Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2023

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: July 20, 2023

Dear Administrator:

On August 24, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 30, 2023

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

Re: Reinspection Results
Event ID: H95B12

Dear Administrator:

On August 24, 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 July 20, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 7, 2023

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

RE: CCN: 245409
Cycle Start Date: July 20, 2023

Dear Administrator:

On July 20, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 20, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 20, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

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

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

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

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

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

Please contact me with any questions regarding this letter.

Sincerely,

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/20/23, 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 complaints were reviewed: H54093790C (MN95355) and H54093843 MN94567) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	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	F 689	How corrective action will be accomplished for those residents found to	8/17/23

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

Electronically Signed | 08/14/2023

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 689	Continued From page 1 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 1 of 3 residents (R3) reviewed for falls. Findings include: R3's admission Minimum Data Set (MDS) dated 7/13/23, indicated R3's diagnoses included left hip fracture, dementia, and restless leg syndrome. R3 had severe cognitive impairment and disorganized thinking that fluctuated throughout the day. R3 required extensive assist of one staff with dressing, hygiene, walking, and locomotion on the unit and required the assist of two staff for bed mobility, transfers, and toileting. In addition, R3 had a fall within the last month and a fall with fracture within the last six months. R3 had one fall while at the facility with no injury. R3's Morse Fall Scale Assessment dated 7/8/23, identified a score of 40 indicating a moderate risk for falls. R3's care plan dated 7/8/23, indicated R3 was a high fall risk related to left femur fracture, rib fractures, cognitive impairment/confusion. Interventions dated 7/8/23 directed staff to provide physical therapy/occupational therapy (PT/OT) to evaluate and gripper socks on when up. Additional interventions dated 7/18/23, directed to keep bed in lowest position and fall mat bedside when in bed. R3's provider visit dated 7/11/23, indicated R3 had a recent fall with a left hip fracture and is at the facility for rehab following the fracture. R3 has a history of falls. Primary diagnosis History of	F 689	have been affected by the deficient. IDT reviewed R3's care plan and implemented bed in lowest position and fall mat at bedside when in bed on 7/18/23. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who have fallen in the facility have the potential to be affected by this deficient practice. Facility will complete a 30-day review of all falls within the facility to ensure medical record includes a causal analysis that identifies potential causal factors and probable root cause and individualized interventions are in place in the care plan. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. DON or designee will review Policy and Procedures related to falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. All licensed nursing staff will be educated on the need to comprehensively assess each fall to identify root cause and individualized interventions. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. All falls will be audited by the DON and NHA to ensure comprehensive assessment and root cause analysis were	

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F 689	Continued From page 2 falls-Has had multiple ED visits for witnessed and unwitnessed falls. Most recently she was admitted 7/1/23 to 7/11/23, for an unwitnessed fall resulting in 6-11 right rib fractures, left inferior pubic ramus fracture and left femoral head fracture. Family feels R3 has been having more frequent falls since moving into the assisted living facility. R3's progress note, dated 7/13/23 at 8:10 p.m. indicated R3 was found on the floor next to her bed, was seated on her buttocks and holding her body upright, was confused and conversive, and unable to state what she was trying to do. R3 was assessed and had no injury, family, director of nursing (DON) and MD notified. R3's record did not include a causal analysis that identified potential causal factors and probable root cause in order to determine individualized interventions that would prevent and/or reduce the risk for falls related to modifiable causal factors/root cause. Despite the lack of analysis, according to a progress note dated 7/18/23 (five days after the fall) a care plan intervention was added to keep bed in lowest position and a fall mat. During an observation on 7/20/23, at 4:00 p.m. R3 was lying in bed with the head of the bed slightly elevated. R3 was awake and talking, however spoke non-sensically. R3's bed was in the lowest position and a mat was on the floor next to her bed. During an interview on 7/20/23, at 3:28 p.m. physical therapist (PT)-A indicated he evaluated R3 on 7/7/23. R3's history was she came to us from an assisted living with a history of falls. R3's	F 689	completed when determining individualized interventions twice weekly for 4 weeks, then weekly for 8 weeks. Audits will be brought to QA Committee for review to determine duration of audits. The date that each deficiency will be corrected: 8/17/23 Person responsible: NHA or Designee	

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F 689	Continued From page 3 last fall resulted in a left hip fracture and multiple rib fractures. R3 was not alert at all, her physical condition was much better than her cognition. During an interview on 7/20/23, at 3:30 p.m. physical therapy assistant (PTA)-A stated R3 needed a lot of cues due to lots due to her significant confusion. PTA-A indicated because R3 was fidgety and had poor cognition increased supervision would probably prevent her from falling. During an interview on 7/20/23, at 3:34 p.m. director of therapy services (DOTS)-A indicated that when a resident falls, the floor nurse would open up an event in risk management. The floor nurse was responsible for implementing an immediate intervention at the time of the fall and update the care plan. During "stand up and stand down meetings" that department heads have Monday through Friday falls were reviewed and discussed. On 7/13/23, during the evening R3 fell out of bed, she was confused at baseline. R3 did not like to get up early and was very social. Good fall interventions would be encouraging her to come out for meals because it would increase supervision and decrease isolation. During an interview on 7/20/23, at 4:08 p.m. registered nurse (RN)-A indicated R3 was very forgetful at baseline. She can be restless, wants to get out of bed, and was frequently incontinent of bladder. RN-A explained he was the nurse working the floor on 7/13/23, when R3 fell out of bed around 7:50 p.m. R3 was unable to say what she was trying to do and was not able to determine the root cause. However, RN-A indicated he did not check to see if R3 was continent at the time of the fall. RN-A did not	F 689		

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F 689	Continued From page 4 check with the aides working the floor when the last time R3 was assisted to the bathroom or last time R3 was assisted with anything. RN-A reviewed R3's record and stated the last time he could find R3 was assisted to the toilet according to her medical record was 12:15 p.m. which was almost 8 hours earlier that day. RN-A stated for fall interventions he put R3's bed in low position and placed a fall mat next to her bed. RN-A verified the care plan was not updated until five days later on 7/18/23, and indicated it should have been updated right away. During an interview on 7/20/23, at 5:01 p.m. director of nursing (DON) stated R3 was very confused per her baseline. R3 was admitted here for rehabilitation as she had a fall with left hip fracture and numerous rib fractures at her previous assisted living facility. DON indicated R3's care plan intervention for fall prevention were not person centered and included PT/OT evaluate and treat and ensure gripper socks were on when she was in bed. DON indicated the fall was not investigated thoroughly to ensure R3's basic needs were being met and therefor unable to determine probable root cause. DON stated they did update the care plan five days after the fall on 7/18/23 to put her bed in low and a fall mat at bedside and stated it should have been done immediately. Facility policy, Fall Reduction Policy, revised 5/18/22, indicated the purpose is to provide an environment that remains free of accident hazards as possible, to identify residents who are at risk of falling and to develop appropriate interventions, and to promote a systemic approach and monitoring process for the care of the residents who have fallen and those who are	F 689		

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F 689	Continued From page 5 determined to be at risk. 1. Any risk factors identified by the Morse Fall Scale, MDS or other assessment should be reviewed and addressed as determined appropriate through the MDS process, including the residents care plan. 2. The PCC Risk Management report will be completed after a resident fall 3. Report will include location of fall, injuries and factors related to the fall such as environmental factors, cognitive factors and/or medical conditions. 4. Evaluate and assess the resident for injury ...6. If no injury is present from, he falls notify the physician of the incident assessment and possible signs of injury and notify the responsible party. 7. Document in the clinical record a summary of the fall, including, but not limited to assessment, intervention, and resident response. 8. Immediate intervention will be added to the care plan and communicated to the care givers. 13. Summary of the incident will be completed by IDT and include care plan review, effectiveness of interventions and root cause of fall.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 7, 2023

Administrator
Edenbrook Of Rochester
1875 19th Street Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: H95B11

Dear Administrator:

The above facility was surveyed on July 20, 2023, through July 20, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please contact me with any questions regarding this letter.

Sincerely,

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 07/20/2023

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EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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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 7/20/23, 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 was issued; 0830. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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EDENBROOK OF ROCHESTER	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54093790C (MN95355) and H54093843C (MN94567) with a licensing order issued at (0830). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	C 07/20/2023

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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 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 1 of 3 residents (R3) reviewed for falls. Findings include: R3's admission Minimum Data Set (MDS) dated	2 830	Corrected.	8/17/23

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2 830	Continued From page 3 7/13/23, indicated R3's diagnoses included left hip fracture, dementia, and restless leg syndrome. R3 had severe cognitive impairment and disorganized thinking that fluctuated throughout the day. R3 required extensive assist of one staff with dressing, hygiene, walking, and locomotion on the unit and required the assist of two staff for bed mobility, transfers, and toileting. In addition, R3 had a fall within the last month and a fall with fracture within the last six months. R3 had one fall while at the facility with no injury. R3's Morse Fall Scale Assessment dated 7/8/23, identified a score of 40 indicating a moderate risk for falls. R3's care plan dated 7/8/23, indicated R3 was a high fall risk related to left femur fracture, rib fractures, cognitive impairment/confusion. Interventions dated 7/8/23 directed staff to provide physical therapy/occupational therapy (PT/OT) to evaluate and gripper socks on when up. Additional interventions dated 7/18/23, directed to keep bed in lowest position and fall mat bedside when in bed. R3's provider visit dated 7/11/23, indicated R3 had a recent fall with a left hip fracture and is at the facility for rehab following the fracture. R3 has a history of falls. Primary diagnosis History of falls-Has had multiple ED visits for witnessed and unwitnessed falls. Most recently she was admitted 7/1/23 to 7/11/23, for an unwitnessed fall resulting in 6-11 right rib fractures, left inferior pubic ramus fracture and left femoral head fracture. Family feels R3 has been having more frequent falls since moving into the assisted living facility. R3's progress note, dated 7/13/23 at 8:10 p.m.	2 830		

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2 830	Continued From page 4 indicated R3 was found on the floor next to her bed, was seated on her buttocks and holding her body upright, was confused and conversive, and unable to state what she was trying to do. R3 was assessed and had no injury, family, director of nursing (DON) and MD notified. R3's record did not include a causal analysis that identified potential causal factors and probable root cause in order to determine individualized interventions that would prevent and/or reduce the risk for falls related to modifiable causal factors/root cause. Despite the lack of analysis, according to a progress note dated 7/18/23 (five days after the fall) a care plan intervention was added to keep bed in lowest position and a fall mat. During an observation on 7/20/23, at 4:00 p.m. R3 was lying in bed with the head of the bed slightly elevated. R3 was awake and talking, however spoke non-sensically. R3's bed was in the lowest position and a mat was on the floor next to her bed. During an interview on 7/20/23, at 3:28 p.m. physical therapist (PT)-A indicated he evaluated R3 on 7/7/23. R3's history was she came to us from an assisted living with a history of falls. R3's last fall resulted in a left hip fracture and multiple rib fractures. R3 was not alert at all, her physical condition was much better than her cognition. During an interview on 7/20/23, at 3:30 p.m. physical therapy assistant (PTA)-A stated R3 needed a lot of cues due to lots due to her significant confusion. PTA-A indicated because R3 was fidgety and had poor cognition increased supervision would probably prevent her from falling.	2 830		

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2 830	Continued From page 5 During an interview on 7/20/23, at 3:34 p.m. director of therapy services (DOTS)-A indicated that when a resident falls, the floor nurse would open up an event in risk management. The floor nurse was responsible for implementing an immediate intervention at the time of the fall and update the care plan. During "stand up and stand down meetings" that department heads have Monday through Friday falls were reviewed and discussed. On 7/13/23, during the evening R3 fell out of bed, she was confused at baseline. R3 did not like to get up early and was very social. Good fall interventions would be encouraging her to come out for meals because it would increase supervision and decrease isolation. During an interview on 7/20/23, at 4:08 p.m. registered nurse (RN)-A indicated R3 was very forgetful at baseline. She can be restless, wants to get out of bed, and was frequently incontinent of bladder. RN-A explained he was the nurse working the floor on 7/13/23, when R3 fell out of bed around 7:50 p.m. R3 was unable to say what she was trying to do and was not able to determine the root cause. However, RN-A indicated he did not check to see if R3 was continent at the time of the fall. RN-A did not check with the aides working the floor when the last time R3 was assisted to the bathroom or last time R3 was assisted with anything. RN-A reviewed R3's record and stated the last time he could find R3 was assisted to the toilet according to her medical record was 12:15 p.m. which was almost 8 hours earlier that day. RN-A stated for fall interventions he put R3's bed in low position and placed a fall mat next to her bed. RN-A verified the care plan was not updated until five days later on 7/18/23, and indicated it should have been updated right away.	2 830		

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2 830	Continued From page 6 During an interview on 7/20/23, at 5:01 p.m. director of nursing (DON) stated R3 was very confused per her baseline. R3 was admitted here for rehabilitation as she had a fall with left hip fracture and numerous rib fractures at her previous assisted living facility. DON indicated R3's care plan intervention for fall prevention were not person centered and included PT/OT evaluate and treat and ensure gripper socks were on when she was in bed. DON indicated the fall was not investigated thoroughly to ensure R3's basic needs were being met and therefor unable to determine probable root cause. DON stated they did update the care plan five days after the fall on 7/18/23 to put her bed in low and a fall mat at bedside and stated it should have been done immediately. Facility policy, Fall Reduction Policy, revised 5/18/22, indicated the purpose is to provide an environment that remains free of accident hazards as possible, to identify residents who are at risk of falling and to develop appropriate interventions, and to promote a systemic approach and monitoring process for the care of the residents who have fallen and those who are determined to be at risk. 1. Any risk factors identified by the Morse Fall Scale, MDS or other assessment should be reviewed and addressed as determined appropriate through the MDS process, including the residents care plan. 2. The PCC Risk Management report will be completed after a resident fall 3. Report will include location of fall, injuries and factors related to the fall such as environmental factors, cognitive factors and/or medical conditions. 4. Evaluate and assess the resident for injury ...6. If no injury is present from, he falls notify the physician of the incident assessment and	2 830		

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2 830	Continued From page 7 possible signs of injury and notify the responsible party. 7. Document in the clinical record a summary of the fall, including, but not limited to assessment, intervention, and resident response. 8. Immediate intervention will be added to the care plan and communicated to the care givers. 13. Summary of the incident will be completed by IDT and include care plan review, effectiveness of interventions and root cause of fall. 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 interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		