



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 12, 2023

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: CCN: 245401
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 18, 2023, we notified you a remedy was imposed. On September 6, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 28, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 18, 2023, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 18, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 18, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 28, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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September 12, 2023

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

Re: Reinspection Results
Event ID: MLKH12

Dear Administrator:

On September 6, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 3, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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August 18, 2023

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: CCN: 245401
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 3, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 18, 2023.

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

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; 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 November 3, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Central Health Care will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 3, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 February 3, 2024, if your facility does not

achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

Central Health Care

August 18, 2023

Page 5

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

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

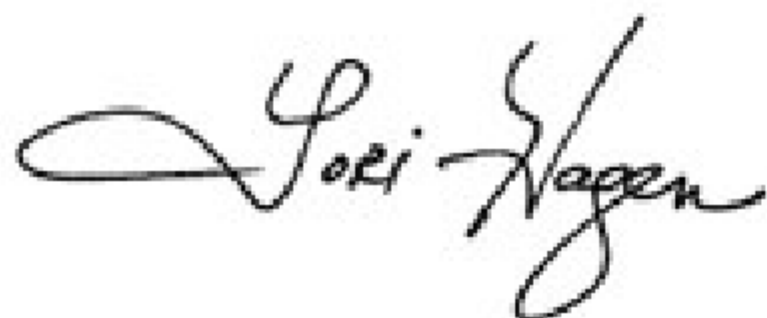
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltr_idr.cfm

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

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

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2023
NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 8/2/23 and 8/3/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H54014069C (MN95574) with deficiencies issued at F607, F689, F685, F867 and F868. 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 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		8/3/23	

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

Electronically Signed

TITLE

(X6) DATE

08/21/2023

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

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F 607	Continued From page 1 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop written policies and procedures that prohibit and prevent abuse to include a protection plan that all residents are protected from physical and psychosocial harm during and after an investigation. In addition, failed to develop written policies and procedures that establish coordination with the quality assurance and performance improvement (QAPI) program. This had the potential to affect 27 residents residing in the facility. Findings include: During an interview on 8/3/23, at 10:48 a.m. the director of nursing (DON) reviewed the undated facility abuse policy and indicated it does not have a protection plan in it. The DON stated it does not define how staff will communicate and coordinate situations of abuse with QAPI.	F 607	All staff trained on updated vulnerable adult abuse prevention plan that notes the need for resident protection from physical and psychosocial harm during and after an abuse investigation. Updated vulnerable adult abuse prevention training was added to the onboarding training material. All staff will receive Vulnerable adult abuse prevention training annually in accordance with regulation. Corrective action as it applies to others: Administrator, DON, and social worker will be educated on the newly revised policy outlining the resident being protected from physical or psychosocial harm during and after an abuse investigation. Recurrence will be prevented by: Audits of all VA reports will be completed to ensure resident safety and compliance with policy monthly x 3 months. VA reports		

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F 607	Continued From page 2	F 607			
F 689 SS=G	Facility policy, "Vulnerable Adult Reporting and Investigation," undated, lacked a resident protection plan that all residents are protected from physical and psychosocial harm during and after an abuse investigation. It also lacked written policies and procedures that establish coordination with the QAPI program. 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 each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 2 of 3 residents (R3 and R2) reviewed for falls. The facilities failure resulted in actual harm when R3's fall required emergency services with sutures to repair a deep laceration to the face. Findings include: During an observation and interview on 8/2/23 at 3:48 p.m. R3 was seated in his wheelchair to the left of his bed watching television. R3 stated the staff are nice, "but it would be nice if they would	F 689	will be reviewed monthly at QAA meetings and quarterly at QAPI meetings.		8/18/23
			1. It is the expectation of Central Healthcare of Le Center that with each fall a post fall huddle will be performed and interventions will be implemented to prevent future falls. Care plans have been reviewed and updated to meet individual safety needs. A facility wide audit was performed on all residents including R3 and R2 and all identified interventions are in place.		
			2. The deficient practice has the potential to impact all residents. Resident's fall risk assessments were reviewed, and care plans have been updated to ensure interventions in place as necessary.		

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F 689	Continued From page 3 help me walk." R3's care plan dated revised 2/1/23 indicated urinary incontinence related to advanced dementia. Interventions dated 1/30/23, included that R3 was able to verbalize to staff the need for toileting, and required extensive assist of one to two staff for toileting needs to include transfers on and off the toilet. R3's safety event, dated 5/7/23 indicated at 3:15 p.m. R3 attempted to stand up in the bathroom and R3 slid off the toilet. Staff was in R3's room at the time of the fall but was unable to get to R3 at the time. No injury identified. Root cause indicated toileting, does not identify a prevention intervention, and indicated the care plan was not reviewed or updated. R3's fall risk assessment dated 5/17/23 identified a score of 17, indicating R3 was at risk for falls. No referrals necessary, continue with current plan of care. R3's safety event, dated 5/25/23 indicated at 3:35 p.m. Social worker (SW)-A found R3 face down on the floor in front of his wheelchair with a puddle of blood next to him on the floor. Nursing came to assess, rolled R3 over and noted a deep laceration on left side under R3's nose with uncontrolled bleeding, a scrape to the middle of his forehead and scrape to R3's left knee. Received provider orders to send R3 to the hospital, ambulance arrived at 3:50 p.m. Root cause was identified as toileting. Does not identify if R3's basic needs were met, such as last time toileted or assisted with a basic care need. Did not identify a prevention intervention.	F 689	3. All nursing staff will be educated on the updated facility fall policy and managing fall risk with focus on performing a post fall huddle to be completed by floor staff, identifying a root cause of the fall, and implementing interventions to prevent future occurrence. Along with a fall investigation form to be completed by DON or designee to ensure appropriate interventions were implemented and monitored for effectiveness. 4. Audits of fall interventions will be completed weekly x 4 weeks and monthly for 3 months. All audits will be brought to and monitored through QAA monthly and QAPI quarterly for further follow-up recommendations. 5. DON or designee responsible for compliance on 8/18/23.		

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F 689	Continued From page 4 R3's after visit summary (AVS) dated 5/25/23 indicated the reason for visit was a fall with a head laceration and contusion of the left knee. R3's progress note, dated 5/26/23 indicated R3 returned to the facility at 11:30 p.m. R3 had three sutures below left nostril, hematoma on the left side of his forehead with abrasion and a few small red abrasions on his nose. R3's left knee also had two red abrasions. R3's significant change, minimum data set (MDS) dated 6/9/23, indicated R3's cognition to be severely impaired, and included the following diagnoses of Parkinson's disease, diabetes, mononeuropathy (damage to the nerve) of bilateral lower limbs, history of nasal bone fracture, and right sided multiple rib fractures. R3 required extensive assist of one staff with bed mobility, transfers, walking, toileting, and personal hygiene. Further indicated one fall with injury. R3's fall risk assessment dated 6/9/23 identified a score of 15, indicating R3 was at risk for falls. No referrals necessary, continue with current plan of care. R3's safety event dated 6/17/23 indicated at 6:45 a.m. an aide helped R3 transfer from his bed to his wheelchair and R3 fell on the floor landing on his buttocks. Will have therapy evaluate resident if he should be an EZ stand in the morning to get up as resident seems to have more difficulty in the morning with transfers. Does not identify if a gait belt was being used or if the care plan was followed. Care Plan was not reviewed. Root cause undetermined, no new prevention intervention put in place.	F 689			

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F 689	Continued From page 5 R3's progress note dated 7/14/23 at 9:30 p.m. indicated R3 was assisted to his room from the common area, as transferred to the hallway R3 stopped, grabbed the rail, and told staff he did not want to go to his room, R3 was offered to go back to the common area which R3 refused. R3 indicated he needed to go to the barn and feed the cows, which is why R3 got up from his wheelchair to go. R3 pulled himself up on the rail lost his balance and landed on the floor. R3 was reassured and was assisted with cares and bed. R3 sustained an abrasion to his left knee that measured four centimeters (cm) x 5 cm, treatment applied. No root cause identified, does not identify the last time R3 was assisted with basic care needs, no prevention intervention put in place. R3's care plan dated 7/31/23 indicated R3 had a fall on 7/14/23 with no injury due to poor balance and unsteady gait, interventions included: for no apparent acute injury, determine and address causative factors of the fall. Care plan lacked person-centered interventions and did not identify what R3's fall risk was. R3's care guide dated 7/31/23 indicated R3 had frequent falls prior to admission, frequently confused, sundown's(symptoms or dementia-related behaviors that may include difficulty sleeping, anxiety, agitation, hallucinations, pacing and disorientation) in the evening, attempt to orient to surroundings during moments of confusion, if restless bring to common area, history of self-transfers, wears incontinent brief, offer toileting via commode before and after meals and transitional times, offer urinal when in bed. Bed in low position when in it and unplugged and remind to use call	F 689			

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F 689	Continued From page 6 light. During an interview on 8/2/23, at 3:09 p.m. nursing assistant, (NA)-A stated, R3 requires two staff assist with transfers, R3 has dementia and sundowners, if you want R3 to be cooperative you have to get to R3 earlier rather than later. If R3 is up in his wheelchair, staff are to use the EZ-stand to toilet him every two hours, R3 does not ask. NA-A stated when R3 is toileted every two hours he is mostly continent. If R3 is in bed, staff do a check and change because once in bed R3 will refuse. R3 is a high risk for falls and has had falls due to R3's dementia because he forgets and thinks things need to be done on the farm. During an interview on 8/2/23, at 3:36 p.m. trained medication aide (TMA)-A stated, R3 requires total assist with all cares, R3 tries to get up frequently on his own, we need to offer toileting frequently with him due to his history of falls. TMA-A was unable to articulate whether R3 was continent or not. During an interview on 8/2/23, at 5:18 p.m. the director of nursing (DON), stated, when a resident falls, the floor nurse would be responsible to assess the resident for injury. If the resident is unable to say what happened due to dementia or confusion the nurse should be checking to ensure that their basic needs were met to include, checking to see if they are incontinent at the time of the fall, last time they were toileted, last time assisted with a basic care need such as a drink of water or something to eat. The DON further explained a root cause of the fall will be determined and should be documented in the progress note, a prevention intervention should be put in place and updated on the care plan	F 689			

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F 689	Continued From page 7 immediately to ensure all staff are aware of new fall prevention interventions. The DON confirmed that R3 has dementia and requires extensive assist with all cares and staff need to anticipate his needs. The DON reviewed R3's facility fall investigations from 5/7/23 to 7/14/23 and confirmed that the basic needs for R3 were not investigated, were not root caused and no prevention interventions have been updated to the current care plan. DON confirmed that R3 did receive injuries from two of his last four falls. The DON stated R3's fall on 5/25/23, the injury was a deep laceration to R3's left upper lip requiring emergency treatment with sutures, a left forehead hematoma and an abrasion to his left knee. The fall on 7/14/23, R3 received a left knee abrasion. The DON stated since they changed electronic health records (EHR) at the beginning of last month, the information from the old EHR was not uploaded to the new EHR record. The DON stated she was in the process of updating everyone's medical records and care plans manually and has not gotten to them all yet. The DON further stated, she updates basic cares and interventions to a word document on all the residents daily and prints them out to give to the caregivers, so they know how to care for the residents. During an observation and interview on 8/2/23, at 2:42 p.m. R2 was seated in his recliner in his room watching television and was unable to recall any falls. R2's Care plan, dated 1/23/23, indicated R2 was at risk for falls related to advancing dementia and the aging process. Interventions dated 1/23/23, included to assure R2 is wearing proper footwear, floor is free of clutter, glare, liquids, and foreign	F 689			

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F 689	Continued From page 8 objects, keep personal items and frequently used items within reach, remind R2 of his own limitations, keep call light in place and answer promptly. An additional problem dated 1/23/23, indicated R2 has incontinence of bowel and bladder related to the advancing aging process. Interventions dated 1/23/23 indicated to give bowel medications as needed, wears disposable products, staff assist with good pericare after each incontinence episode and as needed and required limited to extensive assist with toileting needs. R2's progress note dated 6/27/23, indicated R2 answers to his name, unsure if R2 knows where he is or what time it is, R2 does not talk much or say what he needs anymore. Further indicated unclear if R2 understands others or not and R2 speaks short sentences and is very soft spoken. Staff to ensure R2 is toileted and required extensive assist with toileting and was incontinent of bladder this shift. R2's quarterly, minimum data set (MDS), dated 6/28/23, indicated moderate cognitive impairment, and indicated diagnoses of dementia, post-traumatic stress disorder (PTSD), diabetes and disturbance of emotions and conduct. R2 required supervision with walking and locomotion and extensive assist of one staff for bed mobility, transfers, toileting, dressing and hygiene. R2's fall risk assessment, dated 6/28/23, indicated a score of 11, indicating R2 was at risk for falls. R2's progress note, dated 7/25/23, indicated a physician order was received for a therapy	F 689			

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F 689	Continued From page 9 evaluation to be completed due to R2 has been more unsteady while walking and leans forward when walking. R2's unwitnessed Fall Event, dated 7/27/23, at 11:39 a.m. indicated R2 was found lying on his back on the floor with his head facing the foot of the bed. R2 stated, I slipped off the cardboard and was trying to fix the car. No injuries noted. Fall investigation did not include information on when R2 was last assisted or if R2's basic needs were met. No root cause or prevention intervention indicated to prevent future falls. R2's care guide, dated 7/31/23, indicated R2 transfers with stand by assist with mobility, and was incontinent of bowel and bladder, and to toilet every two hours. During an interview on 8/2/23, at 3:05 p.m. NA-A stated R2 was very quiet in nature, can walk on his own and liked to wander when R2 is not in his room. R2 has started to get more confused lately, staff remind R2 to go to the bathroom, R2 will be continent, R2 has to be offered to go to the bathroom every two hours and does not use the call light to ask. NA-A stated to find out if a resident has had a fall staff would get that in shift report, staff use pocket care plan guides that gives us the updates, one of the nurses here is supposed to update it every day. NA-A stated I do not think R2 has had any falls. During an interview on 8/2/23, at 3:34 p.m. TMA-A stated staff give R2 reminders and cues due to his dementia. R2 likes to sit in his room and watch TV. TMA-A was not aware of any falls for R2. TMA-A stated R2 can walk and was not sure about his continence.	F 689			

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F 689	Continued From page 10 During an interview on 8/2/23, at 4:47 p.m. the DON indicated the facility investigation from R2's fall on 7/27/23, at 11:39 a.m. does not indicate a root cause for his fall, or if it was determined if R2's basic needs were met. The DON stated, there was no prevention intervention put in place to prevent future falls as we were unsure of the root cause. Facility policy, "Central Health Care Fall Protocol," dated 9/13/17, indicated, 1. Immediately after a fall: assess residents physical condition before moving, administer emergency care if determined necessary, fall with injury notify physician, DON, and family, fall without injury: notify DON, family and physician, continue to monitor residents physical and mental status for 72 hours, document findings in the nurses notes. 2. Write a detailed account of any falls using the INCIDENT REPORT form. A witness statement must be completed by the employee who finds the resident on the floor. In the event a family member finds them are to complete the witness report. Outside visitors do not complete them. A detailed description must include, where they were found, what the resident reported they were doing, location of the call light, types of footwear or lack of, location of any assistive device that they were supposed to use. Any information that may be beneficial such as increased anxiety prior to the fall, visitors present, when last attended by staff. 3. Determine immediate safety measures to be taken by staff and add to the resident care plan immediately after the fall. Document safety measures that were implemented and response in the nurses' notes. 4. Communicate measures to staff and add to the resident care plan immediately after the fall, add any new	F 689			

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F 689	Continued From page 11 intervention identified on the Incident report form. 5. Identify the cause of the fall (if able) and determine if it was an isolated incident or has the potential to recur.	F 689			
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide administration to oversee that the facility had adequate resources and guidance for appropriate resident care related to falls. This deficient practice had the potential to affect all 27 residents residing in the facility. Findings include: Refer to F689. The facility job description, Administrator" undated, indicated, nursing home administrators supervise clinical and administrative affairs of nursing and rehabilitation facilities. Typical duties include overseeing staff and personnel, financial matters, medical care, medical supplies, facilities, and other duties as specific positions demand. Policy indicated that the administrator is supervised by the Board of Directors. Qualifications are a four-year bachelor's degree in public health administration or health Services	F 835	Central Health Care has secured a full-time Administrator.	8/10/23	

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F 835	Continued From page 12 Administration and a State Nursing Home Administrator License. Responsibilities include: -Working with clinical staff to create a plan of care for each resident and to oversee resident progress and condition. -Leading teams in the nursing home to ensure all staff members meet goals and fulfill resident expectations. -Upgrading equipment and technology in the facility to reflect the changing needs of its residents. -Brainstorming solutions for financial or practical problems that arise during the facility's operation. During an interview on 8/3/23, at 10:54 a.m. the director of nursing (DON) stated the facility did not have administrator in the building since 6/20/23. DON stated she thought the business office manager (BOM)-A and BOM-B were overseeing the administrator's duties. During an interview on 8/3/23, at 11:15 a.m. BOM-A indicated she had been in this role for 40 plus years and indicated the interim administrators last day was 6/20/23 and was unaware of who at this time was fulfilling the administrator's duties. The BOM-A stated the facility owner (FO)-A told her the facility would have a new administrator start 8/1/23, she was waiting to pass her exam for licensure. The BOM-A had not heard anything since then. During a phone interview on 8/3/23, at 3:15 p.m. potential administrator (PA)-A indicated she had conversations with FO-A as potentially being the	F 835			

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F 835	Continued From page 13 next administrator but indicated she had not passed her state licensure exam and would have to wait six months to take it again. During a phone interview on 8/3/23, at 3:47 p.m. FO-A indicated the interim administrator was from a staffing agency and his assignment was up and he had another facility to go to. FO-A was unable to articulate when his last day was. FO-A stated he was waiting for PA-A to pass her test and once she was licensed, she would be the new administrator. FO-A was not aware PA-A did not pass her test. FO-A was not aware of the concerns with falls in the facility. FO-A also indicated he was not involved in the quality assurance performance improvement (QAPI). FO-A stated he relied heavily on the medical director for that.	F 835			
F 867 SS=F	Facility policy for administration was requested and not received. QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867			8/28/23

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F 867	Continued From page 14 are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;	F 867			

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F 867	Continued From page 15 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867			

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F 867	Continued From page 16 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain a quality assessment and assurance (QAA) committee that was effective in identifying, assessing, performing, developing, and implementing appropriate plans of action related to falls. This deficient practice had the potential to affect all 27 residents currently residing in the facility. Findings include: Review of the facility's QAPI (quality assurance and performance improvement) meeting minutes, dated 6/21/23, indicated the administrator or owner were not present and included: -April, 2023-9 falls -May, 2023-14 falls	F 867	The administrator will lead monthly QAPI/QAA meetings. The administrator will collaborate with the team to ensure program feedback, data systems, and appropriate monitoring. Central Health Care will monitor all adverse event monitoring, develop systematic analysis & action. Policies will be established to develop systematic approach & corrective actions, priorities performance on high-risk or problem prone areas. The administrator will establish quality assessment assurance and report to the governing body. The administrator / designee will be intendance at all QAPI meetings & assure that meeting minutes are taken. Falls will be reviewed at the		

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F 867	Continued From page 17 -one resident on hospice has had multiple falls, hospice OT (occupational therapy) came to assess, resident resistive to interventions offered, regarding parameter mattress, pillows, etc. as all the falls have been out of his bed. Review of the facility's QAPI (quality assurance and performance improvement) meeting minutes, dated 7/12/23, indicated the administrator or owner was not present and included: -nursing converted EMAR systems from Matrix to Point Click Care, live date was 7/6/23. -five noted falls for the month of June; three falls for one individual who routinely self-transfers and moves/covers his motion alarm. One fall was lowered to the floor by staff and one fall was a fall out of a sling of EZ-stand, PT/OT ordered due to not holding onto the EZ-stand, placed in Hoyer lift until evaluated by therapy. Incident Report Log, dated July 2023, identified nine falls, contributing factors not identified. The meeting minutes from June 2023 and July 2023, quality of care issues listed included CMS (Center for Medicare and Medicaid Services) quality measure for Falls. It lacked trends, root cause analysis, prevention measures, and summary of analysis. During an interview on 8/3/23, at 3:01 p.m. DON stated the facility was cited in QAPI, so part of our plan of correction was to do it monthly for 3 months, the old interim administrator was not coordinating QAPI, and the DON started it up again in June 2023, the April and May 2023 was missed. The DON stated the administrator heads	F 867	QAPI meeting. Administrator will lead the development of a QAPI committee and QAPI plan. The Administrator will ensure oversight on all QAPI activities and develop tools to assure effectiveness of all QAPI activities. Evaluation of the QAPI program and its effectiveness will be reviewed annually. The administrator / QAPI designee will attend all meetings.		

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F 867	Continued From page 18 all the QAPI meetings, and all department heads meet quarterly, and discuss quality issues we are currently having and put a plan in place to fix it. The DON stated she was not cueing in on the falls, she made a list of falls that occurred and never got to the point of root causing them. The facility owner (FO)-A has not been involved in the QAPI meetings that would fall on the administrator. The DON stated the facility has not been sharing out QAPI minutes with (FO)-A in the administrator's absence. During a phone interview on 8/3/23, at 3:47 p.m. FO-A stated the interim administrator was from a staffing agency, his assignment was up, he had another facility to go to, and was unable to state when the interim administrators last day was. FO-A stated he was unaware of the concerns with falls in the facility. FO-A stated he was not involved in the facility QAPI program and relied heavily on the medical director for the QAPI program. Facility policy, "QAPI" Quality Assurance and Performance Improvement, dated 4/27/23, indicated the facility shall develop, implement, and maintain ongoing facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality and resolve identified problems. Policy Interpretation and Implementation 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services. 2. Reinforce and build upon effective systems and processed related to the delivery of quality care and services. 3. Provide structure and processes to correct identified quality and/or safety deficiencies. 4. Establish and implement	F 867			

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F 867	Continued From page 19 plans to correct deficiencies, and to monitor the effects of these action plans on resident outcomes. 5. Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. 6. Provide a means to centralize and coordinate comprehensive QAPI activities to meet the needs of the resident and the facility. 7. Establish systems and processes to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is an effective ongoing program. Implementation: 1. The QAPI Committee shall oversee implementation of our QAPI Plan. A QAPI Coordinator shall coordinate QAPI Committee activities, including documentation. 2. This Committee shall meet quarterly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees. 3. The QAPI Committee shall oversee and authorize QAPI activities, including data-collection tools, monitoring tools, and that basis for and appropriateness and effectiveness of QAPI activities. 4. The committee shall approve any corrective actions, including changes in policies and/or procedures, employment practices, standards of care, etc., and shall also monitor all corrective activities for appropriateness and/or the need for alternative measures. 5. The committee may recommend ways to reinforce and expand identified positive approaches and outcomes to various departments or services. 6. Individual departments or services shall develop quality indicators for programs and services in which they are involved, and which affect their function. 7. Information regarding QAPI activities is confidential and may be disclosed only in	F 867			

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F 867	Continued From page 20 accordance with applicable laws and regulations. 8. Departments, services, and committees shall submit their reports to the QAPI committee as directed by the committee. Evaluation: 1. The facility shall evaluate the effectiveness of its QAPI Program at least annually and shall present their conclusions to the owner/governing board for review. 2. The QAPI committee, Administrator, and the governing board shall review and approve a summary of problems and corrective measures. Coordinator: 1. The QAPI coordinator shall attend and/or review minutes of meetings of other committees or departments as needed. 2. The QAPI Coordinator will help other committees, individuals, departments, and/or services develop quality indicators, monitoring tools, criteria, and assessment methodologies, and help them identify and evaluate concerns impacting resident care and safety. 3. The QAPI coordinator will act as a liaison among committees, individuals, services, and/or departments regarding QAPI activities.	F 867			
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868		8/28/23	

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F 868	Continued From page 21 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the required members, the administrator, medical director, and facility owner were in regular attendance of the facilities quality assessment and assurance (QAA) meetings. This had the potential to affect all 27 residents residing in the facility. Findings include: A review of the facility's QAA Meeting attendance sheets indicated the following: -QAA meeting attendance sheet dated 3/8/23, included attendance by the director of nursing	F 868	Central Health Care has procured the services of a full-time Administrator. The Administrator will lead the QAA meetings and assure compliance with federal, state & local regulatory agencies. The facility has created a QAA manual for the team to use. Members of the committee are: Director of nursing Administrator Medical Director Staffing Coordinator Activity Director		

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F 868	Continued From page 22 (DON), administrator, social worker, director of dietary services (DODS)-A, and the activity director. There was no evidence the facility's medical director or designee was in attendance for the meeting. The meeting form was blank regarding the medical director/designee. -QAA meeting attendance sheet dated 6/21/23, included attendance by the medical director, pharmacy consultant by phone, DON, social worker DODS-A, and the activity director. There was no evidence the administrator or the facility owner (FO)-A attended the meeting. The meeting form was blank regarding the administrator. -QAA meeting attendance sheet dated 7/21/23, included attendance by the DON, medical director, social worker, director of dietary services (DODS)-A, and the activity director. There was no evidence the administrator or the facility owner (FO)-A attended the meeting. The meeting form was blank regarding the administrator. During an interview on 8/3/23, at 3:01 p.m. DON stated the old interim administrator was not coordinating QAA and she started it up again in June 2023, the April and May 2023 were missed. The DON stated the administrator heads all the QAA meetings, and all department heads meet quarterly, and we discuss quality issues we are currently having and put a plan in place to fix it. FO-A has not been involved in our QAA meetings. The DON state the facility had not been sharing out QAA minutes with (FO)-A in the administrator's absence. The quarterly meeting schedule was 3/8/23, 6/21/23 and we are due again 9/8/23. During a phone interview on 8/3/23, at 3:47 p.m.	F 868	Nursing Representative Maintenance Director At the monthly QAA meetings, the administrator will lead the review of action items for the QAA committee review and check if they have been completed. Completed checklists with day certain completion will be maintained in the manual.		

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F 868	Continued From page 23 FO-A confirmed the facility did not have an administrator. FO-A indicated he was not involved in the facility QAA program. FO-A stated he relied heavily on the medical director for the QAA program. Facility policy, "QAPI" Quality Assurance and Performance Improvement, dated 4/27/23, indicated Authority: 1. The owner and/or governing board (body) of our facility shall be responsible for the QAPI Program. 2. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements. The facility policy did not include required staff members.	F 868			

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/2/23 and 8/3/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/21/23

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was reviewed H54014069C (MN95574) with a licensing order issued at 0130, 0255 and 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000			

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide administration to oversee that the facility had adequate resources and guidance for appropriate resident care related to falls. This deficient practice had the potential to affect all 27 residents residing in the facility. Findings include: Refer to F689. The facility job description, Administrator" undated, indicated, nursing home administrators supervise clinical and administrative affairs of	2 130	CORRECTED	8/18/23

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2 130	Continued From page 3 nursing and rehabilitation facilities. Typical duties include overseeing staff and personnel, financial matters, medical care, medical supplies, facilities, and other duties as specific positions demand. Policy indicated that the administrator is supervised by the Board of Directors. Qualifications are a four-year bachelor's degree in public health administration or health Services Administration and a State Nursing Home Administrator License. Responsibilities include: -Working with clinical staff to create a plan of care for each resident and to oversee resident progress and condition. -Leading teams in the nursing home to ensure all staff members meet goals and fulfill resident expectations. -Upgrading equipment and technology in the facility to reflect the changing needs of its residents. -Brainstorming solutions for financial or practical problems that arise during the facility's operation. During an interview on 8/3/23, at 10:54 a.m. the director of nursing (DON) stated the facility did not have administrator in the building since 6/20/23. DON stated she thought the business office manager (BOM)-A and BOM-B were overseeing the administrator's duties. During an interview on 8/3/23, at 11:15 a.m. BOM-A indicated she had been in this role for 40 plus years and indicated the interim administrators last day was 6/20/23 and was unaware of who at this time was fulfilling the administrator's duties. The BOM-A stated the facility owner (FO)-A told her the facility would	2 130		

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2 130	Continued From page 4 have a new administrator start 8/1/23, she was waiting to pass her exam for licensure. The BOM-A had not heard anything since then. During a phone interview on 8/3/23, at 3:15 p.m. potential administrator (PA)-A indicated she had conversations with FO-A as potentially being the next administrator but indicated she had not passed her state licensure exam and would have to wait six months to take it again. During a phone interview on 8/3/23, at 3:47 p.m. FO-A indicated the interim administrator was from a staffing agency and his assignment was up and he had another facility to go to. FO-A was unable to articulate when his last day was. FO-A stated he was waiting for PA-A to pass her test and once she was licensed, she would be the new administrator. FO-A was not aware PA-A did not pass her test. FO-A was not aware of the concerns with falls in the facility. FO-A also indicated he was not involved in the quality assurance performance improvement (QAPI). FO-A stated he relied heavily on the medical director for that. Facility policy for administration was requested and not received. SUGGESTED METHOD OF CORRECTION: The corporate owner(s) and or designees could review industry standards for staffing and budgeting for facility fiscal needs, and implement appropriate changes for the quality, health and safety of their resident population. The corporate owners or designees could complete audits of resident cares, resident satisfaction surveys, staffing patterns and staff competency to ensure resident needs are consistently met.	2 130			

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2 130	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 130		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain a quality assessment and assurance (QAA) committee that was effective in identifying, assessing, performing, developing, and implementing appropriate plans of action related to falls. This deficient practice had the potential to affect all 27 residents currently residing in the facility. Findings include: Review of the facility's QAPI (quality assurance and performance improvement) meeting minutes, dated 6/21/23, indicated the administrator or	2 255	CORRECTED	8/21/23

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2 255	Continued From page 6 owner were not present and included: -April, 2023-9 falls -May, 2023-14 falls -one resident on hospice has had multiple falls, hospice OT (occupational therapy) came to assess, resident resistive to interventions offered, regarding parameter mattress, pillows, etc. as all the falls have been out of his bed. Review of the facility's QAPI (quality assurance and performance improvement) meeting minutes, dated 7/12/23, indicated the administrator or owner was not present and included: -nursing converted EMAR systems from Matrix to Point Click Care, live date was 7/6/23. -five noted falls for the month of June; three falls for one individual who routinely self-transfers and moves/covers his motion alarm. One fall was lowered to the floor by staff and one fall was a fall out of a sling of EZ-stand, PT/OT ordered due to not holding onto the EZ-stand, placed in Hoyer lift until evaluated by therapy. Incident Report Log, dated July 2023, identified nine falls, contributing factors not identified. The meeting minutes from June 2023 and July 2023, quality of care issues listed included CMS (Center for Medicare and Medicaid Services) quality measure for Falls. It lacked trends, root cause analysis, prevention measures, and summary of analysis. During an interview on 8/3/23, at 3:01 p.m. DON stated the facility was cited in QAPI, so part of our	2 255		

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2 255	Continued From page 7 plan of correction was to do it monthly for 3 months, the old interim administrator was not coordinating QAPI, and the DON started it up again in June 2023, the April and May 2023 was missed. The DON stated the administrator heads all the QAPI meetings, and all department heads meet quarterly, and discuss quality issues we are currently having and put a plan in place to fix it. The DON stated she was not cueing in on the falls, she made a list of falls that occurred and never got to the point of root causing them. The facility owner (FO)-A has not been involved in the QAPI meetings that would fall on the administrator. The DON stated the facility has not been sharing out QAPI minutes with (FO)-A in the administrator's absence. During a phone interview on 8/3/23, at 3:47 p.m. FO-A stated the interim administrator was from a staffing agency, his assignment was up, he had another facility to go to, and was unable to state when the interim administrators last day was. FO-A stated he was unaware of the concerns with falls in the facility. FO-A stated he was not involved in the facility QAPI program and relied heavily on the medical director for the QAPI program. Facility policy, "QAPI" Quality Assurance and Performance Improvement, dated 4/27/23, indicated the facility shall develop, implement, and maintain ongoing facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality and resolve identified problems. Policy Interpretation and Implementation 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services. 2. Reinforce and build upon effective systems	2 255		

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2 255	Continued From page 8 and processed related to the delivery of quality care and services. 3. Provide structure and processes to correct identified quality and/or safety deficiencies. 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcomes. 5. Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. 6. Provide a means to centralize and coordinate comprehensive QAPI activities to meet the needs of the resident and the facility. 7. Establish systems and processes to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is an effective ongoing program. Implementation: 1. The QAPI Committee shall oversee implementation of our QAPI Plan. A QAPI Coordinator shall coordinate QAPI Committee activities, including documentation. 2. This Committee shall meet quarterly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees. 3. The QAPI Committee shall oversee and authorize QAPI activities, including data-collection tools, monitoring tools, and that basis for and appropriateness and effectiveness of QAPI activities. 4. The committee shall approve any corrective actions, including changes in policies and/or procedures, employment practices, standards of care, etc., and shall also monitor all corrective activities for appropriateness and/or the need for alternative measures. 5. The committee may recommend ways to reinforce and expand identified positive approaches and outcomes to various departments or services. 6. Individual departments or services shall develop quality indicators for programs and services in which	2 255		

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NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 255	Continued From page 9 they are involved, and which affect their function. 7. Information regarding QAPI activities is confidential and may be disclosed only in accordance with applicable laws and regulations. 8. Departments, services, and committees shall submit their reports to the QAPI committee as directed by the committee. Evaluation: 1. The facility shall evaluate the effectiveness of its QAPI Program at least annually and shall present their conclusions to the owner/governing board for review. 2. The QAPI committee, Administrator, and the governing board shall review and approve a summary of problems and corrective measures. Coordinator: 1. The QAPI coordinator shall attend and/or review minutes of meetings of other committees or departments as needed. 2. The QAPI Coordinator will help other committees, individuals, departments, and/or services develop quality indicators, monitoring tools, criteria, and assessment methodologies, and help them identify and evaluate concerns impacting resident care and safety. 3. The QAPI coordinator will act as a liaison among committees, individuals, services, and/or departments regarding QAPI activities. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administrator will be responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255			

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2 830	Continued From page 10	2 830		
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 each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 2 of 3 residents (R3 and R2) reviewed for falls. The facilities failure resulted in actual harm when R3's fall required emergency services with sutures to repair a deep laceration to the face. Findings include: During an observation and interview on 8/2/23 at 3:48 p.m. R3 was seated in his wheelchair to the left of his bed watching television. R3 stated the staff are nice, "but it would be nice if they would help me walk."	2 830	1. Staff educated on the updated facility fall policy to perform a post fall huddle to identify a root cause of the fall and apply appropriate interventions to prevent future occurrences. Fall investigation form to be completed by DON or designee post fall to ensure appropriate interventions in place and monitored to ensure effectiveness of interventions. 2. All residents at risk for falls have the potential to be affected by this practice. Facility wide audit performed to ensure appropriate fall risk interventions are in place per fall risk assessment and updated on individual care plans. 3. Nursing staff educated on updated fall policy, need for post fall huddle, and fall	8/18/23

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2 830	Continued From page 11 R3's care plan dated revised 2/1/23 indicated urinary incontinence related to advanced dementia. Interventions dated 1/30/23, included that R3 was able to verbalize to staff the need for toileting, and required extensive assist of one to two staff for toileting needs to include transfers on and off the toilet. R3's safety event, dated 5/7/23 indicated at 3:15 p.m. R3 attempted to stand up in the bathroom and R3 slid off the toilet. Staff was in R3's room at the time of the fall but was unable to get to R3 at the time. No injury identified. Root cause indicated toileting, does not identify a prevention intervention, and indicated the care plan was not reviewed or updated. R3's fall risk assessment dated 5/17/23 identified a score of 17, indicating R3 was at risk for falls. No referrals necessary, continue with current plan of care. R3's safety event, dated 5/25/23 indicated at 3:35 p.m. Social worker (SW)-A found R3 face down on the floor in front of his wheelchair with a puddle of blood next to him on the floor. Nursing came to assess, rolled R3 over and noted a deep laceration on left side under R3's nose with uncontrolled bleeding, a scrape to the middle of his forehead and scrape to R3's left knee. Received provider orders to send R3 to the hospital, ambulance arrived at 3:50 p.m. Root cause was identified as toileting. Does not identify if R3's basic needs were met, such as last time toileted or assisted with a basic care need. Did not identify a prevention intervention. R3's after visit summary (AVS) dated 5/25/23 indicated the reason for visit was a fall with a head laceration and contusion of the left knee.	2 830	investigation report. 4. DON or designee will audit post fall huddle forms and perform fall investigation after each occurrence to ensure effectiveness of interventions in place. Will be reviewed weekly for 4 weeks and monthly for 3 months. Results will be reviewed monthly at QAA and quarterly at QAPI. 5. Date of correction 8/18/23 6. DON or designee responsible for compliance.	

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2 830	Continued From page 12 R3's progress note, dated 5/26/23 indicated R3 returned to the facility at 11:30 p.m. R3 had three sutures below left nostril, hematoma on the left side of his forehead with abrasion and a few small red abrasions on his nose. R3's left knee also had two red abrasions. R3's significant change, minimum data set (MDS) dated 6/9/23, indicated R3's cognition to be severely impaired, and included the following diagnoses of Parkinson's disease, diabetes, mononeuropathy (damage to the nerve) of bilateral lower limbs, history of nasal bone fracture, and right sided multiple rib fractures. R3 required extensive assist of one staff with bed mobility, transfers, walking, toileting, and personal hygiene. Further indicated one fall with injury. R3's fall risk assessment dated 6/9/23 identified a score of 15, indicating R3 was at risk for falls. No referrals necessary, continue with current plan of care. R3's safety event dated 6/17/23 indicated at 6:45 a.m. an aide helped R3 transfer from his bed to his wheelchair and R3 fell on the floor landing on his buttocks. Will have therapy evaluate resident if he should be an EZ stand in the morning to get up as resident seems to have more difficulty in the morning with transfers. Does not identify if a gait belt was being used or if the care plan was followed. Care Plan was not reviewed. Root cause undetermined, no new prevention intervention put in place. R3's progress note dated 7/14/23 at 9:30 p.m. indicated R3 was assisted to his room from the common area, as transferred to the hallway R3 stopped, grabbed the rail, and told staff he did not	2 830		

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2 830	Continued From page 13 want to go to his room, R3 was offered to go back to the common area which R3 refused. R3 indicated he needed to go to the barn and feed the cows, which is why R3 got up from his wheelchair to go. R3 pulled himself up on the rail lost his balance and landed on the floor. R3 was reassured and was assisted with cares and bed. R3 sustained an abrasion to his left knee that measured four centimeters (cm) x 5 cm, treatment applied. No root cause identified, does not identify the last time R3 was assisted with basic care needs, no prevention intervention put in place. R3's care plan dated 7/31/23 indicated R3 had a fall on 7/14/23 with no injury due to poor balance and unsteady gait, interventions included: for no apparent acute injury, determine and address causative factors of the fall. Care plan lacked person-centered interventions and did not identify what R3's fall risk was. R3's care guide dated 7/31/23 indicated R3 had frequent falls prior to admission, frequently confused, sundown's(symptoms or dementia-related behaviors that may include difficulty sleeping, anxiety, agitation, hallucinations, pacing and disorientation) in the evening, attempt to orient to surroundings during moments of confusion, if restless bring to common area, history of self-transfers, wears incontinent brief, offer toileting via commode before and after meals and transitional times, offer urinal when in bed. Bed in low position when in it and unplugged and remind to use call light. During an interview on 8/2/23, at 3:09 p.m. nursing assistant, (NA)-A stated, R3 requires two staff assist with transfers, R3 has dementia and	2 830		

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2 830	Continued From page 14 sundowners, if you want R3 to be cooperative you have to get to R3 earlier rather than later. If R3 is up in his wheelchair, staff are to use the EZ-stand to toilet him every two hours, R3 does not ask. NA-A stated when R3 is toileted every two hours he is mostly continent. If R3 is in bed, staff do a check and change because once in bed R3 will refuse. R3 is a high risk for falls and has had falls due to R3's dementia because he forgets and thinks things need to be done on the farm. During an interview on 8/2/23, at 3:36 p.m. trained medication aide (TMA)-A stated, R3 requires total assist with all cares, R3 tries to get up frequently on his own, we need to offer toileting frequently with him due to his history of falls. TMA-A was unable to articulate whether R3 was continent or not. During an interview on 8/2/23, at 5:18 p.m. the director of nursing (DON), stated, when a resident falls, the floor nurse would be responsible to assess the resident for injury. If the resident is unable to say what happened due to dementia or confusion the nurse should be checking to ensure that their basic needs were met to include, checking to see if they are incontinent at the time of the fall, last time they were toileted, last time assisted with a basic care need such as a drink of water or something to eat. The DON further explained a root cause of the fall will be determined and should be documented in the progress note, a prevention intervention should be put in place and updated on the care plan immediately to ensure all staff are aware of new fall prevention interventions. The DON confirmed that R3 has dementia and requires extensive assist with all cares and staff need to anticipate his needs. The DON reviewed R3's facility fall investigations from 5/7/23 to 7/14/23 and	2 830			

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2 830	Continued From page 15 confirmed that the basic needs for R3 were not investigated, were not root caused and no prevention interventions have been updated to the current care plan. DON confirmed that R3 did receive injuries from two of his last four falls. The DON stated R3's fall on 5/25/23, the injury was a deep laceration to R3's left upper lip requiring emergency treatment with sutures, a left forehead hematoma and an abrasion to his left knee. The fall on 7/14/23, R3 received a left knee abrasion. The DON stated since they changed electronic health records (EHR) at the beginning of last month, the information from the old EHR was not uploaded to the new EHR record. The DON stated she was in the process of updating everyone's medical records and care plans manually and has not gotten to them all yet. The DON further stated, she updates basic cares and interventions to a word document on all the residents daily and prints them out to give to the caregivers, so they know how to care for the residents. During an observation and interview on 8/2/23, at 2:42 p.m. R2 was seated in his recliner in his room watching television and was unable to recall any falls. R2's Care plan, dated 1/23/23, indicated R2 was at risk for falls related to advancing dementia and the aging process. Interventions dated 1/23/23, included to assure R2 is wearing proper footwear, floor is free of clutter, glare, liquids, and foreign objects, keep personal items and frequently used items within reach, remind R2 of his own limitations, keep call light in place and answer promptly. An additional problem dated 1/23/23, indicated R2 has incontinence of bowel and bladder related to the advancing aging process. Interventions dated 1/23/23 indicated to give	2 830		

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2 830	Continued From page 16 bowel medications as needed, wears disposable products, staff assist with good pericare after each incontinence episode and as needed and required limited to extensive assist with toileting needs. R2's progress note dated 6/27/23, indicated R2 answers to his name, unsure if R2 knows where he is or what time it is, R2 does not talk much or say what he needs anymore. Further indicated unclear if R2 understands others or not and R2 speaks short sentences and is very soft spoken. Staff to ensure R2 is toileted and required extensive assist with toileting and was incontinent of bladder this shift. R2's quarterly, minimum data set (MDS), dated 6/28/23, indicated moderate cognitive impairment, and indicated diagnoses of dementia, post-traumatic stress disorder (PTSD), diabetes and disturbance of emotions and conduct. R2 required supervision with walking and locomotion and extensive assist of one staff for bed mobility, transfers, toileting, dressing and hygiene. R2's fall risk assessment, dated 6/28/23, indicated a score of 11, indicating R2 was at risk for falls. R2's progress note, dated 7/25/23, indicated a physician order was received for a therapy evaluation to be completed due to R2 has been more unsteady while walking and leans forward when walking. R2's unwitnessed Fall Event, dated 7/27/23, at 11:39 a.m. indicated R2 was found lying on his back on the floor with his head facing the foot of the bed. R2 stated, I slipped off the cardboard	2 830		

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2 830	Continued From page 17 and was trying to fix the car. No injuries noted. Fall investigation did not include information on when R2 was last assisted or if R2's basic needs were met. No root cause or prevention intervention indicated to prevent future falls. R2's care guide, dated 7/31/23, indicated R2 transfers with stand by assist with mobility, and was incontinent of bowel and bladder, and to toilet every two hours. During an interview on 8/2/23, at 3:05 p.m. NA-A stated R2 was very quiet in nature, can walk on his own and liked to wander when R2 is not in his room. R2 has started to get more confused lately, staff remind R2 to go to the bathroom, R2 will be continent, R2 has to be offered to go to the bathroom every two hours and does not use the call light to ask. NA-A stated to find out if a resident has had a fall staff would get that in shift report, staff use pocket care plan guides that gives us the updates, one of the nurses here is supposed to update it every day. NA-A stated I do not think R2 has had any falls. During an interview on 8/2/23, at 3:34 p.m. TMA-A stated staff give R2 reminders and cues due to his dementia. R2 likes to sit in his room and watch TV. TMA-A was not aware of any falls for R2. TMA-A stated R2 can walk and was not sure about his continence. During an interview on 8/2/23, at 4:47 p.m. the DON indicated the facility investigation from R2's fall on 7/27/23, at 11:39 a.m. does not indicate a root cause for his fall, or if it was determined if R2's basic needs were met. The DON stated, there was no prevention intervention put in place to prevent future falls as we were unsure of the root cause.	2 830		

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2 830	Continued From page 18 Facility policy, "Central Health Care Fall Protocol," dated 9/13/17, indicated, 1. Immediately after a fall: assess residents physical condition before moving, administer emergency care if determined necessary, fall with injury notify physician, DON, and family, fall without injury: notify DON, family and physician, continue to monitor residents physical and mental status for 72 hours, document findings in the nurses notes. 2. Write a detailed account of any falls using the INCIDENT REPORT form. A witness statement must be completed by the employee who finds the resident on the floor. In the event a family member finds them are to complete the witness report. Outside visitors do not complete them. A detailed description must include, where they were found, what the resident reported they were doing, location of the call light, types of footwear or lack of, location of any assistive device that they were supposed to use. Any information that may be beneficial such as increased anxiety prior to the fall, visitors present, when last attended by staff. 3. Determine immediate safety measures to be taken by staff and add to the resident care plan immediately after the fall. Document safety measures that were implemented and response in the nurses' notes. 4. Communicate measures to staff and add to the resident care plan immediately after the fall, add any new intervention identified on the Incident report form. 5. Identify the cause of the fall (if able) and determine if it was an isolated incident or has the potential to recur. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being	2 830		

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2 830	Continued From page 19 implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			