Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 6, 2026

Administrator
CENTRAL TODD COUNTY CARE CENTER
406 EAST HIGHWAY 71
PO BOX 38
CLARISSA, MN 56440

RE: CCN: 245521
Cycle Start Date: October 29, 2025

Dear Administrator:

On November 10, 2025, we notified you a remedy was imposed. On December 2, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 1, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 25, 2025, be discontinued as of December 1, 2025. (42 CFR 488.417 (b))

In our letter of November 10, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 25, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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January 6, 2026

Administrator
CENTRAL TODD COUNTY CARE CENTER
406 EAST HIGHWAY 71
PO BOX 38
CLARISSA, MN 56440

Re: Reinspection Results
Event ID: 1D9CE4-H1

Dear Administrator:

On December 02, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 29, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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November 10, 2025

Administrator
CENTRAL TODD COUNTY CARE CENTER

406 EAST HIGHWAY 71
PO BOX 38
CLARISSA, MN 56440

RE: CCN: 245521
Cycle Start Date: October 29, 2025

Dear Administrator:

On October 29, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 25, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 25, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 25, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 25, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Central Todd County Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 25, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 29, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

An equal opportunity employer.

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November 10, 2025

Administrator
CENTRAL TODD COUNTY CARE CENTER
406 EAST HIGHWAY 71
PO BOX 38
CLARISSA, MN 56440

Re: State Nursing Home Licensing Orders
Event ID: 1D9CE4-H1

Dear Administrator:

The above facility survey was completed on October 29, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245521	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71 PO BOX 38, CLARISSA, Minnesota, 56440

(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
F0000	INITIAL COMMENTS On 10/27/25 through 10/29/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H55215843C (2640850) with deficiency F689. Deficient practice was identified related to incidental finding at F610, F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in e POC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		11/10/2025
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations	F0610	R1's fall history was thoroughly investigated and the outcomes were communicated to nursing staff to ensure nonrecurrence. Vulnerable Adult policy review and education for all Interdisciplinary Team Leaders with specific focus on resident interviews – including other residents with similar potential exposure and exclusion of involved staff until investigation and correction is completed. Root Cause Analysis training for Interdisciplinary Team Leaders. Review training and policy at next QA meeting. Administrator responsible.	12/01/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245521	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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F0610 SS = E	Continued from page 1 to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive, complete investigation,, including a root cause analysis (RCA) and provide sufficient protection to other residents while the investigation was completed for 1 of 3 residents (R1) who was reviewed for accidents. This had the potential to affect all 19 residents who required staff assistance with a gait belt to transfer. Findings include: R1's quarterly Minimum Data Set dated 8/20/25, identified she was admitted to the facility on 2/7/23, from home/community. She had severely impaired cognition with disorganized thinking, without behaviors. She required substantial/maximal assistance with all transfers. No falls since admission. R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint). R1's quarterly fall safety assessment dated 8/19/25, identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls. R1's progress notes from 10/10/25, identified: -10/10/25 at 8:10 a.m. At approximately 7:00 a.m., licensed practical nurse (LPN) notified writer resident had fallen. Upon entering room, resident sat upright on her bottom on the floor, back was up against the nursing assistant (NA) legs with her legs stretched out towards the window. NA reported that when resident was	F0610		

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F0610 SS = E	Continued from page 2 pivot transferring with assist of one, she tripped over her feet and NA had lowered her to the ground. R1 complained of left hip pain. No redness, swelling, open areas or bruising noted to left hip. No other injuries found upon assessment. R1 denied maltreatment/abuse, stated “no, no one hurt me she just fell”. Denied head strike, wearing shoes, gait belt, and used 4WW at the time of fall. R1 was assisted off the floor with three assist EZ lift, transferred into her wheelchair, and assisted to commode with EZ stand. No complaints of left hip pain stated her right shoulder hurt, but shoulder pain was chronic and unrelated to fall. Range of motion (ROM) was limited in right shoulder due to previous injury and left hip was limited at first while sitting on the ground (stated it was painful when lifted to put the sling strap under her thigh). After she was placed in wheelchair and used sit to stand lift no more complaints of hip pain. Family, director of nursing (DON), and administrator notified. 10/10/25 at 1:05 p.m., R1 sat in recliner with legs elevated. She now complained of severe pain to her left hip/groin that radiated down to knee and numbness to buttocks. She had very limited ROM, could only lift leave an inch or so off the footrest, bent knee about 10 degrees. Left leg appeared shorter that the right while she sat in recliner. R1 winced, grimaced and verbalized pain through assessment and with light touch to her upper left leg. Ice pack applied on top of left groin. As needed (PRN) tramadol administered and primary provider (MD) here to round shortly with priority. Family updated. -10/10/25 at 1:57 p.m., Seen by medical doctor (MD) on rounds. Orders given for R1 to be seen in clinic or ER for pelvic/hip x-ray. Transferred to ER at 2:54 p.m. -10/10/25 at 5:56 p.m., Called received from local ER and updated R1 had broken and dislocated left shoulder and three broken ribs. R1 was going to have surgery. R1’s left shoulder x-ray dated 10/10/25 at 3:45 p.m., identified large Hill-Sachs fracture deformity (a bone injury on the humeral head/upper arm bone ball of the shoulder joint resulting from a shoulder dislocation) with suspected nondisplaced humeral fracture. (the bone fragments, cracked or broken have not significantly shifted but remain in their correct alignment) (can be caused by trauma or fall) and anterior dislocation (front/forward movement of the arm out of socket and occurs when holding arm away from the body usually caused by trauma)Mildly displaced left posterior left side rib fractures 5th, 6th, 7th, and likely 8th.	F0610		

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F0610 SS = E	Continued from page 3 Facility 5-day investigative report summary dated 10/17/25 at 4:54 p.m., R1 had an unsuccessful staff assisted transfer that resulted in her being lowered to the floor by staff. Element of the care plan that was not followed: R1 transfers with assist of one. While not explicitly written in the care plan, gait blet was required and not used for this transfer. R1 had refused gait belt in the past, but not with this transfer. R1 was referred to emergency department (ED) and evaluation showed dislocation of shoulder with fracture of the humoral head that may have been chronic due to presentation and three rib fractures were acute. Shoulder was reduced prior to return to facility. Summary of interview(s) with other residents who may have had contact with the alleged perpetrator (AP) not appliable (na). Action taken to prevent reoccurrence to subjected resident and other residents: gait belt audits conducted each shift to monitor compliance. Continued transfer audit will continue indefinitely. Systemic actions taken staff education and transfer audits on each shift to ensure proper technique and safety equipment usage. The allegation could not be verified because there was insufficient information and facility investigation was inconclusive. NA-A's Corrective Action Notice dated 10/14/25, (four days after R1's fall), identified verbal, written, final warning. NA-A transferred R1 without gait belt, she tripped over her own feet and NA-A reached out grabbed resident to avoid fall and assisted in lowering her to the floor. See in ER and noted shoulder dislocation and fractured ribs. Summary of corrective action: education provided on gait belt use, policy review, and correct sizing of gait belts. Consequences for failure to take corrective action: outlined in summary and progressive disciplinary action. During an observation on 10/27/25 at 12:59 p.m., nursing assistant (NA)-A answered R1's call light. R1 sat in wheelchair and stated she had just returned from seeing the doctor about her left arm fracture. NA-A applied a gait belt underneath her breasts, placed the walker in front of her, connected right arm brace strap across her chest, and brakes on wheelchair. NA-A walked around wheelchair and stood behind R1, reached forward and placed her opened hands flat on top of the gait belt on each side of her waistline. NA-A instructed R1 to stand and pushed firmly against her waistline and assisted her to stand. R1pushed up with left hand on wheelchair arm rest, stood up, took one step with left foot and pivoted so that she stood in front of the recliner. NA-A held onto R1's sides to steady her taking one step to her left so that she was positioned on R1' right side next to the recliner. NA-A pushed	F0610		

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F0610 SS = E	Continued from page 4 inward with her hands flat against the gait belt, while R1 placed her left hand on the recliner armrest and lowered herself down onto the recliner. R1's wheelchair remained with left edge of seat next to recliner at an angle so that NA-A stood in between the recliner and the wheelchair during the transfer. NA-A did not place her hands/fingers underneath the gait belt during this observation. During an observation on 10/28/25 at 12:31 p.m., NA-B entered R1's room and applied a gait belt while she sat in her wheelchair. NA-A positioned her wheelchair sideways off to the right side of the recliner, placed walker in front of her, and brakes on wheelchair. NA-B stood behind the R1's wheelchair, placed her hands/fingers cupped underneath the gait belt on both sides of R1's waistline. R1 pushed herself up from wheelchair with her left hand on the arm rest of the wheelchair and NA-A pulled up on the gait belt to steady her. R1 stood up, held onto the walker and NA-A let go of the gait belt with both hands. NA-A took brakes off wheelchair, pushed it out of the way, moved closer behind R1 and grabbed the gait belt with both hands. During an interview on 10/27/25 at 1:57 p.m., NA-A stated unsure of date early a.m. she attempted to transfer R1 from recliner to commode in her room. A gait belt was not placed on R1prior to the transfer. NA-A stated she stood between the recliner (on her left side) and the commode (on her right side) and held onto R1's backside of her pants with her left hand and right hand was placed on the commode while she stood up and tripped over her foot. NA-A bear hugged her from behind, lowered her to the ground, she did not fall. R1 was heavy, would not bend the left leg made it difficult to lower her down to the floor. NA-A stated she was not aware R1 was at risk for falls and the use of gait belt most likely would have not made a difference in the outcome. During an earlier transfer observed with R1 she stated she did not place her hands under the gait belt and grabbed her pants instead and always transferred her that way. NA-A stated R1 was heavy and easier to use her pants, usually did not grab around her waist area. NA-A stated she had learned how a gait belt should be used from the certified nursing assistant class two years ago. Staff were expected to apply a gait belt under the breasts, fit two fingers under it so not too tight, both sides of the gait belt should have been grabbed with fingers slipped underneath and lift after resident was asked to stand. There were times she grabbed the back side of a resident's pants for an extra boost up. She received gait belt education on how gait belts should be applied	F0610		

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F0610 SS = E	Continued from page 5 only, about one week ago. Prior to the incident she had not received education on how a gait belt should be used correctly since she started work at facility. During an interview on 10/28/25 at 1:48 p.m., NA-B stated staff were expected to use a gait belt with residents that were not independent during transfers/ambulation for the safety of the resident and staff, helped prevent falls and if they lost their balance the gait belt would provide a way to lower them to the floor. R1 has never refused to wear the transfer belt and always used one along with the back of her pants when she transferred her. NA-B stated she had forgotten to use a transfer belt during other resident transfers due to unable to locate one. She had recently received education and audits on how to apply the gait belt only. NA-A stated she stood behind R1's wheelchair during the observed transfer earlier and thought it was the best way to transfer her. If R1 would have started to fall forward she most likely would not be able to stop the fall. She stated where she stood was not safe and should have maybe stood on R1's side instead, not sure. During an interview on 10/28/25 at 3:30 p.m., DON stated R1 had dementia and poor short/long term memory. Staff were expected to use a gait belt to transfer any resident requiring assistance and should have been spelt out in the care plan and Kardex. The use of transfer belts helped provide safe transfers especially with R1's fall. When a gait belt was not used and resident started to fall the staff would most have most likely reached out and grabbed onto an upper extremity or completed a bear hug, and any of those could have resulted in injury especially with the geriatric population. R1 had a degenerative joint disease and would have caused a higher risk for injury without a gait belt which resulted in other means used to break the fall. NA-A was expected to have used a gait belt when R1 was transferred and could have made a difference, her shoulders would have not been affected, and NA-A's hand position would have been different. He was notified of R1's fall on 10/10/25 right after it happened, and no injuries were identified until later that day between 1:00 p.m. and 1:30 p.m. and she was sent to ER and injuries were verified. NA-A was not removed from her duties and allowed to continue to care for residents and transfer them. NA-A did not work the weekend or scheduled but was allowed to continue to work the following dates: October 13th and 14th, 16th, 17th, 20th, 21st, 22nd, 23rd, 25th, 26th, 27th, and 28th. Monday morning, October 13th, 2025, between 7:00 a.m. and 8:00 a.m. he interviewed NA-A and realized a gait belt was not used during the transfer. Education	F0610		

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F0610 SS = E	Continued from page 6 was provided that morning regarding the use of a gait belt during transfers and position of the staff during a transfer was not discussed, thought that would just come with the proper usage of the gait belt. He was not working on site over the weekend and returned to work on Monday, October 13th, 2025. Investigation was initiated and gait belt audits were started on 10/13/25. Gait belt audits were completed on NA-A and had not recalled any issues so thought we were doing good. A root cause analysis was not completed. After NA-A was interviewed he determined the lack of using the gait belt was the problem but could have been more than that. A root cause analysis should have been done and stilled planned on doing one. R1 was interviewed. No other residents were interviewed for this investigation. Education was initiated after the incident on 10/13/25 and 10/14/25 for all nursing staff and provided through the health academy computer system, documents (policy), texts, and audits on application of the gait belt, if it was applied before transfers. The education lacked information on where to stand and how to provide a safe transfer. The staff were informed later with a new audit form where to stand during the transfers, on the resident's strong side. Staff were confused due to inaccurate information provided such as informed of the wrong side to stand on during transfer. DON stated he had misinterpreted as strong side and should have indicated weak side. Facility policy Resident Accidents/Incidents dated 10/17/25, identified all accidents/incidents involving residents must be reported to the DON and/or the administrator. The facility inter-disciplinary team will review all incident reports for potential allegations of abuse. All resident incident reports involving residents are recorded in the point click care system for review by Quality Assurance Committee and Medical Director. Facility policy Protection of Residents During Abuse Investigations dated 10/17/25, identified our facility will protect residents from harm during investigation of abuse allegations. During the abuse investigation, employees accused of participating in the allege abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by the administrator. Facility policy Alleged Abuse Investigations dated 10/17/25, identified all reports of resident alleged abuse, neglect and injuries of unknown source shall be promptly reported and if additional investigation was required facility management will initiate an	F0610		

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F0610 SS = E	Continued from page 7 investigation of the incident. The individual conducting the investigation will take the following steps as appropriate: interview other resident to who the accused employee provides care and services.	F0610		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and implement interventions to reduce the risk of further falls and injury after re-admission from hospital for 1 of 3 residents (R1) reviewed who had fallen and sustained injuries at the facility. Findings include: R1's quarterly Minimum Data Set dated 8/20/25, identified she was admitted to the facility on 2/7/23, from home/community. She had severely impaired cognition with disorganized thinking, without behaviors. She required substantial/maximal assistance with all transfers. No falls since admission. R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint), R1's quarterly fall safety assessment dated 8/19/25, identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls.	F0684	R1 was assessed by therapy for transfers, and care plan was updated as necessary. All residents returning from the hospital will be assessed by nurse upon return. Therapy staff will also screen resident for transfer safety as soon as feasible to confirm nursing assessment and interventions. Surveillance- DON to review hospital return assessments and therapy screen compliance and report findings at the next QA meeting. DON responsible.	12/01/2025

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F0684 SS = D	Continued from page 8 R1's medical record lacked evidence of a fall assessment completed upon R1's return from the hospital. R1's occupational therapy caregiver education instructions for toileting dated 4/26/23, identified R1 may complete pivot transfers with assist of one and FWW/grab bars in central baths during the daytime. Please use bedside commode at bedtime (HS) toileting. Discontinue EZ stand. R1's medical record lacked evidence of a therapy assessment being completed upon R1's return from the hospital. R1's care plan dated 9/16/25, identified alternation in cognition related to Alzheimer's diagnosis with late onset, short/long term memory loss, severe cognitive impairment identified on 8/2025 that varied from intact to severe historically. History of disorganized thinking at times. Alternations in functional abilities/activities of daily living (ADLs) related to left acetabulum (fracture in the socket-shaped bone that forms the hip joint), history of unsafe transfers, and cognitive deficit. Staff were directed to have provided maximum assistance with all transfers with appropriate mobility aids, safety devices, and using and EZ stand when in pain, transfer and change positions slowly due to risk for falls, history of multiple falls, staff assist required for all transitions, impaired balance, history of unsafe self-transfers, pain, minimal impairment in hearing, alteration in cognition and presence of incontinence. R1's progress note dated 10/11/25 at 9:58 a.m., R1 returned from hospital. Nurse to nurse report: R1 was back to baseline. Stand/Pivot transfer. Reduction to left shoulder post fracture/dislocation. Discharge diagnoses: fracture/dislocation left shoulder and 3 to 4 rib fractures. Norco given prior to leaving hospital at 11:00 a.m. Orders: Miralax 17 grams (g) everyday, Hydrocodone prescription (Rx) to be sent to drug store pharmacy. Progress notes lacked evidence an assessment was completed for transfers after R1 was re-admitted to facility from hospital. R1's discharge from hospital orders dated 10/11/25, included reason for hospitalization: fall with left shoulder fracture/dislocation, multiple rib fractures, and pain control. Orders included: Activity without restrictions. May increase daily walking as able. Call	F0684		

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F0684 SS = D	Continued from page 9 provider if getting worse or increase in problems. During an observation on 10/27/25 at 12:59 p.m., nursing assistant (NA)-A answered R1's call light. R1 sat in wheelchair and stated she had just returned from seeing the doctor about her left arm fracture. NA-A applied a gait belt underneath her breasts, placed the walker in front of her, connected right arm brace strap across her chest, and brakes on wheelchair. NA-A walked around wheelchair and stood behind R1, reached forward and placed her opened hands flat on top of the gait belt on each side of her waistline. NA-A instructed R1 to stand and pushed firmly against her waistline and assisted her to stand. R1pushed up with left hand on wheelchair arm rest, stood up, took one step with left foot and pivoted so that she stood in front of the recliner. NA-A held onto R1's sides to steady her taking one step to her left so that she was positioned on R1' right side next to the recliner. NA-A pushed inward with her hands flat against the gait belt, while R1 placed her left hand on the recliner armrest and lowered herself down onto the recliner. R1's wheelchair remained with left edge of seat next to recliner at an angle so that NA-A stood in between the recliner and the wheelchair during the transfer. NA-A did not place her hands/fingers underneath the gait belt during this observation. NA-A removed the gait belt, elevated R1's feet with recliner footrest, covered her with a blanket, and placed call light on top of blanket. NA-A moved quickly and rushed to complete the transfer. NA-A turned off lights, sanitized her hands and left the room. R1's Kardex was observed inside her closet door last updated on 9/2/25, ensure appropriate mobility aides and safety devices used for transfers/positioning. During an observation on 10/28/25 at 12:31 p.m., NA-B entered R1's room and applied a gait belt R1 sat in her wheelchair. NA-A positioned her wheelchair sideways off to the right side of the recliner, placed walker in front of her, and brakes on wheelchair. NA-B stood behind R1's wheelchair, placed her hands/fingers cupped underneath the gait belt on both sides of R1's waist. R1 pushed herself up from wheelchair with her left hand on the arm rest of the wheelchair and NA-A pulled up on the gait belt to steady her. R1 stood up, held onto the walker as NA-A let go of the gait belt with both hands. NA-A took brakes off wheelchair, pushed it out of the way, moved closer behind R1 and grabbed the gait belt with both hands. R1 pivoted to the left, lowered herself down with the left hand on the arm rest of recliner. R1 verbalized confused thought process and stated there must be people upstairs she saw children sliding down the roof in the snow and she was worried	F0684		

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F0684 SS = D	Continued from page 10 about them getting hurt. NA-B removed the gait belt, elevated her legs/feet with recliner footrest, placed call light, sanitized hands and exited the room. During an interview on 10/27/25 at 1:57 p.m., NA-A stated unsure of date early a.m. she attempted to transfer R1 from recliner to commode in her room. A gait belt was not placed on R1prior to the transfer. NA-A stated she stood between the recliner (on her left side) and the commode (on her right side) and held onto R1's backside of her pants with her left hand and right hand was placed on the commode while R1stood up and tripped over her foot. NA-A bear hugged her from behind, lowered her to the ground, she did not fall. R1 was heavy, would not bend the left leg made it difficult to lower her down to the floor. She complained of leg pain and wanted to get up off the floor. Once the nurse arrived, she assessed R1 and with assist of two nurses she was lifted off the floor with a Hoyer lift. NA-A stated she was not aware R1 was at risk for falls and the use of gait belt most likely would have not made a difference in the outcome. During an earlier transfer observed with R1 she stated she did not place her hands under the gait belt and grabbed her pants instead and always transferred her that way. NA-A stated R1 was heavy and easier to use her pants, usually did not grab around her waist area. NA-A stated she had learned how a gait belt should be used from the certified nursing assistant class two years ago. Staff were expected to apply a gait belt under the breasts, fit two fingers under it so not too tight, both sides of the gait belt should have been grabbed with fingers slipped underneath and lift after resident was asked to stand. There were times she grabbed the back side of a resident's pants for an extra boost up. She received gait belt education on how gait belts should be applied only, about one week ago. Prior to the incident she had not received education on how a gait belt should be used correctly since she started work at facility. During an interview on 10/28/25 at 11:04 a.m., family member (FM) stated R1 was unable to stand alone, was a significant fall risk, and had a history of right arm fracture that never healed properly due to her horrible bones. FM stated she had visited R1 many times this year and observed many transfers by staff without the use of a gait belt. The first week of October staff grabbed her pants to transfer her to the commode, pulled pants down, nothing to hang onto, sat down on commode, stood her up without anything to hang onto, pulled up pants, did not seem very safe and placed her at risk for a fall. Staff had assisted R1 with a transfer from wheelchair to car without a gait belt on and hung onto her clothing instead. That type of	F0684		

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F0684 SS = D	Continued from page 11 practice was concerning, clothes were not sturdy enough, she was not a small person, and the top of her pants could have ripped. FM had observed a gait belt on R1's wheelchair at the end of July and was used when she was taken to a family gathering by her sister-in-law to take her to the bathroom. The gait belt had not been observed in her room during the other visits since. FM had not seen or heard R1 refuse the use of a gait belt. FM stated R1 was at a point where one person assist for transfers was not sufficient and she needed at least two staff instead, and most likely if she started to fall more than one person would be required to keep her upright. Another FM informed her R1 was in a lot of pain yesterday during the orthopedic appointment. During an interview on 10/28/25 at 11:28 a.m., occupational therapist (OT) stated when a resident was able to bear weight such as R1, staff would be expected to use a gait belt. The gait belt provided staff something to hold onto and grasp without pulling on resident arms and/or extremities and helped prevent injury to resident and staff. After a resident has had a fall with an injury staff would be expected to communicate with therapy to be re-assessed by physical therapy to determine the safest way to transfer especially with rib fractures to avoid further injury and falls. Seemed odd R1 was deemed back to baseline but a possibility without lower extremity involvement in the fall. Typically, we are given orders to reassess once they return from a hospital stay after fall with injury. After gait belt had been applied the staff would be expected to slide their fingers up underneath the gait belt with thumbs up so that the top side of the fingers/hand were placed against the resident's body. During an interview on 10/28/25 at 12:09 p.m., NA-E stated R1 was at risk for falls, moves slowly, unsteady at times and loses her balance. Before R1's fall she was an assist of one pivot and gait belt for transfers. We have been told the gait belt use was a safety thing, unsure how they really help.NA-E stated if she had used a gait belt during R1's transfers and if she became unsteady or started to fall would be required to pull up on the gait belt to steady her which could have caused more injury and pain to her fractured ribs. She has used the back of her pants at times to hold her up and knew that was not appropriate. R1 has had good days and transferred well with assist of one and then she has had bad days, more confused and unaware of which way to turn and a second staff would be used to assist and/or a stand lift.	F0684		

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F0684 SS = D	Continued from page 12 During an interview on 10/28/25 at 1:48 p.m., NA-B stated she used a gait belt on residents when included in their care plan and/or if she thought they maybe unsteady during transfers or ambulation. Staff were expected to use a gait belt with residents that were not independent during transfers/ambulation for the safety of the resident and staff, helped prevent falls and if they lost their balance the gait belt would provide a way to lower them to the floor. When a resident refused the use of the gait belt, they need to be informed it was necessary to provide a safe transfer. The nurse may be able to help convince them, if not a lift machine maybe needed for transfer. R1 has never refused to wear the transfer belt and always used one along with the back of her pants when she transferred her. NA-B stated she had forgotten to use a transfer belt during other resident transfers due to not being able to locate one. She had recently received education and audits on how to apply the gait belt only. NA-A stated she stood behind R1's wheelchair during the observed transfer earlier and thought it was the best way to transfer her. NA-A stated If R1 would have started to fall forward she most likely would not be able to stop the fall. She stated where she stood was not safe and should have maybe stood on R1's side instead. During an interview on 10/28/25 at 2:15 p.m. Licensed practical nurse (LPN)-B stated R1's cognition was not the best and had a poor memory. R1 transferred with extensive assistance of one to two staff stand/pivot. On 10/11/25, she had received report via telephone from the hospital staff nurse prior to R1's readmission back to the facility that day. She informed the hospital nurse prior to her fall the day before she required extensive assistance of one to transfer. The hospital nurse indicated she transferred in the hospital the same and most likely meant she was at baseline. LPN-B stated she was unaware if a therapy assessment was completed at the hospital or upon readmission back to the facility. During an interview on 10/28/25 at 3:30 p.m., DON stated R1 had dementia and poor short/long term memory. R1 had a degenerative joint disease which would have caused a higher risk for injury without a gait belt which would have provided another means used to break the fall. A nurse-to-nurse report was completed prior to R1's readmission to the facility from the hospital. Generally speaking, the readmissions usually do not take place over the weekends however, this one did, none of the office staff were here when she returned. The staff nurse would have been expected to have completed a readmission assessment and documented it.	F0684		

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F0684 SS = D	Continued from page 13 When a resident returns back from the hospital and not at baseline therapy would have gotten involved. The report received from the hospital nurse was documented R1 was baseline with transfers and pivot. Since we had no issues with how she transferred over the weekend staff continued with assist of 1 to 2 staff and therapy was not involved. A fall risk assessment was expected to be completed if there was a change in condition/quarterly/annually. The fall risk assessment was most likely not done on R1. R1 tripped over her feet when she fell on 10/10/25 and was at baseline when she returned from the hospital and readmitted. During an interview on 10/29/25 at 12:57 p.m., registered nurse (RN)-C stated R1 should have been assessed upon re-admission from the hospital after her fall with fractures. We are usually really good about that, unsure why that was not done, most likely got missed. RN-C stated the nurse was expected to fill out a return from hospital check list/template on the facility electronic medical record (EMR). RN-C stated she would have been concerned about R1's fractures and seemed odd she could have been back to baseline with transfers, unsure if it was a good idea to have one assist with a gait belt. RN-C stated she would have been concerned with the gait belt applied in close proximation of her fractured ribs would not be the safest either. R1 fell and resulted in fractures, therapy should have been contacted and assessed R1 so that staff would transfer her the safest and most appropriate way with fractures and injuries. Facility policy Staff Assisted Resident Transfer dated October 2025, identified the facility will assess each resident and determine the safest transfer method for both resident and staff safety. Resident specific data will be used to determine the method of transfer including but not limited to resident preference, history, clinical condition, physician restrictions, therapy assessment (physical and occupational), and nursing assessment. Resident will be assessed for initial transfer method determination on admission will be per resident interview and admission documentation. Resident will then be re-evaluated after a change in condition and after any transfer related incident (fall, near fall, injury). A stand pivot transfer where resident could weight bear on legs required assist of one to two staff with a gait belt secured on waist, scoot to edge of chair/bed, stand pivot to adjacent destination surface. Facility document Resident Falls dated October 2025, identified fall safety assessment is completed on all	F0684		

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F0684 SS = D	Continued from page 14 new admissions, quarterly, and as needed to assist in determining risk for falls. The resident is evaluated for physical devices to be used to help reduce falls, injury, or incidents. Those at risk for falls or have physical devices will be addressed in the care plan with approaches/interventions to be followed. Requested readmission /assessment policy and not received. Requested hospital therapy assessment/evaluation and not received.	F0684		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to implement standards of practice to ensure a safe transfer for 1 of 3 residents (R1) reviewed for accidents when staff failed to use a transfer belt. This resulted in actual harm when R1 fell during a staff assisted transfer, sustained a fractured and dislocated left arm, multiple rib fractures and was sent to the emergency department (ED) requiring medical treatment and kept overnight for observation and pain control. Findings include: R1's quarterly Minimum Data Set dated 8/20/25, identified she was admitted to the facility on 2/7/23, from home/community. R1 had severe cognitive impairment with disorganized thinking, without behaviors and required substantial/maximal assistance with all transfers. No falls since admission. R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of	F0689	R1 was assessed by therapy for transfers, and care plan was updated as necessary. Transfer belt audits have been completed for R1 as well as other residents requiring gait belts for transfers. Staff Assisted Resident Transfer policy was developed after the incident occurred and finalized on 10/14/2025. All nursing staff were educated on the policy by 10/16/2025. Policy was updated 11/12/2025 to include "return from hospital" in the Timing section for re-evaluation. Specific items in the policy that were highlighted in the education were calling for all Contact Guard and Stand Pivot transfers required the use of a gait belt as a standard of practice. New staff will be educated to the policy on orientation. All current nursing staff have been assessed (competency) for contact guard and stand pivot transfers, or will be prior to working their next shift (unavailable seasonal workers). Policy will also be available for review on annual competency assessment, which was initiated after this incident Competancies will be repeated annually for each staff member. Audits for proper gait belt transfers continue for both affected resident and others that transfer in a similar way. Audit and competency results reviewed at QA meeting. DON responsible.	12/01/2025

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F0689 SS = G	Continued from page 15 ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint), R1's quarterly fall safety assessment dated 8/19/25, identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls. R1's occupational therapy caregiver education instructions for toileting dated 4/26/23, identified R1 may complete pivot transfers with assist of one and 4WW/grab bars in central baths during the daytime. Please use bedside commode at bedtime (HS) toileting. Discontinue EZ stand. R1's orders identified: -10/27/25, Sling to left upper extremity during day, remove for bathing and at night /bedtime for dislocated shoulder. -10/11/25, Hydrocodone/acetaminophen oral tablet 5/325 milligrams (mg) one tablet by mouth (po) every four hours as needed (PRN) for mild pain. -6/12/25, Tramadol hydrochloride (HCl) oral 50 mg tablet po PRN two times a day (b.i.d.) for chronic pain related to (r/t) chronic non-healing fracture of humerus and hip -6/12/25 Tramadol HCl oral 50 mg tablet po b.i.d. for chronic pain r/t non healing fracture of humerus and left hip. R1's Kardex 9/2/25 (posted in her room inside closet door), identified maximum assist with transfers from sitting to standing and transfers. EZ stand as needed (PRN) if in pain. Does not ambulate. Ensure appropriate mobility aides and safety devices used for transfers/positioning. R1's care plan dated 9/16/25, identified alteration in cognition related to Alzheimer's diagnosis with late onset, short/long term memory loss, severe cognitive impairment, identified on 8/2025, that varied from intact to severe historically and a history of disorganized thinking at times. Identified alterations	F0689		

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F0689 SS = G	Continued from page 16 in functional abilities/activities of daily living (ADLs) related to left acetabulum (fracture in the socket-shaped bone that forms the hip joint), history of unsafe transfers, and cognitive deficit. Staff were directed to have provided maximum assistance with all transfers with appropriate mobility aids, safety devices, and using and EZ stand when in pain, transfer and change positions slowly due to risk for falls, history of multiple falls, staff assist required for all transitions related to impaired balance, history of unsafe self-transfers, pain, minimal impairment in hearing, alteration in cognition and presence of incontinence. R1's progress notes from 10/10/25 through 10/13/25, identified: -10/10/25 at 8:10 a.m., at approximately 7:00 a.m., licensed practical nurse (LPN) notified writer resident had fallen. Upon entering room, resident sat upright on her bottom on the floor, back was up against the nursing assistant (NA) legs with her legs stretched out towards the window. NA reported that when R1 was pivot transferring with assist of one, she tripped over her feet and NA had lowered her to the ground. R1 complained of left hip pain. No redness, swelling, open areas or bruising noted to left hip. No other injuries found upon assessment. R1 denied maltreatment/abuse, stated "no, no one hurt me she just fell". Denied head strike, wearing shoes, gait belt, and used 4WW at the time of fall. R1 was assisted off the floor with three assist EZ lift, transferred into her wheelchair, and assisted to commode with EZ stand. No complaints of left hip pain stated her right shoulder hurt, but shoulder pain was chronic and unrelated to fall. Range of motion (ROM) was limited in right shoulder due to previous injury and left hip was limited at first while sitting on the ground (stated it was painful when lifted to put the sling strap under her thigh). After she was placed in wheelchair and used sit to stand lift no more complaints of hip pain. Family, director of nursing (DON), and administrator notified. -10/10/25 at 12:02 p.m., Daughter called back. Writer updated her on fall. No concerns. -10/10/25 at 1:05 p.m., R1 sat in recliner with legs elevated and now complained of severe pain to her left hip/groin that radiated down to knee and numbness to buttocks and had very limited ROM, could only lift leave an inch or so off the footrest, bent knee about 10degrees. R1's left leg appeared shorter that the right while she sat in recliner. R1 winced, grimaced and verbalized pain through assessment and with light	F0689		

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F0689 SS = G	Continued from page 17 touch to her upper left leg. Ice pack applied on top of left groin. As needed (PRN) tramadol administered and primary provider (MD) here to round shortly with priority. Family updated. -10/10/25 at 1:23 p.m., Administered Tramadol orally 50 mg for severe left hip pain and non-healing fracture of the humorous. -10/10/25 at 1:57 p.m., Seen by medical doctor (MD) on rounds. Orders given for R1 to be seen in clinic or ER for pelvic/hip x-ray. -10/10/25 at 2:54 p.m., Transferred to ER. -10/10/25 at 5:56 p.m., Called received from local ER and updated R1 had broken and dislocated left shoulder and three broken ribs. R1 will be having surgery. -10/10/25 at 10:58 p.m., R1 transferred to ER at 2:54 p.m. and will be kept overnight for observation. -10/10/25 at 11:10 p.m., Call received from ER nurse. R1 shoulder relocated. Three broken ribs and possibly four noted on x-rays. Pelvis and hip looked ok on x-rays and was being kept overnight. -10/11/25 at 9:58 a.m., R1 returned from hospital. Nurse to nurse report: R1 was back to baseline. Stand/Pivot transfer. Reduction to left shoulder post fracture/dislocation. Discharge diagnoses: fracture/dislocation left shoulder and 3 to 4 rib fractures. Norco given prior to leaving hospital at 11:00 a.m. Orders: MiraLAX 17 grams (g) everyday, Hydrocodone prescription (Rx) to be sent to drug store pharmacy. -10/11/25 at 5:46 p.m., Administered Hydrocodone-Acetaminophen oral tablet 5-325 mg one by mouth. Ribs and shoulder rated pain at 6 out of 10. -10/11/25 at 8:45 p.m., Follow up on pain scale 0 out of 10; effective. -10/11/25 at 10:00 p.m., Returned from hospital status: assist of one pivot from recliner to wheelchair, wheelchair to toilet or commode. Complained of pain in her left shoulder and left ribs and shoulder, received Norco will good relief. -10/11/25 at 10:53 p.m., Exhibits pain, Norco given, some confused talk but normal for her. Pivot transfers with one.	F0689		

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F0689 SS = G	Continued from page 18 -10/12/25 at 3:25 a.m., Limited motion /movement to both upper extremities. -10/12/25 at 8:17 a.m., Rested well, denied pain and transferred well with transfer belt and two assist to pivot on and off bed side commode. No confusion. -10/12/25 at 8:17 a.m., Transfers with extensive assist of one. Denied pain. -10/13/25 at 10:35 a.m., Continued to function at baseline. No complaints of pain to left shoulder, ribs or left lower extremity (LLE) after fall and ER visit where she was diagnosed with a dislocated shoulder and multiple rib fractures. Appears back to normal. Has been a one assist pivot transfer with gait belt and 4WW. Has not needed any pharm or non-pharm pain interventions PRN. R1's ER visit dated 10/10/25 at 3:14 p.m., identified she presented to ER from nursing home for evaluation of a fall that occurred earlier this morning. According to her caregiver, she was being assisted out of bed when she suddenly complained of pain and was gently lowered to the ground. She immediately reported discomfort in her left shoulder and hip. She describes her pain as localized to the left shoulder, extending down her arm and into her hip, and ankle. Denies loss of consciousness or a strike to the head. Baseline mobility is limited with cognitive impairment. Upon examination an elderly female alert with evidence of dementia, oriented to self only, limited the reliability of the history and close observation was required for subtle changes in mental status or worsening pain. She appeared mildly uncomfortable due to pain but in no acute distress. Her left shoulder demonstrates tenderness to palpitation with limited ROM secondary to pain. Left hip tender with pain on passive movement, ROM is markedly reduced and unable to bear weight. Given the mechanism of injury, localized tenderness, her history of prior hip fracture, the differential diagnosis includes acute fracture (shoulder/hip), contusion, or exacerbation of degenerative joint disease. Review of the imagining results x-ray of left shoulder revealed a large Hill-Sachs deformity (a bone injury on the humeral head/upper arm bone ball of the shoulder joint resulting from a shoulder dislocation) with suspected nondisplaced humeral head fracture (the bone fragments, cracked or broken have not significantly shifted but remain in their correct alignment) (can be caused by trauma or fall) and anterior dislocation (front/forward movement of the arm out of socket and occurs when holding arm away from the body usually caused by	F0689		

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F0689 SS = G	Continued from page 19 trauma) along with mildly displaced posterior rib fractures on the left side (ribs 5 through 8). Pelvic and bilateral hip imaging showed no acute hip or pelvic fractures but demonstrated severe left hip joint narrowing with collapse of femoral head and advanced degenerative changes consistent with chronic pathology. On call orthopedic surgeon successfully performed a closed reduction (a non-surgical procedure completed by a healthcare provider to realign a broken bone by manually manipulating the bone back into its correct position without making an incision) of the left shoulder under fluoroscopy guidance with confirmed appropriate alignment. Given her age, underlying dementia, and associated rib fractures, admission for pain control, observation, and mobility assessment was recommended. Final diagnoses: dislocation of left shoulder/closed, traumatic closed nondisplaced fracture of anatomical neck of left humerus (initial encounter), closed fracture of multiple ribs of left side (initial encounter) and pain. R1's left shoulder x-ray dated 10/10/25 at 3:45 p.m., identified large Hill-Sachs fracture deformity with suspected nondisplaced humeral fracture. Anterior dislocation. Mildly displaced left posterior left side rib fractures 5th, 6th, 7th, and likely 8th. R1's hospital discharge summary dated 10/11/25 at 10:25 a.m., identified she had a fall during a transfer early morning around 7:00 a.m., placed in wheelchair and doing fine. Sometime in the afternoon she displayed discomfort and when seen was crying in pain and complained of left leg pain. She was sent to local emergency room (ER) where x-rays were completed and showed a fracture dislocation and three rib fractures. Left hip showed advanced degenerative joint disease (DJD) and no fractures. Orthopedist was consulted, completed a reduction of the left shoulder fracture dislocation with conscious sedation and placed her on a sling and admitted into acute care at the hospital. Physical assessment identified tenderness to palpitation of the left rib area, tenderness to any rotation of both shoulders and lift hip. She was stable and will be discharged today back to the skilled nursing facility (SKF) followed up by me (primary care provider) within a week and seen by orthopedist in two weeks due to a very difficult and different fracture/dislocation that required ortho for reduction. R1's hospital discharge orders dated 10/11/25, included reason for hospitalization: fall with left shoulder fracture/dislocation, multiple rib fractures, and pain control. Orders included: Activity without restrictions. May increase daily walking as able. Call	F0689		

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F0689 SS = G	Continued from page 20 provider if getting worse or increase in problems. Facility 5-day report dated 10/17/25 at 4:54 p.m., R1 had an unsuccessful staff assisted transfer that resulted in her being lowered to the floor by staff. Element of the care plan that was not followed: R1 transfers with assist of one, while not explicitly written in the care plan, gait belt was required and not used for this transfer. R1 had refused gait belt in the past, but not with this transfer. R1 was referred to ED and evaluation showed dislocation of shoulder with fracture of the humoral head that may have been chronic due to presentation and three rib fractures were acute. Shoulder was reduced prior to return to facility. During an observation on 10/27/25 at 12:59 p.m., nursing assistant (NA)-A answered R1's call light. R1 sat in wheelchair and stated she had just returned from seeing the doctor about her left arm fracture. NA-A applied a gait belt underneath her breasts, placed the walker in front of her, connected right arm brace strap across her chest, and brakes on wheelchair. NA-A walked around wheelchair and stood behind R1, reached forward and placed her opened hands flat on top of the gait belt on each side of her waistline. NA-A instructed R1 to stand and pushed firmly against her waistline and assisted her to stand. R1pushed up with left hand on wheelchair arm rest, stood up, took one step with left foot and pivoted so that she stood in front of the recliner. NA-A held onto R1's sides to steady her taking one step to her left so that she was positioned on R1' right side next to the recliner. NA-A pushed inward with her hands flat against the gait belt, while R1 placed her left hand on the recliner armrest and lowered herself down onto the recliner. R1's wheelchair remained with left edge of seat next to recliner at an angle so that NA-A stood in between the recliner and the wheelchair during the transfer. NA-A did not place her hands/fingers underneath the gait belt during this observation. NA-A removed the gait belt, elevated R1's feet with recliner footrest, covered her with a blanket, and placed call light on top of blanket. NA-A moved quickly and rushed to complete the transfer. NA-A turned off lights, sanitized her hands and left the room. R1's Kardex was observed inside her closet door last updated on 9/2/25, ensure appropriate mobility aides and safety devices used for transfers/positioning. During an observation on 10/28/25 at 12:31 p.m., NA-B entered R1's room and applied a gait belt while she sat in her wheelchair. NA-A positioned her wheelchair sideways off to the right side of the recliner, placed	F0689		

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F0689 SS = G	Continued from page 21 walker in front of her, and brakes on wheelchair. NA-B stood behind the R1's wheelchair, placed her hands/fingers cupped underneath the gait belt on both sides of R1's waistline. R1 pushed herself up from wheelchair with her left hand on the arm rest of the wheelchair and NA-A pulled up on the gait belt to steady her. R1 stood up, held onto the walker and NA-A let go of the gait belt with both hands. NA-A took brakes off wheelchair, pushed it out of the way, moved closer behind R1 and grabbed the gait belt with both hands. R1 pivoted to the left, lowered herself down with the left hand on the arm rest of recliner. R1 verbalized confused thought process and stated there must be people upstairs she saw children sliding down the roof in the snow and she was worried about them getting hurt. NA-B removed the gait belt, elevated her legs/feet with recliner footrest, placed call light, sanitized hands and exited the room. During an interview on 10/27/25 at 1:57 p.m., NA-A stated unsure of date early a.m. she attempted to transfer R1 from recliner to commode in her room without placing a gait belt on R1 prior to the transfer. R1 refused the gait belt in the past. R1 was able to make that decision and the reason a gait belt was not applied. NA-A stated she stood between the recliner (on her left side) and the commode (on her right side) and held onto R1's backside of her pants with her left hand and right hand was placed on the commode while she stood up and tripped over her foot. NA-A bear hugged her from behind, lowered her to the ground, she did not fall. NA-A stated R1 was heavy, would not bend the left leg which made it difficult to lower her down to the floor. She complained of leg pain and wanted to get up off the floor. Once the nurse arrived, she assessed R1 and with assist of two nurses she was lifted off the floor with a Hoyer lift. NA-A stated she was not aware R1 was at risk for falls and the use of gait belt most likely would have not made a difference in the outcome. During the earlier transfer observed with R1 she stated she did not place her hands under the gait belt and grabbed her pants instead and always transferred her that way. NA-A stated R1 was heavy and easier to use her pants, usually did not grab around her waist area. NA-A stated she had learned how a gait belt should be used from the certified nursing assistant class two years ago. Staff were expected to apply a gait belt under the breasts, fit two fingers under it so not too tight, both sides of the gait belt should have been grabbed with fingers slipped underneath and lift after resident was asked to stand. There were times she grabbed the back side of a resident's pants for an extra boost up. She received gait belt education on how gait belts should be applied	F0689		

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F0689 SS = G	Continued from page 22 only about one week ago. Prior to the incident she had not received education on how a gait belt should be used correctly since she started work at facility. During an interview on 10/2725 at 2:24 p.m. registered nurse (RN)-A stated R1's cognition was not intact, and she was unable to make an informed decision as to whether a gait belt should have been used during transfers. R1's refusals were repetitive, and memory was short. R1 was assist of one with a gait belt for transfers. The Kardex located in each resident closet should have identified which residents required a gait belt for transfers. A gait belt should be used to steady a resident with unsteady gait/balance problems, help prevent falls and keep staff and residents safe. The gait belt was considered best practice and resident clothing such as pants were not allowed to be used to transfers residents. Staff were expected to use a gait belt when R1 was transferred for safely. RN-A stated on 10/10/25, at approximately 7:00 a.m., she was informed by a nurse R1 had fallen and needed assistance. RN-A entered R1's room and R1 sat on the floor with her back leaned up against NA-A's lower legs. R1 had a sling on her right arm (had worn it since admission to facility) limited motion and pain was chronic due to past injury. RN-A picked up R1's left leg and she complained of hip pain, gathered vitals and completed an assessment a Hoyer lift was used to lift her off the floor and transferred into the wheelchair. R1 stood up with an EZ stand and transferred to commode, no complaints of pain but later in the day she complained of left sided shoulder/hip/knee/ankle pain. R1 was seen by provider at facility then sent to ER. RN-A stated she thought a gait belt had been used, charted it and later realized a gait belt was not applied by NA-A prior to the transfer/fall. R1 was a large woman, hard to control when she started to go down ended up with fractured ribs and dislocated/fractured left shoulder. During an interview on 10/28/25 at 11:04 a.m., family member (FM) stated R1 was unable to stand alone, was a significant fall risk, and had a history of right arm fracture that never healed properly due to her horrible bones. FM stated she had visited R1 many times this year and observed many transfers by staff without the use of a gait belt. The first week of October staff grabbed her pants to transfer her to the commode, pulled pants down, nothing to hang onto, sat down on commode, stood her up without anything to hang onto, pulled up pants, did not seem very safe and placed her at risk for a fall. Staff had assisted R1 with a transfer from wheelchair to car holding onto her clothes without a gait belt on. FM stated that type of practice was concerning, clothes were not sturdy	F0689		

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F0689 SS = G	Continued from page 23 enough, she was not a small person, and the top of her pants could have ripped. FM had observed a gait belt on R1's wheelchair at the end of July and was used when she was taken to a family gathering by her sister-in-law to take her to the bathroom. The gait belt had not been observed in her room during the other visits since. FM had not seen or heard R1 refuse the use of a gait belt. FM stated R1 was at a point where one person assist for transfers was not sufficient and she needed at least two staff instead. FM stated another member of the family informed her R1 was in a lot of pain yesterday during the orthopedic appointment. During an interview on 10/28/25 at 11:28 a.m., occupational therapist (OT) stated when a resident was able to bear weight such as R1, staff would be expected to use a gait belt. OT stated the gait belt provided staff something to hold onto and grasp without pulling on resident arms and/or extremities and helped prevent injury to resident and staff. Gait belts should have been included in R1's care plan and used to avoid staff from grabbing onto the side of their body to lift R1 up or lower R1 down, if a resident's knees would buckle and they had fragile bones staff would possibly hold too tight or grab an arm and cause injuries. OT stated after a resident has had a fall with an injury staff were expected to communicate with therapy and be re-assessed by physical therapy to determine the safest way to transfer them especially with rib fractures to avoid further injury and falls. OT stated it seemed odd R1 was deemed back to baseline but a possibility without lower extremity involvement in the fall. Typically, we are given orders to reassess once they return from a hospital stay after fall with injury. After gait belt had been applied the staff would be expected to slide their fingers up underneath the gait belt with thumbs up so that the top side of the fingers/hand were placed against the resident's body. Staff should not have used the resident clothing/pants to grab onto during a transfer. When a resident was able to walk or used a walker the staff should stand off to the side and if the resident was to pivot from one spot to another staff would be expected to stand in front of the resident during a transfer. Staff should not stand behind a chair during a transfer; they would not be able to break a fall and lower the resident to the floor if they lost their balance. During an interview on 10/28/25 at 1:48 p.m., NA-B stated she used a gait belt on residents when it was in their care plan and/or if she thought they may be unsteady during transfers or ambulation. Staff were expected to use a gait belt with residents that were	F0689		

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F0689 SS = G	Continued from page 24 not independent during transfers/ambulation for the safety of the resident and staff, helped prevent falls and if they lost their balance the gait belt would provide a way to lower them to the floor. When a resident refused the use of the gait belt, they need to be informed it was necessary to provide a safe transfer. The nurse may be able to help convince them, if not a lift machine maybe needed for transfer. NA-B stated R1 has never refused to wear the transfer belt and always used one along with the back of her pants when she transferred her. NA-B stated she had forgotten to use a transfer belt during other resident transfers due to unable to locate one. NA-B stated she had recently received education and audits on how to apply the gait belt only. NA-A stated she stood behind R1's wheelchair during the observed transfer earlier because she thought it was the best way to transfer R1. However, If R1 would have started to fall forward she most likely would not have been able to stop the fall. NA-A stated where she stood was not safe and should have maybe stood on R1's side instead. During an interview on 10/28/25 at 3:30 p.m. DON stated R1 had dementia and poor short/long term memory. Staff were expected to use a gait belt to transfer any resident requiring assistance and should not have been needed to be spelt out in the care plan and Kardex. The Kardex would have indicated assistive devices such as walkers/EZ stand, and those residents would have required a gait belt for a transfer. The use of transfer belts helped provide safe transfers. During a fall like R1's where a gait belt was not used and resident started to fall the staff would most likely have reached out and grabbed onto an upper extremity or completed a bear hug, and any of those could have resulted in injury especially with the geriatric population. R1 had a degenerative joint disease and would have caused a higher risk for injury without a gait belt which resulted in other means used to break the fall. NA-A was expected to have used a gait belt when R1 was transferred and could have made a difference, her shoulders would have not been affected, and NA-A's hand position would have been different. Education was initiated after the incident on 10/13/25 and 10/14/25 and provided through the health academy computer system, documents (policy), texts, and audits on application of the gait belt, if it was applied before transfers, but lacked information on where to stand and how to provide a safe transfer. The staff were informed later with a new audit form where to stand during the transfers, on the resident's strong side. Staff were confused due to inaccurate information provided such as informed of the wrong side to stand on during transfer. DON stated he had misinterpreted as	F0689		

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F0689 SS = G	Continued from page 25 strong side and should have indicated weak side. During an interview on 10/29/25 at 4:22 p.m., administrator stated safety equipment indicated gait belt but was not identified as such on the resident's care plan/Kardex. ,Staff were expected to use a gait belt during R1's transfer/fall incident on 10/10/25, and a gait belt was not applied. Gait belt use was a standard of care for resident and staff safety. Facility policy Staff Assisted Resident Transfer dated October 2025, identified the facility would assess each resident and determine the safest transfer method for both resident and staff safety. Resident specific data will be used to determine the method of transfer including but not limited to resident preference, history, clinical condition, physician restrictions, therapy assessment (physical and occupational), and nursing assessment. Resident would be assessed for initial transfer method determination on admission will be per resident interview and admission documentation. Resident will then be re-evaluated after a change in condition and after any transfer related incident (fall, near fall, injury). A stand pivot transfer where resident could weight bear on legs required assist of one to two staff with a gait belt secured on waist, scoot to edge of chair/bed, stand pivot to adjacent destination surface. Facility document Resident Falls dated October 2025, identified fall safety assessment is completed on all new admissions, quarterly, and as needed to assist in determining risk for falls. Identified, the resident is evaluated for physical devices to be used to help reduce falls, injury, or incidents. Those at risk for falls or have physical devices were addressed in the care plan with approaches/interventions to be followed.	F0689		

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20000	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 10/27/25 through 10/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		11/10/2025

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

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20000	Continued from page 1 The following complaint was reviewed: H55215843C (2640850) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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 WILL APPEAR ON EACH PAGE.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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.	20830	12/1/2025	12/01/2025

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20830	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to implement standards of practice to ensure a safe transfer for 1 of 3 residents (R1) reviewed for accidents when staff failed to use a transfer belt. This resulted in actual harm when R1 fell during a staff assisted transfer, sustained a fractured and dislocated left arm, multiple rib fractures and was sent to the emergency department (ED) requiring medical treatment and kept overnight for observation and pain control. Findings include: R1's quarterly Minimum Data Set dated 8/20/25, identified she was admitted to the facility on 2/7/23, from home/community. R1 had severe cognitive impairment with disorganized thinking, without behaviors and required substantial/maximal assistance with all transfers. No falls since admission. R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint), R1's quarterly fall safety assessment dated 8/19/25, identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls. R1's occupational therapy caregiver education instructions for toileting dated 4/26/23, identified R1 may complete pivot transfers with assist of one and 4WW/grab bars in central baths during the daytime. Please use bedside commode at bedtime (HS) toileting. Discontinue EZ stand. R1's orders identified: -10/27/25, Sling to left upper extremity during day, remove for bathing and at night /bedtime for dislocated shoulder. -10/11/25, Hydrocodone/acetaminophen oral tablet 5/325 milligrams (mg) one tablet by mouth (po) every four	20830		

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20830	Continued from page 3 hours as needed (PRN) for mild pain. -6/12/25, Tramadol hydrochloride (HCl) oral 50 mg tablet po PRN two times a day (b.i.d.) for chronic pain related to (r/t) chronic non-healing fracture of humerus and hip -6/12/25 Tramadol HCl oral 50 mg tablet po b.i.d. for chronic pain r/t non healing fracture of humerus and left hip. R1's Kardex 9/2/25 (posted in her room inside closet door), identified maximum assist with transfers from sitting to standing and transfers. EZ stand as needed (PRN) if in pain. Does not ambulate. Ensure appropriate mobility aides and safety devices used for transfers/positioning. R1's care plan dated 9/16/25, identified alteration in cognition related to Alzheimer's diagnosis with late onset, short/long term memory loss, severe cognitive impairment, identified on 8/2025, that varied from intact to severe historically and a history of disorganized thinking at times. Identified alterations in functional abilities/activities of daily living (ADLs) related to left acetabulum (fracture in the socket-shaped bone that forms the hip joint), history of unsafe transfers, and cognitive deficit. Staff were directed to have provided maximum assistance with all transfers with appropriate mobility aids, safety devices, and using and EZ stand when in pain, transfer and change positions slowly due to risk for falls, history of multiple falls, staff assist required for all transitions related to impaired balance, history of unsafe self-transfers, pain, minimal impairment in hearing, alteration in cognition and presence of incontinence. R1's progress notes from 10/10/25 through 10/13/25, identified: -10/10/25 at 8:10 a.m., at approximately 7:00 a.m., licensed practical nurse (LPN) notified writer resident had fallen. Upon entering room, resident sat upright on her bottom on the floor, back was up against the nursing assistant (NA) legs with her legs stretched out towards the window. NA reported that when R1 was pivot transferring with assist of one, she tripped over her feet and NA had lowered her to the ground. R1 complained of left hip pain. No redness, swelling, open areas or bruising noted to left hip. No other injuries found upon assessment. R1 denied maltreatment/abuse, stated "no, no one hurt me she just fell". Denied head strike, wearing shoes, gait belt, and used 4WW at the	20830		

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20830	Continued from page 4 time of fall. R1 was assisted off the floor with three assist EZ lift, transferred into her wheelchair, and assisted to commode with EZ stand. No complaints of left hip pain stated her right shoulder hurt, but shoulder pain was chronic and unrelated to fall. Range of motion (ROM) was limited in right shoulder due to previous injury and left hip was limited at first while sitting on the ground (stated it was painful when lifted to put the sling strap under her thigh). After she was placed in wheelchair and used sit to stand lift no more complaints of hip pain. Family, director of nursing (DON), and administrator notified. -10/10/25 at 12:02 p.m., Daughter called back. Writer updated her on fall. No concerns. -10/10/25 at 1:05 p.m., R1 sat in recliner with legs elevated and now complained of severe pain to her left hip/groin that radiated down to knee and numbness to buttocks and had very limited ROM, could only lift leave an inch or so off the footrest, bent knee about 10degrees. R1's left leg appeared shorter that the right while she sat in recliner. R1 winced, grimaced and verbalized pain through assessment and with light touch to her upper left leg. Ice pack applied on top of left groin. As needed (PRN) tramadol administered and primary provider (MD) here to round shortly with priority. Family updated. -10/10/25 at 1:23 p.m., Administered Tramadol orally 50 mg for severe left hip pain and non-healing fracture of the humorous. -10/10/25 at 1:57 p.m., Seen by medical doctor (MD) on rounds. Orders given for R1 to be seen in clinic or ER for pelvic/hip x-ray. -10/10/25 at 2:54 p.m., Transferred to ER. -10/10/25 at 5:56 p.m., Called received from local ER and updated R1 had broken and dislocated left shoulder and three broken ribs. R1 will be having surgery. -10/10/25 at 10:58 p.m., R1 transferred to ER at 2:54 p.m. and will be kept overnight for observation. -10/10/25 at 11:10 p.m., Call received from ER nurse. R1 shoulder relocated. Three broken ribs and possibly four noted on x-rays. Pelvis and hip looked ok on x-rays and was being kept overnight. -10/11/25 at 9:58 a.m., R1 returned from hospital. Nurse to nurse report: R1 was back to baseline. Stand/Pivot transfer. Reduction to left shoulder post	20830		

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20830	Continued from page 5 fracture/dislocation. Discharge diagnoses: fracture/dislocation left shoulder and 3 to 4 rib fractures. Norco given prior to leaving hospital at 11:00 a.m. Orders: MiraLAX 17 grams (g) everyday, Hydrocodone prescription (Rx) to be sent to drug store pharmacy. -10/11/25 at 5:46 p.m., Administered Hydrocodone-Acetaminophen oral tablet 5-325 mg one by mouth. Ribs and shoulder rated pain at 6 out of 10. -10/11/25 at 8:45 p.m., Follow up on pain scale 0 out of 10; effective. -10/11/25 at 10:00 p.m., Returned from hospital status: assist of one pivot from recliner to wheelchair, wheelchair to toilet or commode. Complained of pain in her left shoulder and left ribs and shoulder, received Norco will good relief. -10/11/25 at 10:53 p.m., Exhibits pain, Norco given, some confused talk but normal for her. Pivot transfers with one. -10/12/25 at 3:25 a.m., Limited motion /movement to both upper extremities. -10/12/25 at 8:17 a.m., Rested well, denied pain and transferred well with transfer belt and two assist to pivot on and off bed side commode. No confusion. -10/12/25 at 8:17 a.m., Transfers with extensive assist of one. Denied pain. -10/13/25 at 10:35 a.m., Continued to function at baseline. No complaints of pain to left shoulder, ribs or left lower extremity (LLE) after fall and ER visit where she was diagnosed with a dislocated shoulder and multiple rib fractures. Appears back to normal. Has been a one assist pivot transfer with gait belt and 4WW. Has not needed any pharm or non-pharm pain interventions PRN. R1's ER visit dated 10/10/25 at 3:14 p.m., identified she presented to ER from nursing home for evaluation of a fall that occurred earlier this morning. According to her caregiver, she was being assisted out of bed when she suddenly complained of pain and was gently lowered to the ground. She immediately reported discomfort in her left shoulder and hip. She describes her pain as localized to the left shoulder, extending down her arm and into her hip, and ankle. Denies loss of consciousness or a strike to the head. Baseline mobility is limited with cognitive impairment. Upon	20830		

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20830	Continued from page 6 examination an elderly female alert with evidence of dementia, oriented to self only, limited the reliability of the history and close observation was required for subtle changes in mental status or worsening pain. She appeared mildly uncomfortable due to pain but in no acute distress. Her left shoulder demonstrates tenderness to palpitation with limited ROM secondary to pain. Left hip tender with pain on passive movement, ROM is markedly reduced and unable to bear weight. Given the mechanism of injury, localized tenderness, her history of prior hip fracture, the differential diagnosis includes acute fracture (shoulder/hip), contusion, or exacerbation of degenerative joint disease. Review of the imagining results x-ray of left shoulder revealed a large Hill-Sachs deformity (a bone injury on the humeral head/upper arm bone ball of the shoulder joint resulting from a shoulder dislocation) with suspected nondisplaced humeral head fracture (the bone fragments, cracked or broken have not significantly shifted but remain in their correct alignment) (can be caused by trauma or fall) and anterior dislocation (front/forward movement of the arm out of socket and occurs when holding arm away from the body usually caused by trauma) along with mildly displaced posterior rib fractures on the left side (ribs 5 through 8). Pelvic and bilateral hip imaging showed no acute hip or pelvic fractures but demonstrated severe left hip joint narrowing with collapse of femoral head and advanced degenerative changes consistent with chronic pathology. On call orthopedic surgeon successfully performed a closed reduction (a non-surgical procedure completed by a healthcare provider to realign a broken bone by manually manipulating the bone back into its correct position without making an incision) of the left shoulder under fluoroscopy guidance with confirmed appropriate alignment. Given her age, underlying dementia, and associated rib fractures, admission for pain control, observation, and mobility assessment was recommended. Final diagnoses: dislocation of left shoulder/closed, traumatic closed nondisplaced fracture of anatomical neck of left humerus (initial encounter), closed fracture of multiple ribs of left side (initial encounter) and pain. R1’s left shoulder x-ray dated 10/10/25 at 3:45 p.m., identified large Hill-Sachs fracture deformity with suspected nondisplaced humeral fracture. Anterior dislocation. Mildly displaced left posterior left side rib fractures 5th, 6th, 7th, and likely 8th. R1’s hospital discharge summary dated 10/11/25 at 10:25 a.m., identified she had a fall during a transfer early morning around 7:00 a.m., placed in wheelchair and	20830		

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20830	Continued from page 7 doing fine. Sometime in the afternoon she displayed discomfort and when seen was crying in pain and complained of left leg pain. She was sent to local emergency room (ER) where x-rays were completed and showed a fracture dislocation and three rib fractures. Left hip showed advanced degenerative joint disease (DJD) and no fractures. Orthopedist was consulted, completed a reduction of the left shoulder fracture dislocation with conscious sedation and placed her on a sling and admitted into acute care at the hospital. Physical assessment identified tenderness to palpitation of the left rib area, tenderness to any rotation of both shoulders and lift hip. She was stable and will be discharged today back to the skilled nursing facility (SKF) followed up by me (primary care provider) within a week and seen by orthopedist in two weeks due to a very difficult and different fracture/dislocation that required ortho for reduction. R1's hospital discharge orders dated 10/11/25, included reason for hospitalization: fall with left shoulder fracture/dislocation, multiple rib fractures, and pain control. Orders included: Activity without restrictions. May increase daily walking as able. Call provider if getting worse or increase in problems. Facility 5-day report dated 10/17/25 at 4:54 p.m., R1 had an unsuccessful staff assisted transfer that resulted in her being lowered to the floor by staff. Element of the care plan that was not followed: R1 transfers with assist of one, while not explicitly written in the care plan, gait belt was required and not used for this transfer. R1 had refused gait belt in the past, but not with this transfer. R1 was referred to ED and evaluation showed dislocation of shoulder with fracture of the humoral head that may have been chronic due to presentation and three rib fractures were acute. Shoulder was reduced prior to return to facility. During an observation on 10/27/25 at 12:59 p.m., nursing assistant (NA)-A answered R1's call light. R1 sat in wheelchair and stated she had just returned from seeing the doctor about her left arm fracture. NA-A applied a gait belt underneath her breasts, placed the walker in front of her, connected right arm brace strap across her chest, and brakes on wheelchair. NA-A walked around wheelchair and stood behind R1, reached forward and placed her opened hands flat on top of the gait belt on each side of her waistline. NA-A instructed R1 to stand and pushed firmly against her waistline and assisted her to stand. R1pushed up with left hand on wheelchair arm rest, stood up, took one step with left foot and pivoted so that she stood in front of the	20830		

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20830	Continued from page 8 recliner. NA-A held onto R1's sides to steady her taking one step to her left so that she was positioned on R1' right side next to the recliner. NA-A pushed inward with her hands flat against the gait belt, while R1 placed her left hand on the recliner armrest and lowered herself down onto the recliner. R1's wheelchair remained with left edge of seat next to recliner at an angle so that NA-A stood in between the recliner and the wheelchair during the transfer. NA-A did not place her hands/fingers underneath the gait belt during this observation. NA-A removed the gait belt, elevated R1's feet with recliner footrest, covered her with a blanket, and placed call light on top of blanket. NA-A moved quickly and rushed to complete the transfer. NA-A turned off lights, sanitized her hands and left the room. R1's Kardex was observed inside her closet door last updated on 9/2/25, ensure appropriate mobility aides and safety devices used for transfers/positioning. During an observation on 10/28/25 at 12:31 p.m., NA-B entered R1's room and applied a gait belt while she sat in her wheelchair. NA-A positioned her wheelchair sideways off to the right side of the recliner, placed walker in front of her, and brakes on wheelchair. NA-B stood behind the R1's wheelchair, placed her hands/fingers cupped underneath the gait belt on both sides of R1's waistline. R1 pushed herself up from wheelchair with her left hand on the arm rest of the wheelchair and NA-A pulled up on the gait belt to steady her. R1 stood up, held onto the walker and NA-A let go of the gait belt with both hands. NA-A took brakes off wheelchair, pushed it out of the way, moved closer behind R1 and grabbed the gait belt with both hands. R1 pivoted to the left, lowered herself down with the left hand on the arm rest of recliner. R1 verbalized confused thought process and stated there must be people upstairs she saw children sliding down the roof in the snow and she was worried about them getting hurt. NA-B removed the gait belt, elevated her legs/feet with recliner footrest, placed call light, sanitized hands and exited the room. During an interview on 10/27/25 at 1:57 p.m., NA-A stated unsure of date early a.m. she attempted to transfer R1 from recliner to commode in her room without placing a gait belt on R1 prior to the transfer. R1 refused the gait belt in the past. R1 was able to make that decision and the reason a gait belt was not applied. NA-A stated she stood between the recliner (on her left side) and the commode (on her right side) and held onto R1's backside of her pants with her left hand and right hand was placed on the commode while she stood up and tripped over her foot.	20830		

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20830	Continued from page 9 NA-A bear hugged her from behind, lowered her to the ground, she did not fall. NA-A stated R1 was heavy, would not bend the left leg which made it difficult to lower her down to the floor. She complained of leg pain and wanted to get up off the floor. Once the nurse arrived, she assessed R1 and with assist of two nurses she was lifted off the floor with a Hoyer lift. NA-A stated she was not aware R1 was at risk for falls and the use of gait belt most likely would have not made a difference in the outcome. During the earlier transfer observed with R1 she stated she did not place her hands under the gait belt and grabbed her pants instead and always transferred her that way. NA-A stated R1 was heavy and easier to use her pants, usually did not grab around her waist area. NA-A stated she had learned how a gait belt should be used from the certified nursing assistant class two years ago. Staff were expected to apply a gait belt under the breasts, fit two fingers under it so not too tight, both sides of the gait belt should have been grabbed with fingers slipped underneath and lift after resident was asked to stand. There were times she grabbed the back side of a resident's pants for an extra boost up. She received gait belt education on how gait belts should be applied only about one week ago. Prior to the incident she had not received education on how a gait belt should be used correctly since she started work at facility. During an interview on 10/2725 at 2:24 p.m. registered nurse (RN)-A stated R1's cognition was not intact, and she was unable to make an informed decision as to whether a gait belt should have been used during transfers. R1's refusals were repetitive, and memory was short. R1 was assist of one with a gait belt for transfers. The Kardex located in each resident closet should have identified which residents required a gait belt for transfers. A gait belt should be used to steady a resident with unsteady gait/balance problems, help prevent falls and keep staff and residents safe. The gait belt was considered best practice and resident clothing such as pants were not allowed to be used to transfers residents. Staff were expected to use a gait belt when R1 was transferred for safely. RN-A stated on 10/10/25, at approximately 7:00 a.m., she was informed by a nurse R1 had fallen and needed assistance. RN-A entered R1's room and R1 sat on the floor with her back leaned up against NA-A's lower legs. R1 had a sling on her right arm (had worn it since admission to facility) limited motion and pain was chronic due to past injury. RN-A picked up R1's left leg and she complained of hip pain, gathered vitals and completed an assessment a Hoyer lift was used to lift her off the floor and transferred into the wheelchair. R1 stood up with an EZ stand and transferred to commode, no complaints of pain	20830		

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20830	Continued from page 10 but later in the day she complained of left sided shoulder/hip/knee/ankle pain. R1 was seen by provider at facility then sent to ER. RN-A stated she thought a gait belt had been used, charted it and later realized a gait belt was not applied by NA-A prior to the transfer/fall. R1 was a large woman, hard to control when she started to go down ended up with fractured ribs and dislocated/fractured left shoulder. During an interview on 10/28/25 at 11:04 a.m., family member (FM) stated R1 was unable to stand alone, was a significant fall risk, and had a history of right arm fracture that never healed properly due to her horrible bones. FM stated she had visited R1 many times this year and observed many transfers by staff without the use of a gait belt. The first week of October staff grabbed her pants to transfer her to the commode, pulled pants down, nothing to hang onto, sat down on commode, stood her up without anything to hang onto, pulled up pants, did not seem very safe and placed her at risk for a fall. Staff had assisted R1 with a transfer from wheelchair to car holding onto her clothes without a gait belt on. FM stated that type of practice was concerning, clothes were not sturdy enough, she was not a small person, and the top of her pants could have ripped. FM had observed a gait belt on R1's wheelchair at the end of July and was used when she was taken to a family gathering by her sister-in-law to take her to the bathroom. The gait belt had not been observed in her room during the other visits since. FM had not seen or heard R1 refuse the use of a gait belt. FM stated R1 was at a point where one person assist for transfers was not sufficient and she needed at least two staff instead. FM stated another member of the family informed her R1 was in a lot of pain yesterday during the orthopedic appointment. During an interview on 10/28/25 at 11:28 a.m., occupational therapist (OT) stated when a resident was able to bear weight such as R1, staff would be expected to use a gait belt. OT stated the gait belt provided staff something to hold onto and grasp without pulling on resident arms and/or extremities and helped prevent injury to resident and staff. Gait belts should have been included in R1's care plan and used to avoid staff from grabbing onto the side of their body to lift R1 up or lower R1 down, if a resident's knees would buckle and they had fragile bones staff would possibly hold too tight or grab an arm and cause injuries. OT stated after a resident has had a fall with an injury staff were expected to communicate with therapy and be re-assessed by physical therapy to determine the safest way to transfer them especially with rib fractures to	20830		

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20830	Continued from page 11 avoid further injury and falls. OT stated it seemed odd R1 was deemed back to baseline but a possibility without lower extremity involvement in the fall. Typically, we are given orders to reassess once they return from a hospital stay after fall with injury. After gait belt had been applied the staff would be expected to slide their fingers up underneath the gait belt with thumbs up so that the top side of the fingers/hand were placed against the resident's body. Staff should not have used the resident clothing/pants to grab onto during a transfer. When a resident was able to walk or used a walker the staff should stand off to the side and if the resident was to pivot from one spot to another staff would be expected to stand in front of the resident during a transfer. Staff should not stand behind a chair during a transfer; they would not be able to break a fall and lower the resident to the floor if they lost their balance. During an interview on 10/28/25 at 1:48 p.m., NA-B stated she used a gait belt on residents when it was in their care plan and/or if she thought they may be unsteady during transfers or ambulation. Staff were expected to use a gait belt with residents that were not independent during transfers/ambulation for the safety of the resident and staff, helped prevent falls and if they lost their balance the gait belt would provide a way to lower them to the floor. When a resident refused the use of the gait belt, they need to be informed it was necessary to provide a safe transfer. The nurse may be able to help convince them, if not a lift machine maybe needed for transfer. NA-B stated R1 has never refused to wear the transfer belt and always used one along with the back of her pants when she transferred her. NA-B stated she had forgotten to use a transfer belt during other resident transfers due to unable to locate one. NA-B stated she had recently received education and audits on how to apply the gait belt only. NA-A stated she stood behind R1's wheelchair during the observed transfer earlier because she thought it was the best way to transfer R1. However, If R1 would have started to fall forward she most likely would not have been able to stop the fall. NA-A stated where she stood was not safe and should have maybe stood on R1's side instead. During an interview on 10/28/25 at 3:30 p.m. DON stated R1 had dementia and poor short/long term memory. Staff were expected to use a gait belt to transfer any resident requiring assistance and should not have been needed to be spelt out in the care plan and Kardex. The Kardex would have indicated assistive devices such as walkers/EZ stand, and those residents would have required a gait belt for a transfer. The use of	20830		

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20830	Continued from page 12 transfer belts helped provide safe transfers. During a fall like R1's where a gait belt was not used and resident started to fall the staff would most likely have reached out and grabbed onto an upper extremity or completed a bear hug, and any of those could have resulted in injury especially with the geriatric population. R1 had a degenerative joint disease and would have caused a higher risk for injury without a gait belt which resulted in other means used to break the fall. NA-A was expected to have used a gait belt when R1 was transferred and could have made a difference, her shoulders would have not been affected, and NA-A's hand position would have been different. Education was initiated after the incident on 10/13/25 and 10/14/25 and provided through the health academy computer system, documents (policy), texts, and audits on application of the gait belt, if it was applied before transfers, but lacked information on where to stand and how to provide a safe transfer. The staff were informed later with a new audit form where to stand during the transfers, on the resident's strong side. Staff were confused due to inaccurate information provided such as informed of the wrong side to stand on during transfer. DON stated he had misinterpreted as strong side and should have indicated weak side. During an interview on 10/29/25 at 4:22 p.m., administrator stated safety equipment indicated gait belt but was not identified as such on the resident's care plan/Kardex. ,Staff were expected to use a gait belt during R1's transfer/fall incident on 10/10/25, and a gait belt was not applied. Gait belt use was a standard of care for resident and staff safety. Facility policy Staff Assisted Resident Transfer dated October 2025, identified the facility would assess each resident and determine the safest transfer method for both resident and staff safety. Resident specific data will be used to determine the method of transfer including but not limited to resident preference, history, clinical condition, physician restrictions, therapy assessment (physical and occupational), and nursing assessment. Resident would be assessed for initial transfer method determination on admission will be per resident interview and admission documentation. Resident will then be re-evaluated after a change in condition and after any transfer related incident (fall, near fall, injury). A stand pivot transfer where resident could weight bear on legs required assist of one to two staff with a gait belt secured on waist, scoot to edge of chair/bed, stand pivot to adjacent destination surface.	20830		

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20830	Continued from page 13 Facility document Resident Falls dated October 2025, identified fall safety assessment is completed on all new admissions, quarterly, and as needed to assist in determining risk for falls. Identified, the resident is evaluated for physical devices to be used to help reduce falls, injury, or incidents. Those at risk for falls or have physical devices were addressed in the care plan with approaches/interventions to be followed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		