Electronically Delivered
December 20, 2021

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: October 21, 2021

Dear Administrator:

On December 14, 2021, 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.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

Electronically delivered
November 3, 2021

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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" 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, 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 January 21, 2022 (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 April 21, 2022 (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.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING ______ B. WING ______	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD RED WING, MN 55066**

(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 10/21/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5449029C (MN00077238) with deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5449030C (MN00074567). 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.	F 689		11/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/09/2021

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

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and document review the facility failed to comprehensively assess each fall, identify, and comprehensively analyze causal factors for potential root cause in order to determine potential individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for falls.

Findings include

R2's quarterly Minimum Data Set (MDS) dated 8/17/2021, identified R2 had diagnosis of hypertension, diabetes's, dementia, and anxiety disorder. The MDS indicated R2 did not have cognitive impairment, did not walk, and required extensive assistance from one staff member for transfers, dressing, and toileting. The MDS identified R2 had 2 or more falls with no injury since the last assessment which was R2's quarterly MDS dated 5/21/21.

R2's activities for daily living care plan last reviewed/revised on 8/18/21, indicated R2 required a mechanical standing lift with one staff for transfers, R2 was not ambulatory, and directed staff to offer toileting every 2-3 hours, upon demand, between meals, and as needed.

R2's record identified R2 had 3 falls between 9/6/2021 and 10/11/21.

R2's Event Report dated 9/6/21, at 10:04 p.m. indicated R2 had an unwitnessed fall; "Fell face first in bathroom", R2 stated she was "transferring to toilet". The report had check marks by multiple causal factors and the evaluation of potential

F 689

It is the policy of Benedictine Living Community – Red Wing to follow all Federal, State, and local guidelines, laws and regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citation. The preparations, submission and implementation of this plan of correction will serve as our credible allegation of compliance.

TAG F689

R2’s fall care plan was reviewed by IDT. All interventions in place remain current and appropriate. Reviewed on 11/8/2021.

Reviews of all fall interventions care planned for residents that score as being at high risk for falls on the fall risk observation are being conducted to ensure appropriate and current interventions are in place. Reviews are taking place from 11/4/2021 – 11/22/2021.

Licensed staff re-educated on Benedictine’s post-fall checklist and the implementation of immediate fall interventions within the resident’s care plan immediately following a fall. Education started on 10/22/2021 immediately following survey and will be

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F 689	Continued From page 2 contributory factors was "Resident Safety Awareness Deficit, Altered Gait/Balance." The report indicated a pattern of R2 falling because of self-transfers. The report indicated an immediate intervention was to discontinue oxybutynin (medication to reduce urinary retention). R2's record lacked evidence of a comprehensive analysis of all potential causal factors to develop and implement personalized interventions to prevent and/or reduce the risk of falls from identified causal factors. R2's care plan also lacked evidence of revision. R2's medication administration record revealed R2's Oxybutynin was not discontinued until 9/18/21; the record did not include a review of the effects if any the Oxybutynin had on R2's self-transfers. R2's Event Report dated 9/15/21, at 11:06 p.m. indicated R2 had an unwitnessed fall in her room when R2 attempted to self-transfer from her wheelchair to her recliner. The description included, "resident found on floor in room between bed and her recliner. Laying on her back." The resident stated she was "trying to go to her recliner." The report had check marks by potential causal factors and the evaluation of factors was "Resident Safety Awareness Deficit, Altered Gait/Balance. The report indicated a pattern of R2 falling was self-transfers. The report indicated an immediate intervention was to "approach the idea of moving resident to a room closer to the nurse station." R2's record lacked evidence of a comprehensive analysis of all potential causal factors to develop and implement personalized interventions. In addition, R2's care plan did not include and/or identify new fall interventions.	F 689	completed by 11/22/2021. IDT process expanded to include a review of each fall during IDT to ensure root cause analysis is completed for all falls and ensure that appropriate interventions were placed into the care plan. The results of the care planned fall intervention reviews will be reported through the facility QA committee on 12/14/2021 with ongoing frequency and duration to be determined through analysis and review of results.	

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F 689	Continued From page 3	F 689		

R2's Event Report dated 10/11/21, at 4:09 p.m. indicated R2 had an unwitnessed fall in her room when she attempted self-transfer from her wheelchair to her recliner. The description included, "resident found lying flat on her back in between recliner and her bed." The report had check marks by potential causal factors and the evaluation of factors included, R2 was at risk for falls related to diagnoses, medications, history of falls do to self-transferring, mild cognitive impairment, altered balance, poor safety awareness, and needing assist of one with mechanical stand for appropriate transfers. Nursing to continue to monitor per facility protocol and update provider as needed.
"INTERVENTION: Offer to be transferred to recliner in between meals."

R2's fall care plan last revised on 10/11/21, identified R2 was at risk for falls related to history of falls, impaired balance, short term memory problems, decreased safety awareness with frequent self-transferring, and use of psychotropic medications. The intervention that was added on 10/11/21, was "offer to sit in recliner between meals."

During an interview on 10/21/21, at 9:40 a.m. director of nursing (DON) indicated after a fall occurred, nurses would assess the resident for injury, make the required notifications, and complete the incident report. DON stated the nurse responsible for the resident at the time of the fall would identify causal factors, try to determine the root cause, and implement immediate interventions. DON indicated the resident was supposed to be continuously monitored for changes for 72 hours after the fall.

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F 689	Continued From page 4	F 689		

DON stated the interdisciplinary team would then review the post fall progress notes every morning in addition to reviewing the care plan to ensure appropriate interventions were added.

During an interview on 10/21/21, at 10:43 a.m. licensed practical nurse (LPN)-A indicated after a fall the nurse assigned to that resident would try to find out what caused the fall and put interventions in place that would prevent the re-occurrence. LPN-A stated the care plan was usually updated with that intervention.

During an interview on 10/21/21, at 10:49 a.m. nursing assistant (NA)-A stated R2 has had lots of falls; she "has a whole slew of interventions" and a lot of things were in place. NA-A stated R2 was sometimes confused and didn't always remember to call for help and sometimes she would yell out for help. NA-A stated R2 didn't always remember she could not get up on her own.

During an observation on 10/21/21, at 11:00 a.m. R2 rolled in her wheelchair to the nursing station and told NA-B she had to use the bathroom. NA-B wheeled R2 back to her room and assisted her to the toilet. At 11:57 a.m. R2 sat at the dining room table for lunch. At 2:00 p.m. R2 was observed in her room sitting in her recliner.

During a interview on 10/21/21, at 2:00 p.m. Nursing assistant (NA)-B stated R2 had frequent falls with multiple interventions. NA-B indicated R2 was a "busy body" always on the go, R2 did not always remember she needed help, and would attempt self-transfers. NA-B stated R2 used to be a pivot transfer but now transferred with a mechanical stand-up lift and one staff

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F 689	Continued From page 5 member. NA-B indicated R2 may have a medication change within the last several weeks and thinks that may have decreased the number of times R2 attempted self-transfers. NA-B indicated the newest intervention, was for staff to assist her to her recliner after meals. During a subsequent interview on 10/21/21, at 2:22 p.m. (DON) reviewed R2's record and fall incident reports; DON indicated the causal factors were not comprehensively analyzed. DON indicated after the fall on 9/6/21, R2's record did not include a comprehensive assessment of R2's toileting/voiding patterns after the fall or after the oxybutynin was discontinued and no immediate interventions were implemented however, thought R2's frequency in self-transfers in the bathroom had decreased. DON indicated after the fall on 9/15, R2's care plan was not revised with new interventions, DON stated the IDT had been evaluating a possible room change, however it was recently determined that would probably cause R2 more confusion. DON indicated after R2 had falls, immediate interventions to prevent and/or reduce the risk should have been developed and implemented. Facility policy Integrated Fall Management dated 2013 included the following: Purpose: Fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls, and reduce further injury from falls. Post Fall Procedure- 7) When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition ...11) The environment of the fall is evaluated for possible contributing factors and addressed. 12.) The interdisciplinary team reviews the fall and	F 689		

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F 689	Continued From page 6 care plan changes and may if needed implement additional interventions. 13) Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and preventions. 14) documentation of the above items is completed.	F 689		

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

Electronically delivered
November 3, 2021

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

Re: State Nursing Home Licensing Orders
Event ID: RO3L11

Dear Administrator:

The above facility was surveyed on October 21, 2021 through October 21, 2021 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:

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

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments	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 10/21/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5449029C (MN00077238) with a licensing order issued at 0830. The following complaint was found to be UNSUBSTANTIATED: H5449030C (MN00074567) The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess each fall, identify, and comprehensively analyze causal factors for potential root cause in order to determine potential individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for	2 830	It is the policy of Benedictine Living Community – Red Wing to follow all Federal, State, and local guidelines, laws and regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents,	11/22/21

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2 830	Continued From page 3 falls. Findings include R2's quarterly Minimum Data Set (MDS) dated 8/17/2021, identified R2 had diagnosis of hypertension, diabetes's, dementia, and anxiety disorder. The MDS indicated R2 did not have cognitive impairment, did not walk, and required extensive assistance from one staff member for transfers, dressing, and toileting. The MDS identified R2 had 2 or more falls with no injury since the last assessment which was R2's quarterly MDS dated 5/21/21. R2's activities for daily living care plan last reviewed/revised on 8/18/21, indicated R2 required a mechanical standing lift with one staff for transfers, R2 was not ambulatory, and directed staff to offer toileting every 2-3 hours, upon demand, between meals, and as needed. R2's record identified R2 had 3 falls between 9/6/2021 and 10/11/21. R2's Event Report dated 9/6/21, at 10:04 p.m. indicated R2 had an unwitnessed fall; "Fell face first in bathroom", R2 stated she was "transferring to toilet". The report had check marks by multiple causal factors and the evaluation of potential contributory factors was "Resident Safety Awareness Deficit, Altered Gait/Balance." The report indicated a pattern of R2 falling because of self-transfers. The report indicated an immediate intervention was to discontinue oxybutynin (medication to reduce urinary retention). R2's record lacked evidence of a comprehensive analysis of all potential causal factors to develop and implement personalized interventions to	2 830	or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citation. The preparations, submission and implementation of this plan of correction will serve as our credible allegation of compliance. R2's fall care plan was reviewed by IDT. All interventions in place remain current and appropriate. Reviewed on 11/8/2021. Reviews of all fall interventions care planned for residents that score as being at high risk for falls on the fall risk observation are being conducted to ensure appropriate and current interventions are in place. Reviews are taking place from 11/4/2021 – 11/22/2021. Licensed staff re-educated on Benedictine's post-fall checklist and the implementation of immediate fall interventions within the resident's care plan immediately following a fall. Education started on 10/22/2021 immediately following survey and will be completed by 11/22/2021. IDT process expanded to include a review of each fall during IDT to ensure root cause analysis is completed for all falls and ensure that appropriate interventions were placed into the care plan. The results of the care planned fall intervention reviews will be reported through the facility QA committee on	

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2 830	Continued From page 4 prevent and/or reduce the risk of falls from identified causal factors. R2's care plan also lacked evidence of revision. R2's medication administration record revealed R2's Oxybutynin was not discontinued until 9/18/21; the record did not include a review of the effects if any the Oxybutynin had on R2's self-transfers. R2's Event Report dated 9/15/21, at 11:06 p.m. indicated R2 had an unwitnessed fall in her room when R2 attempted to self-transfer from her wheelchair to her recliner. The description included, "resident found on floor in room between bed and her recliner. Laying on her back." The resident stated she was "trying to go to her recliner." The report had check marks by potential causal factors and the evaluation of factors was "Resident Safety Awareness Deficit, Altered Gait/Balance. The report indicated a pattern of R2 falling was self-transfers. The report indicated an immediate intervention was to "approach the idea of moving resident to a room closer to the nurse station." R2's record lacked evidence of a comprehensive analysis of all potential causal factors to develop and implement personalized interventions. In addition, R2's care plan did not include and/or identify new fall interventions. R2's Event Report dated 10/11/21, at 4:09 p.m. indicated R2 had an unwitnessed fall in her room when she attempted self-transfer from her wheelchair to her recliner. The description included, "resident found lying flat on her back in between recliner and her bed." The report had check marks by potential causal factors and the evaluation of factors included, R2 was at risk for falls related to diagnoses, medications, history of falls do to self-transferring, mild cognitive	2 830	12/14/2021 with ongoing frequency and duration to be determined through analysis and review of results.	

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impairment, altered balance, poor safety awareness, and needing assist of one with mechanical stand for appropriate transfers. Nursing to continue to monitor per facility protocol and update provider as needed.
"INTERVENTION: Offer to be transferred to recliner in between meals."

R2's fall care plan last revised on 10/11/21, identified R2 was at risk for falls related to history of falls, impaired balance, short term memory problems, decreased safety awareness with frequent self-transferring, and use of psychotropic medications. The intervention that was added on 10/11/21, was "offer to sit in recliner between meals."

During an interview on 10/21/21, at 9:40 a.m. director of nursing (DON) indicated after a fall occurred, nurses would assess the resident for injury, make the required notifications, and complete the incident report. DON stated the nurse responsible for the resident at the time of the fall would identify causal factors, try to determine the root cause, and implement immediate interventions. DON indicated the resident was supposed to be continuously monitored for changes for 72 hours after the fall. DON stated the interdisciplinary team would then review the post fall progress notes every morning in addition to reviewing the care plan to ensure appropriate interventions were added.

During an interview on 10/21/21, at 10:43 a.m. licensed practical nurse (LPN)-A indicated after a fall the nurse assigned to that resident would try to find out what caused the fall and put interventions in place that would prevent the re-occurrence. LPN-A stated the care plan was usually updated with that intervention.

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During an interview on 10/21/21, at 10:49 a.m. nursing assistant (NA)-A stated R2 has had lots of falls; she "has a whole slew of interventions" and a lot of things were in place. NA-A stated R2 was sometimes confused and didn't always remember to call for help and sometimes she would yell out for help. NA-A stated R2 didn't always remember she could not get up on her own.

During an observation on 10/21/21, at 11:00 a.m. R2 rolled in her wheelchair to the nursing station and told NA-B she had to use the bathroom. NA-B wheeled R2 back to her room and assisted her to the toilet. At 11:57 a.m. R2 sat at the dining room table for lunch. At 2:00 p.m. R2 was observed in her room sitting in her recliner.

During a interview on 10/21/21, at 2:00 p.m. Nursing assistant (NA)-B stated R2 had frequent falls with multiple interventions. NA-B indicated R2 was a "busy body" always on the go, R2 did not always remember she needed help, and would attempt self-transfers. NA-B stated R2 used to be a pivot transfer but now transferred with a mechanical stand-up lift and one staff member. NA-B indicated R2 may have a medication change within the last several weeks and thinks that may have decreased the number of times R2 attempted self-transfers. NA-B indicated the newest intervention, was for staff to assist her to her recliner after meals.

During a subsequent interview on 10/21/21, at 2:22 p.m. (DON) reviewed R2's record and fall incident reports; DON indicated the causal factors were not comprehensively analyzed. DON indicated after the fall on 9/6/21, R2's record did not include a comprehensive assessment of R2's

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2 830	Continued From page 7	2 830		

toileting/voiding patterns after the fall or after the oxybutynin was discontinued and no immediate interventions were implemented however, thought R2's frequency in self-transfers in the bathroom had decreased. DON indicated after the fall on 9/15, R2's care plan was not revised with new interventions, DON stated the IDT had been evaluating a possible room change, however it was recently determined that would probably cause R2 more confusion. DON indicated after R2 had falls, immediate interventions to prevent and/or reduce the risk should have been developed and implemented.

Facility policy Integrated Fall Management dated 2013 included the following:
Purpose: Fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls, and reduce further injury from falls.
Post Fall Procedure- 7) When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition ...11) The environment of the fall is evaluated for possible contributing factors and addressed. 12.) The interdisciplinary team reviews the fall and care plan changes and may if needed implement additional interventions. 13) Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and preventions. 14) documentation of the above items is completed.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating

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2 830	Continued From page 8 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		