Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 12, 2021

Administrator
The Waterview Shores LLC
402 - 13th Avenue
Two Harbors, MN 55616

RE: CCN: 245471
Cycle Start Date: June 18, 2021

Dear Administrator:

On June 28, 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 10, 2021

Administrator
The Waterview Shores LLC
402 - 13th Avenue
Two Harbors, MN 55616

RE: CCN: 245471
Cycle Start Date: June 26, 2021

Dear Administrator:

On May 26, 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 August 26, 2021 (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 November 26, 2021 (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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161   Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING ______ B. WING ______	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	**402 - 13TH AVENUE TWO HARBORS, MN 55616**

(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 5/24/21/21, through 5/26/21, 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: H5471023C (MN72794) with a deficiency issued at F689. The following complaints were found to be UNSUBSTANTIATED: H5471022C (MN73045) H5471024C (MN71797) 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	F 689		6/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/16/2021

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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify individualized risk factors to reduce the likelihood of falls, and failed to develop a comprehensive care plan which identified fall risk factors and/or implement resident centered interventions to reduce the risk of falls for 2 of 3 residents (R2, R4) reviewed for accidents. Findings included: R2's Admission Record printed 5/26/21, indicated R2's diagnoses included visual loss of left eye and osteoporosis (bone weakness). R2's admission Minimum Data Set (MDS) dated 4/16/21, indicated R2 had moderate cognitive impairment, impaired vision, required extensive assistance with transfers and ambulation, and no history of falls prior to admission. R2's Care Area Assessment (CAA) dated 4/16/21, indicated R2 was a high risk for falls related to anti-depressant use and vertigo. The CAA indicated R2 had one fall since admission, and was attending physical therapy/occupational therapy (PT/OT) to improve her balance. The CAA indicated R2 would be care planned for fall risk. R2's care plan updated and received 5/26/21, indicated R2 was risk for falls related to impaired mobility. The care plan directed the staff to follow PT/OT orders, R2 was to always wear gripper socks when not up and wearing her shoes, keep	F 689	Immediate Corrective Action: Resident #2 and #3's care plans were reviewed and updated with a comprehensive care plan which identified fall risk factors and resident centered interventions were implemented to reduce the risk of falls. Corrective Action as it applies to others: The Policy and Procedure for Fall Prevention and Management were reviewed and remain current. All residents will be reviewed to ensure a comprehensive assessment/care plan has been completed for falls and appropriate resident centered interventions are in place. All management nurses will be re-educated on the Fall Prevention and Management Policy and education will include the need to complete a comprehensive assessment/care plan and appropriate resident centered interventions after falls. Recurrence will be prevented by: Audits of 5 residents who have had falls will be assessed weekly x 4 then monthly x 2 to ensure that a comprehensive assessment/care plan was completed and appropriate resident centered interventions were put into place after	

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F 689	Continued From page 2 call-light within reach, monitor and document on safety. The care plan further directed to review information on past falls and attempt to determine cause of falls, record root cause and remove any potential causes if possible. Review of the facility provided incident reports from 2/25/21, through 5/24/21, indicated R2 had falls on 4/18/21, and 5/5/21. On 4/19/21, R2's progress note indicated the facility has contacted R2's daughter related to a fall. On 5/5/21, R2's progress note indicated she was transferring back to bed with assistance from a nursing assistant (NA) and her feet were slipping so she was gently lowered to the floor. R2's vital signs were stable and she had no injury. New gripper socks were applied as her old ones were not gripping well due effects of washing. The NA was not using a gait belt, and staff education was provided. R2's family was updated. R2's medical record lacked a comprehensive assessment following the fall, and lacked interventions to prevent subsequent falls following her falls on 4/18/21, and 5/5/21. R4's Admission Record printed 5/26/21, indicated R4's diagnoses included reduced mobility, lower back pain, kyphosis (abnormality of the spine causing excessive curvature of the upper back) and osteoporosis (bone weakness). R4's admission MDS dated 4/7/21, indicated R4 had severe cognitive impairment, required extensive assistance with transfers and ambulation, and had history of falls prior to	F 689	falls. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Manager/Designee	

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F 689	Continued From page 3	F 689		

admission.

R4's Care Area Assessment (CAA) dated 4/7/21, indicated R4 was at high risk for falls related to history of falls, unsteadiness, weakness, and lack of safety awareness. The CAA indicated R4 had three falls since admission.

R4's Care Plan initiated 4/7/21, indicated R4 was risk for falls, with a goal to be safe and free from falls. The care plan directed staff to do frequent checks, move R4 to a room closer to the desk, administer scheduled pain medication, weighted blanket for her lap when restless, wear gripper socks at night, keep room clean and free of clutter, floor mat next to bed, and keep call-light within reach.

Review of the facility provided incident reports from 2/25/21, through 5/24/21, indicated R4 had falls on 4/1/21, 4/2/21, 4/3/21, 4/5/21, 4/10/21, 4/12/21, 4/15/21, 4/17/21, 4/18/21, 5/3/21, 5/8/21, 5/17/21, and 5/23/21. R4's medical record lacked indication of monitoring R2 post fall, completing post fall vital signs, and fall interventions.

On 5/24/21, at 10:05 p.m. a progress note indicated R4 per fall on 5/23/21, staff instructed to check on R4 more frequently if napping in room due to impulsiveness. The note also indicated an order was obtained due to review of mediations and concerns R4 may not be evacuating bowels entirely which can contribute to feeling of having to go to the bathroom and restlessness. The note indicated R4 had medications in place for pain management, and upon frequent interviews at random times since admission R4 has no complaints of pain overall. R4 had significant cognitive impairment and was very restless at this

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F 689	Continued From page 4	F 689		

time. If R4 does not respond to interventions, consideration for Hospice may be appropriate as R4 may be having terminal agitation. Will discuss with rounding MD in the morning for further consideration in light of frequent falls at home and continues agitation with falls despite multiple interventions.

On 5/25/21, at 3:12 p.m. during interview, the director of nursing (DON) confirmed the documentation of R2's fall on 4/18/21, and 5/5/21, lacked a comprehensive assessment, and root cause analysis and follow up were not completed for R2's falls. The DON stated they should have been. The DON also verified R4 had multiple repeated falls from 4/1/21, through 5/23/21. The DON stated the facility failed to complete comprehensive assessments, root cause analysis and review/add interventions to address the falls at the time of the incidents. The DON stated it was not until 5/24/21, that additional interventions, a comprehensive assessment and root cause analysis were completed for R4's most recent fall on 5/23/21.

The facility policy Fall Prevention and Management revised 2/21, defined the purpose of the protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy directed that nursing staff are to complete a Fall Risk Evaluation to identify and document residents risk factors. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy further directed staff identify causes of a fall, define details of the fall, vitals to be monitored for

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F 689	Continued From page 5 24 hours post fall and monitor and document resident's response and effectiveness of interventions for 72 hours post fall.	F 689		

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Electronically delivered
June 10, 2021

Administrator
The Waterview Shores LLC
402 - 13th Avenue
Two Harbors, MN 55616

Re: State Nursing Home Licensing Orders
Event ID: 9J1Z11

Dear Administrator:

The above facility was surveyed on May 24, 2021 through May 26, 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	00844	A. BUILDING: ____ B. WING ____	C 05/26/2021

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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 5/24/21, through 5/26/21, 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.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5471023C (MN72794) with a licensing order issued at 0830. The following complaints were found to be UNSUBSTANTIATED: H5471022C (MN73045) H5471024C (MN71797) 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 interview and document review, the facility failed to identify individualized risk factors to reduce the likelihood of falls, and failed to develop a comprehensive care plan which identified fall risk factors and/or implement resident centered interventions to reduce the risk of falls for 2 of 3 residents (R2, R4) reviewed for	2 830	Immediate Corrective Action: Resident #2 and #3's care plans were reviewed and updated with a comprehensive care plan which identified fall risk factors and resident centered interventions were implemented to reduce	6/18/21

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	00844	A. BUILDING: ______ B. WING ______	C 05/26/2021

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2 830

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accidents.

Findings included:

R2's Admission Record printed 5/26/21, indicated R2's diagnoses included visual loss of left eye and osteoporosis (bone weakness).

R2's admission Minimum Data Set (MDS) dated 4/16/21, indicated R2 had moderate cognitive impairment, impaired vision, required extensive assistance with transfers and ambulation, and no history of falls prior to admission.

R2's Care Area Assessment (CAA) dated 4/16/21, indicated R2 was a high risk for falls related to anti-depressant use and vertigo. The CAA indicated R2 had one fall since admission, and was attending physical therapy/occupational therapy (PT/OT) to improve her balance. The CAA indicated R2 would be care planned for fall risk.

R2's care plan updated and received 5/26/21, indicated R2 was risk for falls related to impaired mobility. The care plan directed the staff to follow PT/OT orders, R2 was to always wear gripper socks when not up and wearing her shoes, keep call-light within reach, monitor and document on safety. The care plan further directed to review information on past falls and attempt to determine cause of falls, record root cause and remove any potential causes if possible.

Review of the facility provided incident reports from 2/25/21, through 5/24/21, indicated R2 had falls on 4/18/21, and 5/5/21.

On 4/19/21, R2's progress note indicated the facility has contacted R2's daughter related to a

2 830

the risk of falls.

Corrective Action as it applies to others:

The Policy and Procedure for Fall Prevention and Management were reviewed and remain current.

All residents will be reviewed to ensure a comprehensive assessment/care plan has been completed for falls and appropriate resident centered interventions are in place.

All management nurses will be re-educated on the Fall Prevention and Management Policy and education will include the need to complete a comprehensive assessment/care plan and appropriate resident centered interventions after falls.
Recurrence will be prevented by:
Audits of 5 residents who have had falls will be assessed weekly x 4 then monthly x 2 to ensure that a comprehensive assessment/care plan was completed and appropriate resident centered interventions were put into place after falls. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.

Corrections will be monitored by:

DON/Nurse Manager/Designee

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fall.

On 5/5/21, R2's progress note indicated she was transferring back to bed with assistance from a nursing assistant (NA) and her feet were slipping so she was gently lowered to the floor. R2's vital signs were stable and she had no injury. New gripper socks were applied as her old ones were not gripping well due effects of washing. The NA was not using a gait belt, and staff education was provided. R2's family was updated.

R2's medical record lacked a comprehensive assessment following the fall, and lacked interventions to prevent subsequent falls following her falls on 4/18/21, and 5/5/21.

R4's Admission Record printed 5/26/21, indicated R4's diagnoses included reduced mobility, lower back pain, kyphosis (abnormality of the spine causing excessive curvature of the upper back) and osteoporosis (bone weakness).

R4's admission MDS dated 4/7/21, indicated R4 had severe cognitive impairment, required extensive assistance with transfers and ambulation, and had history of falls prior to admission.

R4's Care Area Assessment (CAA) dated 4/7/21, indicated R4 was at high risk for falls related to history of falls, unsteadiness, weakness, and lack of safety awareness. The CAA indicated R4 had three falls since admission.

R4's Care Plan initiated 4/7/21, indicated R4 was risk for falls, with a goal to be safe and free from falls. The care plan directed staff to do frequent checks, move R4 to a room closer to the desk, administer scheduled pain medication, weighted

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blanket for her lap when restless, wear gripper socks at night, keep room clean and free of clutter, floor mat next to bed, and keep call-light within reach.

Review of the facility provided incident reports from 2/25/21, through 5/24/21, indicated R4 had falls on 4/1/21, 4/2/21, 4/3/21, 4/5/21, 4/10/21, 4/12/21, 4/15/21, 4/17/21, 4/18/21, 5/3/21, 5/8/21, 5/17/21, and 5/23/21. R4's medical record lacked indication of monitoring R2 post fall, completing post fall vital signs, and fall interventions.

On 5/24/21, at 10:05 p.m. a progress note indicated R4 per fall on 5/23/21, staff instructed to check on R4 more frequently if napping in room due to impulsiveness. The note also indicated an order was obtained due to review of mediations and concerns R4 may not be evacuating bowels entirely which can contribute to feeling of having to go to the bathroom and restlessness. The note indicated R4 had medications in place for pain management, and upon frequent interviews at random times since admission R4 has no complaints of pain overall. R4 had significant cognitive impairment and was very restless at this time. If R4 does not respond to interventions, consideration for Hospice may be appropriate as R4 may be having terminal agitation. Will discuss with rounding MD in the morning for further consideration in light of frequent falls at home and continues agitation with falls despite multiple interventions.

On 5/25/21, at 3:12 p.m. during interview, the director of nursing (DON) confirmed the documentation of R2's fall on 4/18/21, and 5/5/21, lacked a comprehensive assessment, and root cause analysis and follow up were not completed for R2's falls. The DON stated they should have

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been. The DON also verified R4 had multiple repeated falls from 4/1/21, through 5/23/21. The DON stated the facility failed to complete comprehensive assessments, root cause analysis and review/add interventions to address the falls at the time of the incidents. The DON stated it was not until 5/24/21, that additional interventions, a comprehensive assessment and root cause analysis were completed for R4's most recent fall on 5/23/21.

The facility policy Fall Prevention and Management revised 2/21, defined the purpose of the protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy directed that nursing staff are to complete a Fall Risk Evaluation to identify and document residents risk factors. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The policy further directed staff identify causes of a fall, define details of the fall, vitals to be monitored for 24 hours post fall and monitor and document resident's response and effectiveness of interventions for 72 hours post fall.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure comprehensive root cause analysis are completed to reduce the likelihood of subsequent falls as well as develop a comprehensive care plan which identifies fall risk factors and/or implement resident centered interventions.
The DON or designee could educate all appropriate staff on the policies and procedures.

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2 830	Continued From page 7 The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		