisting her to the commode. FM-A further indicated R2 had to go to the hospital for stitches as a result of that fall. Further clarified the fall occurred on 8/7/24 and

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F 609	Continued From page 5	F 609		

R2 reports that she frequently only has one person assisting her although she is supposed to have two.

During an interview on 8/21/24 at 3:30 p.m., nursing assistant (NA)-A indicated she was assisting R2 at the time of the 8/7/24 fall. NA-A indicated she was an agency NA, and it was her first time working with R2. She was told R2 required only one person assist with gait belt and walker. Further indicated she was independently transferring R2 with gait belt and walker when R2 leaned forward and fell and hit her head.

During an interview on 8/20/24 at 9:30 a.m., registered nurse (RN)-B indicated she was working at the time of R2's fall on 8/7/24. Further identified on 8/7/24, R2 had fallen transferring to the commode and had bleeding from the left eye and was sent to the ED. Indicated NA-A alerted her to the fall and was in the room with R2 but did not know if NA-A had assisted R2 or not. RN-B "assumed" NA-A was waiting for help but was not sure of the details and confirmed R2 was a two person assist with walker and gait belt but "thought" R2 had self-transferred causing her to fall.

During an interview on 8/20/24 at 9:20 a.m., the administrator indicated they would only report falls if the facility would be at fault or could have done something to prevent it. Regarding R2 and R3's falls with injury, the administrator indicated he considered reporting to the SA but the care plan was followed, and the facility was not at fault.

During a follow-up interview on 8/21/24 at 2:00 p.m., the administrator reviewed the facility incident reports and acknowledged that vital

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F 609	Continued From page 6	F 609		

pieces of the investigations were missing and that the investigations were not thorough enough to determine if the care plan was followed or that neglect did or did not occur.

The facility policy titled, Reporting of Accidents and Incidents last updated 10/19/22, indicates the facility shall take ongoing steps to identify each resident at risk for accidents and/or falls, and adequately plan care, implement procedures to prevent accidents. In addition, residents shall receive a complete, comprehensive, accurate and reproduceable assessment of their functional capacity and the degree of accident risk to which each resident's condition places them. This assessment shall be standardized within the facility shall be carried out in an informal manner on a day-to-day basis and as needed to prevent injury and/or accidents within the facility. The facility shall ensure that all alleged violation involving, abuse, neglect, mistreatment of resident property including injuries of unknown source are reported immediately to the administrator and to other agencies in accordance with state law through established procedures. Accura HealthCare shall have evidence that all alleged violations are thoroughly investigated and shall prevention further potential abuse while the investigation is in process. Further identifies the administrator or the director of nursing shall determine if the incident/allegation meets the criteria for "Reportable Incident". All incidents deemed reportable under MN stature are submitted to MDH via the on-line reporting system immediately (as soon as possible).

The facility policy titled, Fall Risk and Prevention Guidelines with revision date February 23,

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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 609	Continued From page 7 indicates It is critical for nursing centers to address and mitigate adverse events and potential adverse events. An action plan, otherwise known as a mitigation plan, is a necessary response to adverse events and potential adverse events. For many such events, it is important to respond and start the mitigation process immediately. Housing Manager/ED must be notified immediately at the time of the adverse event. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete an accurate and thorough investigation of falls to determine the	F 610	F (610) PLAN OF CORRECTION Grand Meadow Senior Living denies it	9/6/24

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	245367	A. BUILDING ______ B. WING ______	C 08/22/2024

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root cause, if the care plan was followed, and if the fall was reportable to the State Agency (SA) for 3 of 3 residents (R2, R3, and R4) reviewed for falls.

Finding include

R2's admission Minimum Data Set (MDS) dated 5/26/24, indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2 diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling.

R2's care plan last revised on 6/12/24, identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, Dyson [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist.

R2's Fall report dated 5/27/24 at 9:16 p.m., indicated nursing assistant (NA) was transferring resident from WC (wheelchair) to bed when resident fell onto right knee. R2 sustained an abrasion on the right knee. Note dated 5/28/24, indicated interdisciplinary team (IDT) reviewed fall report and determined resident fell to knee while transferring to bed with NA. No injuries and the

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violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.

1. In continuing compliance with F 610, Investigate/Prevent/Correct Alleged Violation. Grand Meadow Senior Living corrected the deficiency by reviewing, updating and implementing new fall investigation guidelines on 08/21/2024.

2. To correct the deficiency and to ensure the problem does not recur all staff were educated on new fall investigation guidelines on 08/21/2024 by the Director of Nursing. The Director of Nursing and/or designee will audit fall reports for thorough investigation 3 times per week for 12 weeks and then randomly to ensure continued compliance.

3. As part of Grand Meadow Senior Living s ongoing commitment to quality assurance, the Director or Nursing and/or

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intervention was to educate staff on safety when transferring resident. No other fall information was included. R1's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R2's care plan had been followed at the time of the fall.

R2's Fall report dated 6/24/24 at 9:13 p.m., indicated R2 was lying on her back on the floor and had hit her head. R2 stated she was reaching when she fell. Root cause indicated R2 slid out of wheelchair while trying to rearrange things. There was no further information about the fall. Further, the record did not include a thorough investigation and/or comprehensive fall analysis that would include but not limited to if R2's care plan was followed at the time of the fall.

R2's Fall report dated 6/25/24 at 7:00 p.m., indicated R2 was found on the floor after reaching to pick trash off the floor. Nurse recommended R2 use her call light. Note section updated 7/3/24 identified R2 was trying to pick garbage off the floor, staff will place call light reminder signs in R2's room. R2's record did not include a thorough investigation and/or comprehensive fall analysis that would include but not limited to if R2's care plan had been followed at the time of the fall.

R2's Progress Note dated 8/5/24 at 3:53 p.m., indicated a therapist reported that R2 had fallen in therapy. Further described knees became weak, fell back into the wheelchair, hyperextended, and slid down to the floor. The medical record did not include a Fall report. Further R2's record did not include a thorough investigation and/or comprehensive fall analysis

designee will report identified concerns through the community s QA Process.

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for probable root cause(s).

R2 Fall report dated 8/7/24 at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a laceration to the left eye and emergency medical services (EMS) were called for transport to the emergency department (ED). A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. Notes section dated 8/14/24, identified R2 was transferring without assistance. R2's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause which would have identified according to NA-A's interview on 8/21/24 at 3:30 the report was not accurate.

During an interview on 8/21/24 at 3:30 p.m., NA-A indicated she was assisting R2 at the time of the 8/7/24 fall. NA-A indicated it was her first time working with R2. She was told R2 required only one person assist with gait belt and walker. NA-A had been independently transferring R2 with gait belt and walker when R2 leaned forward and fell and hit her head. NA-A indicated the nurse did not ask her any questions about what happened or how the fall happened. Indicated she thought a nurse would usually ask her for a detailed explanation of the fall but stated, "I thought it was pretty weird that she did not ask me anything". Further denied being asked by any employee of the facility about the fall.

During observation and interview on 8/20/24 at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, "things aren't going very well here". Further clarified she

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fell "a few weeks ago", hit her head, and went to the hospital for stitches, Stated, "I usually transfer with two people but there was only one [staff] here".

During an interview on 8/21/24 at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but R2 had reported that when she fell on 8/7/24 and hit her head, there was only one person assisting her to the commode. R2 had reported to FM-A staff frequently transferred her with only one.

During an interview on 8/20/24 at 9:30 a.m., registered nurse (RN)-B indicated she was working at the time of R2's fall on 8/7/24. Further identified on 8/7/24, R2 had fallen transferring to the commode and had bleeding from the left eye and was sent to the ED. Indicated NA-A alerted her to the fall and was in the room with R2 but did not know if NA-A had assisted R2 or not. RN-B "assumed" NA-A was waiting for help but was not sure of the details and confirmed R2 was a two person assist with walker and gait belt but "thought" R2 had self-transferred causing her to fall.

R3's quarterly MDS dated 7/11/24, indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease.

R3's fall care plan last revised on 5/9/24,

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indicated R3 had limited physical mobility and a history of falling. Interventions included requires one staff with gait belt and a walker for ambulation and transferring.

R3's fall report dated 7/4/24 at 11:20 p.m., indicated R3 had tried to self-transfer to bed and missed causing a fall to the floor with no apparent injuries. The report identified possible causal factors as gait imbalance and ambulating without assist. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall.

R3's fall report dated 7/18/24 at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell. Further indicates R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the ED for evaluation. The report identified furniture, weakness, and ambulating without assist to be a potential causal factor. A follow up noted dated 7/31/24, identified R3 had an unwitnessed fall when he was trying to get through a doorway when he went weak with intervention as ED evaluation and increase checks upon return. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall.

R3's ED After Visit Summary dated 7/18/24,

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indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger.

R3's fall report dated 7/21/24 at 10 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. The fall report indicates R3 was oriented to person only. R3 had confusion and was ambulating without assist as potential causal factors. Follow note dated 7/31/24, indicates R3 had an unwitnessed fall and immediate intervention was to "encourage to sleep in bed". There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall.

R3's fall report dated 7/24/24 at 7 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have "open area to feet, toes, and a large hematoma to left upper eye". R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. The fall report indicated items out of reach, other with no description, gait imbalance, recent illness, weakness, ambulating without assist, improper footwear, and oxygen tubing on the floor, and overnight catheter bag were all identified as possible causal factors to the fall. A follow up note on 7/25/24 indicated R3 was deceased due to respiratory complications. R3's record did not include a thorough investigation and/or

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F 610	Continued From page 14 comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. During an interview on 8/20/24 at 9:30 a.m., registered nurse (RN)-B identified she was working at the time of R3's fall on 7/24/24. Indicated R3 was a high fall risk, history of dementia and occasionally forgetful, recently had COVID, and had been isolated in his room with the door closed for 10 days. On 7/24/24, she heard him yelling and found him on the floor with "gashes" to his toes, heels and a hematoma to his head resulting in R3 transferring to the ED. RN-B indicated R3 was to be checked on every two hours but was not sure when he was checked on prior to his fall or when he was last assisted to the toilet. She "thought" he was independent but was not sure. R4's quarterly MDS dated 6/4/24, indicated R4 was cognitively intact, has unclear speech but makes himself understood, limitation in range of motion in all extremities and requires staff limited assist with bed mobility, transfers, eating, and toilet use. Diagnoses include Huntington's disease (disease of the nerve cells in the brain that affects a person's movements, thinking ability, and mental health), repeated falls, muscle spasms, cramp and spasm, and anxiety disorder. R4's care plan indicated staff assist of one, gait belt, and walker required for transfers and toileting. R4 does self-transfer. The fall prevention interventions identified in the fall reports were not added to the care plan from 6/9/24 to 8/20/24.	F 610		

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F 610	Continued From page 15 R4's medical record indicates R4 most recent falls were 6/11/24 at 10:24 p.m., 6/12/24 at 8 p.m., 6/13/24 at 9:11 a.m., 6/16/24 at 2:11 p.m., 6/21/24 at 10:54 a.m., 6/28/24 at 11:25 a.m., 7/2/24 at 7 p.m., 7/3/24 at 4:10 p.m., 7/12/24 at 1:54 a.m., 7/15/24 at 8:55 a.m., 7/22/24 at 8:55 a.m., 7/23/24 at 5 p.m., 7/28/24 at 3:01 p.m., 8/4/24 at 9:20 a.m., 8/6/24 at 1:45 p.m., 8/6/24 at 5:25 p.m., 8/17/24 at 7:50 a.m., 8/17/24 at 10:50 a.m., 8/19/24 at 4:35 p.m., and at 8/20/24 at 12:20 p.m.. Twenty (20) falls total from 6/11/24 to 8/19/24. In review of R4 records it was not evident for all 20 falls a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R4's care plan had been followed at the time of the fall. During an interview on 8/20/24 at 11:10 a.m., registered nurse (RN)-D indicated R4 falls a lot because he is impulsive. Further indicated difficult to investigate his falls and were inquiring if there was a way not to do any more fall reports on him because he falls so frequently. During an interview on 8/20/24 at 9:30 a.m., RN-B indicated the nurses do not do the fall investigations or the post fall huddle. Instead, they ask what happened and document the results in the progress notes. During an interview on 8/21/24 at 12:15 p.m., the administrator indicated all falls in the facility get reported to him. Further identified the only investigation on the regular falls without injury would be the incident reports unless, there was an injury then he would investigate it as well. The administrator indicated he expects nursing staff to	F 610		

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F 610	Continued From page 16 follow the facility's policies and procedures to determine if "we caused any injuries or whether the care plan was followed and had everything in place". During an interview on 8/22/24 at 12:30 p.m., the regional nurse manager indicated the expectation of the clinical team would be to do a post fall huddle and get the information to determine the root cause of the fall and identify and implement the appropriate fall prevention interventions. During a follow-up interview on 8/21/24 at 2:00 p.m., the administrator reviewed the facility incident reports and acknowledged that vital pieces of the investigations were missing and that the investigations were not thorough enough to determine if the care plan was followed or that neglect did or did not occur. During an interview on 8/22/24 at 12:00 p.m. the medical director indicated the facility does have a high number of falls but felt the lack of consistent nursing management and staff turnover has contributed to the fall policies not being implement adequately. The facility's policy titled, Fall Risk and Prevention Guidelines directs clinical staff to: Conduct interviews of; the resident, the first responder, the person who last saw the resident, any witnesses. Make note of the resident's immediate surroundings and the position the resident/tenant was found. Determine from staff the provision of the last cares, what the cares were and when they were provided. Review the record for medications in use; psychotropic, narcotics, diuretics, anticonvulsants, cardiovascular meds etc. Review the record for any medications/doses	F 610		

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F 610	Continued From page 17 changed in the previous 30 days. Review recent laboratory values. Review the plan of care to determine care provided was consistent with plan. The nurse reviews the information collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated. Complete Adverse Event, Report in Risk Management, Complete Post Fall Data Collection in Electronic Medical Record, Update SNF Care Plan and NAR Care Plan/HHA Care Plan, 24-hour Report Updated, Family Medical Practitioner, DNS and ED notified of incident. IDT discussion of Incident for Review. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		9/16/24

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F 657	Continued From page 18 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan for 3 of 3 residents (R2) who were reviewed for falls. Findings include: R2's admission Minimum Data Set (MDS) dated 5/26/24, indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2 diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling. R2's care plan last revised on 6/12/24, identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, Dyson [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist.	F 657	F (657) PLAN OF CORRECTION Grand Meadow denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 657, Care Plan Timing and Revision. Grand Meadow Senior Living corrected the deficiency by ensuring R2, R3, R4 and all like resident care plans were updated with current fall interventions by the MDSC by 09/06/2024.	

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F 657	Continued From page 19 R2's Fall report dated 6/24/24 at 21:13 (9:13 p.m.), indicated R2 was lying on her back on the floor and had hit her head. The report lacked a new immediate intervention to prevent further falls. Root cause analysis indicated R2 slid out of wheelchair while trying to rearrange things. Although a reacher was identified as an appropriate intervention, it was not added to R2's care plan until 8/20/24 and had been in place since 6/12/24. R2's Fall report dated 6/25/24 at 19:00 (7:00 p.m.), indicated R2 was found on the floor after reaching to pick trash off the floor. Root cause was identified as trying to pick garbage off the floor with the added intervention to put a reminder to use call light sign in room however, R2's care plan was not updated to reflect the intervention until 8/20/24. R2's Fall report dated 7/2/24 at 18:25 (6:25 p.m.), indicated R2 was found on the floor in front of the wheelchair. R2 complained of left elbow pain. The fall report lacked a comprehensive assessment of the fall. Although the intervention was to put Dysem [sic] in wheelchair to prevent sliding, it was not added to the care plan until 8/20/24. R3's quarterly MDS dated 7/11/24, indicates R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease.	F 657	2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on ensuring fall interventions are added to care plans on 08/21/24 by the Director of Nursing. The Director of Nursing and/or designee will audit care plans for fall interventions 3 times per week for 12 weeks and then randomly to ensure continued compliance. 3. As part of Grand Meadow Senior Living s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community s QA Process.	

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F 657	Continued From page 20	F 657		

R3's fall care plan last revised on 5/9/24, indicated R3 had limited physical mobility and a history of falling. Interventions included requires one staff with gait belt and a walker for ambulation and transferring.

R3's fall report dated 7/4/24 at 11:20 p.m., indicated R3 had tried to transfer to bed and missed causing a fall to the floor with no apparent injuries. The medical record lacked updates to the care plan related to fall prevention.

R3's fall report dated 7/18/24 at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell. Further indicates R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the ED for evaluation. The medical record lacked updates to the care plan related to fall prevention.

R3's Progress Noted dated 7/19/24 at 10:45 a.m., identifies R3 returned from the ED following a closed reduction procedure his 5th metacarpal falange {sic}and had a temporary soft cast on and was to follow up with orthopedics. The medical record lacked updates to the care plan related to a change in activity of daily living (ADL) status.

R3's fall report dated 7/21/24 at 10 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. Immediate intervention was to "encourage to sleep in bed". The medical record lacked updates to the care plan related to fall prevention.

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F 657	Continued From page 21	F 657		

During an interview on 8/20/24 at 9:30 a.m., RN-B indicated R3 was a high fall risk and had several falls trying to self-transfer. Further indicated R3 had a history of dementia and was forgetful. Identified R3 had been diagnosed with COVID-19 and was in isolation for 10 days with his door shut but did not know how often staff checked for safety or personal needs. Did not update the care plan to reflect the change of condition.

R4's quarterly MDS dated 6/4/24, indicated R4 was cognitively intact, has unclear speech but makes himself understood, limitation in range of motion in all extremities and requires staff limited assist with bed mobility, transfers, eating, and toilet use. Diagnoses include Huntington's disease (disease of the nerve cells in the brain that affects a person's movements, thinking ability, and mental health), repeated falls, muscle spasms, cramp and spasm, and anxiety disorder.

R4's Morse Fall Scale dated 6/13/24 indicated R4 was at a high risk for falling.

R4's medical record indicates R4 most recent falls were 6/11/24 at 10:24 p.m., 6/12/24 at 8 p.m., 6/13/24 at 9:11 a.m., 6/16/24 at 2:11 p.m., 6/21/24 at 10:54 a.m., 6/28/24 at 11:25 a.m., 7/2/24 at 7 p.m., 7/3/24 at 4:10 p.m., 7/12/24 at 1:54 a.m., 7/15/24 at 8:55 a.m., 7/22/24 at 8:55 a.m., 7/23/24 at 5 p.m., 7/28/24 at 3:01 p.m., 8/4/24 at 9:20 a.m., 8/6/24 at 1:45 p.m., 8/6/24 at 5:25 p.m., 8/17/24 at 7:50 a.m., 8/17/24 at 10:50 a.m., 8/19/24 at 4:35 p.m., and at 8/20/24 at 12:20 p.m.. Twenty (20) falls total from 6/11/24 to 8/19/24.

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F 657	Continued From page 22	F 657		

R4's care plan indicated staff assist of one, gait belt, and walker required for transfers and toileting. R4 does self-transfer. The fall prevention interventions identified in the fall reports were not added to the care plan from 6/9/24 to 8/20/24.

During interview on 8/20/24 at 9:30 a.m., RN-B indicated after a fall they "sometimes put some kind of intervention in place" and would be documented in the resident progress note if they did. RN-B indicated staff nurses do not update the care plans and did not know who was responsible for updating the care plan or if the care plans are updated after a fall.

During an interview on 8/21/24 at 3:45 p.m., NA-B indicated fall interventions were sometimes written on a white board in the nurse's station or was communicated through oral report. NA-B explained she does not look at the resident care plans or Kardex.

During an interview on 8/22/24 at 12:00 p.m., RN-C indicated fall interventions should be put on the care plan once they are determined. Further verified care plans were not updated with fall interventions and it is an area that needs to be improved.

During an interview on 8/22/24 at 12:15 p.m., the administrator indicated the expectation is nursing staff follow the facilities process or procedures.

The facility's policy titled, Fall Risk and Prevention Guidelines last revised February 2023, directs clinical staff to review the plan of care to determine care provided was consistent with plan. The nurse reviews the information

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F 657	Continued From page 23 collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury for 2 of 2 residents (R3 and R2) with history of falls. This resulted in actual harm for R3 when he sustained a hand fracture and lacerations to his face and foot and R2 when she sustained a laceration above the eye that required sutures as a result of a fall. Findings include: R3's quarterly Minimum Data Set (MDS) dated 7/11/24, indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic	F 689	F (689) PLAN OF CORRECTION Grand Meadow denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	9/16/24

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F 689	Continued From page 24 obstructive pulmonary disease. R3's Care Area Assessment (CAA) dated 4/17/24, indicated R3 triggered for cognitive loss/dementia, self-care and mobility, and falls. R3's Fall CAA indicated R3 was at risk for falls related to recent hospitalization, diagnoses, and physical limitations. R3's Morse Fall Scale dated 6/19/24, indicated R3 was at a high risk for falls. R3's Physical Therapy Treatment Encounter Note dated 7/6/24 indicated R3 verbalized need for full time mobility assist for all weight bearing mobility; however, reduced insight and judgement limits patients understanding of fall risk. R3's fall care plan last revised on 5/9/24, indicated R3 had limited physical mobility and a history of falling. Interventions included: required one staff with gait belt and a walker for ambulation, and transferring. R3's fall report dated 7/4/24 at 11:20 p.m., indicated R3 had tried to self-transfer to bed and missed causing a fall to the floor with no apparent injuries. The report identified there were no predisposing environmental factors, gait imbalance as a predisposing physiological factor and ambulating without assist as a predisposing situation factor. R3's fall record did not include any further information about the fall. R3's medical records did not include a comprehensive fall analysis for root cause, nor interventions for the identified risk factors from the fall report such as, but not limited, self-ambulating, that would prevent falls and/or	F 689	1. In continuing compliance with F 689, Free of Accident Hazards/ Supervision/Devices. Grand Meadow Senior Living corrected the deficiency by completing a comprehensive fall analysis and completed a comprehensive fall risk assessment to investigate R2 and R3 falls for root cause and reviewed their care plan for accuracy. For R3, resident discharged from facility on 7/25/2024. No further action needed. For R2, the care plan has been updated to ensure consistent two-person transfer assistance and access to assistive devices, with staff re-educated on compliance. R2 has completed therapy following the incident, is receiving occupational therapy twice weekly, and is scheduled for a physical therapy evaluation on September 12, 2024. Additionally, signage has been placed in the R2's room. All residents have the potential to be affected by the alleged deficient practice. The MDSC and/or designee completed audits 9/6/24 of residents at high risk for falls with falls. A complete comprehensive analysis for root cause was completed and care plans updated and reviewed for accuracy. Furthermore, the facility has reviewed care plans for all high fall-risk residents, prioritizing those with cognitive impairments or physical limitations. Care plans have been updated where necessary to ensure appropriate interventions are in place. 2. To correct the deficiency and to ensure the problem does not recur a new fall investigation guideline was implemented on 08/21/2024. All staff completed training	

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F 689	Continued From page 25 mitigate the risk of falls or falls with major injury. R3's fall report dated 7/18/24 at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell. The report further indicated R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the emergency department (ED) for evaluation. The report identified furniture, weakness, and ambulating without assist to be a potential causal factor. A follow up noted dated 7/31/24, identified R3 had an unwitnessed fall when he was trying to get through a doorway when he went weak with intervention as ED evaluation and increase checks upon return. R3's record did not include any further information about the fall. R3's record did not identify an assessment that determined and/or defined frequency of "checks" R3 required based on his risk factors, mannerisms, and behaviors. Furthermore, not evident the care plan, care sheets, and/or orders were revised to include the intervention of "increase checks". Additionally, R3's records did not include a comprehensive fall analysis for root cause, nor interventions for the identified risk factors from the fall report such as, but not limited, self-ambulating and furniture that would prevent falls and/or mitigate the risk of falls or falls with major injury. R3's ED After Visit Summary dated 7/18/24, indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger.	F 689	on the new fall investigation guidelines on 08/21/2024. An external consultant has been secured to support ongoing performance of the fall prevention program, starting at the end of September 2024. The Director of Nursing and/or designee will audit fall process compliance 5 times per week for 12 weeks and then randomly to ensure continued compliance. 3. As part of Grand Meadow Senior Living’s ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community’s QA Process.	

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R3's Progress Noted dated 7/19/24 at 10:45 a.m., identified R3 returned from the ED following a closed reduction procedure of his 5th metacarpal falange {sic}and had a temporary soft cast on and was to follow up with orthopedics.

R3's fall report dated 7/21/24 at 10:00 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. The fall report indicated R3 was oriented to person only. R3 had confusion and was ambulating without assist as potential causal factors. Follow-up note dated 7/31/24, indicated R3 had an unwitnessed fall and immediate intervention was to "encourage to sleep in bed". R3's fall record did not include any further information about the fall, nor evident R3's care plan/care sheets were revised to include the intervention.

In review of R3's records identified a comprehensive fall analysis for root cause and interventions was not completed that addressed risk factors included in the fall report, even though the report identified R3 had confusion and self-transferred, the intervention for increased checks was not individualized and/or assessed to address that risk factor. Further, no evidence the intervention of "increase checks" was provided and was evaluated for effectiveness.

R3's fall report dated 7/24/24 at 7:00 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have "open area to feet, toes, and a large hematoma to left upper

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eye". R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. The fall report indicated items out of reach, other with no description, gait imbalance, recent illness, weakness, ambulating without assist, improper footwear, and oxygen tubing on the floor, and overnight catheter bag were all identified as possible causal factors to the fall. A follow up note on 7/25/24 indicated R3 was deceased due to respiratory complications.

During an interview on 8/20/24 at 9:30 a.m., RN-B indicated R3 was a high fall risk and had several falls trying to self-transfer. Further indicated R3 had a history of dementia and was forgetful. Identified R3 had been diagnosed with COVID-19 and was in isolation for 10 days with his door shut but did not know how often staff checked for safety or personal needs. R3 had apparent injuries during two recent falls; one he broke his hand, and the last fall, his head, a couple of toes, and heel were "gashed open".

R2's admission MDS dated 5/26/24, indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2's diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling.

R2's updated Brief Interview for Mental Status dated 7/8/24, indicated R2 was cognitively intact.

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R2's CAA dated 5/29/24, indicated R2 triggered for cognitive loss/dementia, functional abilities (self-care and mobility), and urinary incontinence. In addition, R2 triggered for falls related to fall history and high-risk medications. The Fall CAA further indicated R2 is alert and oriented, able to make needs known, and will call for staff assist with toileting but is impulsive and may forget.

R2's admission Morse Fall Scale, dated 5/20/24, indicated R2 was at a high risk for falls.

R2's Physical Therapy Progress Report dated 6/20/24, indicated R2 required assist of two for safety with the second assist for wheelchair management due to tendency towards right trunk lean and decreased right lower extremity foot clearance and stride length.

R2's care plan last revised on 6/12/24, identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, Dyson [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist.

The undated form labeled CNA (certified nursing assistant) Individual Report Sheet indicated R2's transfer status was assist of 2 (two).

R2's Fall report dated 5/27/24 at 9:16 p.m., indicated NA was transferring resident from WC (wheelchair) to bed when resident fell onto right knee. R2 sustained an abrasion on the right knee. Note dated 5/28/24, indicated interdisciplinary

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team (IDT) reviewed fall report and determined resident fell to knee while transferring to bed with NA. No injuries and intervention was to educate staff on safety when transferring resident. No other information about the fall was documented.

R2's record did not include a comprehensive fall analysis that identified probable root cause including if the care plan was followed, if the care plan was appropriate, and/or if R2 had a change in transfer ability.

R2's Fall report dated 6/24/24 at 9:13 p.m., indicated R2 was lying on her back on the floor and had hit her head. R2 stated she was reaching when she fell. Root cause analysis indicated R2 slid out of wheelchair while trying to rearrange things. Note section dated 7/1/24, indicated R2 was reaching for something outside of her grasp. The intervention was to keep her reacher within reach of her so that she can utilize it. The reacher was an intervention that had already been put in place on 6/12/24.

R2's record did not include a comprehensive fall analysis that included but not limited to if R2's care plan was followed and/or if R2 had the ability to use the reacher. Further did not identify any other interventions that would mitigate R2 from re-current falls related to the same identified cause.

R2's Fall report dated 6/25/24 at 7:00 p.m., indicated R2 was found on the floor after reaching to pick trash off the floor. Nurse recommended R2 use her call light. Note section updated 7/3/24 identified R2 was trying to pick garbage off the floor, staff will place call light reminder signs in R2's room. There was no further information

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about the fall.

R2's record did not include a comprehensive fall analysis that included but not limited to if R2's care plan was followed and/or if R2 had the ability to use the reacher. Further did not identify any other interventions that would mitigate R2 from re-current falls related to the same identified cause.

R2's Fall report dated 7/2/24 at 6:25 p.m., indicated R2 was found on the floor in front of the wheelchair. R2 fell while trying to throw something away. R2 complained of left elbow pain. Notes section dated 7/3/24 identified R2 fell trying to throw something away and her chair cushion was found on the floor. Intervention for staff to put dyson [sic] under wheelchair cushion to prevent it from sliding off. Although the intervention was to put Dycem [sic] in wheelchair to prevent sliding, it was not added to the care plan until 8/20/24. R2's fall record did not include any further information about the fall including a comprehensive analysis that included but not limited to if R2's care plan was followed at the time of the fall.

R2's Progress Note dated 8/5/24 at 3:53 p.m., indicated a therapist reported that R2 had fallen in therapy. Further described knees became weak, fell back into the wheelchair, hyperextended, and slid down to the floor. The medical record lacked a fall report, comprehensive assessment, root cause analysis, and intervention to prevent further falls.

R2 Fall report dated 8/7/24 at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a

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	245367	A. BUILDING ______ B. WING ______	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE GRAND MEADOW, MN 55936

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F 689	Continued From page 31	F 689		

laceration to the left eye and emergency medical services (EMS) were called for transport to the ED. A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. Notes section dated 8/14/24, identified R2 was transferring without assistance and the intervention was to re-educate R2 on pendant (call light usage). No other information was included and the record did not include a comprehensive analysis that would have identified R2's transfer care plan that directed 2 staff assist was not followed per interview with nursing assistant (NA)-A on 8/21/24 at 3:30 p.m. NA-A reported she was working with R2 at the time of the fall with injury. NA-A explained it was her first time assisting R2 and unknown NA told her that R2 transferred with one staff assist, gait belt, and walker. She assisted R2 to transfer to the commode when R2 leaned forward, and NA-A could not stop the fall.

R2's After Visit Summary dated 8/7/24, indicated R2 was evaluated in the ED following a fall and diagnosed with a face laceration and head injury.

During observation and interview on 8/20/24 at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, "things aren't going very well here". R2 further clarified she fell "a few weeks ago", hit her head, and went to the hospital for stitches, Stated, "I usually transfer with two people but there was only one [staff] here".

During an interview on 8/21/24 at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but

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F 689	Continued From page 32 R2 had reported that when she fell and hit her head, there was only one person assisting her to the commode. FM-A further indicated R2 had to go to the hospital for stitches as a result of that fall. Further clarified the fall occurred on 8/7/24 and R2 reports that she frequently only has one person assisting her although she is supposed to have two. During an interview on 8/21/24 at 3:45 p.m., NA-B indicated R2 had always required two staff assist to transfer. Further identified they use a cheat sheet (CNA Individual Report Sheet) to learn how residents transfer but did not know how often it was updated. During interview on 8/20/24 at 9:30 a.m., registered nurse (RN)-B indicated she was working on 8/7/24 and responded to R2's fall. Indicated R2 was care planned to transfer with two staff assist at all times. Further stated that they "sometimes put some kind of intervention in place" and would be documented in the resident progress note if they did. During an interview on 8/22/24 at 12:30 p.m., the regional nurse manager indicated the expectation of the clinical team would be to do a post fall huddle and get the information to determine the root cause of the fall and identify and implement the appropriate fall prevention interventions. During an interview on 8/21/24 at 12:15 p.m., the administrator reviewed R3's falls and confirmed the record did not include a comprehensive analysis for any of R3's falls. Adminstartor identified increase in checks was not defined nor documented and could not determine how frequently the checks had been completed and	F 689		

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F 689	Continued From page 33 therefor could not ascertain the effectiveness of the intervention. Adminstartor conceded that the facility was not performing in depth assessments and expected the facility's fall process and procedures be followed for all falls. The facility's policy titled, Fall Risk and Prevention Guidelines directs clinical staff to: Conduct interviews of; the resident, the first responder, the person who last saw the resident, any witnesses. Make note of the resident's immediate surroundings and the position the resident/tenant was found. Determine from staff the provision of the last cares, what the cares were and when they were provided. Review the record for medications in use; psychotropic, narcotics, diuretics, anticonvulsants, cardiovascular meds etc. Review the record for any medications/doses changed in the previous 30 days. Review recent laboratory values. Review the plan of care to determine care provided was consistent with plan. The nurse reviews the information collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated. Complete Adverse Event, Report in Risk Management, Complete Post Fall Data Collection in Electronic Medical Record, Update SNF Care Plan and NAR Care Plan/HHA Care Plan, 24-hour Report Updated, Family Medical Practitioner, DNS and ED notified of incident. IDT discussion of Incident for Review. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable. All falls are trended, analyzed and interventions introduced for areas of concern via monthly QAPI Meetings. Tracking of these discussions are listed within QAPI Minutes Ppt.	F 689		

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F 867	Continued From page 34	F 867		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		9/16/24

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F 867	Continued From page 35	F 867		

facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and

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F 867	Continued From page 36 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop, implement, monitor, and evaluate falls quality improvement project (QIP)	F 867	F (867) PLAN OF CORRECTION Grand Meadow denies it violated any	

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F 867 Continued From page 37

that was an identified problem-prone area to improve performance and ensure sustainability. This had the potential to affect all residents residing in the facility.

Findings include

SEE F689: Based on observation, interview, and document review the facility failed to compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury for 2 of 2 residents (R3 and R2) with history of falls. This resulted in actual harm for R3 when he sustained a hand fracture and lacerations to his face and foot and R2 when she sustained a laceration above the eye that required sutures as a result of a fall.

During the facility resident record review on 8/20/24 for resident sample selection revealed from 6/11/24 through 8/20/24, the facility had 29 fall incidents between three residents. R2 had 5 falls in which one fall resulted in a laceration that required sutures, R3 had 4 falls in which one fall resulted in a hand fracture and lacerations to face and foot, and R4 had 20 falls that did not result in major injuries. In further review of records it was not evident the facility completed comprehensive causal analysis for any of the 29 falls. During review of the facility's quality assurance activities, even though the facility identified falls as a problem prone area, it was not evident the facility developed and implemented action plans to improve. Further, it was not evident the quality assurance committee had identified causal analysis was not being completed and in certain instances the care plan was not followed and/or the care plan was not revised to include the new

F 867

federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.

1. In continuing compliance with F 867, QAPI improvement Activities. Grand Meadow Senior Living Corrected the deficiency by developing and implementing a formal Quality Improvement Plan (QIP) specifically targeting falls by 09/06/2024. Executive Director and/or designee reviewed all QIPs identified in problem prone areas and completed action plans per the regulation.

2. To correct the deficiency and to ensure the problem does not recur all staff were educated on the QAPI process and Quality Improvement Plan related to falls by 09/06/24 by the Director of Nursing and Executive Director. The Executive Director and/or designee will audit fall QIP weekly for 12 weeks and then randomly for continued compliance.

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F 867	Continued From page 38 interventions after a fall occurred. The facility's quality assurance documentation included the following: On 8/22/24, the administrator provided Grand Meadow QAPI/QAA (quality assurance performance improvement/quality assurance activity): Minutes Power Point. The power point included a slide titled Nursing/Clinical which had a table that identified the State Quality Indicators (QI) Analysis of Trends/All Areas Below 75th Percentile from December 2023 to May 2024. The QI's listed included Falls and Falls with major injury. The table identified from December to May there were no falls with major injury. From the December 2023 to May 2024 the fall quality indicator was below 75th percentile; April was 44.4% and May was 41.2%. In the column titled Action Plan (include reasons WHY QM's [quality measures] above average +SMART goals & progress) included a summation for May which indicated quality measures improved for falls however, did not identify activities that were completed or rational on how the metric was improved. The next slide identified in May 2024 there were 10 falls and in June there were 20 falls. Trends for May included "we had 10 falls this month with 2 repeat residents ...The second resident has shown non-compliance however, we haven't been able to fully determine the reason for the falls." June 2024 analysis included we had 20 falls this month, 3 residents with repeat falls. One resident account for 9 of the falls." No further analysis of trending and/or action plan was included in the slide show. Review of the facility's corresponding Quality Assessment and Assurance Action Plan for the	F 867	3. As part of Grand Meadow Senior Livings s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community s QA Process.	

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F 867	Continued From page 39 falls quality measure identified no action plans for April 2024, May 2024, and June 2024. The Action plan for falls with an implementation date of 7/25/24 included the action "DON [director of nursing] or another assigned person will audit fall interventions monthly to ensure greater effectiveness". The responsible team member was identified as the DON with a target date of 8/28/24. The progress and evaluation were not completed. Review of QUAPI documents did not include any evidence audits had completed after the implementation date of 7/25/24. During an interview on 8/22/24 at approximately 11:30 a.m. administrator stated the quality committee met monthly. All the departments were represented by their managers and the pharmacist and medical director also attended in person or by phone. Quality improvement projects were determined based on the State and Federal quality performance measures. Each department was responsible for collecting the information pertaining to each of the identified quality improvement projects and created the slide to share with the committee on the progress and results. The administrator stated he would only get the slide and not the records and/or audits that were used to account for the data presented to the committee. Administrator verified between April through July 2024 the only action plan created for all the quality projects identified in the slide show was for falls that was implemented on July 25th and was not complete with an entire activity plan. The administrator confirmed there were no previous action plans for falls prior to that date. The administrator explained even though the fall QIP did not identify activities the facility had implemented care plan audits that the social worker was completing	F 867		

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F 867	Continued From page 40 however could not articulate what the social worker was auditing on the care plans. Administrator also indicated the facility had started interdisciplinary meetings in April 2024 where falls were discussed, however in review of the meeting minutes there was limited information, or no information documented other than "fall" next to the resident's name. During an interview on 8/22/24 at 12:00 p.m. medical director (MD) stated she was newer to the facility within the last several months and was still acclimating to her new role as medical director. MD stated an awareness of the facility's high fall incidence but was not aware the facility did not have any action plans for the fall quality improvement project. MD indicated she thought the fall policy/program was not being implemented correctly. MD has been providing medical input on potential causes for at the individual resident level.	F 867		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2024

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: State Nursing Home Licensing Orders
Event ID: GP5N11

Dear Administrator:

The above facility was surveyed on August 20, 2024, through August 22, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/20, 8/21, and 8/22/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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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
2 000	Continued From page 1	2 000		

and identify the date when they will be completed.

The following complaints were reviewed: H53676887C (MN00105692); H53676768C (MN00105571); and H53676508C (MN00105358) with a licensing order issued at 0830.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is

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2 000	Continued From page 2 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 compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury for 2 of 2 residents (R3 and R2) with history of falls. This resulted in actual harm for R3 when he sustained a hand fracture and lacerations to his face and foot and R2 when she sustained a laceration above the eye that required sutures as	2 830	Corrected.	9/16/24

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2 830	Continued From page 3 a result of a fall. Findings include: R3's quarterly Minimum Data Set (MDS) dated 7/11/24, indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease. R3's Care Area Assessment (CAA) dated 4/17/24, indicated R3 triggered for cognitive loss/dementia, self-care and mobility, and falls. R3's Fall CAA indicated R3 was at risk for falls related to recent hospitalization, diagnoses, and physical limitations. R3's Morse Fall Scale dated 6/19/24, indicated R3 was at a high risk for falls. R3's Physical Therapy Treatment Encounter Note dated 7/6/24 indicated R3 verbalized need for full time mobility assist for all weight bearing mobility; however, reduced insight and judgement limits patients understanding of fall risk. R3's fall care plan last revised on 5/9/24, indicated R3 had limited physical mobility and a history of falling. Interventions included: required one staff with gait belt and a walker for ambulation, and transferring. R3's fall report dated 7/4/24 at 11:20 p.m., indicated R3 had tried to self-transfer to bed and missed causing a fall to the floor with no apparent injuries. The report identified there were no	2 830		

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2 830	Continued From page 4 predisposing environmental factors, gait imbalance as a predisposing physiological factor and ambulating without assist as a predisposing situation factor. R3's fall record did not include any further information about the fall. R3's medical records did not include a comprehensive fall analysis for root cause, nor interventions for the identified risk factors from the fall report such as, but not limited, self-ambulating, that would prevent falls and/or mitigate the risk of falls or falls with major injury. R3's fall report dated 7/18/24 at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell. The report further indicated R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the emergency department (ED) for evaluation. The report identified furniture, weakness, and ambulating without assist to be a potential causal factor. A follow up noted dated 7/31/24, identified R3 had an unwitnessed fall when he was trying to get through a doorway when he went weak with intervention as ED evaluation and increase checks upon return. R3's record did not include any further information about the fall. R3's record did not identify an assessment that determined and/or defined frequency of "checks" R3 required based on his risk factors, mannerisms, and behaviors. Furthermore, not evident the care plan, care sheets, and/or orders were revised to include the intervention of "increase checks". Additionally, R3's records did not include a comprehensive fall analysis for root cause, nor interventions for the identified risk	2 830		

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2 830	Continued From page 5 factors from the fall report such as, but not limited, self-ambulating and furniture that would prevent falls and/or mitigate the risk of falls or falls with major injury. R3's ED After Visit Summary dated 7/18/24, indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger. R3's Progress Noted dated 7/19/24 at 10:45 a.m., identified R3 returned from the ED following a closed reduction procedure of his 5th metacarpal falange {sic}and had a temporary soft cast on and was to follow up with orthopedics. R3's fall report dated 7/21/24 at 10:00 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. The fall report indicated R3 was oriented to person only. R3 had confusion and was ambulating without assist as potential causal factors. Follow-up note dated 7/31/24, indicated R3 had an unwitnessed fall and immediate intervention was to "encourage to sleep in bed". R3's fall record did not include any further information about the fall, nor evident R3's care plan/care sheets were revised to include the intervention. In review of R3's records identified a comprehensive fall analysis for root cause and interventions was not completed that addressed risk factors included in the fall report, even though the report identified R3 had confusion and self-transferred, the intervention for increased checks was not individualized and/or assessed to address that risk factor. Further, no evidence the	2 830		

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intervention of "increase checks" was provided and was evaluated for effectiveness.

R3's fall report dated 7/24/24 at 7:00 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have "open area to feet, toes, and a large hematoma to left upper eye". R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. The fall report indicated items out of reach, other with no description, gait imbalance, recent illness, weakness, ambulating without assist, improper footwear, and oxygen tubing on the floor, and overnight catheter bag were all identified as possible causal factors to the fall. A follow up note on 7/25/24 indicated R3 was deceased due to respiratory complications.

During an interview on 8/20/24 at 9:30 a.m., RN-B indicated R3 was a high fall risk and had several falls trying to self-transfer. Further indicated R3 had a history of dementia and was forgetful. Identified R3 had been diagnosed with COVID-19 and was in isolation for 10 days with his door shut but did not know how often staff checked for safety or personal needs. R3 had apparent injuries during two recent falls; one he broke his hand, and the last fall, his head, a couple of toes, and heel were "gashed open".

R2's admission MDS dated 5/26/24, indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2's diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects

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2 830	Continued From page 7 walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling. R2's updated Brief Interview for Mental Status dated 7/8/24, indicated R2 was cognitively intact. R2's CAA dated 5/29/24, indicated R2 triggered for cognitive loss/dementia, functional abilities (self-care and mobility), and urinary incontinence. In addition, R2 triggered for falls related to fall history and high-risk medications. The Fall CAA further indicated R2 is alert and oriented, able to make needs known, and will call for staff assist with toileting but is impulsive and may forget. R2's admission Morse Fall Scale, dated 5/20/24, indicated R2 was at a high risk for falls. R2's Physical Therapy Progress Report dated 6/20/24, indicated R2 required assist of two for safety with the second assist for wheelchair management due to tendency towards right trunk lean and decreased right lower extremity foot clearance and stride length. R2's care plan last revised on 6/12/24, identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, Dyson [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist. The undated form labeled CNA (certified nursing assistant) Individual Report Sheet indicated R2's	2 830		

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transfer status was assist of 2 (two).

R2's Fall report dated 5/27/24 at 9:16 p.m., indicated NA was transferring resident from WC (wheelchair) to bed when resident fell onto right knee. R2 sustained an abrasion on the right knee. Note dated 5/28/24, indicated interdisciplinary team (IDT) reviewed fall report and determined resident fell to knee while transferring to bed with NA. No injuries and intervention was to educate staff on safety when transferring resident. No other information about the fall was documented.

R2's record did not include a comprehensive fall analysis that identified probable root cause including if the care plan was followed, if the care plan was appropriate, and/or if R2 had a change in transfer ability.

R2's Fall report dated 6/24/24 at 9:13 p.m., indicated R2 was lying on her back on the floor and had hit her head. R2 stated she was reaching when she fell. Root cause analysis indicated R2 slid out of wheelchair while trying to rearrange things. Note section dated 7/1/24, indicated R2 was reaching for something outside of her grasp. The intervention was to keep her reacher within reach of her so that she can utilize it. The reacher was an intervention that had already been put in place on 6/12/24.

R2's record did not include a comprehensive fall analysis that included but not limited to if R2's care plan was followed and/or if R2 had the ability to use the reacher. Further did not identify any other interventions that would mitigate R2 from re-current falls related to the same identified cause.

R2's Fall report dated 6/25/24 at 7:00 p.m.,

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indicated R2 was found on the floor after reaching to pick trash off the floor. Nurse recommended R2 use her call light. Note section updated 7/3/24 identified R2 was trying to pick garbage off the floor, staff will place call light reminder signs in R2's room. There was no further information about the fall.

R2's record did not include a comprehensive fall analysis that included but not limited to if R2's care plan was followed and/or if R2 had the ability to use the reacher. Further did not identify any other interventions that would mitigate R2 from re-current falls related to the same identified cause.

R2's Fall report dated 7/2/24 at 6:25 p.m., indicated R2 was found on the floor in front of the wheelchair. R2 fell while trying to throw something away. R2 complained of left elbow pain. Notes section dated 7/3/24 identified R2 fell trying to throw something away and her chair cushion was found on the floor. Intervention for staff to put dyson [sic] under wheelchair cushion to prevent it from sliding off. Although the intervention was to put Dycem [sic] in wheelchair to prevent sliding, it was not added to the care plan until 8/20/24. R2's fall record did not include any further information about the fall including a comprehensive analysis that included but not limited to if R2's care plan was followed at the time of the fall.

R2's Progress Note dated 8/5/24 at 3:53 p.m., indicated a therapist reported that R2 had fallen in therapy. Further described knees became weak, fell back into the wheelchair, hyperextended, and slid down to the floor. The medical record lacked a fall report, comprehensive assessment, root cause analysis,

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and intervention to prevent further falls.

R2 Fall report dated 8/7/24 at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a laceration to the left eye and emergency medical services (EMS) were called for transport to the ED. A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. Notes section dated 8/14/24, identified R2 was transferring without assistance and the intervention was to re-educate R2 on pendant (call light usage). No other information was included and the record did not include a comprehensive analysis that would have identified R2's transfer care plan that directed 2 staff assist was not followed per interview with nursing assistant (NA)-A on 8/21/24 at 3:30 p.m. NA-A reported she was working with R2 at the time of the fall with injury. NA-A explained it was her first time assisting R2 and unknown NA told her that R2 transferred with one staff assist, gait belt, and walker. She assisted R2 to transfer to the commode when R2 leaned forward, and NA-A could not stop the fall.

R2's After Visit Summary dated 8/7/24, indicated R2 was evaluated in the ED following a fall and diagnosed with a face laceration and head injury.

During observation and interview on 8/20/24 at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, "things aren't going very well here". R2 further clarified she fell "a few weeks ago", hit her head, and went to the hospital for stitches, Stated, "I usually transfer with two people but there was only one [staff] here".

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During an interview on 8/21/24 at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but R2 had reported that when she fell and hit her head, there was only one person assisting her to the commode. FM-A further indicated R2 had to go to the hospital for stitches as a result of that fall. Further clarified the fall occurred on 8/7/24 and R2 reports that she frequently only has one person assisting her although she is supposed to have two.

During an interview on 8/21/24 at 3:45 p.m., NA-B indicated R2 had always required two staff assist to transfer. Further identified they use a cheat sheet (CNA Individual Report Sheet) to learn how residents transfer but did not know how often it was updated.

During interview on 8/20/24 at 9:30 a.m., registered nurse (RN)-B indicated she was working on 8/7/24 and responded to R2's fall. Indicated R2 was care planned to transfer with two staff assist at all times. Further stated that they "sometimes put some kind of intervention in place" and would be documented in the resident progress note if they did.

During an interview on 8/22/24 at 12:30 p.m., the regional nurse manager indicated the expectation of the clinical team would be to do a post fall huddle and get the information to determine the root cause of the fall and identify and implement the appropriate fall prevention interventions.

During an interview on 8/21/24 at 12:15 p.m., the administrator reviewed R3's falls and confirmed the record did not include a comprehensive analysis for any of R3's falls. Adminstartor

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2 830	Continued From page 12 identified increase in checks was not defined nor documented and could not determine how frequently the checks had been completed and therefor could not ascertain the effectiveness of the intervention. Adminstartor conceded that the facility was not performing in depth assessments and expected the facility's fall process and procedures be followed for all falls. The facility's policy titled, Fall Risk and Prevention Guidelines directs clinical staff to: Conduct interviews of; the resident, the first responder, the person who last saw the resident, any witnesses. Make note of the resident's immediate surroundings and the position the resident/tenant was found. Determine from staff the provision of the last cares, what the cares were and when they were provided. Review the record for medications in use; psychotropic, narcotics, diuretics, anticonvulsants, cardiovascular meds etc. Review the record for any medications/doses changed in the previous 30 days. Review recent laboratory values. Review the plan of care to determine care provided was consistent with plan. The nurse reviews the information collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated. Complete Adverse Event, Report in Risk Management, Complete Post Fall Data Collection in Electronic Medical Record, Update SNF Care Plan and NAR Care Plan/HHA Care Plan, 24-hour Report Updated, Family Medical Practitioner, DNS and ED notified of incident. IDT discussion of Incident for Review. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable. All falls are trended, analyzed and interventions introduced for areas of concern via monthly QAPI Meetings. Tracking of these discussions are	2 830		

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2 830	Continued From page 13 listed within QAPI Minutes Ppt. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and or/revise policies and procedures to comprehensively assess and investigate falls to determine the root cause and implement appropriate interventions. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		