DEPARTMENT OF HEALTH

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

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.

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

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: 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
	245512	A. BUILDING _____ B. WING _____	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 1/20/21 to 1/21/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5512036C (MN69105) with a deficiency cited at F689 The following complaints were also SUBSTANTIATED however, a deficiency was not issued due to actions take by the facility prior to investigation: H5512035C (MN66693) H5512034C (MN66510) H5512033C (MN63762) H5512032C (MN62614) H5512031C (MN56695) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		2/15/21

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

Electronically Signed | 02/15/2021

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 §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 Risk Assessment, Prevention and Management Policy to ensure the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. R2 assessed for high fall risk via John Hopkins Fall Risk tool on 12/14/20 & 2/10/21. Comprehensive assessment by MDS RN Coordinator for continued review of causal factors for falls for R2 & comprehensive care plan updates with problem areas and approaches updated 1/29/21 for R2. B. MDS RN Coordinators comprehensive review of residents who identify as high risk for falls via Johns Hopkins Fall Risk Assessment tool upon admission, quarterly, and as necessary. All residents care plans updated on causal factors for falls risk and to ensure interventions in place to prevent falls. MATRIX EMR system Yellow flag on face sheet for all residents at high risk for falls by March 8, 2021. C. Fall Scene Investigation Tool for licensed staff to complete at time of fall.	

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F 689	Continued From page 2 lit, clutter free environment, proper footwear and call light within reach. 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 supervision. The correlating progress note dated 12/17/20, at 8:40 p.m. indicated R2 had been experiencing hallucinations and was found on the floor yelling at a man in her room. R2 stated she had sat on the floor and had been self transferring most of the shift. -12/17/20, at 9:30 p.m. R2 was found on the floor. The potential causative factors were identified as confusion and hallucinations. The correlating progress note dated 12/17/20, at 10:39 p.m. indicated R2 was heard yelling at someone, when staff entered room she was on the floor at the foot of the bed. Family was notified and felt R2 may have had a UTI. -12/18/20, at 5:45 a.m. R2 was found on the floor. No potential causative factors were identified . A correlating progress note dated 12/18/20, indicated R2 was found on the floor by her chair in the corner of the room at 5:45 a.m.. R2 sustained a skin tear to her left elbow. -12/18/20, R2 found on the floor in her room at 8:00 a.m. No potential causative factors were identified . A correlating progress note indicated R2 was seated on the floor next to her bed and	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 on February 4, 2021. For all staff not attending meeting, information packets were given out on February 9, 2021 - staff	

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F 689	Continued From page 3 indicated she was looking for something under her bed. -12/23/20, at 1:00 p.m. R2 was found on the floor of her room. The potential causative factors were identified as UTI resulting in hallucinations, anxiety and impulsive behavior which led to getting up independently without her walker. Intervention identified as 30 minute checks. A correlating progress note dated 12/23/20, at 1:30 p.m. indicated R2's alarm sounded and staff responded to find her sitting on the floor just north of the bathroom door. R2 stated she was trying to get some pictures. -12/23/20, at 2:00 p.m. R2 was found on the floor in her room. The potential causative factors were identified as UTI resulting in hallucinations, anxiety and impulsive behavior which led to getting up independently without her walker. Interventions included continue with 30 minute checks and leave door open to maintain better visual for staff. R2 had been incontinent at the time of the fall. The correlating progress note 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 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. -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	F 689	to sign that they have read and understood information prior to their next shift and education provided with all new employee training. L. DON or her designee will audit all Fall Scene Investigation Tool as falls occur, to ensure documentation of comprehensive assessment is completed. M. DON or her designee will audit Falls care plans upon admission, quarterly and with each occurrence of a fall, to ensure interventions are appropriate and implemented. N. Falls comprehensive assessments/interventions/care plan update audits added to QAPI agenda for quarterly meetings. O. Completion date March 8, 2021	

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F 689	Continued From page 4	F 689		

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.

-1/11/21, R2 was attempting to get out of bed and sat down on the floor at 1:40 a.m. R2 had been incontinent at the time of the fall. The root cause was determined to be confusion. R2 was placed on 30 minute checks. However, this was a previous intervention identified from the fall on 12/23/20.

- 1/13/21, at 6:00 p.m. R2 was found with one foot inside the doors leading to the assisted living wing of the facility. R2 was seated with her back facing the doors. The root cause indicated mental status changed/confusion. Thirty minute checks were implemented; however this was an intervention implemented since 12/23/21.

- 1/14/21, at 2:42 a.m. R2 staff responded to R2's bed alarm and found her on the floor on her buttocks. The potential causative factors of the fall was identified as confusion. No new interventions were identified to attempt to prevent future falls.

- 1/18/21, R2 was found on the floor across from

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F 689	Continued From page 5	F 689		

her room at 4:00 a.m. The fall was not witnessed. No potential causative factors were identified and no new intervention were initiated. The corresponding progress note dated 1/18/21, indicated R2 had walked into another residents room, walked out and sat on the floor; however, the report identified the "fall" was unwitnessed.

During observation on 1/20/21, R2 was propelling herself in the hallway in her wheel chair. R2's wheel chair had auto locking brakes and and a chair alarm. At 12:37 p.m. R2 was in bed with her eyes closed an her alarm on. R2's door was open.

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

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F 689	Continued From page 6 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 re-assessment was requested but not received.	F 689		

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	00461	B. WING _____ A. BUILDING: _____	C 01/21/2021

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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 1/20/21 to 1/21/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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	

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5512036C (MN69105) with a licensing order issed at MN Rule 4658.0520 Subp 0830.1 The following complaints were also SUBSTANTIATED however, licensing orders were not issued due to actions take by the facility prior to investigation: H5512035C (MN66693) H5512034C (MN66510) H5512033C (MN63762) H5512032C (MN62614) H5512031C (MN56695) 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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000	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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00461	A. BUILDING: _____ B. WING _____	C 01/21/2021

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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	WILL APPEAR ON EACH PAGE.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 830	Corrected	2/15/21

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2 830	Continued From page 3 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 lit, clutter free environment, proper footwear and call light within reach. 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	2 830		

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2 830	Continued From page 4 supervision. The correlating progress note dated 12/17/20, at 8:40 p.m. indicated R2 had been experiencing hallucinations and was found on the floor yelling at a man in her room. R2 stated she had sat on the floor and had been self transferring most of the shift. -12/17/20, at 9:30 p.m. R2 was found on the floor. The potential causative factors were identified as confusion and hallucinations. The correlating progress note dated 12/17/20, at 10:39 p.m. indicated R2 was heard yelling at someone, when staff entered room she was on the floor at the foot of the bed. Family was notified and felt R2 may have had a UTI. -12/18/20, at 5:45 a.m. R2 was found on the floor. No potential causative factors were identified . A correlating progress note dated 12/18/20, indicated R2 was found on the floor by her chair in the corner of the room at 5:45 a.m.. R2 sustained a skin tear to her left elbow. -12/18/20, R2 found on the floor in her room at 8:00 a.m. No potential causative factors were identified . A correlating progress note indicated R2 was seated on the floor next to her bed and indicated she was looking for something under her bed. -12/23/20, at 1:00 p.m. R2 was found on the floor of her room. The potential causative factors were identified as UTI resulting in hallucinations, anxiety and impulsive behavior which led to getting up independently without her walker. Intervention identified as 30 minute checks. A correlating progress note dated 12/23/20, at 1:30 p.m. indicated R2's alarm sounded and staff responded to find her sitting on the floor just north of the bathroom door. R2 stated she was trying to	2 830		

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2 830	Continued From page 5 get some pictures. -12/23/20, at 2:00 p.m. R2 was found on the floor in her room. The potential causative factors were identified as UTI resulting in hallucinations, anxiety and impulsive behavior which led to getting up independently without her walker. Interventions included continue with 30 minute checks and leave door open to maintain better visual for staff. R2 had been incontinent at the time of the fall. The correlating progress note 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 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. -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.	2 830		

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2 830	Continued From page 6 -1/11/21, R2 was attempting to get out of bed and sat down on the floor at 1:40 a.m. R2 had been incontinent at the time of the fall. The root cause was determined to be confusion. R2 was placed on 30 minute checks. However, this was a previous intervention identified from the fall on 12/23/20. - 1/13/21, at 6:00 p.m. R2 was found with one foot inside the doors leading to the assisted living wing of the facility. R2 was seated with her back facing the doors. The root cause indicated mental status changed/confusion. Thirty minute checks were implemented; however this was an intervention implemented since 12/23/21. - 1/14/21, at 2:42 a.m. R2 staff responded to R2's bed alarm and found her on the floor on her buttocks. The potential causative factors of the fall was identified as confusion. No new interventions were identified to attempt to prevent future falls. - 1/18/21, R2 was found on the floor across from her room at 4:00 a.m. The fall was not witnessed. No potential causative factors were identified and no new intervention were initiated. The corresponding progress note dated 1/18/21, indicated R2 had walked into another residents room, walked out and sat on the floor; however, the report identified the "fall" was unwitnessed. During observation on 1/20/21, R2 was propelling herself in the hallway in her wheel chair. R2's wheel chair had auto locking brakes and and a chair alarm. At 12:37 p.m. R2 was in bed with her eyes closed an her alarm on. R2's door was open.	2 830		

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2 830	Continued From page 7 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 re-assessment was requested but not received. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 8 The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		