

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered March 3, 2021

Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, MN 56542

RE: CCN: 245512 Cycle Start Date: March 3, 2021

Dear Administrator:

On February 26, 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 5, 2021

Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, MN 56542

RE: CCN: 245512 Cycle Start Date: January 21, 2021

Dear Administrator:

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

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

First Care Living Center February 5, 2021 Page 2

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:

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Email: Jennifer.bahr@state.mn.us Office: (218) 308-2104 Mobile: (218) 368-3683

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

First Care Living Center February 5, 2021 Page 3

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 April 21, 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 July 21, 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

First Care Living Center February 5, 2021 Page 4 Feel free to contact me if you have questions.

Sincerely,

5 6

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

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM A	02/22/202 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	ING LIGITI	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	C 01/2	: 1/20 <u>21</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F 00	D		
	was completed at complaint investiga not to be in compli Requirements for I The following com SUBSTANTIATED H5512036C (MN6 F689 The following com SUBSTANTIATED issued due to action investigation: H5512035C (MN6 H5512034C (MN6 H5512032C (MN6) H5512031C (MN6) H551200 H551	9105) with a deficiency cited at plaints were also however, a deficiency was not ons take by the facility prior to 6693) 6510) 3762) 2614) 6695) of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will ation of compliance.				
	on-site revisit of yo validate that subst regulations has be your verification.	acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with				
		azards/Supervision/Devices (1)(2)	F 68	9		2/15/21
	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		x6) date 02/15/202

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.

TATEMENT	CS FOR MEDICAR	XE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURV COMPLETE	/EY
	FCORRECTION	IDENTIFICATION NOWBER.	A. BUILDING		second in the second	
		245512	B. WING	M EDCEM	C	24
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE	01/21/20	21
		INA UAUNI		900 HILLIGOSS BOULEVARD SOUTHEAS	has I V. I.	
FIRST C	ARE LIVING CENTE	R		FOSSTON, MN 56542		
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F 689	Continued From	bage 1	F 689			
	§483.25(d) Accid	-				
	The facility must					
	§483.25(d)(1) The	e resident environment remains				
	as free of accider	nt hazards as is possible; and				
	8483 25(d)(2)Eac	h resident receives adequate				
		issistance devices to prevent				
	accidents.					
	This REQUIREM	ENT is not met as evidenced				
	by:					
		ation, interview and document		F689 First Care Living Center		
		failed to comprehensively		established and complies with Fa	III Risk	
		ctors of falls and attempt new neffort to prevent falls for 1 of 3		Assessment, Prevention and Management Policy to ensure the	rocidont	
		viewed with multiple falls.		environment remains as free of a		
				hazards as possible; and each re		
	Findings include:			receives adequate supervision ar		
				assistance devices to prevent ac		
		eturn anticipated Minimum Data		A. R2 assessed for high fall risk		
		12/19/20, indicated she was		Hopkins Fall Risk tool on 12/14/2		
		ely impaired and required nce from two staff for transfers		2/10/21. Comprehensive assessr MDS RN Coordinator for continue		
		MDS indicated R2 had an		of causal factors for falls for R2 8		
	•	er and was occasionally		comprehensive care plan update		
		vel and bladder during the		problem areas and approaches u		
	assessment perio	d. The MDS further identified		1/29/21 for R2.		
		a fall with fracture prior to		B. MDS RN Coordinators		
		facility and had two or more falls		comprehensive review of residen		
	since admission.			identify as high risk for falls via Jo Hopkins Fall Risk Assessment to		
	R2's care plan da	ted 12/14/20, identified a risk for		admission, quarterly, and as nece		
		in, fall history and limited		All residents care plans updated		
	mobility. The care	e plan indicated R2 sustained		causal factors for falls risk and to	ensure	
		reased confusion due to urinary		interventions in place to prevent f		
		TI)'s and dementia resulting in		MATRIX EMR system Yellow flag		
		npts. The care plan directed		sheet for all residents at high risk	tor falls	
		s door open when in her room to ation by staff. The care plan also		by March 8, 2021. C. Fall Scene Investigation Too	l for	
		of bed and chair alarms, a well		licensed staff to complete at time		

Facility ID: 00461

	OF DEFICIENCIES	XE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	MB NO. 09 (X3) DATE SL	
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
120	ENBI		IAU	// EBAEL	C	pi
	LATIN	245512	B. WING		01/21/2	2021
NAME OF F	ROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTE	R	-	00 HILLIGOSS BOULEVARD SOUTHEAST		
			F	OSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CC	(X5) DMPLETION DATE
F 689	Continued From	page 2	F 689			
	lit, clutter free env call light within re	vironment, proper footwear and ach.		Interdisciplinary Team meetings weekdays, Monday through Friday huddle to review falls that have oc		
	R2's Event Report note(s) identified	rts and correlating progress the following:		for causal factors and to ensure tin interventions on care plans and to	nely	
	in her room. R2 v) p.m. R2 was found on the floor vas hallucinating at the time of		interventions are implemented. D. R2's Primary Physician review orders for all medication side	red	
	causative factors	een incontinent. The potential of the fall was identified as R2's nfusion and hallucinations. Initial		effects/necessity 2/3/21 & 2/9/21. E. Urology consultant for R2 on 1 for urinary assessment.	/27/21	
	supervision. The	to provide one to one correlating progress note dated p.m. indicated R2 had been		F. Pharmacy consultant review of medication for side effects which r cause risk of falling on 1/18/21.		
	experiencing hall floor yelling at a r	ucinations and was found on the nan in her room. R2 stated she for and had been self		 G. Pharmacy consultant monthly of all falls occuring since last mon review to identify if medications side 	ths'	
	transferring most	of the shift.) p.m. R2 was found on the floor.		effects are a causal factor. H. Certified Geriatric Nurse pract visit for R2 on1/26/21 for assessm		
	The potential cau	sative factors were identified as lucinations. The correlating		anxiety disorder. I. R2 restorative aide program		
	indicated R2 was staff entered roor	ted 12/17/20, at 10:39 p.m. heard yelling at someone, when n she was on the floor at the		scheduled 3x weekly, program rev monthly with Physical therapist an Coordinator.		
	may have had a l			J. Physical therapist and MDS Coordinator to provide oversite/rev restorative nursing aide program f	or	
	No potential caus correlating progre	5 a.m. R2 was found on the floor. active factors were identified . A ess note dated 12/18/20,		residents on restorative nursing ai program monthly. K. Licensed staff educated verba	lly and	
	in the corner of th	found on the floor by her chair ne room at 5:45 a.m R2 tear to her left elbow.		with paper instructions on Fall pre- strategies at staff meetings on Fel 2021. Nursing Assistants educated	oruary 3, d	
	8:00 a.m. No pote	ind on the floor in her room at ential causative factors were		verbally and with paper instruction Fall prevention strategies at staff r on February 4, 2021. For all staff r	neeting not	
		elating progress note indicated n the floor next to her bed and		attending meeting, information pac were given out on February 9, 202		

Facility ID: 00461

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIE	245512 R	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	01/2	21/20 <u>21</u>
	ARE LIVING CENTE	ILA LALIN	9	00 HILLIGOSS BOULEVARD SOUTHEAS OSSTON, MN 56542	The state	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 689	Continued From	page 3	F 689			
	her bed. -12/23/20, at 1:00 of her room. The identified as UTL anxiety and impul getting up indepe Intervention ident correlating progre p.m. indicated R2 responded to find of the bathroom of get some pictures -12/23/20, at 2:00 in her room. The identified as UTL anxiety and impul getting up indepe Interventions inclu- checks and leave visual for staff. R2 time of the fall. Th dated 12/23/20, it responded to R2's the floor next to h getting up to get h were identified to -12/24/20, at 6:45 The potential cau confusion. The c dated 12/24/20, it trying to get to the	 p.m. R2 was found on the floor potential causative factors were resulting in hallucinations, lsive behavior which led to ndently without her walker. uded continue with 30 minute door open to maintain better 2 had been incontinent at the ne correlating progress note ndicated at 2:00 p.m. staff s alarm and found her sitting on er bed. R2 reported she was ner trash can. No interventions attempt to prevent future falls. 6 a.m. R2 was found on the floor. sative factors was identified as orresponding progress note ndicated R2 stated she was be bathroom. No interventions 		to sign that they have read and understood information prior to th shift and education provided with employee training. L. DON or her designee will au Scene Investigation Tool as falls ensure documentation of compre- assessment is completed. M. DON or her designee will au care plans upon admission, quar with each occurrence of a fall, to interventions are appropriate and implemented. N. Falls comprehensive assessments/interventions/care p update audits added to QAPI age quarterly meetings. O. Completion date March 8, 200	all new dit all Fall occur, to chensive dit Falls terly and ensure d	
	-12/24/20, at 2:10	attempt to prevent future falls.) p.m. R2 was found on the floor tated she hit her head when she				

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		AND HUMAN SERVICES			FORM	02/22/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	
	ENDI	245512	B. WING		01/2	C 21/20 <u>21</u>
	PROVIDER OR SUPPLIER	IA UAUT		TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST	-11	
FIRST C	ARE LIVING CENTER	R		OSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 4	F 689			
		ack. R2 was sent to the				
	potential causative confusion related to	ment for evaluation. The factor was identified as o UTI. No interventions other e identified to attempt to				
	her room. R2 indic crackers. Last time had been incontine cause of fall determ	m. R2 was found on the floor in ated she was looking for her toileted was left blank but R2 ent at the time of the fall. Root nined to be confusion due to ons were identified to attempt ills.				
	sat down on the flo incontinent at the ti was determined to on 30 minute chec	ttempting to get out of bed and oor at 1:40 a.m. R2 had been ime of the fall. The root cause be confusion. R2 was placed ks. However, this was a on identified from the fall on				
	foot inside the door wing of the facility. facing the doors. T status changed/co were implemented	o.m. R2 was found with one rs leading to the assisted living R2 was seated with her back he root cause indicated mental nfusion. Thirty minute checks ; however this was an nented since 12/23/21.				
	bed alarm and four buttocks. The pote fall was identified a interventions were future falls.	.m. R2 staff responded to R2's nd her on the floor on her ntial causative factors of the is confusion. No new identified to attempt to prevent				

If continuation sheet Page 5 of 7

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		B NO. 0938-039 (3) DATE SURVEY COMPLETED C	
	CAIDI	245512	B. WING	LENCEME	01/21/2021	
NAME OF F	PROVIDER OR SUPPLIE		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
FIRST CARE LIVING CENTER		900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 689	Continued From p	bage 5	F 689			
	No potential caus no new intervention corresponding pro- indicated R2 had room, walked out the report identifie	a.m. The fall was not witnessed. ative factors were identified and on were initiated. The ogress note dated 1/18/21, walked into another residents and sat on the floor; however, ed the "fall" was unwitnessed. on on 1/20/21, R2 was propelling				
	wheel chair had a chair alarm. At 12	way in her wheel chair. R2's uto locking brakes and and a 2:37 p.m. R2 was in bed with her er alarm on. R2's door was				
	assistant (NA)-As quickly and stated alarms. NA-A stat after meals and tr but said R2 did no stated R2 liked to but said staff did no they were very but	on 1/21/21, at 9:36 a.m. nursing stated R2 got agitated very d R2 had both bed and chair ted staff tried to lay her down ried to engage her in activities ot sit still for very long. NA-A have staff sit and visit with her not always have time because usy. NA-A stated when R2's n staff would respond and R2 on the floor.				
	social services de The DON stated t would discuss the DON stated they what contributed t were also discuss with therapy admi The DON stated t looked at recent r	director of nursing (DON) and esignee (SSD) were interviewed. cypically after a resident fell, staff a fall in morning huddle. The discussed the fall to determine to the fall. The DON stated falls sed during a weekly fall meeting inistration and nursing staff. the interdisciplinary team (IDT) nedication changes or doctor R2 had bed sensors and chair				

Facility ID: 00461

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		AND HUMAN SERVICES			FORM	02/22/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		COM	E SURVEY PLETED
D	ENDI	245512	B. WING	VIENCEM		C 21/2021
NAME OF F	PROVIDER OR SUPPLIER	NU AUNN		TREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	R		FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	SSD stated activity more engaged but The DON and SSD falls had occurred shifts but were una based on the ident IDT had identified for R2's falls, the D R2's bowel and bla since admission.	age 6 aff to her movements. The v staff were trying to keep R2 stated she was very impulsive. D indicated they felt a lot of R2's on the evening and overnight able to verbalize interventions ified pattern. Further while the UTI's to be contributing factor OON stated no re-evaluation of adder had been completed fall intervention and s requested but not received.	F 689			

Facility ID: 00461

If continuation sheet Page 7 of 7

Minnesc	linnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		E SURVEY IPLETED		
		00461	B. WING		C 21/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		IGOSS BOU N, MN 56542	LEVARD SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 000	000 Initial Comments						
	*****ATTE	NTION*****					
	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						
	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.						
	conducted to deter Licensure. Your fac compliance with the indicate in your ele you have reviewed date when they will	/21, an abbreviated survey was mine compliance with State cility was found to be NOT in e MN State Licensure. Please ctronic plan of correction that these orders, and identify the	3	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			
ABORATOR	Linnesota Department of Health ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Electronically Signed 02/15/21						

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		00461	B. WING	CIN	C 01/21	/2021
	ROVIDER OR SUPPLIEF			STATE, ZIP CODE	01/21	/2021
		900 HILL		LEVARD SOUTHEAST		
-IRST CA	ARE LIVING CENTE	R FOSSTO	N, MN 5654	2		
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STATE FORM

Minneso	ta Department of H	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00461		B. WING	ET.		C 21/202 <u>1</u>
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2		GOSS BOU N, MN 56542	LEVARD SOUTHEAS	ST	
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2 830	Continued From pa	age 3		2 830			
	review, the facility assess causal fact interventions in an	failed to comprehensiv ors of falls and attemp effort to prevent falls f ewed with multiple fall	ot new for 1 of 3				
	Findings include:						
	Set (MDS) dated 1 severely cognitivel extensive assistan and toileting. The I indwelling catheter incontinent of bow assessment period R2 had sustained	turn anticipated Minimu 2/19/20, indicated she y impaired and require ce from two staff for tr MDS indicated R2 had and was occasionally el and bladder during t d. The MDS further ide a fall with fracture prior acility and had two or n	was d ansfers an he ntified r to				
	falls related to pair mobility. The care falls related to incr tract infections (UT self transfer attem staff to leave R2's increase visualizat identified the use of	ed 12/14/20, identified n, fall history and limite plan indicated R2 sust eased confusion due t FI)'s and dementia resu pts. The care plan dire door open when in her ion by staff. The care p of bed and chair alarms ronment, proper footw ch.	d ained o urinary ulting in cted room to blan also s, a well				
	R2's Event Report note(s) identified th	s and correlating progr ne following:	ress				
	in her room. R2 wa the fall and had be causative factors of condition with conf	p.m. R2 was found on as hallucinating at the en incontinent. The po of the fall was identified fusion and hallucination provide one to one	time of itential I as R2's				
Minnesota De STATE FORI	epartment of Health M			6899	2YMF11	If continue	ation sheet 4 of 9
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Minnesc	ta Department of He	ealth			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	
FIRST C	ARE LIVING CENTER		LIGOSS BOUL DN, MN 56542	EVARD SOUTHEAST	
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2 830	Continued From pa	age 4	2 830		
	12/17/20, at 8:40 p experiencing halluc floor yelling at a ma had sat on the floor transferring most o -12/17/20, at 9:30 p The potential cause confusion and hallu progress note date indicated R2 was h staff entered room foot of the bed. Far may have had a U	o.m. R2 was found on the floo ative factors were identified as ucinations. The correlating id 12/17/20, at 10:39 p.m. heard yelling at someone, whe she was on the floor at the mily was notified and felt R2	e r. s		
	No potential causa correlating progres indicated R2 was for in the corner of the sustained a skin te	tive factors were identified . A s note dated 12/18/20, ound on the floor by her chair room at 5:45 a.m R2 ar to her left elbow.			
	8:00 a.m. No poter identified . A correl R2 was seated on	d on the floor in her room at atial causative factors were ating progress note indicated the floor next to her bed and looking for something under			
Minnocoto D	of her room. The p identified as UTI re anxiety and impuls getting up independ Intervention identific correlating progres p.m. indicated R2's responded to find h	o.m. R2 was found on the floo otential causative factors were sulting in hallucinations, ive behavior which led to dently without her walker. ded as 30 minute checks. A s note dated 12/23/20, at 1:30 s alarm sounded and staff her sitting on the floor just nor bor. R2 stated she was trying t	e) h		

Minnesc	ta Department of He	ealth					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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2 830	in her room. The pridentified as UTI reanxiety and impuls getting up independent interventions include checks and leave of visual for staff. R2 time of the fall. The dated 12/23/20, income for the floor next to he getting up to get here were identified to a -12/24/20, at 6:45 a The potential cause confusion. The co- dated 12/24/20, income for the were identified to a -12/24/20, at 2:10 prin her room. R2 staf fell and heard a crase emergency departs potential causative confusion related to than treatment were prevent future falls - 1/1/21, at 9:01 p.1 her room. R2 indice crackers. Last time had been incontine cause of fall deterr	p.m. R2 was found o otential causative face soulting in hallucination ive behavior which lead dently without her was ded continue with 30 door open to maintain had been incontinent e correlating progress dicated at 2:00 p.m. s alarm and found her r bed. R2 reported s er trash can. No inter the factors was ide rresponding progress dicated R2 stated she bathroom. No intervent futtempt to prevent fut out. R2 was found on ated she hit her head ack. R2 was sent to the ment for evaluation. factor was identified o UTI. No intervention re identified to attempt of the time of the nined to be confusion ons were identified to attempt on the time of the nined to be confusion on the time of the time of the nined to be confusion on the time of the time of the nined to be confusion on the time of the time of the nined to be confusion on the time of the time of the time of the nined to be confusion on the time of the nined to be confusion on the time of time of the time of the time of the time of time of the time of the time of time of time of time of the time of ti	ctors were ons, ed to alker. minute n better it at the s note staff r sitting on he was rventions ture falls. on the floor. on the floor. on the floor d when she the The d as ons other pt to the floor in g for her nk but R2 fall. Root n due to				
Minnesota D	epartment of Health						
STATE FOR				6899	2YMF11	lf continu	ation sheet 6 of 9

Minnesota Department of Health							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER			GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
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2 830	Continued From pa	age 6		2 830			
	sat down on the flo incontinent at the ti was determined to on 30 minute check previous intervention 12/23/20. - 1/13/21, at 6:00 p foot inside the door wing of the facility. facing the doors. T status changed/con were implemented; intervention implem - 1/14/21, at 2:42 a bed alarm and four buttocks. The poter fall was identified a interventions were future falls. - 1/18/21, R2 was f her room at 4:00 a. No potential causar no new interventior corresponding prog- indicated R2 had w room, walked out a the report identified During observation herself in the hallway wheel chair had au chair alarm. At 12:3	ttempting to get out of or at 1:40 a.m. R2 had me of the fall. The roo be confusion. R2 was on identified from the fa .m. R2 was found with rs leading to the assist R2 was seated with he he root cause indicated fusion. Thirty minute of however this was an nented since 12/23/21. .m. R2 staff responded to her on the floor on h ntial causative factors is confusion. No new identified to attempt to found on the floor acros m. The fall was not wit tive factors were identi in were initiated. The gress note dated 1/18/2 valked into another resi and sat on the floor; ho d the "fall" was unwitne on 1/20/21, R2 was p ay in her wheel chair. Fa to locking brakes and a farm on. R2's door w	I been t cause placed a all on one ed living er back d mental checks d to R2's ner of the prevent ss from tnessed. fied and 21, idents wever, ssed. ropelling R2's and a with her				
Minnesota D	epartment of Health						

Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	ARE LIVING CENTER	900 HILI	IGOSS BOUL	EVARD SOUTHEAST		
		FOSSTO	N, MN 56542			
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2 830	Continued From pa	age 7	2 830			
	During interview or assistant (NA)-A st quickly and stated alarms. NA-A state after meals and trie but said R2 did not stated R2 liked to h but said staff did no they were very bus alarm sound, often would already be o At 12:20 p.m. the d social services des The DON stated ty would discuss the f DON stated they di what contributed to were also discusse with therapy admin The DON stated th looked at recent m visits. She stated R sensors and identifi falls but alerting sta SSD stated activity more engaged but The DON and SSD falls had occurred of shifts but were una based on the identified I for R2's falls, the D R2's bowel and bla since admission. A policy related to f	n 1/21/21, at 9:36 a.m. nursing ated R2 got agitated very R2 had both bed and chair d staff tried to lay her down ed to engage her in activities s it still for very long. NA-A have staff sit and visit with her ot always have time because y. NA-A stated when R2's staff would respond and R2	f s			
		THOD OF CORRECTION:				
Minnesota D	epartment of Health		0000			

Minneso	ta Department of H	ealth	_			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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FIRST CA	ARE LIVING CENTER	FOSSTO	N, MN 5654	2		
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2 830	review/revise polic falls, accidents and proper assessment implemented. They policies and proce and monitoring coult these policies coult results of these aut facility's Quality Ast	age 8 sing or designee, could ies and procedures related to d resident supervision to assure at and interventions are being y could re-educate staff on the dures. A system for evaluating nsistent implementation of d be developed, with the dits being brought to the surance Committee for review. R CORRECTION: Twenty-one	2 830			
STATE FOR			6899	2YMF11	If continua	tion sheet 9 of 9