

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.

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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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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.

First Care Living Center
February 5, 2021
Page 4
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

PRINTED: 02/22/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	I= M I M I	245512	B. WING _	A/I  =   Y/=  =  \/	01/21/2021	
NAME OF F	PROVIDER OR SUPPLIER	NG AGNI		STREET ADDRESS, CITY, STATE, ZIP CODE	_   1	
FIRST C	ARE LIVING CENTER		4 . Tagger . 14	900 HILLIGOSS BOULEVARD SOUTHEAST		
				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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTIO	N
F 000	INITIAL COMMEN	тѕ	F 00	0		
	was completed at y complaint investigation to be in complicated at your complete and to be in complicated as a complete and the following complete and the following complete at your complete and the following complete at your c	plaints were also however, a deficiency was not ons take by the facility prior to 6693) 6510) 3762)				
	H5512031C (MN56) The facility's plan of as your allegation of Department's acceenrolled in ePOC, at the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has be your verification.	of correction (POC) will serve of compliance upon the optance. Because you are your signature is not required the first page of the CMS-2567 nic submission of the POC will atton of compliance.  acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with	F 68	9	2/15/21	
L ABORATOR)	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

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.

**Electronically Signed** 

02/15/2021

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES	A. BUILDING	<b>[</b> `	3) DATE SURVEY COMPLETED
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(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 APPROPRIA DEFICIENCY)	
F 689	Continued From page 1 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess causal factors of falls and attempt new interventions in an effort to prevent falls for 1 of 3 residents (R2) reviewed with multiple falls.  Findings include:  R2's discharge, return anticipated Minimum Data Set (MDS) dated 12/19/20, indicated she was severely cognitively impaired and required extensive assistance from two staff for transfers and toileting. The MDS indicated R2 had an indwelling catheter and was occasionally incontinent of bowel and bladder during the assessment period. The MDS further identified R2 had sustained a fall with fracture prior to admission to the facility and had two or more falls since admission.  R2's care plan dated 12/14/20, identified a risk for falls related to pain, fall history and limited mobility. The care plan indicated R2 sustained falls related to increased confusion due to urinary tract infections (UTI)'s and dementia resulting in self transfer attempts. The care plan directed staff to leave R2's door open when in her room to increase visualization by staff. The care plan also identified the use of bed and chair alarms, a well	F 689	F689 First Care Living Center has established and complies with Fall Ris Assessment, Prevention and Management Policy to ensure the res environment remains as free of accid hazards as possible; and each reside receives adequate supervision and assistance devices to prevent accider A. R2 assessed for high fall risk via Hopkins Fall Risk tool on 12/14/20 & 2/10/21. Comprehensive assessment MDS RN Coordinator for continued re of causal factors for falls for R2 & comprehensive care plan updates wit problem areas and approaches updat 1/29/21 for R2.  B. MDS RN Coordinators comprehensive review of residents wit identify as high risk for falls via Johns Hopkins Fall Risk Assessment tool up admission, quarterly, and as necessa All residents care plans updated on causal factors for falls risk and to ensinterventions in place to prevent falls. MATRIX EMR system Yellow flag on f sheet for all residents at high risk for the by March 8, 2021.  C. Fall Scene Investigation Tool for licensed staff to complete at time of falls.	ident ent nts. John by eview h ted ho on ry. ure face falls

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	COM	E SURVEY IPLETED
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	ARE LIVING CENTER	10 AVIIII		900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	
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F 689	R2's Event Reports note(s) identified th -12/17/20, at 8:40 p in her room. R2 wa the fall and had bee causative factors of condition with confuintervention was to supervision. The confusion at the fall and had sat on the floor yelling at a mathad sat on the floor transferring most of the potential causat confusion and hall uprogress note dated indicated R2 was here at the following progress and the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained a skin teat-12/18/20, R2 found the corner of the sustained t	and correlating progress e following:  I.m. R2 was found on the floor is hallucinating at the time of incontinent. The potential is the fall was identified as R2's usion and hallucinations. Initial provide one to one included in the fall was found on the incontinent one indicated R2 had been inations and was found on the in in her room. R2 stated she and had been self if the shift.  I.m. R2 was found on the floor. Intive factors were identified as cinations. The correlating in 12/17/20, at 10:39 p.m. in eard yelling at someone, when is she was on the floor at the infly was notified and felt R2 in incompanion. The correlation is in the floor in the floor by her chair room at 5:45 a.m R2 in the floor in her room at don't her floor in	F 689	Interdisciplinary Team meetings weekdays, Monday through Friday in AM huddle to review falls that have occurred for causal factors and to ensure timely interventions on care plans and to ensure interventions are implemented.  D. R2's Primary Physician reviewed orders for all medication side effects/necessity 2/3/21 & 2/9/21.  E. Urology consultant for R2 on 1/27/21 for urinary assessment.  F. Pharmacy consultant review of R2's medication for side effects which may cause risk of falling on 1/18/21.  G. Pharmacy consultant monthly review of all falls occuring since last months' review to identify if medications side effects are a causal factor.  H. Certified Geriatric Nurse practitioner visit for R2 on1/26/21 for assessment of anxiety disorder.  I. R2 restorative aide program scheduled 3x weekly, program reviewed monthly with Physical therapist and MDS Coordinator.  J. Physical therapist and MDS Coordinator to provide oversite/review of restorative nursing aide program for residents on restorative nursing aide program monthly.  K. Licensed staff educated verbally and with paper instructions on Fall prevention strategies at staff meetings on February 3, 2021. Nursing Assistants educated verbally and with paper instructions on Fall prevention strategies at staff meeting	
	identified . A correla	tial causative factors were ating progress note indicated the floor next to her hed and		on February 4, 2021. For all staff not attending meeting, information packets were given out on February 9, 2021 - staff	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  NG	COMPLETED
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F 689	indicated she was her bed.  -12/23/20, at 1:00 of her room. The pidentified as UTI reanxiety and impuls getting up indepen Intervention identificorrelating progres p.m. indicated R2's responded to find I of the bathroom doget some pictures.  -12/23/20, at 2:00 in her room. The pidentified as UTI reanxiety and impuls getting up indepen Interventions includences and leaved visual for staff. R2 time of the fall. The dated 12/23/20, incresponded to R2's the floor next to he getting up to get he were identified to a -12/24/20, at 6:45. The potential caus confusion. The codated 12/24/20, incrying to get to the were identified to a -12/24/20, at 2:10.	p.m. R2 was found on the floor otential causative factors were esulting in hallucinations, ive behavior which led to dently without her walker. ied as 30 minute checks. A is note dated 12/23/20, at 1:30 is alarm sounded and staff her sitting on the floor just north foor. R2 stated she was trying to	F 68	to sign that they have read and understood information prior to shift and education provided wemployee training.  L. DON or her designee will a scene Investigation Tool as fall ensure documentation of compassessment is completed.  M. DON or her designee will a care plans upon admission, ques with each occurrence of a fall, interventions are appropriate a implemented.  N. Falls comprehensive assessments/interventions/car update audits added to QAPI a quarterly meetings.  O. Completion date March 8,	a their next ith all new audit all Fall ls occur, to prehensive audit Falls arterly and to ensure nd e plan igenda for

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		E SURVEY PLETED
	ROVIDER OR SUPPLIER	245512	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	01/3	C 21/20 <u>21</u>
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F 689	emergency department potential causative confusion related to than treatment were prevent future falls.  - 1/1/21, at 9:01 p.m. her room. R2 indicatorackers. Last time had been incontined cause of fall determent. UTI. No intervention to prevent future fall.  -1/11/21, R2 was at sat down on the floor incontinent at the time was determined to lon 30 minute check previous intervention 12/23/20.  - 1/13/21, at 6:00 p. foot inside the doors wing of the facility. If facing the doors. The status changed/conwere implemented; intervention implemented; intervention implemented as interventions were infuture falls.	ck. R2 was sent to the nent for evaluation. The factor was identified as UTI. No interventions other e identified to attempt to n. R2 was found on the floor in ted she was looking for her toileted was left blank but R2 at at the time of the fall. Root lined to be confusion due to ns were identified to attempt	F 685	9		

AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:			A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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F 689	her room at 4:00 a No potential causa no new interventio corresponding pro indicated R2 had v room, walked out a the report identifie  During observation herself in the hallw wheel chair had at chair alarm. At 12: eyes closed an he open.  During interview of assistant (NA)-A s quickly and stated alarms. NA-A state after meals and tri but said R2 did no stated R2 liked to but said staff did n they were very bus alarm sound, ofter would already be of  At 12:20 p.m. the social services des The DON stated ty would discuss the DON stated they of what contributed to were also discuss with therapy admir The DON stated th looked at recent m visits. She stated for	a.m. The fall was not witnessed. Attive factors were identified and in were initiated. The gress note dated 1/18/21, walked into another residents and sat on the floor; however, it the "fall" was unwitnessed.  In on 1/20/21, R2 was propelling vay in her wheel chair. R2's uto locking brakes and and a 37 p.m. R2 was in bed with her ralarm on. R2's door was  In 1/21/21, at 9:36 a.m. nursing tated R2 got agitated very R2 had both bed and chair ed staff tried to lay her down ed to engage her in activities the sit still for very long. NA-A have staff sit and visit with her of always have time because by NA-A stated when R2's in staff would respond and R2	F 68	9	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER	10 110111	r.	STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		C 21/20 <u>21</u>
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F 689	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 identi IDT had identified to for R2's falls, the D R2's bowel and bla since admission.	aff to her movements. The staff were trying to keep R2 stated she was very impulsive. Indicated they felt a lot of R2's on the evening and overnight ble to verbalize interventions ified pattern. Further while the JTI's to be contributing factor ON stated no re-evaluation of dder had been completed	F 689			

PRINTED: 02/22/2021

**FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00461 01/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*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 1/20/21 to 1/21/21, an abbreviated survey was Minnesota Department of Health is conducted to determine compliance with State documenting the State Licensing Correction Orders using federal software. Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please Tag numbers have been assigned to

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

date when they will be completed.

indicate in your electronic plan of correction that

you have reviewed these orders, and identify the

02/15/21 Electronically Signed

STATE FORM If continuation sheet 1 of 9 2YMF11

TITLE

Minnesota state statutes/rules for Nursing

Homes. The assigned tag number appears in the far left column entitled "ID

(X6) DATE

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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نسا		00461	B. WING	<del></del>	01/21/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	₹	GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
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2 000	Continued From pa	age 1	2 000			٦
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Minnesota Department of Health

STATE FORM 2YMF11 If continuation sheet 2 of 9

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STATEMENT OF DEFICIENCIES (X1)

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ANDFLAN	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		AL 10	
		00461	B. WING	<del></del>	01/2	C 21/202 <u>1                                   </u>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	?	GOSS BOUI I, MN 56542	LEVARD SOUTHEAST		
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2 000	is necessary for St enter the word "CC available for text. Y electronic State lice heading completion be corrected prior to the Minnesota Dep is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI THIS WILL APPEA	Although no plan of correction ate Statutes/Rules, please DRRECTED" in the box fou must then indicate in the ensure process, under the n date, the date your orders will to electronically submitting to partment of Health. The facility C and therefore a signature is bottom of the first page of ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.	2 000	WILL APPEAR ON EACH PAGE.		2/15/21
	receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from tresident must rema prefers to remain in	n general. A resident must re and treatment, personal and it supervision based on and preferences as identified in eresident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident in bed.		Corrected		

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PRINTED: 02/22/2021 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00461 01/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 3 2 8 3 0 review, the facility failed to comprehensively assess causal factors of falls and attempt new interventions in an effort to prevent falls for 1 of 3 residents (R2) reviewed with multiple falls. Findings include: R2's discharge, return anticipated Minimum Data Set (MDS) dated 12/19/20, indicated she was severely cognitively impaired and required extensive assistance from two staff for transfers and toileting. The MDS indicated R2 had an indwelling catheter and was occasionally incontinent of bowel and bladder during the assessment period. The MDS further identified

R2's care plan dated 12/14/20, identified a risk for falls related to pain, fall history and limited mobility. The care plan indicated R2 sustained falls related to increased confusion due to urinary tract infections (UTI)'s and dementia resulting in self transfer attempts. The care plan directed staff to leave R2's door open when in her room to increase visualization by staff. The care plan also identified the use of bed and chair alarms, a well lit, clutter free environment, proper footwear and call light within reach.

R2 had sustained a fall with fracture prior to admission to the facility and had two or more falls

since admission.

R2's Event Reports and correlating progress note(s) identified the following:

-12/17/20, at 8:40 p.m. R2 was found on the floor in her room. R2 was hallucinating at the time of the fall and had been incontinent. The potential causative factors of the fall was identified as R2's condition with confusion and hallucinations. Initial intervention was to provide one to one

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		00461	B. WING		01/2	21/202 <u>1</u>
NAME OF PROVID	ER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST CARE L	IVING CENTER		GOSS BOUL N, MN 56542	EVARD SOUTHEAST		
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supe 12/17 expe floor had strans -12/1 The p confu programmer foot of may -12/1 No programmer foot of may -12/1 8:00 ident R2 w indicate her b -12/2 of he ident anxiet gettir Intervorre p.m.	7/20, at 8:40 p. riencing hallud yelling at a massat on the floor offerring most of 7/20, at 9:30 p. potential causausion and hallud ress note date ated R2 was hentered room of the bed. Far have had a UT 8/20, at 5:45 at otential causate lating progressated R2 was fee corner of the ained a skin test ated as well at the result of the bed. R2 was fee corner of the ained a skin test at 8/20, R2 found a.m. No potential causate at 8/20, R2 found a.m. No potential causate at the result of the room. The per room. The per room. The per room independent of the progressing up independent of the room independe	orrelating progress note dated .m. indicated R2 had been sinations and was found on the an in her room. R2 stated she rand had been self f the shift.  o.m. R2 was found on the floor. ative factors were identified as acinations. The correlating d 12/17/20, at 10:39 p.m. eard yelling at someone, when she was on the floor at the mily was notified and felt R2	2 830			

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-12/24/20, at 6:45 a.m. R2 was found on the floor. The potential causative factors was identified as confusion. The corresponding progress note dated 12/24/20, indicated R2 stated she was trying to get to the bathroom. No interventions were identified to attempt to prevent future falls.

dated 12/23/20, indicated at 2:00 p.m. staff responded to R2's alarm and found her sitting on the floor next to her bed. R2 reported she was getting up to get her trash can. No interventions were identified to attempt to prevent future falls.

-12/24/20, at 2:10 p.m. R2 was found on the floor in her room. R2 stated she hit her head when she fell and heard a crack. R2 was sent to the emergency department for evaluation. The potential causative factor was identified as confusion related to UTI. No interventions other than treatment were identified to attempt to prevent future falls.

- 1/1/21, at 9:01 p.m. R2 was found on the floor in her room. R2 indicated she was looking for her crackers. Last time toileted was left blank but R2 had been incontinent at the time of the fall. Root cause of fall determined to be confusion due to UTI. No interventions were identified to attempt to prevent future falls.

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STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA AND BLAND CORPORTION  (X2) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00461	B. WING	-	01/2	C 2 <mark>1/2021</mark>
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
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2 830	Continued From pa	ige 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. The status changed/cor were implemented; intervention implemented: intervention implemented alarm and four buttocks. The potential was identified a	ttempting to get out of bed and or at 1:40 a.m. R2 had been me of the fall. The root cause be confusion. R2 was placed as. However, this was a on identified from the fall on .m. R2 was found with one as leading to the assisted living R2 was seated with her back he root cause indicated mental afusion. Thirty minute checks however this was an mented since 12/23/21.  .m. R2 staff responded to R2's and her on the floor on her intial causative factors of the s confusion. No new identified to attempt to prevent				
	her room at 4:00 a. No potential causal no new intervention corresponding prog indicated R2 had w room, walked out a	found on the floor across from m. The fall was not witnessed. tive factors were identified and n were initiated. The gress note dated 1/18/21, valked into another residents and sat on the floor; however, if the "fall" was unwitnessed.				
	herself in the hallwa wheel chair had au chair alarm. At 12:3	on 1/20/21, R2 was propelling ay in her wheel chair. R2's to locking brakes and and a 37 p.m. R2 was in bed with her alarm on. R2's door was				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00461 01/21/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 7 2 8 3 0 During interview on 1/21/21, at 9:36 a.m. nursing assistant (NA)-A stated R2 got agitated very quickly and stated R2 had both bed and chair alarms. NA-A stated staff tried to lay her down after meals and tried to engage her in activities but said R2 did not sit still for very long, NA-A stated R2 liked to have staff sit and visit with her but said staff did not always have time because they were very busy. NA-A stated when R2's alarm sound, often staff would respond and R2 would already be on the floor. At 12:20 p.m. the director of nursing (DON) and social services designee (SSD) were interviewed. The DON stated typically after a resident fell, staff would discuss the fall in morning huddle. The DON stated they discussed the fall to determine what contributed to the fall. The DON stated falls were also discussed during a weekly fall meeting with therapy administration and nursing staff. The DON stated the interdisciplinary team (IDT) looked at recent medication changes or doctor visits. She stated R2 had bed sensors and chair sensors and identified they were not preventing falls but alerting staff to her movements. The SSD stated activity staff were trying to keep R2 more engaged but stated she was very impulsive. The DON and SSD indicated they felt a lot of R2's falls had occurred on the evening and overnight shifts but were unable to verbalize interventions based on the identified pattern. Further while the IDT had identified UTI's to be contributing factor for R2's falls, the DON stated no re-evaluation of R2's bowel and bladder had been completed since admission. A policy related to fall intervention and

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re-assessment was requested but not received.

SUGGESTED METHOD OF CORRECTION:

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facility's Quality Assurance Committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one

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(21) days.