Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 31, 2023

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

RE: CCN: 245449
Cycle Start Date: November 10, 2022

Dear Administrator:

On November 29, 2022, we notified you a remedy was imposed. On December 30, 2022 and January 24, 2023 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 23, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 26, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 29, 2022, 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 January 26, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 23, 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 Therefore, the NATCEP prohibition is rescinded.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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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January 31, 2023

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

Re: Reinspection Results
Event ID: 9DI312 and 53DD12

Dear Administrator:

On December 30, 2022 and January 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 surveys completed on November 10, 2022 and December 28, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2023

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

RE: CCN: 245449
Cycle Start Date: November 10, 2022

Dear Administrator:

On November 29, 2022, we informed you of imposed enforcement remedies.

On December 28, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 26, 2023.

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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 26, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 26, 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.

As we notified you in our letter of November 29, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 26, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
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 - 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 May 10, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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/ 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 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 12/28/2022

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 12/27/22 and 12/28/22 , 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, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54497016C (MN89397), with a deficiency cited at (F689 and F690). 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=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 689	This plan of correction constitutes the	1/23/23

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

Electronically Signed | 01/13/2023

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 review the facility failed to complete comprehensive fall analysis to determine accurate causal factors and implement care plan interventions to prevent or mitigate the risk of recurrent falls for 2 of 3 residents (R1, R3) reviewed for falls. The facility's failures resulted in actual harm when R1's care plan was not followed resulting in a left hip fracture. Findings include: R1's face sheet, printed 12/28/22, identified R1 diagnoses: left femur fracture and hemiplegia (one-sided muscle paralysis or weakness) following a stroke affecting the left non-dominant side. R1's fall Care Area Assessment (CAA) dated 2/8/22, identified R1 was at increased risk for falls related to left sided hemiplegia and incontinence. R1 had one fall this quarter related to self-transfer attempt; R1 was aware she needed to call for staff assistance. R1's fall assessment dated 10/13/22, identified R1 was high risk for falls. Identified R1's fall interventions included: use call light for assist, one staff assist with transfers to bed and wheelchair and two staff assist for toileting and walking. R1's quarterly Minimum Data Set (MDS) dated 10/17/22, identified R1 did not have cognitive impairment. R1 required extensive assistance from two staff for toileting and transfers. R1 was frequently incontinent of bowel and bladder which identified R1 had a decline in bladder and bowel continence since MDS dated 7/18/22. The MDS indicated R1 did not have any falls within the last	F 689	facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F689 SS: G Free of Accident Hazards/Supervision/Devices R1 was initially reviewed on 1/5/2023 by IDT, bladder diary initiated, information reviewed and clinical IDT decided to extend bladder diary review period out an additional three days to obtain more information to establish resident elimination patterns more clearly. Once further information has been obtained and evaluated a new toileting program will be implemented and updated within the resident's plan of care. This will be completed by 1/17/2023. Documentation related to fall events on 10/25/2021 and 12/14/2022 were reviewed by the clinical IDT on 1/5/2023 for R1. Immediate interventions were placed following each fall and were reviewed by the clinical IDT and remain appropriate. R3 was reviewed by IDT on 1/5/2023. Based on assessment, resident's toileting care plan was updated to reflect current interventions to promote increased	

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F 689	Continued From page 2 three months. R1's discharge MDS assessment dated 12/14/22, identified R1 had 1 fall with major injury. R1's care plan dated 12/15/21, R1 was at risk for falls due to requiring assistants with activities of daily living (ADL)'s and mobility, left sided weakness, and episodes of incontinence. Additionally, R1 had a history of self-transfers. R1's fall intervention included assist to toilet prior to bed (start 10/25/21). Bowel/bladder care plan dated 7/19/22, reflected R1's toileting program had changed from every 2-3 hours to toilet R1 upon demand. During an observation and interview on 12/27/22, at 12:59 p.m. R1 sat in her wheelchair in her room. R1 stated she needed two staff to assist her to the toilet. She was not on a toileting schedule but wished she was. R1 would put on her call light when she needed to go. R1 explained when she put her call light on to be taken to the bathroom, by the time two staff were available to take her, it would be too late; "they never get here on time". R1 reported the day she fell she had put on her call light for help to use the bathroom; she waited and waited and waited. Somehow, she ended up on the floor but could not remember what she was doing that caused her to fall to floor. Her fall resulted in a broken hip. R1's progress note dated 12/14/22, at 9:40 a.m. identified R1 was found on the floor of her bathroom lying on her left side. R1 had put on her call light and waiting for staff to assist her with toileting. R1 had reported moderate hip and thigh pain in her left lower extremity (LLE) with movement along with pelvic pain. At 11:18 a.m.	F 689	continence with staff assistance as well as resident's method of communicating toileting needs. Documentation related to the fall events that occurred on 9/6/22, 9/14/22, 9/15/22, and 12/20/22 were reviewed for R3 by the clinical IDT on 1/5/2023. Immediate interventions were placed following each fall and were reviewed by the clinical IDT and remain appropriate. Residents of the facility determined to be at high risk for falls (10 or higher on the FALL RISK ACUITY OBSERVATION FROM MOST CURRENT OBSERVATION) and requiring assistance with transfers have the potential to be affected. All identified residents have been reviewed for appropriate toileting programs in conjunction with current fall interventions. Each resident's fall risk is assessed upon admission, quarterly, annually and with significant changes, in addition to after each fall. Following the MDS schedule, the clinical IDT team will review each resident's fall care planned approaches to validate continued appropriateness and effectiveness. Direct care nursing staff are being provided with re-education of fall investigations, care plan interventions and facility fall protocol by nursing leadership staff. Education will be reinforced during January's monthly nursing meetings and as needed on an individual basis. All	

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F 689	Continued From page 3 R1 was complaining of increased pain in LLE and pelvic area and requested to be sent to the emergency room. At 6:15 p.m. R1 was admitted to the hospital for left hip fracture. R1's fall care plan was revised on 12/14/22 with new intervention of antiroll brakes applied to wheelchair R1's resident occurrence management project (ROMP), dated 12/15/22, identified R1 had an unwitnessed fall when she was found on the floor in her bathroom, had her call light for toileting assist and wheelchair brakes were not being utilized. Root cause indicated, "resident safety awareness deficit," and the prevention intervention was to apply antiroll brakes to R1's wheelchair and Dycem to wheelchair. R1's care plan was revised on 12/15/22 to reflect the Dycem to wheelchair. The ROMP did not identify if R1's toileting care plan was followed at the time of her fall. Even though R1's MDS dated 10/17/22 identified R1 had an increase in bowel and bladder incontinence, R1's record did not include a causal analysis or clinical evaluation of R1's increased incontinence. Further it was not evident R1's toileting plan was revised to improve bowel and bladder continence and mitigate R1's fall risk for self-transfers. During an interview on 12/27/22, at 1:59 p.m. licensed practical nurse (LPN)-A explained she was working on 12/14/22 when R1 had her fall that resulted in left hip fracture. Nursing assistant (NA)-A had reported to her R1 had been found on the floor in the bathroom. R1 had her call light on waiting for staff to assist her with toileting and	F 689	working direct care staff will have received this education on or before January 23rd, 2023. Audits of fall investigations including implemented fall interventions, contributing risk factors, root cause, and care plan revisions will be conducted by the clinical IDT. These audits will be completed three times a week for six weeks, then two times per week times for two weeks, then as deemed necessary to validate compliance per QC. The results of the care planned fall intervention reviews will be reported through the facility QA committee on 2/21/2023 with ongoing frequency and duration to be determined through analysis and review of results. Substantial compliance will be achieved by January 23rd, 2023.	

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F 689	Continued From page 4 was not aware of how long R1's call light had been on. LPN-A reviewed R1's fall documentation and indicated resident safety awareness deficit was not the appropriate root cause and documentation did not address toileting. During a phone interview on 12/27/22, at 4:00 p.m. nursing assistant (NA)-A explained she worked on 12/14/22 when R1 fell. She was the only aide scheduled to work on the unit that R1 resided on. At around 7:30 a.m. NA-A had changed R1's brief that was very wet, washed and dressed R1, however did not take her to the toilet. R1 then went down to breakfast. Sometime after breakfast R1 put on her call light to use the bathroom. Since R1 needed two staff assist, NA-A shut R1's call light off, left R1's room to find help with the transfer. After she left R1's room, she was side-tracked by a dietary staff member who told her she needed to assist a resident across the hall from R1. NA-A indicated after she was done assisting that resident, she noticed R1's call light on again. She went into R1's room and found R1 on the bathroom floor. We got R1 off the floor and transferred her to her bed. Once R1 was back in her bed, we tried to roll her on her side to check her brief to see if it was wet, but she was too sore. NA-A was not sure if R1 had been incontinent. R1 was sent to the emergency room because of the pain. During an interview on 12/28/22, at 12:40 p.m. director nursing (DON) indicated the facility had a video surveillance and had reviewed the footage from 12/14/22. DON reported R1 had put her call light on twice. The first time was at 8:50 a.m., NA-A answered the call light and turned it off and walked back out of the room. The second time	F 689		

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F 689	Continued From page 5 R1 put her call light on was at 9:18 a.m. R1's call light remained on until she was found on the floor by NA-A at 9:40 a.m. DON reported R1 was not assisted to the bathroom twice per her request which resulted in R1 waiting over 50 minutes since she first requested to be assisted to the bathroom. DON further verified this fall resulted in a left fractured hip. DON stated the root cause of the fall was R1 was not toileted on demand per the care plan. DON stated R1 had a decline in bowel and bladder continence and was not able to articulate why R1's toileting care plan was changed from every 2-3-hour toileting to on demand toileting. Further, the interventions that had been put into place did not address toileting to prevent future falls. R3 R3's face sheet printed 12/28/22, identified R3 had diagnoses of benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. R3's significant change MDS dated, 9/9/22, identified R3 had severe cognitive impairment and required limited assist of one staff to assist with transfers and toileting, was occasionally incontinent of bladder and always continent of bowel. R3's fall Care Area Assessment (CAA) dated 9/12/22, identified R3 was at increased risk for falls related to impaired balance, weakness, decreased awareness, and history of falls. R3 has had one fall in the facility since admission. R3's quarterly MDS dated 12/7/22, identified R3 had moderate cognitive impairment and required extensive assist of one staff to assist with	F 689		

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F 689	Continued From page 6 transfers and toileting, was frequently incontinent of bladder, always continent of bowel and had one fall with injury. R3's care plan dated 12/8/22, indicated R3 was at risk for falls related to assist with ADL's and mobility, prescribed medication use, weakness, history of falls and self-transfers. Interventions dated 8/11/22 included place call light and frequently used items within reach. 9/6/22, offer gripper socks daily, 9/14/22 urinal at bedside, and 9/15/22 grip strips in place by left side of bed and expanded on 12/20/22. R3's toileting program dated, 8/15/22, directed staff to toilet R3 upon demand. During an observation and interview on 12/28/22, at 2:24 p.m. R3 sat on the edge of his bed wearing a t-shirt, white brief, and purple grippy socks. R3's urinal was on the headboard of the bed and out of R3's reach. R3 stated he was aware of when he needed to go to the bathroom, and he needed staff to assist him. R3 explained he used his call light when he needed to go but sometimes it took a long time, so then he would take himself because he didn't want to go in his pants. There has been a lot of times he has fallen trying to get himself to the bathroom. R3's progress report dated, 9/14/22, at 2:09 a.m. R3 initiated call light, staff went to his room, sitting on the floor leaning up against his recliner. R3 stated he was trying to go to the bathroom but when he stood up, he felt dizzy and slipped. R3 sustained skin tear on his left lower arm from his watch. Reminded R3 to wait for staff to assist him to the toilet due to high risk of fall. Given urinal by the bedside. Corresponding Event Report dated 9/26/22, identified additional	F 689		

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	245449	A. BUILDING _____ B. WING _____	C 12/28/2022

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

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F 689	Continued From page 7 intervention of grip strips placed on the floor next to bed. R3's ROMP form dated 10/3/22, identified the aforementioned fall documentation. Root cause was altered gait/balance and resident safety awareness deficit. New intervention: R3 was reminded to wait for staff to assist him to the toilet due to high risk of fall, grip strips placed next to bed and given urinal by the bedside. R3's progress report dated 12/20/22, at 11:41 a.m. R3 was found on right side, almost on stomach with head under the foot of the bed. No injury noted. Staff had seen resident approx. 20 min prior to discovery of fall. Staff had assisted to bathroom, back to recliner, and given blanket at that time. R3 stated he was trying to, "go to the bathroom." The report did not specify if staff had toileted R3 while in the bathroom. R3 sustained 1 cm (centimeter) skin tear to right forehead above eye noted. Immediate intervention was to expand grippy strips on the floor. R3's ROMP form dated 12/26/22, identified the aforementioned fall documentation. R3 was interviewed and stated he was attempting to self-transfer to the bathroom. Root cause was altered gait/balance and resident safety awareness deficit. Intervention was to extend grip strips on floor to area where fall occurred. Although fall documentation on 9/14/22 and on 12/20/22 indicated R3 was attempting to go to the bathroom at the the time of the fall, the assessments did not indicate or address if R3's toileting care plan had been followed. Further it was not evident an analysis/evaluation of R3's toileting program was appropriate for R3.	F 689		

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F 689	Continued From page 8 During an interview on 12/28/22, at 11:42 a.m. LPN-B reviewed R3's fall records. LPN-B indicated on 9/14/22, R3 did not have gripper socks on per the care plan. However, it was not determined if they had been on and R3 had taken them off. Because he fell trying to get to the bathroom, the intervention was to put a urinal at bedside. The fall documentation on 12/20/22 did not identify if R3 was continent at the time of the fall and if R3's urinal had been within reach. LPN-B reported there was not enough information to determine root cause or if the care plan had been followed at the time of the fall; it cannot be ascertained if the new fall prevention interventions were appropriate to prevent recurrent falls. During an interview on 12/28/22, at 12:09 p.m. director of nursing (DON) explained the facilities fall program which included: the nurse would assess the resident, complete required notifications, write a progress note. Then the unit manager completed the Event form, the interdisciplinary team (IDT) then fills out the ROMP form. The ROMP form includes the IDT's root cause analysis and prevention interventions. They have monthly fall meetings with the unit managers, pharmacist, and the medical director. The DON reviewed R3's fall record, and verified there was not enough information to determine if R3's care plan was followed. The root causes in R3's ROMP forms were generalized and the root cause for both of R3's falls should have been toileting. DON confirmed R3's toileting plan of, "on demand" was not re-evaluated or determined to be appropriate for R3 after his falls. Facility policy titled, "Integrated Fall	F 689		

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F 689	Continued From page 9 Management," dated 8/24/17, indicated a purpose: Fall risk assessment, identification, and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. Policy: Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort ... Procedure: 3. Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment. 4. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		1/23/23

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F 690	Continued From page 10 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify, assess, and provide appropriate treatment and services to develop an individualized toileting program to maintain or improve bowel/bladder continence resulting in a decline in continence for 2 of 2 residents (R1 and R3) reviewed for incontinence. Findings include: R1 R1's face sheet printed 12/28/22, identified R1 had the following diagnoses: left femur fracture and hemiplegia/hemiparesis following a stroke affecting the left non-dominant side.	F 690	F690 SS: D Bowel/Bladder Incontinence, Catheter, UTI R1 and direct care staff were interviewed regarding elimination patterns and preferences. In addition, plan of care reviewed and a bowel and bladder elimination diary initiated. Information was reviewed and the clinical IDT determined an extension of the bladder diary review period was necessary to obtain more information to further establish resident elimination patterns more clearly. Once further information has been obtained and evaluated a new toileting program will be implemented and updated within the	

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F 690	Continued From page 11 R1's bowel and bladder Care Area Assessment (CAA) dated 2/11/22, identified R1 has occasional episodes of bowel and bladder incontinence and was dependent on staff for cares and mobility related to history of stroke with left sided hemiplegia (weakness/paralysis). The CAA indicated R1 was toileted by staff every 2-3 hours, upon demand, and as needed. R1's bowel assessment, dated 7/15/22, identified R1 was always continent of bowel and occasionally incontinent of bladder, toileting program changed from every 2-3-hour toileting to on demand toileting. The assessment did not identify R1's type of urinary incontinence (overflow, urge, mixed, stress). R1's record did not identify an evaluation or analysis that identified why the toileting program was changed from every 2-3 hours to "on demand". R1's quarterly Minimum Data Set (MDS) dated 7/18/22, identified R1 was cognitive and required an extensive assist of two with toileting and transfers, also identified that R1 was occasionally incontinent of bladder and always continent of bowel. R1's bowel assessment dated 10/13/22, identified R1 was frequently incontinent of bowel and frequently incontinent of bladder. The assessment did not identify R1's type of urinary incontinence. R1's toileting program was unchanged from previous assessment; identified R1 was toileted upon demand. R1's quarterly MDS dated 10/17/22, identified R1 was cognitive and required an extensive assist of two with toileting and transfers, also identified that R1 was frequently incontinent of bowel and	F 690	resident's plan of care. This will be completed by 1/17/2023. R3 and direct care staff were interviewed regarding elimination patterns and preferences. Elimination information was reviewed by IDT on 1/5/2023. Based on assessment, resident's toileting care plan was updated to reflect current interventions to promote increased continence with staff assistance as well as resident's method of communicating toileting needs. Current residents of the facility who experience episodes of incontinence and require staff assistance with toileting and/or toileting hygiene have the potential to be affected. All identified residents are currently being reviewed by the clinical IDT for appropriate toileting programming to support their toileting needs and care plans updated as need identified to reflect any changes. These reviews will all be completed by 1/23/2023. Direct care nursing staff are being provided education regarding the addition of elimination diaries, re-education regarding notification of noted changes in resident elimination patterns or changes in level of continence, and the importance of point of care charting completion at the time the care is provided. Re-education provided on appropriate interventions to promote highest level of continence for each resident. This education will be completed by 1/23/2023.	

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F 690	Continued From page 12 bladder. R1's care plan dated 12/21/22, indicated R1 has a self-care deficit with the following activities of daily living (ADL); bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel, and bladder related to stroke with left sided hemiplegia. R1's bowel and bladder care plan identified R1 was frequently incontinent of bowel and bladder. Corresponding intervention identified R1 required two staff assist to toilet R1 upon demand. Even though R1's bowel assessment dated 10/13/22 and the MDS dated 10/17/22 identified R1 had an increase in bowel and bladder incontinence, R1's record did not include a causal analysis or clinical evaluation of R1's increased incontinence. Further it was not evident R1's toileting plan was revised to improve bowel and bladder continence and/or prevent further decline. Additionally, the record did not indicate the physician was notified of the increase in R1's incontinence of bowel and bladder. During an observation and interview on 12/27/22, at 12:59 p.m. R1 sat in her wheelchair in her room. R1stated she needed two staff to her assist her to the toilet. She was not on a toileting schedule and would put on her call light when she needed to go. R1 explained when she put her call light on to be taken to the bathroom, by the time two staff were available to take her, it would be too late; "they never get here on time". R1 indicated she felt bad asking for help because the staff are busy, "I just wish they would just come by and ask me". R1 reported the day she fell she had put on her call light for help to use the bathroom; she waited and waited and waited.	F 690	Each resident's bowel and bladder patterns and preferences will be assessed upon admission, quarterly, annually and with significant changes, in addition to any noted changes in elimination. Following the MDS schedule, the clinical IDT team will review each resident's bowel and bladder assessments and care planned interventions to validate current reflection of resident status related to level of continence and personalized approaches are implemented and appropriate. Clinical IDT will conduct audits of bowel and bladder elimination diaries, bowel and bladder care plan review, and previous observations to determine changes in continence and possible need for further personalized interventions. These audits will be completed on any bowel and bladder assessments due during that timeframe for 8 weeks. Audits of direct care staff performance during their shift in implementing an individualized toileting program for a resident will be conducted 3x a week x 4 weeks then 2x a week x 4 weeks and as needed thereafter as determined by quality council to ensure proper programming is being completed as indicated in the resident care plan. The results of the bowel and bladder audits will be reported through the facility QA committee on 2/21/2023 and 3/21/2023 with ongoing frequency and duration to be determined through analysis and review of results.	

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F 690	Continued From page 13 Somehow, she ended up on the floor in her bathroom which resulted in a broken hip. During a subsequent interview on 12/28/22, at 2:32 p.m. R1 stated she was aware of when she needed to use the bathroom but because she had to wait so long to be toileted the urine just leaked from her bladder into her incontinent brief. During an interview on 12/28/22, at 11:17 a.m. licensed practical nurse (LPN)- B reviewed R1's record. LPN-B identified R1 had a decline in bowel and bladder continence. Between 7/15/22 and 10/13/22 R1 went from always continent of bowel and occasionally incontinent of bladder to frequently incontinent of bowel and bladder. She did not know why R1 had an increase in bowel and bladder incontinence. LPN-B was not able to articulate or aware of treatments and services that would improve or maintain bowel and bladder function. LPN-B was not able to articulate why R1's toileting care plan was changed from every 2 to 3 hours toileting to on demand toileting. LPN-B indicated R1's toileting plan was not revised after assessments identified increase in bowel and bladder incontinence. During an interview on 12/28/22, at 12:40 p.m. director of nursing (DON) stated R1 had a decline in bowel and bladder continence from 7/15/22 to 10/13/22. when R1 went from always continent of bowel and occasionally incontinent of bladder to frequently incontinent of bowel and bladder. DON was unable to articulate treatment and services plan to improve or maintain bowel and bladder services. DON was also unable to articulate why R1's toileting care plan was changed from every 2-3-hour toileting to on demand toileting. R3	F 690	Substantial compliance will be achieved by January 23rd, 2023.	

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F 690	Continued From page 14 R3's face sheet printed 12/28/22, identified R3 had diagnoses that included: dementia, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, and anxiety. R3's bowel assessment, dated 8/17/22, identified R3 was occasionally incontinent of bowel and bladder. R3 has a history of self-transfers to the toilet and has performed some toileting hygiene cares independently. R3 was toileted upon demand using toilet, urinal, and brief to meet toileting needs. The assessment did not identify R3's type of urinary incontinence. Further R3's record did not include an evaluation or analysis of how it was determined R3's toileting program was "on demand" R3's significant change, MDS, dated, 9/9/22, identified R3 had severe cognitive impairment required limited assist of one staff to assist with transfers and toileting, was occasionally incontinent of bladder and always continent of bowel. R3's bowel and bladder CAA dated 9/12/22, identified R3 had occasional episodes of bladder incontinence and was dependent on staff for toileting needs related to impaired balance, but was known to self-transfer. R3's bowel assessment dated 12/6/22, identified R3 was frequently incontinent of bladder and always continent of bowel. R3 has a history of self-transfers to the toilet and has performed some toileting hygiene cares independently. R3 was toileted upon demand using toilet, urinal, and brief to meet toileting needs. R3's quarterly MDS dated 12/7/22, identified R3	F 690		

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F 690	Continued From page 15 had moderate cognitive impairment required extensive assist of one person to assist with transfers and toileting, was frequently incontinent of bladder and always continent of bowel. R3's care plan dated 12/8/22, identified R3 had a selfcare deficit related to activities of daily living (ADL) that included: bathing, grooming, oral cares, ambulation, transfers, mobility, vision, bowel, and bladder. R3 could verbally ask for assistance. R3's bowel/bladder care plan identified R3 had episodes of bladder continence. He often self-transfers to the toilet and performed hygiene independently. R3 preferred to be toileted upon demand which helped him to remain free from skin break down and maintain dignity. R3 used the toilet with one staff assist and used a pull-up for protection. Even though R3's bowel assessment dated 12/6/22 and the MDS dated 12/7/22 identified R3 had an increase bladder incontinence, R3's record did not include a causal analysis or clinical evaluation of R3's increased incontinence. Further it was not evident R3's toileting plan was revised to improve bladder continence and/or prevent further decline. Additionally, the record did not indicate the physician was notified of the increase in R3's bladder incontinence. During an observation and interview on 12/28/22, at 2:24 p.m. R3 sat on the edge of his bed wearing a t-shirt and a white brief. R3 reported was aware when he had to go to the bathroom and would put on his call light for staff to help. Sometimes staff took a while, so he would take himself to the bathroom. R3 explained a lot of times he fell trying to get to the bathroom. R3 indicated staff did not come and ask if he had to	F 690		

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F 690	Continued From page 16 use the bathroom. During an interview on 12/28/22 at 11:56 a.m. LPN-B reviewed R3's record and indicated R3 had a decline in bladder continence from 8/17/22 to 12/6/22. R3 went from having occasional incontinent of bladder to frequently incontinent of bladder. LPN-A was unable to articulate treatments and services to improve or maintain bowel and bladder services. During an interview on 12/28/22, at 12:31 p.m. DON indicated toileting plans were based on documentation of continent/incontinent episodes documented in the record, through comprehensive bowel and bladder assessments, and staff and resident interviews. If there was any decline between assessments, we would need to obtain more data such as pattern of voiding which would identify more specific care plan approaches. DON explained the facility went away from the 3-day bowel and bladder voiding diary because it was thought to be a repeat/redundant assessment. DON reviewed R3's record. DON verified R3 had a decline in bladder continence and there was not a treatment plan to improve or maintain R3's continence. Policy for bowel and bladder continence was requested and not received.	F 690		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 53DD11

Dear Administrator:

The above facility was surveyed on December 27, 2022 through December 28, 2022 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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 12/28/2022

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

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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 12/27/22 and 12/28/22, 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.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54497016C (MN89397), with a licensing order issued at 0830 and 0910. 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 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.	2 000		

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2 000	Continued From page 2 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 complete comprehensive fall analysis to determine accurate causal factors and implement care plan interventions to prevent or mitigate the risk of recurrent falls for 2 of 3 residents (R1, R3) reviewed for falls. The facility's failures resulted in actual harm when R1's care plan was not followed resulting in a left hip fracture. Findings include: R1's face sheet, printed 12/28/22, identified R1	2 830	Corrected.	1/23/23

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2 830	Continued From page 3 diagnoses: left femur fracture and hemiplegia (one-sided muscle paralysis or weakness) following a stroke affecting the left non-dominant side. R1's fall Care Area Assessment (CAA) dated 2/8/22, identified R1 was at increased risk for falls related to left sided hemiplegia and incontinence. R1 had one fall this quarter related to self-transfer attempt; R1 was aware she needed to call for staff assistance. R1's fall assessment dated 10/13/22, identified R1 was high risk for falls. Identified R1's fall interventions included: use call light for assist, one staff assist with transfers to bed and wheelchair and two staff assist for toileting and walking. R1's quarterly Minimum Data Set (MDS) dated 10/17/22, identified R1 did not have cognitive impairment. R1 required extensive assistance from two staff for toileting and transfers. R1 was frequently incontinent of bowel and bladder which identified R1 had a decline in bladder and bowel continence since MDS dated 7/18/22. The MDS indicated R1 did not have any falls within the last three months. R1's discharge MDS assessment dated 12/14/22, identified R1 had 1 fall with major injury. R1's care plan dated 12/15/21, R1 was at risk for falls due to requiring assistants with activities of daily living (ADL)'s and mobility, left sided weakness, and episodes of incontinence. Additionally, R1 had a history of self-transfers. R1's fall intervention included assist to toilet prior to bed (start 10/25/21). Bowel/bladder care plan dated 7/19/22, reflected R1's toileting program had changed from every 2-3 hours to toilet R1	2 830		

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2 830	Continued From page 4 upon demand. During an observation and interview on 12/27/22, at 12:59 p.m. R1 sat in her wheelchair in her room. R1 stated she needed two staff to assist her to the toilet. She was not on a toileting schedule but wished she was. R1 would put on her call light when she needed to go. R1 explained when she put her call light on to be taken to the bathroom, by the time two staff were available to take her, it would be too late; "they never get here on time". R1 reported the day she fell she had put on her call light for help to use the bathroom; she waited and waited and waited. Somehow, she ended up on the floor but could not remember what she was doing that caused her to fall to floor. Her fall resulted in a broken hip. R1's progress note dated 12/14/22, at 9:40 a.m. identified R1 was found on the floor of her bathroom lying on her left side. R1 had put on her call light and waiting for staff to assist her with toileting. R1 had reported moderate hip and thigh pain in her left lower extremity (LLE) with movement along with pelvic pain. At 11:18 a.m. R1 was complaining of increased pain in LLE and pelvic area and requested to be sent to the emergency room. At 6:15 p.m. R1 was admitted to the hospital for left hip fracture. R1's fall care plan was revised on 12/14/22 with new intervention of antiroll brakes applied to wheelchair R1's resident occurrence management project (ROMP), dated 12/15/22, identified R1 had an unwitnessed fall when she was found on the floor in her bathroom, had her call light for toileting assist and wheelchair brakes were not being	2 830		

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2 830	Continued From page 5 utilized. Root cause indicated, "resident safety awareness deficit," and the prevention intervention was to apply antiroll brakes to R1's wheelchair and Dycem to wheelchair. R1's care plan was revised on 12/15/22 to reflect the Dycem to wheelchair. The ROMP did not identify if R1's toileting care plan was followed at the time of her fall. Even though R1's MDS dated 10/17/22 identified R1 had an increase in bowel and bladder incontinence, R1's record did not include a causal analysis or clinical evaluation of R1's increased incontinence. Further it was not evident R1's toileting plan was revised to improve bowel and bladder continence and mitigate R1's fall risk for self-transfers. During an interview on 12/27/22, at 1:59 p.m. licensed practical nurse (LPN)-A explained she was working on 12/14/22 when R1 had her fall that resulted in left hip fracture. Nursing assistant (NA)-A had reported to her R1 had been found on the floor in the bathroom. R1 had her call light on waiting for staff to assist her with toileting and was not aware of how long R1's call light had been on. LPN-A reviewed R1's fall documentation and indicated resident safety awareness deficit was not the appropriate root cause and documentation did not address toileting. During a phone interview on 12/27/22, at 4:00 p.m. nursing assistant (NA)-A explained she worked on 12/14/22 when R1 fell. She was the only aide scheduled to work on the unit that R1 resided on. At around 7:30 a.m. NA-A had changed R1's brief that was very wet, washed and dressed R1, however did not take her to the toilet. R1 then went down to breakfast. Sometime	2 830		

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2 830	Continued From page 6 after breakfast R1 put on her call light to use the bathroom. Since R1 needed two staff assist, NA-A shut R1's call light off, left R1's room to find help with the transfer. After she left R1's room, she was side-tracked by a dietary staff member who told her she needed to assist a resident across the hall from R1. NA-A indicated after she was done assisting that resident, she noticed R1's call light on again. She went into R1's room and found R1 on the bathroom floor. We got R1 off the floor and transferred her to her bed. Once R1 was back in her bed, we tried to roll her on her side to check her brief to see if it was wet, but she was too sore. NA-A was not sure if R1 had been incontinent. R1 was sent to the emergency room because of the pain. During an interview on 12/28/22, at 12:40 p.m. director nursing (DON) indicated the facility had a video surveillance and had reviewed the footage from 12/14/22. DON reported R1 had put her call light on twice. The first time was at 8:50 a.m., NA-A answered the call light and turned it off and walked back out of the room. The second time R1 put her call light on was at 9:18 a.m. R1's call light remained on until she was found on the floor by NA-A at 9:40 a.m. DON reported R1 was not assisted to the bathroom twice per her request which resulted in R1 waiting over 50 minutes since she first requested to be assisted to the bathroom. DON further verified this fall resulted in a left fractured hip. DON stated the root cause of the fall was R1 was not toileted on demand per the care plan. DON stated R1 had a decline in bowel and bladder continence and was not able to articulate why R1's toileting care plan was changed from every 2-3-hour toileting to on demand toileting. Further, the interventions that had been put into place did not address toileting to prevent future falls.	2 830		

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2 830	Continued From page 7 R3 R3's face sheet printed 12/28/22, identified R3 had diagnoses of benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. R3's significant change MDS dated, 9/9/22, identified R3 had severe cognitive impairment and required limited assist of one staff to assist with transfers and toileting, was occasionally incontinent of bladder and always continent of bowel. R3's fall Care Area Assessment (CAA) dated 9/12/22, identified R3 was at increased risk for falls related to impaired balance, weakness, decreased awareness, and history of falls. R3 has had one fall in the facility since admission. R3's quarterly MDS dated 12/7/22, identified R3 had moderate cognitive impairment and required extensive assist of one staff to assist with transfers and toileting, was frequently incontinent of bladder, always continent of bowel and had one fall with injury. R3's care plan dated 12/8/22, indicated R3 was at risk for falls related to assist with ADL's and mobility, prescribed medication use, weakness, history of falls and self-transfers. Interventions dated 8/11/22 included place call light and frequently used items within reach. 9/6/22, offer gripper socks daily, 9/14/22 urinal at bedside, and 9/15/22 grip strips in place by left side of bed and expanded on 12/20/22. R3's toileting program dated, 8/15/22, directed staff to toilet R3 upon demand. During an observation and interview on 12/28/22,	2 830		

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2 830	Continued From page 8 at 2:24 p.m. R3 sat on the edge of his bed wearing a t-shirt, white brief, and purple grippy socks. R3's urinal was on the headboard of the bed and out of R3's reach. R3 stated he was aware of when he needed to go to the bathroom, and he needed staff to assist him. R3 explained he used his call light when he needed to go but sometimes it took a long time, so then he would take himself because he didn't want to go in his pants. There has been a lot of times he has fallen trying to get himself to the bathroom. R3's progress report dated, 9/14/22, at 2:09 a.m. R3 initiated call light, staff went to his room, sitting on the floor leaning up against his recliner. R3 stated he was trying to go to the bathroom but when he stood up, he felt dizzy and slipped. R3 sustained skin tear on his left lower arm from his watch. Reminded R3 to wait for staff to assist him to the toilet due to high risk of fall. Given urinal by the bedside. Corresponding Event Report dated 9/26/22, identified additional intervention of grip strips placed on the floor next to bed. R3's ROMP form dated 10/3/22, identified the aforementioned fall documentation. Root cause was altered gait/balance and resident safety awareness deficit. New intervention: R3 was reminded to wait for staff to assist him to the toilet due to high risk of fall, grip strips placed next to bed and given urinal by the bedside. R3's progress report dated 12/20/22, at 11:41 a.m. R3 was found on right side, almost on stomach with head under the foot of the bed. No injury noted. Staff had seen resident approx. 20 min prior to discovery of fall. Staff had assisted to bathroom, back to recliner, and given blanket at that time. R3 stated he was trying to, "go to the	2 830		

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2 830	Continued From page 9 bathroom." The report did not specify if staff had toileted R3 while in the bathroom. R3 sustained 1 cm (centimeter) skin tear to right forehead above eye noted. Immediate intervention was to expand grippy strips on the floor. R3's ROMP form dated 12/26/22, identified the aforementioned fall documentation. R3 was interviewed and stated he was attempting to self-transfer to the bathroom. Root cause was altered gait/balance and resident safety awareness deficit. Intervention was to extend grip strips on floor to area where fall occurred. Although fall documentation on 9/14/22 and on 12/20/22 indicated R3 was attempting to go to the bathroom at the the time of the fall, the assessments did not indicate or address if R3's toileting care plan had been followed. Further it was not evident an analysis/evaluation of R3's toileting program was appropriate for R3. During an interview on 12/28/22, at 11:42 a.m. LPN-B reviewed R3's fall records. LPN-B indicated on 9/14/22, R3 did not have gripper socks on per the care plan. However, it was not determined if they had been on and R3 had taken them off. Because he fell trying to get to the bathroom, the intervention was to put a urinal at bedside. The fall documentation on 12/20/22 did not identify if R3 was continent at the time of the fall and if R3's urinal had been within reach. LPN-B reported there was not enough information to determine root cause or if the care plan had been followed at the time of the fall; it cannot be ascertained if the new fall prevention interventions were appropriate to prevent recurrent falls. During an interview on 12/28/22, at 12:09 p.m.	2 830		

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2 830	Continued From page 10 director of nursing (DON) explained the facilities fall program which included: the nurse would assess the resident, complete required notifications, write a progress note. Then the unit manager completed the Event form, the interdisciplinary team (IDT) then fills out the ROMP form. The ROMP form includes the IDT's root cause analysis and prevention interventions. They have monthly fall meetings with the unit managers, pharmacist, and the medical director. The DON reviewed R3's fall record, and verified there was not enough information to determine if R3's care plan was followed. The root causes in R3's ROMP forms were generalized and the root cause for both of R3's falls should have been toileting. DON confirmed R3's toileting plan of, "on demand" was not re-evaluated or determined to be appropriate for R3 after his falls. Facility policy titled, "Integrated Fall Management," dated 8/24/17, indicated a purpose: Fall risk assessment, identification, and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. Policy: Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort ... Procedure: 3. Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment. 4. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider,	2 830		

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2 830	Continued From page 11 pharmacist, physical therapist, occupational therapist, and speech therapist. 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		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		1/23/23

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2 910	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify, assess, and provide appropriate treatment and services to develop an individualized toileting program to maintain or improve bowel/bladder continence resulting in a decline in continence for 2 of 2 residents (R1 and R3) reviewed for incontinence. Findings include: R1 R1's face sheet printed 12/28/22, identified R1 had the following diagnoses: left femur fracture and hemiplegia/hemiparesis following a stroke affecting the left non-dominant side. R1's bowel and bladder Care Area Assessment (CAA) dated 2/11/22, identified R1 has occasional episodes of bowel and bladder incontinence and was dependent on staff for cares and mobility related to history of stroke with left sided hemiplegia (weakness/paralysis). The CAA indicated R1 was toileted by staff every 2-3 hours, upon demand, and as needed. R1's bowel assessment, dated 7/15/22, identified R1 was always continent of bowel and occasionally incontinent of bladder, toileting program changed from every 2-3-hour toileting to on demand toileting. The assessment did not identify R1's type of urinary incontinence (overflow, urge, mixed, stress). R1's record did not identify an evaluation or analysis that identified why the toileting program was changed from every 2-3 hours to "on demand". R1's quarterly Minimum Data Set (MDS) dated 7/18/22, identified R1 was cognitive and required	2 910	Corrected.	

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	00150	A. BUILDING: _____ B. WING _____	C 12/28/2022

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2 910	Continued From page 13 an extensive assist of two with toileting and transfers, also identified that R1 was occasionally incontinent of bladder and always continent of bowel. R1's bowel assessment dated 10/13/22, identified R1 was frequently incontinent of bowel and frequently incontinent of bladder. The assessment did not identify R1's type of urinary incontinence. R1's toileting program was unchanged from previous assessment; identified R1 was toileted upon demand. R1's quarterly MDS dated 10/17/22, identified R1 was cognitive and required an extensive assist of two with toileting and transfers, also identified that R1 was frequently incontinent of bowel and bladder. R1's care plan dated 12/21/22, indicated R1 has a self-care deficit with the following activities of daily living (ADL); bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel, and bladder related to stroke with left sided hemiplegia. R1's bowel and bladder care plan identified R1 was frequently incontinent of bowel and bladder. Corresponding intervention identified R1 required two staff assist to toilet R1 upon demand. Even though R1's bowel assessment dated 10/13/22 and the MDS dated 10/17/22 identified R1 had an increase in bowel and bladder incontinence, R1's record did not include a causal analysis or clinical evaluation of R1's increased incontinence. Further it was not evident R1's toileting plan was revised to improve bowel and bladder continence and/or prevent further decline. Additionally, the record did not indicate the physician was notified of the increase in R1's	2 910		

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2 910	Continued From page 14 incontinence of bowel and bladder. During an observation and interview on 12/27/22, at 12:59 p.m. R1 sat in her wheelchair in her room. R1stated she needed two staff to her assist her to the toilet. She was not on a toileting schedule and would put on her call light when she needed to go. R1 explained when she put her call light on to be taken to the bathroom, by the time two staff were available to take her, it would be too late; "they never get here on time". R1 indicated she felt bad asking for help because the staff are busy, "I just wish they would just come by and ask me". R1 reported the day she fell she had put on her call light for help to use the bathroom; she waited and waited and waited. Somehow, she ended up on the floor in her bathroom which resulted in a broken hip. During a subsequent interview on 12/28/22, at 2:32 p.m. R1 stated she was aware of when she needed to use the bathroom but because she had to wait so long to be toileted the urine just leaked from her bladder into her incontinent brief. During an interview on 12/28/22, at 11:17 a.m. licensed practical nurse (LPN)- B reviewed R1's record. LPN-B identified R1 had a decline in bowel and bladder incontinence. Between 7/15/22 and 10/13/22 R1 went from always continent of bowel and occasionally incontinent of bladder to frequently incontinent of bowel and bladder. She did not know why R1 had an increase in bowel and bladder incontinence. LPN-B was not able to articulate or aware of treatments and services that would improve or maintain bowel and bladder function. LPN-B was not able to articulate why R1's toileting care plan was changed from every 2 to 3 hours toileting to on demand toileting. LPN-B indicated R1's toileting plan was not revised after assessments identified increase in bowel and	2 910		

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2 910	Continued From page 15 bladder incontinence. During an interview on 12/28/22, at 12:40 p.m. director of nursing (DON) stated R1 had a decline in bowel and bladder incontinence from 7/15/22 to 10/13/22. when R1 went from always continent of bowel and occasionally incontinent of bladder to frequently incontinent of bowel and bladder. DON was unable to articulate treatment and services plan to improve or maintain bowel and bladder services. DON was also unable to articulate why R1's toileting care plan was changed from every 2-3-hour toileting to on demand toileting. R3 R3's face sheet printed 12/28/22, identified R3 had diagnoses that included: dementia, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, and anxiety. R3's bowel assessment, dated 8/17/22, identified R3 was occasionally incontinent of bowel and bladder. R3 has a history of self-transfers to the toilet and has performed some toileting hygiene cares independently. R3 was toileted upon demand using toilet, urinal, and brief to meet toileting needs. The assessment did not identify R3's type of urinary incontinence. Further R3's record did not include an evaluation or analysis of how it was determined R3's toileting program was "on demand" R3's significant change, MDS, dated, 9/9/22, identified R3 had severe cognitive impairment required limited assist of one staff to assist with transfers and toileting, was occasionally incontinent of bladder and always continent of bowel.	2 910		

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2 910	Continued From page 16 R3's bowel and bladder CAA dated 9/12/22, identified R3 had occasional episodes of bladder incontinence and was dependent on staff for toileting needs related to impaired balance, but was known to self-transfer. R3's bowel assessment dated 12/6/22, identified R3 was frequently incontinent of bladder and always continent of bowel. R3 has a history of self-transfers to the toilet and has performed some toileting hygiene cares independently. R3 was toileted upon demand using toilet, urinal, and brief to meet toileting needs. R3's quarterly MDS dated 12/7/22, identified R3 had moderate cognitive impairment required extensive assist of one person to assist with transfers and toileting, was frequently incontinent of bladder and always continent of bowel. R3's care plan dated 12/8/22, identified R3 had a selfcare deficit related to activities of daily living (ADL) that included: bathing, grooming, oral cares, ambulation, transfers, mobility, vision, bowel, and bladder. R3 could verbally ask for assistance. R3 ' s bowel/bladder care plan identified R3 had episodes of bladder incontinence. He often self-transfers to the toilet and performed hygiene independently. R3 preferred to be toileted upon demand which helped him to remain free from skin break down and maintain dignity. R3 used the toilet with one staff assist and used a pull-up for protection. Even though R3's bowel assessment dated 12/6/22 and the MDS dated 12/7/22 identified R3 had an increase bladder incontinence, R3's record did not include a causal analysis or clinical evaluation of R3's increased incontinence. Further it was not evident R3's toileting plan was	2 910		

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2 910	Continued From page 17 revised to improve bladder continence and/or prevent further decline. Additionally, the record did not indicate the physician was notified of the increase in R3's bladder incontinence. During an observation and interview on 12/28/22, at 2:24 p.m. R3 sat on the edge of his bed wearing a t-shirt and a white brief. R3 reported was aware when he had to go to the bathroom and would put on his call light for staff to help. Sometimes staff took a while, so he would take himself to the bathroom. R3 explained a lot of times he fell trying to get to the bathroom. R3 indicated staff did not come and ask if he had to use the bathroom. During an interview on 12/28/22 at 11:56 a.m. LPN-B reviewed R3's record and indicated R3 had a decline in bladder incontinence from 8/17/22 to 12/6/22. R3 went from having occasional incontinent of bladder to frequently incontinent of bladder. LPN-A was unable to articulate treatments and services to improve or maintain bowel and bladder services. During an interview on 12/28/22, at 12:31 p.m. DON indicated toileting plans were based on documentation of continent/incontinent episodes documented in the record, through comprehensive bowel and bladder assessments, and staff and resident interviews. If there was any decline between assessment, we would need to obtain more data such as pattern of voiding which would identify more specific care plan approaches. DON explained the facility went away from the 3-day bowel and bladder voiding diary because it was thought to be a repeat/redundant assessment. DON reviewed R3 ' s record. DON verified R3 had a decline in bladder continence and there was not a treatment	2 910		

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2 910	Continued From page 18 plan to improve or maintain R3's continence. Policy for bowel and bladder continence was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies on completing comprehensive bowel and bladder assessments and modalities to prevent decline. Staff could then be provided with education pertaining to assesments.Review/revise resident care plans for individualized toileting programs based on the assessment. The DON or designee could conduct audits of resident cares to ensure their personal toileting needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		