



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 28, 2025

Administrator
St. Marks Living
400 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: February 21, 2025

Dear Administrator:

On March 13, 2025, we notified you a remedy was imposed. On May 20, 2025, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 22, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2025 be discontinued as of May 22, 2025. (42 CFR 488.417 (b))

In our letter of March 13, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 21, 2025. 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,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 28, 2025

Administrator
St. Marks Living
400 15th Avenue Southwest
Austin, MN 55912

Re: Reinspection Results
Event ID: 2NHQ12

Dear Administrator:

On April 15, 2025, 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 March 19, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2025

Administrator
St. Mark's Living
400 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: February 21, 2025

Dear Administrator:

On March 13, 2025, we informed you of imposed enforcement remedies.

- Civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2025. (42 CFR 488.417 (b))

On March 19, 2025, the Minnesota Department(s) of Health and Public Safety completed a complaint survey and it has been determined that your facility continues to **not** to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 21, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 21, 2025.

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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 \$13,343; 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 May 21, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St. Mark's Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 21, 2025. 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.

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, Regional Operations Supervisor, Rapid Response
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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 21, 2025 (six months after the

identification of noncompliance), if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to

St. Mark's Living

March 31, 2025

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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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 04/11/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2025	
NAME OF PROVIDER OR SUPPLIER ST MARKS LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(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 3/18/25 & 3/19/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53698787C (MN00111047), with deficiencies cited at F684, F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document			F 684			4/11/25
					F684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/09/2025

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 684	Continued From page 1 review, the facility failed to comprehensively assess and monitor non-pressure related impairments in skin integrity for 3 of 3 (R1, R2, R3) residents reviewed for injuries. Additionally the facility failed to ensure appropriate interventions were in place to reduce bruising for 1 of 1 resident (R1) at risk for bruising due to taking an anticoagulant (medication that prevents blood clots from forming) Findings include R1 R1's face sheet dated 3/19/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), diabetes mellitus (condition that affects how the body uses sugar as fuel), and atrial fibrillation (condition causing rapid heartbeat that commonly causes poor blood flow). R1's focus care plan dated 8/7/24, identified R1 is at risk for bruising/bleeding/adverse effects with anticoagulant therapy with a goal of skin will remain intact and minimal bruising. Interventions included: monitor, document, and report bruising. R1's order summary dated 3/19/25, identified R1 was on an anticoagulant for atrial fibrillation. R1's skin assessment on 2/24/25 at 3:02 a.m., identified R1 had a new bruise on right inner upper arm measuring 33 centimeters (cm) x 20 cm. The assessment did not include characteristics of the bruise. R1's progress note dated 2/24/25 at 4:32 a.m., identified R1 was observed thrashing around under cover and a large 33 centimeters (cm) x 20			F 684	Ss=D The facility will comprehensively review each resident that has a non-pressure related injury. Resident's R1, R2, and R3 charts were audited for compliance with current interventions related to non-pressure injury. The care plan was audited, and changes were made to interventions based upon assessment. ¿All current residents, including new admissions and those with a change in condition, will be evaluated for non-pressure injuries, with particular focus on those at risk due to anticoagulant use. Interventions will be care planned accordingly. All licensed nurses will receive education on proper documentation and monitoring of non-pressure skin injuries, and the importance of proactive interventions for residents at high risk for bruising, particularly those on anticoagulants. Staff will also be re-educated on following the facility's current skin integrity monitoring protocol. The Director of Nursing, or designee, will conduct weekly audits on 20% of resident skin assessments and care plans to		

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F 684	Continued From page 2 cm, bruise noted to right upper arm and resident stated it happened from hitting his side rails while boosting self-up in bed. Noted resident is on anticoagulant and pad protectors needed for side rails. Will pass along in shift report regarding bruise and bed rail concern. R1's skin assessment dated 2/24/25, identified a bruise on right upper arm measuring 33 cm x 20 cm and was caused by bumping into bed rail. R1 denied pain and skin condition poor and is on anticoagulation medications. Licensed nurse analysis identified recommendation for protection pads on side rails. R1's record did not identify protection pads placed on bed rails or monitoring of the bruise. R1's outside medical record dated 2/24/25, identified physician notified that R1 was observed thrashing around under his covers and obtained a large bruise to upper right inner arm. Measurement of 33 cm x 20 cm. R1 denies pain to the area. No noticeable warmth and skin in poor condition. In review of R1's record between 2/24/25 and 3/19/25, there was no indication the bruising was continuously monitored or assessed to identify worsening or improvement. During an observation and interview on 3/18/25 at 3:56 p.m., R1 was seated in his wheelchair in his room. R1's bed had a positioning bar on the left and right side, however, did not have any protective covers on them. Observed two long brown clothlike sleeves with openings on the hand area sitting on nightstand folded up. Registered nurse (RN)-A observed R1's left forearm and noted a bruise measuring 14 ½ cm x	F 684	ensure non-pressure injuries are accurately identified and addressed after all current residents have had a comprehensive skin assessment. Audit results will be reviewed monthly in the quality assurance performance improvement committee for review monthly for a minimum of 90 days to ensure ongoing compliance.		

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F 684	Continued From page 3 10 cm and was described as irregular in shape, purple in color and raised to touch, without pain, and no warmth. RN-A also noted 1 cm x 1.5 cm purple, circular, raised area in the left arm near the antecubital area (triangular depression on the inner surface of the elbow joint). No bruise noted on the upper right inner arm. R1 stated the bruise on his right arm was from bumping his bars in his bed but is gone now. RN-A stated R1 bumps his arms on the rails when turning side to side and has fragile skin. RN-A has not seen any protection pads on R1's bed to protect his arms and was unsure whether he used protective sleeves on his arms. RN-A explained since R1 was on a blood thinner she would notify the physician of the bruising and new hematoma by sending a situation, background, assessment, and recommendation (SBAR). Review of R1's record on 3/19/25, did not identify physician notification of the hematoma or bruising on left forearm observed on 3/18/25. During an interview on 3/19/25 at 11:10 a.m., licensed practical nurse (LPN)-A stated for any new skin issues like bruising or hematoma a skin assessment should be done, the physician should be notified, and an order to monitor the hematoma/bruise only if the physician orders the monitoring. During an interview on 3/19/25 at 2:20 p.m., director of nursing (DON) stated she was aware of R1 having frequent bruising on his arms from bumping his arms on the bars on his bed. DON stated after the bruise observed on 2/24/25 no protective pads had been placed on the bars, however they did get protective sleeves for staff to place on R1's arms at night but the sleeves for	F 684			

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F 684	Continued From page 4 his arms were not in the care plan or monitoring in place. R2 R2's face sheet indicated R2 had diagnoses that included chronic kidney disease stage 4 (loss of kidney function that can cause easy bruising and delay wound healing). R2's care plan focus dated 2/27/25, noted R2 had a potential impairment to skin integrity. Interventions included: - Lotion on dry skin areas as necessary (dated 1/25/24) - Skin barrier crème/ointment to protect skin as needed (dated 1/25/24) - Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (dated 1/25/24) - Wound/skin treatments as ordered (dated 2/1/24) - Resident will utilize pressure-relieving/reducing pad while in chair (dated 3/4/25) Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., noted it was "not part of the medical record." R2 had an unwitnessed fall on 3/14/25 at 1:15 a.m. in her bathroom and had pain to the lower-left back and red/purple color observed in two areas measuring: 7.5 x 12 & 9 x 8. With no other skin issues observed." The injuries section included "Injury type: bruise (flat), injury location: rear left iliac crest [upper part of hip bones]." R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Appearance: "pain reported on her lower-left			F 684			

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F 684	Continued From page 5 back. Red/purple color observed in two areas measuring 7.5 x 12 & 9 x 8," range of motion "good" and without discomfort, no other skin issues noted. The SBAR progress note did not include a comprehensive assessment of the two noted areas of discoloration on R2's lower back. The documented assessment was limited to size (without an identified unit of measurement or identification of which individual bruise was measured), color, general location, range of motion, and the presence of pain. R2's fall care plan focus dated 3/14/25, noted R2 had an "unwitnessed fall without apparent injury" on 3/14/25. The intervention was 'call, don't fall' signs placed in resident room. R2's fall care plan did not identify R2's injury of multiple bruises on her back. R2's skin care plan was not revised to identify the bruises or related goals or interventions R2's progress note dated 3/15/25 at 11:25 a.m., included "Did noticed [sic] couple bruises on back from fall. Will continue to monitor." R2's progress note dated 3/17/25 at 11:31 a.m., indicated the on-call provider was contacted to provide an update about R2's decreased activities participation "due to having increased pain." The on-call provider "stated to continue to monitor and if bruising gets bigger as if there was [a] hematoma [closed wound where blood collects outside of blood vessels] under the skin or if pain or ROM gets worse, we will need to send resident in for evaluation. R2's task charting for nursing assistants (NA's)	F 684			

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F 684	Continued From page 6 included a Skin Observation task. Options included: scratched, red area, discoloration, skin tear, open area, none of the above observed, resident not available, or resident refused. Charting from 3/14/25 to 3/18/25 included: - "None of the above observed" on: 3/14/25 at 2:34 a.m., 6:30 a.m., 10:29 p.m., and 11:30 p.m.; on 3/15/25 at 8:30 p.m.; on 3/16/25 at 3:26 a.m. and 2:53 p.m.; on 3/17/25 at 4:28 a.m., 11:06 a.m., and 10:29 p.m.; and on 3/18/25 at 1:10 a.m. - "Discoloration" on 3/15/25 at 7:55 a.m., with follow-up questions "Is this a new skin condition?" marked "yes" and "Where is the discolored area located?" marked "back." - "Discoloration" on 3/16/25 at 6:30 a.m., with follow-up questions "Is this a new skin condition?" marked "no" and "Where is the discolored area located?" marked "back." R2's progress notes from 3/14/25 through 3/18/25 did not identify additional assessments or monitoring of the bruises on R2's back. During an interview on 3/18/25 at 3:05 p.m., trained medication aide (TMA)-B stated nurses are responsible for assessing a resident after a fall. TMA-B further noted nurses were responsible for ongoing monitoring after a fall and this would be located on the resident's TAR. On 3/18/25 at 3:28 p.m., R2 was resting in the recliner in her room. RN-A observed the bruises on R2's back, noting there was a "little bit of bruising" on her left lower back that was light green in color. RN-A measured the bruising and noted three bruises. The first measured 9.0 cm x 6.0. The second bruise, underneath the first, was 7.0 cm x 1.5 cm. The third, a "line of purple bruising here under her [R2's] waistband" was 9.0	F 684			

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F 684	Continued From page 7 cm x 2.0 cm tall. RN-A stated this was the first time she had seen the bruises and noted they would have been assessed when R2 fell as nurses are "typically supposed to do a head-to-toe [assessment] after a fall." RN-A explained nurses were supposed to fill out a fall checklist/packet and risk management documentation for every fall and this is where injuries would be charted. RN-A stated, "I don't think we would do [document] a skin assessment unless we saw something, we would only chart if something was noted." RN-A noted that for bruising "I think we are just supposed to notify the provider and monitor it to make sure it's getting better." RN-A would know if a bruise was getting better by looking back at the skin assessment of the initial injury to see if it was getting smaller. RN-A reviewed and identified the documentation of R2's bruises in the EHR only identified two bruises and there was no documentation of a third bruise. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she would complete a skin assessment after a fall if a resident had any injuries such as a skin tear, bruise, scratch, or if they broke a bone. Skin assessments were normally completed weekly, and she would note if a resident had a healing bruise from a recent fall and take measurements. Skin injuries should be monitored until they heal but was not sure how often a bruise should be monitored, she would have to ask the DON. LPN-A would document further monitoring in a progress note. LPN-A confirmed a physician order was not needed for nurses to implement plan for monitoring. LPN-A would assess the color, if it was healing, the length and measurements, any tenderness, any surrounding	F 684			

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F 684	Continued From page 8 redness, and the location. LPN-A stated she did not know how she could tell if a bruise was getting better or worse if there was a lack of documentation and/or comprehensive assessment of a bruise. During an interview on 3/19/24 at 2:19 p.m., DON confirmed R2's record lacked a post-fall Skin Assessment, there was only an assessment of the bruises in the risk management incident report which "was not a comprehensive assessment." The DON would expect a comprehensive assessment of bruising to include measurements, color, number and location, associated swelling, abrasions, bleeding, range of motion, and pain. DON "did not see a comprehensive assessment of the bruises at any point" and this "does not meet expectations for following professional standards of practice and facility protocol." DON would expect bruises to be monitored every shift with documentation of the size, location, color and any change in color, swelling, pain, ROM, anything new, and any changes or progress noted. DON confirmed monitoring of R2's bruises "wasn't done" and it was "not monitored in line with expectations and standards of practice." DON would expect to see the bruises on R2's care plan along with measurements, how it was obtained, what staff need to monitor for, and any treatments. The DON confirmed the bruises were not on R2's care plan. R3 R3's face sheet dated 3/19/25, identified diagnoses of history of falling, macular degeneration of left eye (eye disease that causes vision loss), heart failure, and emphysema (chronic lung disease that damages the lungs' air			F 684			

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F 684	Continued From page 9 sacs). R3's focus care plan dated 2/19/25, identified potential impairment to skin integrity. Goal to be free from any skin-related infection. Interventions included: lotion dry skin, reposition while in chair: offload at least 1 minute, skin barrier cream, use caution during transfers and bed mobility to prevent striking arms, leg, and hands against any sharp or hard surface. R3's progress note dated 3/5/25 at 6:39 a.m., identified R3 was found on the floor on her left side with her recliner tipped forward and sustained a hematoma on her left side of her forehead and a skin tear on her left forearm. R3's record did not identify a comprehensive assessment of the hematoma or skin tear. Review of R3's record between 3/4/25 to 3/19/25, did not identify any monitoring of hematoma/bruise on left forehead. R3's skin assessment dated 3/6/25, identified a left forehead bruise measuring 3 cm x 3 ½ cm and skin tear on right elbow measuring 2 cm x 1 cm., and overall impression of healing, however, did not identify color of bruise or pain. R3's Skin Assessment date 3/13/25 at 11:59 a.m., identified skin dry and intact and areas healed. During an observation and interview on 3/19/25 at 10:33 a.m., R3 was in her room, seated in her recliner. R3 was observed to have a yellow color bruise on her left forehead about 3 cm in diameter. R3 denied pain from the bruise and stated she must have gotten it from a fall she had a while back.	F 684			

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F 684	Continued From page 10 During an interview on 3/18/25 at 4:10 p.m., RN-A identified R3 had had a fall on 3/4/25 and sustained a hematoma on her left forehead and currently measuring 2.5 cm x 2 ½ cm, flat, faint-yellow color around the edges only, and without pain. RN-A stated the faint-yellow color of the bruise shows it was healing. During an interview on 3/19/25 at 1:12 p.m., director of nursing (DON) stated R1's record did not identify communication to the physician of R1's new hematoma/bruising on left forearm or any monitoring of the area. DON further stated R3's record did not identify any monitoring of the hematoma/bruise on her left forehead and her expectation would be for the physician to be notified in a timely manner for any new skin issues and a nursing order placed in the TAR to monitor these skin issues until healed. Facility policy titled Skin Assessment Policy dated 1/25, included: "It is the policy of St. Marks Living to conduct comprehensive skin assessments for all residents to prevent, identify, and manage skin integrity issues, including pressure injuries, wounds, infections, and other dermatologic conditions ... 2. Routine Skin Assessments - Daily Observations: CNAs shall observe residents' skin during routine care (bathing dressing, repositioning) and report concerns to the charge nurse ... 4. Wound Care Management. - Any new or worsening wounds shall be assessed and documented, including size, depth, color, drainage, and signs of infection. - The wound care team or physician shall be consulted for appropriate treatment plans... 5. Documentation and Reporting - All skin assessments, findings, and interventions shall be documented in the	F 684			

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F 684	Continued From page 11	F 684			
F 689 SS=D	resident's electronic health record (EHR)." 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 comprehensively assess and evaluate causal factors for a fall and develop and monitor the effectiveness of appropriate interventions to reduce the risk of falls for 3 of 3 residents (R2, R1, R3) reviewed. Additionally, the facility failed to implement identified interventions for 2 of 3 residents (R1, R3) reviewed. Findings include: R2 R2's face sheet indicated R2 admitted to the facility on 1/25/24 and had diagnoses including unspecified dementia with anxiety, generalized muscle weakness, unsteadiness on feet, and a history of falling. R2's admitting diagnosis was a left femur fracture. R2's care plan focus dated 1/25/24, identified R2 was at risk for falls related to left hip fracture. Interventions included: call light within reach/encourage use of call light for assistance	F 689			4/11/25
			F689 Ss=D 1. Corrective Action for Identified Residents: Residents R1, R2, and R3 were immediately reassessed following their falls. Causal factors were analyzed using the facility's post-fall review tool, and the care plans were revised with person-centered interventions specific to the identified risks. IDT reviewed each case and implemented immediate and long-term interventions. 2. Identification of Other Residents Affected: All residents identified as high fall risk who have had a fall or major injury in the past 90 days will be reviewed. Each fall will be analyzed for causal factors, and care		

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F 689	Continued From page 12 as needed, ensure R2 is wearing appropriate footwear (non-skid socks or rubber-soled shoes) during transfer/ambulation/mobilizing in wheelchair, physical and occupational therapies as ordered, and follow facility fall protocol. R2's care plan focus dated 1/25/24, identified R2 had an activities of daily living (ADL's) self-care performance deficit related to unspecified dementia with anxiety. Interventions dated 6/4/24, included: R2 required assistance by one staff to move between surfaces as necessary for transfers and propelled herself in a wheelchair around the facility, and R2 required assistance by one staff for toileting and would pivot transfer with stand by assist. An additional focus dated 1/25/24, identified R2 had limited physical mobility, and a corresponding intervention noted R2 did not walk. R2's provider note dated 1/30/25, included a diagnosis of history of falling (chronic). Fall-related risk factors identified were: age greater than 80, female, disability, functional limitation or limitations in ADL's, cognitive impairments, gait impairment, balance impairments, decreased muscle strength, previous falls, depression, more than four medication or psychoactive medications, diabetes, arthritis, urinary incontinence, and pain. R2's annual Minimum Data Set (MDS) dated 2/27/25, indicated R2 had no falls since the prior assessment. R2 required supervision or touching assistance with toileting hygiene, moderate assistance with toilet transfers, and used a manual wheelchair independently. R2's had moderate cognitive impairment and did not exhibit rejection of care or behaviors.			F 689	plans will be audited and revised as necessary to reflect appropriate, individualized fall prevention interventions. 3. Systemic Changes Implemented: All licensed nurses and nursing assistants will be re-educated on: Completing immediate documentation after a fall Implementing and documenting immediate interventions Conducting post-fall analysis and ensuring care plan updates An interdisciplinary team (IDT) meeting will be held within 24–48 hours after each fall to review the event, determine root cause, and revise interventions as needed. The facility will reinforce use of the current fall risk protocol and the IDT fall review process. 4. Ongoing Monitoring and Quality Assurance: The Director of Nursing or designee will: Conduct audits after every fall, verifying that immediate interventions were implemented, post-fall analysis completed, and care plans updated Ensure each fall is reviewed by the IDT within 48 hours		

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F 689	Continued From page 13 R2's Morse Fall Scale assessment dated 2/27/25, indicated R2 had fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait (stooped but able to lift head without losing balance, steps are short and resident may shuffle), and knew the limits of her ability to ambulate safely. The total score of 50 points identified R2 as a high risk for falls. R2's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/5/25, identified R2 had an actual problem/need and "when the resident was assessed, she had a hard time recalling the three words that were said to her at the beginning of the assessment ... [R2] has a medical diagnosis of unspecified dementia, unspecified severity, with anxiety, which could be a reason for not remembering things when asked." Facility paper Fall Report Packet/Checklist for R2 dated 3/14/25 at 1:15 a.m., included a Floor Nurse Checklist, Management Checklist, Falls Root Cause Analysis and Witness Statement, list of fall interventions, and Incident Root Cause Analysis (Five Why's). The Falls Root Cause Analysis and Witness Statement identified R2 fell in her bathroom unwitnessed while transferring/toileting/self-transferring and described the scene of the fall and observation of the resident as in the SBAR note. R2 complained of pain and requested toileting at the time of the fall and stated she slid off the edge of the toilet while turning and sitting down. She was alert and oriented, wore nonslip footwear, and care plan was followed. Call light was in reach and turned on, door closed, television and lights off, room was cool, and the last time R2 was toileted prior			F 689	Conduct weekly audits of 20% of high-risk residents to verify intervention effectiveness and adherence to protocol for a minimum of 90 days Audit results and fall trends will be reported and reviewed monthly in the QAPI committee to ensure sustained improvement and identify further actions if needed.		

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F 689	Continued From page 14 to the fall was blank with note "self-toilets." Suggestions for prevention of another fall included: resident educated to turn on bathroom light, too dark with night light, and a sign for reminder. Interventions put in place immediately to prevent reoccurrence included: resident education, lighting turned on, and frequent checks. The Incident Root Cause Analysis (Five Why's) page was not completed. Boxes "root cause has been determined" and "complete five why's for root cause analysis" were not checked, and nurse and manager signatures were blank. The packet was provided in paper form and was not present in R2's electronic health record (EHR). Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., included a note identifying it was "not part of the medical record." An incident description of R2's fall and immediate actions taken were transcribed in the SBAR progress note. It further included: - Injury type: bruise (flat), injury location: rear left iliac crest (upper part of hip bones). - Level of consciousness: alert, mobility: wheelchair bound. - Mental status: oriented to person, oriented to situation, oriented to place, and oriented to time. - Predisposing environmental factors: poor lighting. - Predisposing physiological factors: No boxes checked and box labeled "N/A - no apparent causative factor" also not checked. - Predisposing situation factors: during transfer, and during transfer without assist/assistive device. - Other information: resident used her wheelchair from recliner to bathroom.	F 689			

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F 689	Continued From page 15 R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Situation: At 1:15 a.m. R2's bathroom call light was activated, a nursing assistant (NA) answered and reported to the nurse that R2 had fallen. The nurse observed R2 sitting up on her buttocks next to the toilet. - Background: R2 attempted to toilet herself, the bathroom light was off with only a night light on, gripper socks were on R2's feet, R2 stated she had already pulled her pants up and reported she tried to sit down on the toilet and slid off from the side. - Appearance: R2 was calm and denied hitting her head, neurological checks were started and within normal limits (no abnormalities noted), R2 assisted off the floor and into her wheelchair with a mechanical lift and two staff, R2 then assisted with toileting and noted to have a dry brief, no other skin issues noted, follow-up vital signs taken, and neurological checks continued. - Recommendation: Reminders given to R2 to turn on the overhead bathroom light when using the toilet or transferring, also reminded to call for assistance that night if needing to use the bathroom due to the potential for pain or stiffness that could affect transferring. R2 agreed with this and staff would continue to monitor. R2's Morse Fall Scale assessment dated 3/14/25, indicated R2 had not ever fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait, and knew the limits of her ability to ambulate safely. The total score of 25 points identified R2 as a moderate risk for falls. The assessment failed to identify R2 had a history of falls, and impaired gait (difficulty rising from chair,			F 689			

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F 689	Continued From page 16 cannot walk unassisted). R2's care plan included a focus dated 3/14/25, of "a moderate risk for falls (Morse score 25-44), 3/14/2025 - unwitnessed fall without apparent injury" and intervention of "call, don't fall signs placed in room." In review of R2's fall record, although the report identified the causal factor of R2 self-transferred without assistance related to toileting, R2's record did not include an assessment that determined R2's individualized toileting program, did not include a comprehensive assessment that identified the frequency of R2's "checks", nor an assessment that identified if R2 could use the call light appropriately related to her impaired cognition. R2's progress notes did not identify an assessment or evaluation of the causal factors of R2's fall. In addition, progress notes did not identify how appropriate interventions to decrease the risk of additional falls were developed or monitored for effectiveness. On 3/18/25 at 1:27 p.m., R2 was sitting in the recliner in her room. R2 stated she fell recently when she got up to go to the bathroom, her hand slipped while turning around to sit on the toilet and she fell on the ground and hit her lower back. She had "always" taken herself to the bathroom, but staff had been helping her since her fall. She "hadn't used the call light when I've been here until now." R2 noted she had resumed toileting herself independently a day or so ago and "went by myself this afternoon." R2 stated she needed to use the bathroom and shifted in the recliner, attempting to get up. This surveyor reminded R2	F 689			

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F 689	Continued From page 17 to use the call light. R2 pressed the call light, NA-D entered, and NA-D assisted R2 with transferring from the recliner to wheelchair and wheelchair to toilet. NA-D stated, "I was kind of confused because she usually doesn't call or ask for help. That's why I thought it was weird her light was on ... I've never had her call for help getting up." During an interview on 3/18/25 at 2:10 p.m., NA-D stated she had never seen R2's call light on before and R2 had never called for help. NA-D stated R2 was independent with transfers. During an interview on 3/18/25 at 2:15 p.m., trained medication aide (TMA)-A stated R2 transferred independently and didn't ask for help. TMA-A noted R2 fell recently and "we had to tell her you have to ask us [for help]." TMA-A stated R2 had only been toileting with staff assistance since her fall. On 3/18/25 at 3:28 p.m., registered nurse (RN)-A indicated R2 was normally independent with transfers even though the care plan indicated she needed assistance from staff. RN-A asked R2, "You normally transfer yourself, don't you? Has someone been helping you transfer after your fall, or have you been moving yourself still?" R2 replied, "moving myself mostly, but sometimes I call for help." RN-A noted that after a fall, nurses filled out the paper fall packet with a checklist, fall investigation, and neurological checks and gave it to the DON. During an interview on 3/19/25 at 10:04 a.m., NA-C stated R2 was one assist for transfers and toilet use and did not have a toileting schedule. NA-C thought "she probably kind of sneaks in	F 689			

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F 689	Continued From page 18 there to the bathroom without us knowing to toilet on her own. I think ever since she came here she has done that." NA-C stated R2 recently fell in her bathroom at night in the dark while self-transferring and "I guess really the only intervention is to encourage the call light ... it would have been prevented if she had just had her call light on." During an interview on 3/19/25 at 10:15 a.m., NA-A stated R2 self-transferred and "toileted independently during the day." She expressed concern that R2's "memory has really been slipping." NA-A stated she thought R2 was okay to self-transfer independently. NA-A then checked the nursing assistant care sheet and noted R2 was identified as assist of one but stated R2 self-transferred most of the time. When asked how staff managed this self-transferring, NA-A stated, "I don't know that it has even been addressed to be honest with you. Everyone knows she self-transfers." NA-A stated R2 was not a fall risk and there was nothing related to falls that staff needed to do for her. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she was aware of R2's recent fall and R2 was an assist of one but frequently transferred herself. LPN-A did not consider self-transferring to be a behavior. LPN-A stated R2 could read the 'call, don't fall' signs placed in her room but "does she follow directions, no." LPN-A noted, "we don't do a follow up on it" after a new fall intervention is put in place and there was "no re-assessment" of an intervention's efficacy. On 3/19/24 at 12:58 p.m., R2 was sitting in the recliner in her room. R2 informed this surveyor			F 689			

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F 689	Continued From page 19 that she needed to use bathroom, stated "I think I can get into my [wheel]chair," and lowered the recliner legs. This surveyor asked R2 what she did if she needed to use the bathroom and R2 stated, "I go by myself." This surveyor reminded R2 to press her call light for staff assistance. R2 pressed her call light, NA-A entered the room, and R2 stated "I guess I've got to have help to get up she [this surveyor] says." NA-A then assisted R2 with transfer from recliner to wheelchair and wheelchair to toilet. During an interview on 3/19/25 at 8:55 a.m., the DON stated fall paper packets were completed by nurses after a fall and were not part of individual resident medical records, they were part of the facility's fall investigation. She reviewed the packets upon completion. The DON stated nurses complete the root cause analysis of a fall by asking the 'five why's' outlined in the packet and then updated care plans with an appropriate intervention. The root cause analyses were reviewed at interdisciplinary team (IDT) meetings, but there was "nowhere in the medical record that documents the packet has been reviewed and the root cause discussed" and the "packets are not completed consistently." During an interview on 3/19/24 at 2:19 p.m., DON stated there was no causal analysis completed for R2's fall on 3/14/25. The DON stated she would expect it to be completed in the falls packet, transcribed into the EHR in a progress note, and identified on the care plan. DON stated the facility's incident report "does not include a comprehensive causal analysis of the fall." R2 was one assist for transfers, she was unaware of R2's tendency to self-transfer, and noted R2 "lacks safety awareness if she is transferring	F 689			

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F 689	Continued From page 20 independently." DON confirmed the incident report's analysis of R2's fall failed to identify multiple predisposing factors and was not complete or accurate. DON confirmed the Morse Fall Scale dated 3/14/25 failed to identify R2's history of falls and impaired gait and "was not accurate." The DON confirmed R2's falls care plan was not up to date or accurate. "I can't really explain what the cause of her fall was and how that was determined." The DON further stated, "We don't know that the intervention is appropriate, it is a 'call don't fall' sign. They don't work for people with cognitive impairment ... clearly we're not doing the right thing for her. If the intervention is not appropriate, then it's not going to be measurable in terms of effectiveness." R2 R2's face sheet indicated R2 admitted to the facility on 1/25/24 and had diagnoses including unspecified dementia with anxiety, generalized muscle weakness, unsteadiness on feet, and a history of falling. R2's admitting diagnosis was a left femur fracture. R2's care plan focus dated 1/25/24, identified R2 was at risk for falls related to left hip fracture. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure R2 is wearing appropriate footwear (non-skid socks or rubber-soled shoes) during transfer/ambulation/mobilizing in wheelchair, physical and occupational therapies as ordered, and follow facility fall protocol. R2's care plan focus dated 1/25/24, identified R2 had an activities of daily living (ADL's) self-care performance deficit related to unspecified			F 689			

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F 689	Continued From page 21 dementia with anxiety. Interventions dated 6/4/24, included: R2 required assistance by one staff to move between surfaces as necessary for transfers and propelled herself in a wheelchair around the facility, and R2 required assistance by one staff for toileting and would pivot transfer with stand by assist. An additional focus dated 1/25/24, identified R2 had limited physical mobility, and a corresponding intervention noted R2 did not walk. R2's provider note dated 1/30/25, included a diagnosis of history of falling (chronic). Fall-related risk factors identified were: age greater than 80, female, disability, functional limitation or limitations in ADL's, cognitive impairments, gait impairment, balance impairments, decreased muscle strength, previous falls, depression, more than four medication or psychoactive medications, diabetes, arthritis, urinary incontinence, and pain. R2's annual Minimum Data Set (MDS) dated 2/27/25, indicated R2 had no falls since the prior assessment. R2 required supervision or touching assistance with toileting hygiene, moderate assistance with toilet transfers, and used a manual wheelchair independently. R2's had moderate cognitive impairment and did not exhibit rejection of care or behaviors. R2's Morse Fall Scale assessment dated 2/27/25, indicated R2 had fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait (stooped but able to lift head without losing balance, steps are short and resident may shuffle), and knew the limits of her ability to ambulate safely. The total score of 50 points			F 689			

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F 689	Continued From page 22 identified R2 as a high risk for falls. R2's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/5/25, identified R2 had an actual problem/need and "when the resident was assessed, she had a hard time recalling the three words that were said to her at the beginning of the assessment ... [R2] has a medical diagnosis of unspecified dementia, unspecified severity, with anxiety, which could be a reason for not remembering things when asked." Facility paper Fall Report Packet/Checklist for R2 dated 3/14/25 at 1:15 a.m., included a Floor Nurse Checklist, Management Checklist, Falls Root Cause Analysis and Witness Statement, list of fall interventions, and Incident Root Cause Analysis (Five Why's). The Falls Root Cause Analysis and Witness Statement identified R2 fell in her bathroom unwitnessed while transferring/toileting/self-transferring and described the scene of the fall and observation of the resident as in the SBAR note. R2 complained of pain and requested toileting at the time of the fall and stated she slid off the edge of the toilet while turning and sitting down. She was alert and oriented, wore nonslip footwear, and care plan was followed. Call light was in reach and turned on, door closed, television and lights off, room was cool, and the last time R2 was toileted prior to the fall was blank with note "self-toilets." Suggestions for prevention of another fall included: resident educated to turn on bathroom light, too dark with night light, and a sign for reminder. Interventions put in place immediately to prevent reoccurrence included: resident education, lighting turned on, and frequent checks. The Incident Root Cause Analysis (Five Why's) page was not completed. Boxes "root	F 689			

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F 689	Continued From page 23 cause has been determined" and "complete five why's for root cause analysis" were not checked, and nurse and manager signatures were blank. The packet was provided in paper form and was not present in R2's electronic health record (EHR). Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., included a note identifying it was "not part of the medical record." An incident description of R2's fall and immediate actions taken were transcribed in the SBAR progress note. It further included: - Injury type: bruise (flat), injury location: rear left iliac crest (upper part of hip bones). - Level of consciousness: alert, mobility: wheelchair bound. - Mental status: oriented to person, oriented to situation, oriented to place, and oriented to time. - Predisposing environmental factors: poor lighting. - Predisposing physiological factors: No boxes checked and box labeled "N/A - no apparent causative factor" also not checked. - Predisposing situation factors: during transfer, and during transfer without assist/assistive device. - Other information: resident used her wheelchair from recliner to bathroom. R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Situation: At 1:15 a.m. R2's bathroom call light was activated, a nursing assistant (NA) answered and reported to the nurse that R2 had fallen. The nurse observed R2 sitting up on her buttocks next to the toilet. - Background: R2 attempted to toilet herself, the	F 689			

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F 689	Continued From page 24 bathroom light was off with only a night light on, gripper socks were on R2's feet, R2 stated she had already pulled her pants up and reported she tried to sit down on the toilet and slid off from the side. - Appearance: R2 was calm and denied hitting her head, neurological checks were started and within normal limits (no abnormalities noted), R2 assisted off the floor and into her wheelchair with a mechanical lift and two staff, R2 then assisted with toileting and noted to have a dry brief, no other skin issues noted, follow-up vital signs taken, and neurological checks continued. - Recommendation: Reminders given to R2 to turn on the overhead bathroom light when using the toilet or transferring, also reminded to call for assistance that night if needing to use the bathroom due to the potential for pain or stiffness that could affect transferring. R2 agreed with this and staff would continue to monitor. R2's Morse Fall Scale assessment dated 3/14/25, indicated R2 had not ever fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait, and knew the limits of her ability to ambulate safely. The total score of 25 points identified R2 as a moderate risk for falls. The assessment failed to identify R2 had a history of falls, and impaired gait (difficulty rising from chair, cannot walk unassisted). R2's care plan included a focus dated 3/14/25, of "a moderate risk for falls (Morse score 25-44), 3/14/2025 - unwitnessed fall without apparent injury" and intervention of "call, don't fall signs placed in room." In review of R2's fall record, although the report	F 689			

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F 689	Continued From page 25 identified the causal factor of R2 self-transferred without assistance related to toileting, R2's record did not include an assessment that determined R2's individualized toileting program, did not include a comprehensive assessment that identified the frequency of R2's "checks", nor an assessment that identified if R2 could use the call light appropriately related to her impaired cognition. R2's progress notes did not identify an assessment or evaluation of the causal factors of R2's fall. In addition, progress notes did not identify how appropriate interventions to decrease the risk of additional falls were developed or monitored for effectiveness. On 3/18/25 at 1:27 p.m., R2 was sitting in the recliner in her room. R2 stated she fell recently when she got up to go to the bathroom, her hand slipped while turning around to sit on the toilet and she fell on the ground and hit her lower back. She had "always" taken herself to the bathroom, but staff had been helping her since her fall. She "hadn't used the call light when I've been here until now." R2 noted she had resumed toileting herself independently a day or so ago and "went by myself this afternoon." R2 stated she needed to use the bathroom and shifted in the recliner, attempting to get up. This surveyor reminded R2 to use the call light. R2 pressed the call light, NA-D entered, and NA-D assisted R2 with transferring from the recliner to wheelchair and wheelchair to toilet. NA-D stated, "I was kind of confused because she usually doesn't call or ask for help. That's why I thought it was weird her light was on ... I've never had her call for help getting up."	F 689			

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F 689	Continued From page 26 During an interview on 3/18/25 at 2:10 p.m., NA-D stated she had never seen R2's call light on before and R2 had never called for help. NA-D stated R2 was independent with transfers. During an interview on 3/18/25 at 2:15 p.m., trained medication aide (TMA)-A stated R2 transferred independently and didn't ask for help. TMA-A noted R2 fell recently and "we had to tell her you have to ask us [for help]." TMA-A stated R2 had only been toileting with staff assistance since her fall. On 3/18/25 at 3:28 p.m., registered nurse (RN)-A indicated R2 was normally independent with transfers even though the care plan indicated she needed assistance from staff. RN-A asked R2, "You normally transfer yourself, don't you? Has someone been helping you transfer after your fall, or have you been moving yourself still?" R2 replied, "moving myself mostly, but sometimes I call for help." RN-A noted that after a fall, nurses filled out the paper fall packet with a checklist, fall investigation, and neurological checks and gave it to the DON. During an interview on 3/19/25 at 10:04 a.m., NA-C stated R2 was one assist for transfers and toilet use and did not have a toileting schedule. NA-C thought "she probably kind of sneaks in there to the bathroom without us knowing to toilet on her own. I think ever since she came here she has done that." NA-C stated R2 recently fell in her bathroom at night in the dark while self-transferring and "I guess really the only intervention is to encourage the call light ... it would have been prevented if she had just had her call light on."			F 689			

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F 689	Continued From page 27 During an interview on 3/19/25 at 10:15 a.m., NA-A stated R2 self-transferred and "toileted independently during the day." She expressed concern that R2's "memory has really been slipping." NA-A stated she thought R2 was okay to self-transfer independently. NA-A then checked the nursing assistant care sheet and noted R2 was identified as assist of one but stated R2 self-transferred most of the time. When asked how staff managed this self-transferring, NA-A stated, "I don't know that it has even been addressed to be honest with you. Everyone knows she self-transfers." NA-A stated R2 was not a fall risk and there was nothing related to falls that staff needed to do for her. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she was aware of R2's recent fall and R2 was an assist of one but frequently transferred herself. LPN-A did not consider self-transferring to be a behavior. LPN-A stated R2 could read the 'call, don't fall' signs placed in her room but "does she follow directions, no." LPN-A noted, "we don't do a follow up on it" after a new fall intervention is put in place and there was "no re-assessment" of an intervention's efficacy. On 3/19/24 at 12:58 p.m., R2 was sitting in the recliner in her room. R2 informed this surveyor that she needed to use bathroom, stated "I think I can get into my [wheel]chair," and lowered the recliner legs. This surveyor asked R2 what she did if she needed to use the bathroom and R2 stated, "I go by myself." This surveyor reminded R2 to press her call light for staff assistance. R2 pressed her call light, NA-A entered the room, and R2 stated "I guess I've got to have help to get up she [this surveyor] says." NA-A then assisted	F 689			

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F 689	Continued From page 28 R2 with transfer from recliner to wheelchair and wheelchair to toilet. During an interview on 3/19/25 at 8:55 a.m., the DON stated fall paper packets were completed by nurses after a fall and were not part of individual resident medical records, they were part of the facility's fall investigation. She reviewed the packets upon completion. The DON stated nurses complete the root cause analysis of a fall by asking the 'five why's' outlined in the packet and then updated care plans with an appropriate intervention. The root cause analyses were reviewed at interdisciplinary team (IDT) meetings, but there was "nowhere in the medical record that documents the packet has been reviewed and the root cause discussed" and the "packets are not completed consistently." During an interview on 3/19/24 at 2:19 p.m., DON stated there was no causal analysis completed for R2's fall on 3/14/25. The DON stated she would expect it to be completed in the falls packet, transcribed into the EHR in a progress note, and identified on the care plan. DON stated the facility's incident report "does not include a comprehensive causal analysis of the fall." R2 was one assist for transfers, she was unaware of R2's tendency to self-transfer, and noted R2 "lacks safety awareness if she is transferring independently." DON confirmed the incident report's analysis of R2's fall failed to identify multiple predisposing factors and was not complete or accurate. DON confirmed the Morse Fall Scale dated 3/14/25 failed to identify R2's history of falls and impaired gait and "was not accurate." The DON confirmed R2's falls care plan was not up to date or accurate. "I can't really explain what the cause of her fall was and how	F 689			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2025	
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F 689	Continued From page 29 that was determined." The DON further stated, "We don't know that the intervention is appropriate, it is a 'call don't fall' sign. They don't work for people with cognitive impairment ... clearly we're not doing the right thing for her. If the intervention is not appropriate, then it's not going to be measurable in terms of effectiveness." R1 R1's face sheet dated 3/19/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), diabetes mellitus (condition that affects how the body uses sugar as fuel), and atrial fibrillation (condition causing rapid heartbeat that commonly causes poor blood flow). R1's quarterly Minimum Data Set (MDS) dated 1/31/25, identified R1 had moderate cognitive impairment, no falls since admission, maximum assistance for all transfers, and on an anticoagulant. R1's fall focus care plan dated 8/7/24, identified R1 was at risk for fall related to venous insufficiency and cellulitis to lower extremities. Goal to be free from falls. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure appropriate footwear during transfer, ambulation and/or mobilizing in wheelchair, routine safety checks, and adequate lighting. R1's fall record dated 2/19/25 at 3:30 p.m., identified R1 was found on floor lying on floor on left side. Skin tear on left elbow and bridge of nose. Immediate action taken was neurological exam, vitals, and skin assessment. Sent to			F 689			

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F 689	Continued From page 30 emergency department (ED) for evaluation. R1's fall record did not include a comprehensive analysis of the fall nor identify a root cause of the fall. The record also included a fall packet checklist dated 2/19/25, included an incident root cause analysis form, however it did not identify a root cause of the fall and unsigned. R1's focus care plan initiated on 2/19/25, identified R1 had an actual fall with minor injuries related to poor balance on 2/19/25. Goal to resume usual activities without further incident. Intervention initiated on 2/19/25 of call, do not fall signs hung in room. R1's progress note dated 2/20/25 at 2:37 a.m., identified R1 returned from ED and did not find anything of concern with labs/testing. During an observation and interview on 3/18/25 at 1:28 p.m. R1 was seated in his recliner. R1's call light was laying over his bed, approximately 5 feet away from where R1 was seated. R1was observed to be itching on both arms and stated he needed a nurse. R1 asked this surveyor to get staff to help him, because he was unable to locate his call light to press. R1 stated, "How am I supposed to ask for help if my call light is not here." Trained medication aide (TMA)-A and nursing assistant (NA)-B entered R1's room and applied lotion to bilateral arms and when completed as nursing assistant was going to leave the room, R1 asked NA-B if he could give him his call light before he left the room. During an interview on 3/18/25 at 3:21 p.m., registered nurse (RN)-A stated a residents call light should always be within reach to prevent further falls and reduce attempts to self-transfer.			F 689			

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F 689	Continued From page 31 R3 R3's face sheet dated 3/19/25, identified diagnoses of history of falling, macular degeneration of left eye (eye disease that causes vision loss), heart failure, and emphysema (chronic lung disease that damages the lungs' air sacs). R3's significant change MDS dated 3/11/25, identified R3 had severe cognitive impairment and needed moderate assistance for transfers. R3's focus care plan dated 2/19/25, identified R3 was at risk for fall due to macular degeneration and heart failure. Goal to be free from falls. Interventions included: call light within reach, ensure appropriate footwear during transfer, ambulation, and/or mobilizing inwheelchair, and adequate lighting/clear pathway in room. R3's fall incident report dated 3/4/25 at 11:45 p.m., identified R3 was found lying on the floor on her left side and her recliner tipped forward. Right pupil sluggish to respond to light, hematoma (collection of blood outside of the blood vessels) noted on the left side of forehead, and skin tear to left forearm. Immediate intervention of neurological exams began and vitals. Other information: R3 recently admitted to hospice service and received first dose of anti-anxiety medication on 3/4/25. R3's fall record did not include a comprehensive analysis of the fall nor identify a root cause of the fall and did not identify R3's recliner being tipped forward. R3's fall packet checklist dated 3/5/25, included an incident root cause analysis form, however it did not identify a root cause of the fall and	F 689			

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F 689	Continued From page 32 unsigned. R3's focus care plan dated 3/5/25, identified R3 had an actual fall with minor injury related to poor vision. Goal will resume usual activities without further incident. Intervention initiated on 3/5/25 of large soft call light with texture placed to make it easier for resident to feel. During an observation and interview on 3/19/25 at 10:33 a.m., R3 was in her room, seated in a recliner. R3 began using the button on the ride side of the recliner and was repeatedly moved the leg rests up and down. R3 was observed to have a yellow color bruise on her left forehead about 3 cm in diameter. R3 stated she did not recall how she obtained the bruise on her forehead and said it must have been from a fall. R3 was observed to not have a call light within her reach however, a large pad call light was placed about four feet away from R3 in a different chair. R3 stated she did not know where here call light was and began using both hands in her chair attempting to feel for the call light. NA-C then entered R3's room and verified that the call light was out of R3's reach and proceeded to place R3's call light on R3's arm of her recliner. NA-C stated if a resident does not have a call light in reach they would be "stranded" and may attempt to self-transfer. During an interview on 3/19/25 at 10:34 a.m., NA-A stated she did not think R3 could use the electric recliner by herself safely, and said she told management of her concern before. Because the recliner was still being used, staff just check on her often when she was in it. NA-A stated the electric recliner is not a lift chair and only allowed the leg rests to go up and down.	F 689			

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F 689	Continued From page 33 During an interview on 3/19/25 at 4:30 p.m., director of nursing (DON) stated R3 had become more confused since admission and an evaluation for independent use of her electric recliner had not been completed. DON further stated R1 and R3's medical record did not identify a comprehensive assessment of the falls that would include an evaluation for a causal factors, nor evident fall prevention interventions monitored for the effectiveness. DON's expectations would be for all staff to ensure that all fall prevention care plan interventions were implemented, and that all residents should always have a call light within reach. Facility policy titled Falls and Fall Risk, Managing dated 12/07, included: "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ... Prioritizing Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once) ... Monitoring Subsequent Falls and Fall Risk: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or re-consider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate	F 689			

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F 689	Continued From page 34 the situation and whether it is appropriate to continue or change current interventions. As needed, the Attending Physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2025

Administrator
St Marks Living
400 15th Avenue Southwest
Austin, MN 55912

Re: State Nursing Home Licensing Orders
Event ID: 2NHQ11

Dear Administrator:

The above facility was surveyed on March 18, 2025, through March 19, 2025, 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, Regional Operations Supervisor, Rapid Response
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
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00394	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2025
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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 3/18/25 & 3/19/25, 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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/09/25

Minnesota Department of Health

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H53698787C (MN00111047) with licensing orders issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor non-pressure related impairments in skin integrity for 3 of 3 (R1, R2, R3) residents reviewed for injuries. Additionally the facility failed to ensure appropriate interventions were in place to reduce bruising for 1 of 1 resident (R1) at risk for bruising due to taking an anticoagulant (medication that prevents blood clots from forming)	2 830	Complete	4/11/25	

Minnesota Department of Health

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2 830	Continued From page 3 Findings include R1 R1's face sheet dated 3/19/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), diabetes mellitus (condition that affects how the body uses sugar as fuel), and atrial fibrillation (condition causing rapid heartbeat that commonly causes poor blood flow). R1's focus care plan dated 8/7/24, identified R1 is at risk for bruising/bleeding/adverse effects with anticoagulant therapy with a goal of skin will remain intact and minimal bruising. Interventions included: monitor, document, and report bruising. R1's order summary dated 3/19/25, identified R1 was on an anticoagulant for atrial fibrillation. R1's skin assessment on 2/24/25 at 3:02 a.m., identified R1 had a new bruise on right inner upper arm measuring 33 centimeters (cm) x 20 cm. The assessment did not include characteristics of the bruise. R1's progress note dated 2/24/25 at 4:32 a.m., identified R1 was observed thrashing around under cover and a large 33 centimeters (cm) x 20 cm, bruise noted to right upper arm and resident stated it happened from hitting his side rails while boosting self-up in bed. Noted resident is on anticoagulant and pad protectors needed for side rails. Will pass along in shift report regarding bruise and bed rail concern. R1's skin assessment dated 2/24/25, identified a bruise on right upper arm measuring 33 cm x 20 cm and was caused by bumping into bed rail. R1 denied pain and skin condition poor and is on	2 830			

Minnesota Department of Health

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2 830	Continued From page 4 anticoagulation medications. Licensed nurse analysis identified recommendation for protection pads on side rails. R1's record did not identify protection pads placed on bed rails or monitoring of the bruise. R1's outside medical record dated 2/24/25, identified physician notified that R1 was observed thrashing around under his covers and obtained a large bruise to upper right inner arm. Measurement of 33 cm x 20 cm. R1 denies pain to the area. No noticeable warmth and skin in poor condition. In review of R1's record between 2/24/25 and 3/19/25, there was no indication the bruising was continuously monitored or assessed to identify worsening or improvement. During an observation and interview on 3/18/25 at 3:56 p.m., R1 was seated in his wheelchair in his room. R1's bed had a positioning bar on the left and right side, however, did not have any protective covers on them. Observed two long brown clothlike sleeves with openings on the hand area sitting on nightstand folded up. Registered nurse (RN)-A observed R1's left forearm and noted a bruise measuring 14 ½ cm x 10 cm and was described as irregular in shape, purple in color and raised to touch, without pain, and no warmth. RN-A also noted 1 cm x 1.5 cm purple, circular, raised area in the left arm near the antecubital area (triangular depression on the inner surface of the elbow joint). No bruise noted on the upper right inner arm. R1 stated the bruise on his right arm was from bumping his bars in his bed but is gone now. RN-A stated R1 bumps his arms on the rails when turning side to side and has fragile skin. RN-A has not seen any protection pads on R1's bed to protect his arms	2 830			

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2 830	Continued From page 5 and was unsure whether he used protective sleeves on his arms. RN-A explained since R1 was on a blood thinner she would notify the physician of the bruising and new hematoma by sending a situation, background, assessment, and recommendation (SBAR). Review of R1's record on 3/19/25, did not identify physician notification of the hematoma or bruising on left forearm observed on 3/18/25. During an interview on 3/19/25 at 11:10 a.m., licensed practical nurse (LPN)-A stated for any new skin issues like bruising or hematoma a skin assessment should be done, the physician should be notified, and an order to monitor the hematoma/bruise only if the physician orders the monitoring. During an interview on 3/19/25 at 2:20 p.m., director of nursing (DON) stated she was aware of R1 having frequent bruising on his arms from bumping his arms on the bars on his bed. DON stated after the bruise observed on 2/24/25 no protective pads had been placed on the bars, however they did get protective sleeves for staff to place on R1's arms at night but the sleeves for his arms were not in the care plan or monitoring in place. R2 R2's face sheet indicated R2 had diagnoses that included chronic kidney disease stage 4 (loss of kidney function that can cause easy bruising and delay wound healing). R2's care plan focus dated 2/27/25, noted R2 had a potential impairment to skin integrity. Interventions included: - Lotion on dry skin areas as necessary (dated	2 830			

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2 830	Continued From page 6 1/25/24) - Skin barrier crème/ointment to protect skin as needed (dated 1/25/24) - Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (dated 1/25/24) - Wound/skin treatments as ordered (dated 2/1/24) - Resident will utilize pressure-relieving/reducing pad while in chair (dated 3/4/25) Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., noted it was "not part of the medical record." R2 had an unwitnessed fall on 3/14/25 at 1:15 a.m. in her bathroom and had pain to the lower-left back and red/purple color observed in two areas measuring: 7.5 x 12 & 9 x 8. With no other skin issues observed." The injuries section included "Injury type: bruise (flat), injury location: rear left iliac crest [upper part of hip bones]." R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Appearance: "pain reported on her lower-left back. Red/purple color observed in two areas measuring 7.5 x 12 & 9 x 8," range of motion "good" and without discomfort, no other skin issues noted. The SBAR progress note did not include a comprehensive assessment of the two noted areas of discoloration on R2's lower back. The documented assessment was limited to size (without an identified unit of measurement or identification of which individual bruise was measured), color, general location, range of motion, and the presence of pain.	2 830			

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2 830	Continued From page 7 R2's fall care plan focus dated 3/14/25, noted R2 had an "unwitnessed fall without apparent injury" on 3/14/25. The intervention was 'call, don't fall' signs placed in resident room. R2's fall care plan did not identify R2's injury of multiple bruises on her back. R2's skin care plan was not revised to identify the bruises or related goals or interventions R2's progress note dated 3/15/25 at 11:25 a.m., included "Did noticed [sic] couple bruises on back from fall. Will continue to monitor." R2's progress note dated 3/17/25 at 11:31 a.m., indicated the on-call provider was contacted to provide an update about R2's decreased activities participation "due to having increased pain." The on-call provider "stated to continue to monitor and if bruising gets bigger as if there was [a] hematoma [closed wound where blood collects outside of blood vessels] under the skin or if pain or ROM gets worse, we will need to send resident in for evaluation. R2's task charting for nursing assistants (NA's) included a Skin Observation task. Options included: scratched, red area, discoloration, skin tear, open area, none of the above observed, resident not available, or resident refused. Charting from 3/14/25 to 3/18/25 included: - "None of the above observed" on: 3/14/25 at 2:34 a.m., 6:30 a.m., 10:29 p.m., and 11:30 p.m.; on 3/15/25 at 8:30 p.m.; on 3/16/25 at 3:26 a.m. and 2:53 p.m.; on 3/17/25 at 4:28 a.m., 11:06 a.m., and 10:29 p.m.; and on 3/18/25 at 1:10 a.m. - "Discoloration" on 3/15/25 at 7:55 a.m., with follow-up questions "Is this a new skin condition?" marked "yes" and "Where is the discolored area located?" marked "back." - "Discoloration" on 3/16/25 at 6:30 a.m., with	2 830			

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2 830	Continued From page 8 follow-up questions "Is this a new skin condition?" marked "no" and "Where is the discolored area located?" marked "back." R2's progress notes from 3/14/25 through 3/18/25 did not identify additional assessments or monitoring of the bruises on R2's back. During an interview on 3/18/25 at 3:05 p.m., trained medication aide (TMA)-B stated nurses are responsible for assessing a resident after a fall. TMA-B further noted nurses were responsible for ongoing monitoring after a fall and this would be located on the resident's TAR. On 3/18/25 at 3:28 p.m., R2 was resting in the recliner in her room. RN-A observed the bruises on R2's back, noting there was a "little bit of bruising" on her left lower back that was light green in color. RN-A measured the bruising and noted three bruises. The first measured 9.0 cm x 6.0. The second bruise, underneath the first, was 7.0 cm x 1.5 cm. The third, a "line of purple bruising here under her [R2's] waistband" was 9.0 cm x 2.0 cm tall. RN-A stated this was the first time she had seen the bruises and noted they would have been assessed when R2 fell as nurses are "typically supposed to do a head-to-toe [assessment] after a fall." RN-A explained nurses were supposed to fill out a fall checklist/packet and risk management documentation for every fall and this is where injuries would be charted. RN-A stated, "I don't think we would do [document] a skin assessment unless we saw something, we would only chart if something was noted." RN-A noted that for bruising "I think we are just supposed to notify the provider and monitor it to make sure it's getting better." RN-A would know if a bruise was getting better by looking back at the skin assessment of	2 830			

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2 830	Continued From page 9 the initial injury to see if it was getting smaller. RN-A reviewed and identified the documentation of R2's bruises in the EHR only identified two bruises and there was no documentation of a third bruise. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she would complete a skin assessment after a fall if a resident had any injuries such as a skin tear, bruise, scratch, or if they broke a bone. Skin assessments were normally completed weekly, and she would note if a resident had a healing bruise from a recent fall and take measurements. Skin injuries should be monitored until they heal but was not sure how often a bruise should be monitored, she would have to ask the DON. LPN-A would document further monitoring in a progress note. LPN-A confirmed a physician order was not needed for nurses to implement plan for monitoring. LPN-A would assess the color, if it was healing, the length and measurements, any tenderness, any surrounding redness, and the location. LPN-A stated she did not know how she could tell if a bruise was getting better or worse if there was a lack of documentation and/or comprehensive assessment of a bruise. During an interview on 3/19/24 at 2:19 p.m., DON confirmed R2's record lacked a post-fall Skin Assessment, there was only an assessment of the bruises in the risk management incident report which "was not a comprehensive assessment." The DON would expect a comprehensive assessment of bruising to include measurements, color, number and location, associated swelling, abrasions, bleeding, range of motion, and pain. DON "did not see a comprehensive assessment of the bruises at any	2 830			

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2 830	Continued From page 10 point" and this "does not meet expectations for following professional standards of practice and facility protocol." DON would expect bruises to be monitored every shift with documentation of the size, location, color and any change in color, swelling, pain, ROM, anything new, and any changes or progress noted. DON confirmed monitoring of R2's bruises "wasn't done" and it was "not monitored in line with expectations and standards of practice." DON would expect to see the bruises on R2's care plan along with measurements, how it was obtained, what staff need to monitor for, and any treatments. The DON confirmed the bruises were not on R2's care plan. R3 R3's face sheet dated 3/19/25, identified diagnoses of history of falling, macular degeneration of left eye (eye disease that causes vision loss), heart failure, and emphysema (chronic lung disease that damages the lungs' air sacs). R3's focus care plan dated 2/19/25, identified potential impairment to skin integrity. Goal to be free from any skin-related infection. Interventions included: lotion dry skin, reposition while in chair: offload at least 1 minute, skin barrier cream, use caution during transfers and bed mobility to prevent striking arms, leg, and hands against any sharp or hard surface. R3's progress note dated 3/5/25 at 6:39 a.m., identified R3 was found on the floor on her left side with her recliner tipped forward and sustained a hematoma on her left side of her forehead and a skin tear on her left forearm. R3's record did not identify a comprehensive assessment of the hematoma or skin tear.	2 830			

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2 830	Continued From page 11 Review of R3's record between 3/4/25 to 3/19/25, did not identify any monitoring of hematoma/bruise on left forehead. R3's skin assessment dated 3/6/25, identified a left forehead bruise measuring 3 cm x 3 ½ cm and skin tear on right elbow measuring 2 cm x 1 cm., and overall impression of healing, however, did not identify color of bruise or pain. R3's Skin Assessment date 3/13/25 at 11:59 a.m., identified skin dry and intact and areas healed. During an observation and interview on 3/19/25 at 10:33 a.m., R3 was in her room, seated in her recliner. R3 was observed to have a yellow color bruise on her left forehead about 3 cm in diameter. R3 denied pain from the bruise and stated she must have gotten it from a fall she had a while back. During an interview on 3/18/25 at 4:10 p.m., RN-A identified R3 had had a fall on 3/4/25 and sustained a hematoma on her left forehead and currently measuring 2.5 cm x 2 ½ cm, flat, faint-yellow color around the edges only, and without pain. RN-A stated the faint-yellow color of the bruise shows it was healing. During an interview on 3/19/25 at 1:12 p.m., director of nursing (DON) stated R1's record did not identify communication to the physician of R1's new hematoma/bruising on left forearm or any monitoring of the area. DON further stated R3's record did not identify any monitoring of the hematoma/bruise on her left forehead and her expectation would be for the physician to be notified in a timely manner for any new skin issues and a nursing order placed in the TAR to	2 830			

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2 830	Continued From page 12 monitor these skin issues until healed. Facility policy titled Skin Assessment Policy dated 1/25, included: "It is the policy of St. Marks Living to conduct comprehensive skin assessments for all residents to prevent, identify, and manage skin integrity issues, including pressure injuries, wounds, infections, and other dermatologic conditions ... 2. Routine Skin Assessments - Daily Observations: CNAs shall observe residents' skin during routine care (bathing dressing, repositioning) and report concerns to the charge nurse ... 4. Wound Care Management. - Any new or worsening wounds shall be assessed and documented, including size, depth, color, drainage, and signs of infection. - The wound care team or physician shall be consulted for appropriate treatment plans... 5. Documentation and Reporting - All skin assessments, findings, and interventions shall be documented in the resident's electronic health record (EHR)." Based on observation, interview, and document review, the facility failed to comprehensively assess and evaluate causal factors for a fall and develop and monitor the effectiveness of appropriate interventions to reduce the risk of falls for 3 of 3 residents (R2, R1, R3) reviewed. Additionally, the facility failed to implement identified interventions for 2 of 3 residents (R1, R3) reviewed. Findings include: R2 R2's face sheet indicated R2 admitted to the facility on 1/25/24 and had diagnoses including unspecified dementia with anxiety, generalized muscle weakness, unsteadiness on feet, and a history of falling. R2's admitting diagnosis was a	2 830			

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2 830	Continued From page 13 left femur fracture. R2's care plan focus dated 1/25/24, identified R2 was at risk for falls related to left hip fracture. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure R2 is wearing appropriate footwear (non-skid socks or rubber-soled shoes) during transfer/ambulation/mobilizing in wheelchair, physical and occupational therapies as ordered, and follow facility fall protocol. R2's care plan focus dated 1/25/24, identified R2 had an activities of daily living (ADL's) self-care performance deficit related to unspecified dementia with anxiety. Interventions dated 6/4/24, included: R2 required assistance by one staff to move between surfaces as necessary for transfers and propelled herself in a wheelchair around the facility, and R2 required assistance by one staff for toileting and would pivot transfer with stand by assist. An additional focus dated 1/25/24, identified R2 had limited physical mobility, and a corresponding intervention noted R2 did not walk. R2's provider note dated 1/30/25, included a diagnosis of history of falling (chronic). Fall-related risk factors identified were: age greater than 80, female, disability, functional limitation or limitations in ADL's, cognitive impairments, gait impairment, balance impairments, decreased muscle strength, previous falls, depression, more than four medication or psychoactive medications, diabetes, arthritis, urinary incontinence, and pain. R2's annual Minimum Data Set (MDS) dated 2/27/25, indicated R2 had no falls since the prior assessment. R2 required supervision or touching	2 830			

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2 830	Continued From page 14 assistance with toileting hygiene, moderate assistance with toilet transfers, and used a manual wheelchair independently. R2's had moderate cognitive impairment and did not exhibit rejection of care or behaviors. R2's Morse Fall Scale assessment dated 2/27/25, indicated R2 had fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait (stooped but able to lift head without losing balance, steps are short and resident may shuffle), and knew the limits of her ability to ambulate safely. The total score of 50 points identified R2 as a high risk for falls. R2's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/5/25, identified R2 had an actual problem/need and "when the resident was assessed, she had a hard time recalling the three words that were said to her at the beginning of the assessment ... [R2] has a medical diagnosis of unspecified dementia, unspecified severity, with anxiety, which could be a reason for not remembering things when asked." Facility paper Fall Report Packet/Checklist for R2 dated 3/14/25 at 1:15 a.m., included a Floor Nurse Checklist, Management Checklist, Falls Root Cause Analysis and Witness Statement, list of fall interventions, and Incident Root Cause Analysis (Five Why's). The Falls Root Cause Analysis and Witness Statement identified R2 fell in her bathroom unwitnessed while transferring/toileting/self-transferring and described the scene of the fall and observation of the resident as in the SBAR note. R2 complained of pain and requested toileting at the time of the fall and stated she slid off the edge of the toilet while turning and sitting down. She was alert and	2 830			

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2 830	Continued From page 15 oriented, wore nonslip footwear, and care plan was followed. Call light was in reach and turned on, door closed, television and lights off, room was cool, and the last time R2 was toileted prior to the fall was blank with note "self-toilets." Suggestions for prevention of another fall included: resident educated to turn on bathroom light, too dark with night light, and a sign for reminder. Interventions put in place immediately to prevent reoccurrence included: resident education, lighting turned on, and frequent checks. The Incident Root Cause Analysis (Five Why's) page was not completed. Boxes "root cause has been determined" and "complete five why's for root cause analysis" were not checked, and nurse and manager signatures were blank. The packet was provided in paper form and was not present in R2's electronic health record (EHR). Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., included a note identifying it was "not part of the medical record." An incident description of R2's fall and immediate actions taken were transcribed in the SBAR progress note. It further included: - Injury type: bruise (flat), injury location: rear left iliac crest (upper part of hip bones). - Level of consciousness: alert, mobility: wheelchair bound. - Mental status: oriented to person, oriented to situation, oriented to place, and oriented to time. - Predisposing environmental factors: poor lighting. - Predisposing physiological factors: No boxes checked and box labeled "N/A - no apparent causative factor" also not checked. - Predisposing situation factors: during transfer, and during transfer without assist/assistive device.	2 830			

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2 830	Continued From page 16 - Other information: resident used her wheelchair from recliner to bathroom. R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Situation: At 1:15 a.m. R2's bathroom call light was activated, a nursing assistant (NA) answered and reported to the nurse that R2 had fallen. The nurse observed R2 sitting up on her buttocks next to the toilet. - Background: R2 attempted to toilet herself, the bathroom light was off with only a night light on, gripper socks were on R2's feet, R2 stated she had already pulled her pants up and reported she tried to sit down on the toilet and slid off from the side. - Appearance: R2 was calm and denied hitting her head, neurological checks were started and within normal limits (no abnormalities noted), R2 assisted off the floor and into her wheelchair with a mechanical lift and two staff, R2 then assisted with toileting and noted to have a dry brief, no other skin issues noted, follow-up vital signs taken, and neurological checks continued. - Recommendation: Reminders given to R2 to turn on the overhead bathroom light when using the toilet or transferring, also reminded to call for assistance that night if needing to use the bathroom due to the potential for pain or stiffness that could affect transferring. R2 agreed with this and staff would continue to monitor. R2's Morse Fall Scale assessment dated 3/14/25, indicated R2 had not ever fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait, and knew the limits of her ability to ambulate safely. The total score of 25 points identified R2 as a moderate risk for falls. The	2 830			

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2 830	Continued From page 17 assessment failed to identify R2 had a history of falls, and impaired gait (difficulty rising from chair, cannot walk unassisted). R2's care plan included a focus dated 3/14/25, of "a moderate risk for falls (Morse score 25-44), 3/14/2025 - unwitnessed fall without apparent injury" and intervention of "call, don't fall signs placed in room." In review of R2's fall record, although the report identified the causal factor of R2 self-transferred without assistance related to toileting, R2's record did not include an assessment that determined R2's individualized toileting program, did not include a comprehensive assessment that identified the frequency of R2's "checks", nor an assessment that identified if R2 could use the call light appropriately related to her impaired cognition. R2's progress notes did not identify an assessment or evaluation of the causal factors of R2's fall. In addition, progress notes did not identify how appropriate interventions to decrease the risk of additional falls were developed or monitored for effectiveness. On 3/18/25 at 1:27 p.m., R2 was sitting in the recliner in her room. R2 stated she fell recently when she got up to go to the bathroom, her hand slipped while turning around to sit on the toilet and she fell on the ground and hit her lower back. She had "always" taken herself to the bathroom, but staff had been helping her since her fall. She "hadn't used the call light when I've been here until now." R2 noted she had resumed toileting herself independently a day or so ago and "went by myself this afternoon." R2 stated she needed to use the bathroom and shifted in the recliner,	2 830			

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2 830	Continued From page 18 attempting to get up. This surveyor reminded R2 to use the call light. R2 pressed the call light, NA-D entered, and NA-D assisted R2 with transferring from the recliner to wheelchair and wheelchair to toilet. NA-D stated, "I was kind of confused because she usually doesn't call or ask for help. That's why I thought it was weird her light was on ... I've never had her call for help getting up." During an interview on 3/18/25 at 2:10 p.m., NA-D stated she had never seen R2's call light on before and R2 had never called for help. NA-D stated R2 was independent with transfers. During an interview on 3/18/25 at 2:15 p.m., trained medication aide (TMA)-A stated R2 transferred independently and didn't ask for help. TMA-A noted R2 fell recently and "we had to tell her you have to ask us [for help]." TMA-A stated R2 had only been toileting with staff assistance since her fall. On 3/18/25 at 3:28 p.m., registered nurse (RN)-A indicated R2 was normally independent with transfers even though the care plan indicated she needed assistance from staff. RN-A asked R2, "You normally transfer yourself, don't you? Has someone been helping you transfer after your fall, or have you been moving yourself still?" R2 replied, "moving myself mostly, but sometimes I call for help." RN-A noted that after a fall, nurses filled out the paper fall packet with a checklist, fall investigation, and neurological checks and gave it to the DON. During an interview on 3/19/25 at 10:04 a.m., NA-C stated R2 was one assist for transfers and toilet use and did not have a toileting schedule. NA-C thought "she probably kind of sneaks in	2 830			

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2 830	Continued From page 19 there to the bathroom without us knowing to toilet on her own. I think ever since she came here she has done that." NA-C stated R2 recently fell in her bathroom at night in the dark while self-transferring and "I guess really the only intervention is to encourage the call light ... it would have been prevented if she had just had her call light on." During an interview on 3/19/25 at 10:15 a.m., NA-A stated R2 self-transferred and "toileted independently during the day." She expressed concern that R2's "memory has really been slipping." NA-A stated she thought R2 was okay to self-transfer independently. NA-A then checked the nursing assistant care sheet and noted R2 was identified as assist of one but stated R2 self-transferred most of the time. When asked how staff managed this self-transferring, NA-A stated, "I don't know that it has even been addressed to be honest with you. Everyone knows she self-transfers." NA-A stated R2 was not a fall risk and there was nothing related to falls that staff needed to do for her. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she was aware of R2's recent fall and R2 was an assist of one but frequently transferred herself. LPN-A did not consider self-transferring to be a behavior. LPN-A stated R2 could read the 'call, don't fall' signs placed in her room but "does she follow directions, no." LPN-A noted, "we don't do a follow up on it" after a new fall intervention is put in place and there was "no re-assessment" of an intervention's efficacy. On 3/19/24 at 12:58 p.m., R2 was sitting in the recliner in her room. R2 informed this surveyor that she needed to use bathroom, stated "I think I	2 830			

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2 830	Continued From page 20 can get into my [wheel]chair," and lowered the recliner legs. This surveyor asked R2 what she did if she needed to use the bathroom and R2 stated, "I go by myself." This surveyor reminded R2 to press her call light for staff assistance. R2 pressed her call light, NA-A entered the room, and R2 stated "I guess I've got to have help to get up she [this surveyor] says." NA-A then assisted R2 with transfer from recliner to wheelchair and wheelchair to toilet. During an interview on 3/19/25 at 8:55 a.m., the DON stated fall paper packets were completed by nurses after a fall and were not part of individual resident medical records, they were part of the facility's fall investigation. She reviewed the packets upon completion. The DON stated nurses complete the root cause analysis of a fall by asking the 'five why's' outlined in the packet and then updated care plans with an appropriate intervention. The root cause analyses were reviewed at interdisciplinary team (IDT) meetings, but there was "nowhere in the medical record that documents the packet has been reviewed and the root cause discussed" and the "packets are not completed consistently." During an interview on 3/19/24 at 2:19 p.m., DON stated there was no causal analysis completed for R2's fall on 3/14/25. The DON stated she would expect it to be completed in the falls packet, transcribed into the EHR in a progress note, and identified on the care plan. DON stated the facility's incident report "does not include a comprehensive causal analysis of the fall." R2 was one assist for transfers, she was unaware of R2's tendency to self-transfer, and noted R2 "lacks safety awareness if she is transferring independently." DON confirmed the incident report's analysis of R2's fall failed to identify	2 830			

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2 830	Continued From page 21 multiple predisposing factors and was not complete or accurate. DON confirmed the Morse Fall Scale dated 3/14/25 failed to identify R2's history of falls and impaired gait and "was not accurate." The DON confirmed R2's falls care plan was not up to date or accurate. "I can't really explain what the cause of her fall was and how that was determined." The DON further stated, "We don't know that the intervention is appropriate, it is a 'call don't fall' sign. They don't work for people with cognitive impairment ... clearly we're not doing the right thing for her. If the intervention is not appropriate, then it's not going to be measurable in terms of effectiveness." R2 R2's face sheet indicated R2 admitted to the facility on 1/25/24 and had diagnoses including unspecified dementia with anxiety, generalized muscle weakness, unsteadiness on feet, and a history of falling. R2's admitting diagnosis was a left femur fracture. R2's care plan focus dated 1/25/24, identified R2 was at risk for falls related to left hip fracture. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure R2 is wearing appropriate footwear (non-skid socks or rubber-soled shoes) during transfer/ambulation/mobilizing in wheelchair, physical and occupational therapies as ordered, and follow facility fall protocol. R2's care plan focus dated 1/25/24, identified R2 had an activities of daily living (ADL's) self-care performance deficit related to unspecified dementia with anxiety. Interventions dated 6/4/24, included: R2 required assistance by one staff to move between surfaces as necessary for	2 830			

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2 830	Continued From page 22 transfers and propelled herself in a wheelchair around the facility, and R2 required assistance by one staff for toileting and would pivot transfer with stand by assist. An additional focus dated 1/25/24, identified R2 had limited physical mobility, and a corresponding intervention noted R2 did not walk. R2's provider note dated 1/30/25, included a diagnosis of history of falling (chronic). Fall-related risk factors identified were: age greater than 80, female, disability, functional limitation or limitations in ADL's, cognitive impairments, gait impairment, balance impairments, decreased muscle strength, previous falls, depression, more than four medication or psychoactive medications, diabetes, arthritis, urinary incontinence, and pain. R2's annual Minimum Data Set (MDS) dated 2/27/25, indicated R2 had no falls since the prior assessment. R2 required supervision or touching assistance with toileting hygiene, moderate assistance with toilet transfers, and used a manual wheelchair independently. R2's had moderate cognitive impairment and did not exhibit rejection of care or behaviors. R2's Morse Fall Scale assessment dated 2/27/25, indicated R2 had fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait (stooped but able to lift head without losing balance, steps are short and resident may shuffle), and knew the limits of her ability to ambulate safely. The total score of 50 points identified R2 as a high risk for falls. R2's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/5/25, identified R2 had an	2 830			

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2 830	Continued From page 23 actual problem/need and "when the resident was assessed, she had a hard time recalling the three words that were said to her at the beginning of the assessment ... [R2] has a medical diagnosis of unspecified dementia, unspecified severity, with anxiety, which could be a reason for not remembering things when asked." Facility paper Fall Report Packet/Checklist for R2 dated 3/14/25 at 1:15 a.m., included a Floor Nurse Checklist, Management Checklist, Falls Root Cause Analysis and Witness Statement, list of fall interventions, and Incident Root Cause Analysis (Five Why's). The Falls Root Cause Analysis and Witness Statement identified R2 fell in her bathroom unwitnessed while transferring/toileting/self-transferring and described the scene of the fall and observation of the resident as in the SBAR note. R2 complained of pain and requested toileting at the time of the fall and stated she slid off the edge of the toilet while turning and sitting down. She was alert and oriented, wore nonslip footwear, and care plan was followed. Call light was in reach and turned on, door closed, television and lights off, room was cool, and the last time R2 was toileted prior to the fall was blank with note "self-toilets." Suggestions for prevention of another fall included: resident educated to turn on bathroom light, too dark with night light, and a sign for reminder. Interventions put in place immediately to prevent reoccurrence included: resident education, lighting turned on, and frequent checks. The Incident Root Cause Analysis (Five Why's) page was not completed. Boxes "root cause has been determined" and "complete five why's for root cause analysis" were not checked, and nurse and manager signatures were blank. The packet was provided in paper form and was not present in R2's electronic health record	2 830			

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2 830	Continued From page 24 (EHR). Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., included a note identifying it was "not part of the medical record." An incident description of R2's fall and immediate actions taken were transcribed in the SBAR progress note. It further included: - Injury type: bruise (flat), injury location: rear left iliac crest (upper part of hip bones). - Level of consciousness: alert, mobility: wheelchair bound. - Mental status: oriented to person, oriented to situation, oriented to place, and oriented to time. - Predisposing environmental factors: poor lighting. - Predisposing physiological factors: No boxes checked and box labeled "N/A - no apparent causative factor" also not checked. - Predisposing situation factors: during transfer, and during transfer without assist/assistive device. - Other information: resident used her wheelchair from recliner to bathroom. R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Situation: At 1:15 a.m. R2's bathroom call light was activated, a nursing assistant (NA) answered and reported to the nurse that R2 had fallen. The nurse observed R2 sitting up on her buttocks next to the toilet. - Background: R2 attempted to toilet herself, the bathroom light was off with only a night light on, gripper socks were on R2's feet, R2 stated she had already pulled her pants up and reported she tried to sit down on the toilet and slid off from the side. - Appearance: R2 was calm and denied hitting	2 830			

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2 830	Continued From page 25 her head, neurological checks were started and within normal limits (no abnormalities noted), R2 assisted off the floor and into her wheelchair with a mechanical lift and two staff, R2 then assisted with toileting and noted to have a dry brief, no other skin issues noted, follow-up vital signs taken, and neurological checks continued. - Recommendation: Reminders given to R2 to turn on the overhead bathroom light when using the toilet or transferring, also reminded to call for assistance that night if needing to use the bathroom due to the potential for pain or stiffness that could affect transferring. R2 agreed with this and staff would continue to monitor. R2's Morse Fall Scale assessment dated 3/14/25, indicated R2 had not ever fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait, and knew the limits of her ability to ambulate safely. The total score of 25 points identified R2 as a moderate risk for falls. The assessment failed to identify R2 had a history of falls, and impaired gait (difficulty rising from chair, cannot walk unassisted). R2's care plan included a focus dated 3/14/25, of "a moderate risk for falls (Morse score 25-44), 3/14/2025 - unwitnessed fall without apparent injury" and intervention of "call, don't fall signs placed in room." In review of R2's fall record, although the report identified the causal factor of R2 self-transferred without assistance related to toileting, R2's record did not include an assessment that determined R2's individualized toileting program, did not include a comprehensive assessment that identified the frequency of R2's "checks", nor an assessment that identified if R2 could use the call	2 830			

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2 830	Continued From page 26 light appropriately related to her impaired cognition. R2's progress notes did not identify an assessment or evaluation of the causal factors of R2's fall. In addition, progress notes did not identify how appropriate interventions to decrease the risk of additional falls were developed or monitored for effectiveness. On 3/18/25 at 1:27 p.m., R2 was sitting in the recliner in her room. R2 stated she fell recently when she got up to go to the bathroom, her hand slipped while turning around to sit on the toilet and she fell on the ground and hit her lower back. She had "always" taken herself to the bathroom, but staff had been helping her since her fall. She "hadn't used the call light when I've been here until now." R2 noted she had resumed toileting herself independently a day or so ago and "went by myself this afternoon." R2 stated she needed to use the bathroom and shifted in the recliner, attempting to get up. This surveyor reminded R2 to use the call light. R2 pressed the call light, NA-D entered, and NA-D assisted R2 with transferring from the recliner to wheelchair and wheelchair to toilet. NA-D stated, "I was kind of confused because she usually doesn't call or ask for help. That's why I thought it was weird her light was on ... I've never had her call for help getting up." During an interview on 3/18/25 at 2:10 p.m., NA-D stated she had never seen R2's call light on before and R2 had never called for help. NA-D stated R2 was independent with transfers. During an interview on 3/18/25 at 2:15 p.m., trained medication aide (TMA)-A stated R2 transferred independently and didn't ask for help.	2 830			

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2 830	Continued From page 27 TMA-A noted R2 fell recently and "we had to tell her you have to ask us [for help]." TMA-A stated R2 had only been toileting with staff assistance since her fall. On 3/18/25 at 3:28 p.m., registered nurse (RN)-A indicated R2 was normally independent with transfers even though the care plan indicated she needed assistance from staff. RN-A asked R2, "You normally transfer yourself, don't you? Has someone been helping you transfer after your fall, or have you been moving yourself still?" R2 replied, "moving myself mostly, but sometimes I call for help." RN-A noted that after a fall, nurses filled out the paper fall packet with a checklist, fall investigation, and neurological checks and gave it to the DON. During an interview on 3/19/25 at 10:04 a.m., NA-C stated R2 was one assist for transfers and toilet use and did not have a toileting schedule. NA-C thought "she probably kind of sneaks in there to the bathroom without us knowing to toilet on her own. I think ever since she came here she has done that." NA-C stated R2 recently fell in her bathroom at night in the dark while self-transferring and "I guess really the only intervention is to encourage the call light ... it would have been prevented if she had just had her call light on." During an interview on 3/19/25 at 10:15 a.m., NA-A stated R2 self-transferred and "toileted independently during the day." She expressed concern that R2's "memory has really been slipping." NA-A stated she thought R2 was okay to self-transfer independently. NA-A then checked the nursing assistant care sheet and noted R2 was identified as assist of one but stated R2 self-transferred most of the time. When asked	2 830			

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2 830	Continued From page 28 how staff managed this self-transferring, NA-A stated, "I don't know that it has even been addressed to be honest with you. Everyone knows she self-transfers." NA-A stated R2 was not a fall risk and there was nothing related to falls that staff needed to do for her. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she was aware of R2's recent fall and R2 was an assist of one but frequently transferred herself. LPN-A did not consider self-transferring to be a behavior. LPN-A stated R2 could read the 'call, don't fall' signs placed in her room but "does she follow directions, no." LPN-A noted, "we don't do a follow up on it" after a new fall intervention is put in place and there was "no re-assessment" of an intervention's efficacy. On 3/19/24 at 12:58 p.m., R2 was sitting in the recliner in her room. R2 informed this surveyor that she needed to use bathroom, stated "I think I can get into my [wheel]chair," and lowered the recliner legs. This surveyor asked R2 what she did if she needed to use the bathroom and R2 stated, "I go by myself." This surveyor reminded R2 to press her call light for staff assistance. R2 pressed her call light, NA-A entered the room, and R2 stated "I guess I've got to have help to get up she [this surveyor] says." NA-A then assisted R2 with transfer from recliner to wheelchair and wheelchair to toilet. During an interview on 3/19/25 at 8:55 a.m., the DON stated fall paper packets were completed by nurses after a fall and were not part of individual resident medical records, they were part of the facility's fall investigation. She reviewed the packets upon completion. The DON stated nurses complete the root cause analysis of a fall	2 830			

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2 830	Continued From page 29 by asking the 'five why's' outlined in the packet and then updated care plans with an appropriate intervention. The root cause analyses were reviewed at interdisciplinary team (IDT) meetings, but there was "nowhere in the medical record that documents the packet has been reviewed and the root cause discussed" and the "packets are not completed consistently." During an interview on 3/19/24 at 2:19 p.m., DON stated there was no causal analysis completed for R2's fall on 3/14/25. The DON stated she would expect it to be completed in the falls packet, transcribed into the EHR in a progress note, and identified on the care plan. DON stated the facility's incident report "does not include a comprehensive causal analysis of the fall." R2 was one assist for transfers, she was unaware of R2's tendency to self-transfer, and noted R2 "lacks safety awareness if she is transferring independently." DON confirmed the incident report's analysis of R2's fall failed to identify multiple predisposing factors and was not complete or accurate. DON confirmed the Morse Fall Scale dated 3/14/25 failed to identify R2's history of falls and impaired gait and "was not accurate." The DON confirmed R2's falls care plan was not up to date or accurate. "I can't really explain what the cause of her fall was and how that was determined." The DON further stated, "We don't know that the intervention is appropriate, it is a 'call don't fall' sign. They don't work for people with cognitive impairment ... clearly we're not doing the right thing for her. If the intervention is not appropriate, then it's not going to be measurable in terms of effectiveness." R1 R1's face sheet dated 3/19/25, identified	2 830			

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2 830	Continued From page 30 diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), diabetes mellitus (condition that affects how the body uses sugar as fuel), and atrial fibrillation (condition causing rapid heartbeat that commonly causes poor blood flow). R1's quarterly Minimum Data Set (MDS) dated 1/31/25, identified R1 had moderate cognitive impairment, no falls since admission, maximum assistance for all transfers, and on an anticoagulant. R1's fall focus care plan dated 8/7/24, identified R1 was at risk for fall related to venous insufficiency and cellulitis to lower extremities. Goal to be free from falls. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure appropriate footwear during transfer, ambulation and/or mobilizing in wheelchair, routine safety checks, and adequate lighting. R1's fall record dated 2/19/25 at 3:30 p.m., identified R1 was found on floor lying on floor on left side. Skin tear on left elbow and bridge of nose. Immediate action taken was neurological exam, vitals, and skin assessment. Sent to emergency department (ED) for evaluation. R1's fall record did not include a comprehensive analysis of the fall nor identify a root cause of the fall. The record also included a fall packet checklist dated 2/19/25, included an incident root cause analysis form, however it did not identify a root cause of the fall and unsigned. R1's focus care plan initiated on 2/19/25, identified R1 had an actual fall with minor injuries related to poor balance on 2/19/25. Goal to resume usual activities without further incident.	2 830			

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2 830	Continued From page 31 Intervention initiated on 2/19/25 of call, do not fall signs hung in room. R1's progress note dated 2/20/25 at 2:37 a.m., identified R1 returned from ED and did not find anything of concern with labs/testing. During an observation and interview on 3/18/25 at 1:28 p.m. R1 was seated in his recliner. R1's call light was laying over his bed, approximately 5 feet away from where R1 was seated. R1was observed to be itching on both arms and stated he needed a nurse. R1 asked this surveyor to get staff to help him, because he was unable to locate his call light to press. R1 stated, "How am I supposed to ask for help if my call light is not here." Trained medication aide (TMA)-A and nursing assistant (NA)-B entered R1's room and applied lotion to bilateral arms and when completed as nursing assistant was going to leave the room, R1 asked NA-B if he could give him his call light before he left the room. During an interview on 3/18/25 at 3:21 p.m., registered nurse (RN)-A stated a residents call light should always be within reach to prevent further falls and reduce attempts to self-transfer. R3 R3's face sheet dated 3/19/25, identified diagnoses of history of falling, macular degeneration of left eye (eye disease that causes vision loss), heart failure, and emphysema (chronic lung disease that damages the lungs' air sacs). R3's significant change MDS dated 3/11/25, identified R3 had severe cognitive impairment and needed moderate assistance for transfers.	2 830			

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2 830	Continued From page 32 R3's focus care plan dated 2/19/25, identified R3 was at risk for fall due to macular degeneration and heart failure. Goal to be free from falls. Interventions included: call light within reach, ensure appropriate footwear during transfer, ambulation, and/or mobilizing in wheelchair, and adequate lighting/clear pathway in room. R3's fall incident report dated 3/4/25 at 11:45 p.m., identified R3 was found lying on the floor on her left side and her recliner tipped forward. Right pupil sluggish to respond to light, hematoma (collection of blood outside of the blood vessels) noted on the left side of forehead, and skin tear to left forearm. Immediate intervention of neurological exams began and vitals. Other information: R3 recently admitted to hospice service and received first dose of anti-anxiety medication on 3/4/25. R3's fall record did not include a comprehensive analysis of the fall nor identify a root cause of the fall and did not identify R3's recliner being tipped forward. R3's fall packet checklist dated 3/5/25, included an incident root cause analysis form, however it did not identify a root cause of the fall and unsigned. R3's focus care plan dated 3/5/25, identified R3 had an actual fall with minor injury related to poor vision. Goal will resume usual activities without further incident. Intervention initiated on 3/5/25 of large soft call light with texture placed to make it easier for resident to feel. During an observation and interview on 3/19/25 at 10:33 a.m., R3 was in her room, seated in a recliner. R3 began using the button on the ride side of the recliner and was repeatedly moved the leg rests up and down. R3 was observed to have	2 830			

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2 830	Continued From page 33 a yellow color bruise on her left forehead about 3 cm in diameter. R3 stated she did not recall how she obtained the bruise on her forehead and said it must have been from a fall. R3 was observed to not have a call light within her reach however, a large pad call light was placed about four feet away from R3 in a different chair. R3 stated she did not know where here call light was and began using both hands in her chair attempting to feel for the call light. NA-C then entered R3's room and verified that the call light was out of R3's reach and proceeded to place R3's call light on R3's arm of her recliner. NA-C stated if a resident does not have a call light in reach they would be "stranded" and may attempt to self-transfer. During an interview on 3/19/25 at 10:34 a.m., NA-A stated she did not think R3 could use the electric recliner by herself safely, and said she told management of her concern before. Because the recliner was still being used, staff just check on her often when she was in it. NA-A stated the electric recliner is not a lift chair and only allowed the leg rests to go up and down. During an interview on 3/19/25 at 4:30 p.m., director of nursing (DON) stated R3 had become more confused since admission and an evaluation for independent use of her electric recliner had not been completed. DON further stated R1 and R3's medical record did not identify a comprehensive assessment of the falls that would include an evaluation for a causal factors, nor evident fall prevention interventions monitored for the effectiveness. DON's expectations would be for all staff to ensure that all fall prevention care plan interventions were implemented, and that all residents should always have a call light within reach.	2 830			

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2 830	Continued From page 34 Facility policy titled Falls and Fall Risk, Managing dated 12/07, included: "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ... Prioritizing Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once) ... Monitoring Subsequent Falls and Fall Risk: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or re-consider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the Attending Physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. SUGGESTED METHOD OF CORRECTION:	2 830			

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2 830	Continued From page 35 The administrator, director of nursing (DON), or designee could review/revise policies and procedures on assessment and monitoring of bruises and review all residents with bruises to assure they are receiving ongoing assessment and monitoring along with necessary treatment/services. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could conduct random audits of the delivery of care and review nursing assessments to ensure appropriate care and services are implemented. The administrator, DON, or designee could then take that information to their quality assessment and performance improvement (QAPI) committee to assess the need for further improvement. In addition, the DON or designee could review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analysis of falls occurs for fall prevention. The DON or designee could conduct measurable audits of falls to ensure analysis of the root cause is completed and identify if appropriate interventions to prevent falls are in place and monitored for effectiveness. The DON or designee could educate staff of those interventions. The results of audits could be taken to QAPI to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830			