Electronically Submitted
September 22, 2021

Administrator
Minnewaska Community Health Services
605 Main Street, Po Box 40
Starbuck, MN 56381

RE: CCN: 245537
Cycle Start Date: August 31, 2021

Dear Administrator:

On August 31, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office 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 October 7, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 7, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 7, 2021, (42 CFR 488.417 (b)).

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.

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 $11,160; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 31, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Minnewaska Community Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 31, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
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, Licensing and Certification Program 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

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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) 565-9462

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/26/21 through 8/31/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5537033C (MN76019), with a deficiency cited at (F689). H5537034C (MN75436), with a deficiency cited at (F689). H5537038C (MN76099), however no deficiency was cited. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to complete a root cause analysis and develop interventions to prevent reoccurring falls for 1 of 3 residents (R1) which resulted in R1 falling 11 times causing one fracture, and minor injuries that required first aid. R1 remained at risk for serious injury from frequent falls. The IJ began on 8/17/21, and the immediacy was removed on 8/30/21. The above findings constituted substandard quality of care, and an extended survey was conducted from 8/30/21 to 8/31/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=J	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 complete a root cause analysis and develop interventions to prevent reoccurring falls for 1 of 3 residents (R1) which resulted in R1 falling 11 times causing one fracture, and minor injuries that required first aid. This resulted in an immediate jeopardy (IJ) situation for R1 who remained at risk for serious injury from frequent falls. The IJ began on 8/17/21, when R1 had 3 falls requiring emergency services in 48 hours which resulted in a wound over his eyebrow requiring Steri-Strips, a new bruise on right shoulder, right eye was still bruised and swollen and was admitted to the hospital and determined to have a right hand, 5th metacarpal fracture. The facility had no evidence of completing post fall root cause analysis or developing and implementing	F 689	Preparation, submission and implementation of this plan of correction does not constitute an admission or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein This plan of correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. Resident identified has been transferred and has yet to return from hospital. Upon readmission a full comprehensive assessment will be conducted, and a new fall risk assessment will be completed with care planned interventions as appropriate	9/1/21

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F 689	Continued From page 2 new interventions as a response to the falls. On 8/27/21, at 3:49 p.m. the director of nursing (DON) and administrator were notified of IJ for R1. The IJ was removed on 8/30/21, at 5:06 p.m., however non-compliance remained at an isolated scope and severity of a G, actual harm that is not immediate jeopardy. Findings include: R1's admission minimal data set (MDS) dated 7/27/21, indicated R1 had diagnoses which included hip fracture, anxiety disorder and had severely impaired cognition. Further review of MDS, indicated R1 required extensive assistance of one staff member for most activities of daily living which included bed mobility, ambulation in room, dressing, and toileting. R1's care plan dated 8/27/21, indicated R1 was at risk for falls related to diagnosis of history of falls and right hip fracture. Interventions for R1's falls included stop sign placed in room 8/24/21, fall mats at bedside 8/18/21, night light 8/13/21, frequent reminders for resident to use call light and ask for assistance before ambulation/transfers 8/3/21, re-orientate resident to call light use and safe transfers 8/2/21, call don't fall sign placed in resident's room 7/22/21, and 7/21/21, assist with mobility, medications as ordered, anticipate needs, call light within reach, adequate lighting allowed, room free from clutter. Review of R1's progress notes are as follows: On 7/22/21, R1 had unwitnessed fall at approximately 7:00 a.m. this morning. Immediate intervention of call don't fall sign put in R1's room.	F 689	for falls to decrease risk of harm. 1. Fall Prevention Program Policy a. Each resident of Minnewaska Lutheran Home will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 2. IDT Process (Post-Fall) a. IDT meetings are completed every business date. b. Nursing Management will utilize Post-Fall Assessment Form (See attachment) to identify RCA. i. Individual who observes resident post-apparent fall will complete witness statement to be included in the determination of RCA. c. Fall Tracking Log will be utilized to assess trends and aid in the RCA. d. RCA will be reviewed next business date by IDT. i. Nurse Management will complete temporary RCA via Post-Fall Assessment Form if post-fall does not occur on business day and is to be reviewed on next IDT meeting. 3. Nursing Staff Education a. Licensed Nursing Staff will be provided education on appropriate interventions for fall prevention. i. Appropriate interventions for individuals who had cognitive impairment as evidence by BIMs assessment that is completed by facility. ii. Intervention example list will be provided within Fall Prevention Program b. All staff will be provided education on Fall Prevention Program (see attachment).	

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F 689	Continued From page 3 On 7/22/21, interdisciplinary team (IDT): R1's fall from 7/21/21, was discussed during meeting. R1 is on 15-minute checks and interventions will be to place call don't fall signs in R1's room. On 7/26/21, certified nursing assistant reported that she was ambulating R1 to bed from recliner and resident became weak and was eased to the floor. R1 did not sustain injury. Immediate intervention placed included staff will continue to do frequent checks on R1 and provide "tender loving care" (TLC). On 7/27/21, IDT meeting to discuss 7/26/21, fall concluded "will continue with current fall preventions. Will also continue with PT [physical therapy]/OT [occupational therapy] as ordered to aid in transfers/ambulation." On 7/31/21, R1 had unwitnessed fall in room. R1 self-ambulated over to his closet using his walker and then fell into the closet "breaking the door". "Abrasion noted to right arm, cleansed and Tegaderm applied." Immediate intervention implemented "resident re-educated to call light." On 8/2/21, IDT met to discuss 7/31/21, fall "interventions will remain, in addition to reorientation to use of call light, and transfer assistance with staff present. Approximate 15-minute checks will continue with documentation to be done via paper." On 8/2/21, R1 had unwitnessed fall in his room. R1 reported hitting his head, back of head swollen. R1 had complaints of headache. "911 called and resident sent to ER [emergency room] for further evaluation for immediate intervention." R1 will be "spending at least one night d/t [due to]	F 689	4. Director of nursing as well as Quality Assurance nurse will audit to ensure that policy and procedure are being followed and that RCA□s are being completed the first business day after every fall at the daily IDT meeting. Administrator will audit the DON and QA nurse once a week for 3 months then bring to quality assurance committee for review. IJ plan was submitted to MDH in it's entirety on 08/27/2021	

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F 689	Continued From page 4	F 689		

a skull fracture."

On 8/4/21, IDT met to discuss R1's fall on 8/2/21, "Resident's room remains free of clutter, appropriate footwear worn and on during time of fall, and call don't fall signs were in place. Nursing order discharged for 15-minute checks due to intervention not being effective. Interventions will remain, in addition to reorientation of use of call light, and transfer assistance with staff present."

On 8/6/21, R1 had unwitnessed fall in bedroom. R1 did not sustain an injury. Immediate intervention implemented included "will continue to monitor resident. Re-educated resident on use of call light."

No progress notes for the IDT meeting to discuss R1's fall on 8/6/21.

On 8/16/21, R1 had witnessed fall while self-ambulating unattended in the hallway. R1 was witnessed to bump his head, but no injuries noted at this time. Progress note lacked evidence that an immediate intervention was implemented to prevent future falls.

On 8/17/21, IDT met to discuss R1's 8/16/21, fall "Intervention put into place is to continue to educate resident to ask for assistance. It was also discussed that resident will be transitioning to memory care unit when opening is available. Resident is out of isolation and will be able to participate in activities and come out to meals."

On 8/17/21, R1 had unwitnessed fall in R1's room. R1 was face down alongside R1's bed. R1 was noted to have "blood coming from right eyebrow line. Pressure immediately placed.

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F 689	Continued From page 5	F 689		

Wound cleaned and Steri-Strips placed over eyebrow. 911 called and updated hospital on transfer." R1 left facility at 7:00 p.m. via ambulance.

On 8/17/21, R1 returned to the facility at 10:40 p.m.

On 8/18/21, R1 had unwitnessed fall at 5:15 a.m. in the morning. R1 was found sitting on the floor mat that was placed on the evening of 8/17/21, after fall. R1 was noted to have a new bruise on right shoulder, right eye was still bruised and swollen no other injuries were noted. Immediate intervention was "call light given to resident and reminded him to use call light. Floor mat back in place and bed lowered."

On 8/18/21, IDT met to discuss R1's two falls within the last 24 hours. "he did sustain a small laceration near right eyebrow and has bruising to right hand, right shoulder, and right eye. Room was uncluttered, fall mats at bedside, proper footwear in place. IDT review and intervention is to continue with frequent reminders and re-education for call light use,"

On 8/19/21, R1 had unwitnessed fall at 10:00 p.m., in bathroom near the front of the facility. There was no injury observed. Ambulance arrived at 10:45 p.m. to pick up R1.

On 8/20/21, R1 was admitted to the hospital for an "infection of unknown origin" and R1 had a "boxer's fracture" in his right hand. Resident's right hand, 5th metacarpal is fractured, and he is being fitted for a splint."

On 8/20/21, IDT met related to "fall, medication

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

changes at hospital, Amiodarone was decreased, with blood pressure parameters. No other recommendations at this point." No additional notes were included as to the cause or incident related to fracture.

On 8/23/21, "family declines the need for Memory Clinic at this time and would like no changes to occur with his psychotropic medications at this time. Discussion of bladder training, and family declined this due to resident not being successful in the past. Will continue to revisit at a later date."

On 8/23/21, R1 was observed in the grass at the building next door to the facility. R1 was transferred by ambulance for further evaluation.

On 8/23/21, R1 had unwitnessed fall in his room. R1 was found on the floor mat laying on his right side. R1 sustained skin tear to both elbows. Progress note lacked evidence of an immediate intervention to prevent future fall and injuries.

On 8/24/21, IDT met to discuss previous falls from 8/23/21. "WanderGuard was placed on resident. Stop signs placed in resident room. Call light will be switched to a flat bottom. Family declines the need for a pendant call light, stating they felt resident would not understand how to use it."

During observation on 8/27/21, at 7:43 a.m. R1 was lying in bed on his right side. R1's bed was lower to the floor and floor mat was next to bed. On R1's left side of the bed, there was a silver triangle call system. The call light was observed hanging from the left side of R1's bed and was upside down. This call light was placed as a fall intervention after R1's latest fall on 8/24/21,

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	245537	A. BUILDING _____ B. WING _____	C 08/31/2021

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however this call light would not have notified staff as intended by the way it was hanging upside down off the bed rendering it in operable. In addition, there were two paper signs taped to R1's bathroom door one being a stop sign and the other said Call Don't Fall despite R1's cognition status being severely impaired.

On 8/27/21, 7:46 a.m. licensed practical nurse (LPN)-A poked her head into R1's room and continues to walk down the hall. R1's call light continued in the same position.

On 8/27/21, at 7:48 a.m. DON entered R1's room and stated, "sound asleep". R1's call light continued in the same position.

On 8/27/21, at 8:04 a.m. LPN-A again poked her head into R1's room and continued to walk down the hall. R1's call light continued the same.

On 8/27/21, at 8:20 a.m. nursing assistant (NA)-A and NA-B enter R1's room to assist with morning cares. When asked about the call light hanging upside down off R1's bed, NA-A stated "if he moves or stands up it is motion censored, so it alerts staff quickly" and placed it back as before hanging off the bed upside down on the left side.

On 8/27/21, at 3:21 p.m. LPN-B indicated the fall procedure included "looking at the situation and see what we could have been done to prevent the fall. We [staff] place an immediate intervention usually in the notes and it is care planned for what we did." Further, LPN-B indicated R1 was a high fall risk and had poor cognition. When asked what interventions were in place for R1's falls, LPN-B responded, "15-minute checks, call don't fall sign, and floor mat."

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F 689	Continued From page 8 On 8/27/21, at 8:55 a.m. when asked what the facility's fall procedure was, NA-B stated "we [staff] set a protocol to keep them [residents] from falling again. We think what will prevent another fall, so it doesn't happen again. Sometimes it's a little tricky. We try to keep them safe like a floor mat or monitoring them one on one if we have to sit there we do. We try to take every step we can keep them safe." Further, NA-B indicated R1 was a high fall risk and is beginning to have "sun-downers [state of confusion that occurs later in the afternoon and into the night most often found in patients who have dementia or Alzheimer's disease.] in the evenings and that is when he has taken a tumble usually." NA-B stated R1 has had "a lot of falls" and indicated R1's fall interventions included the floor mat, monitor R1 every 10 minutes at least, sensor on his bed and low bed. In addition, when asked about the sensor on his bed NA-B stated, R1 is not able to use the call light appropriately and that is another reason why they moved to the bed sensor as it will detect any movement and senses his body moving or getting out of bed and will make a beeping noise to alert staff he is moving. However, NA-B continued to state, "I don't think [R1] would know how to use his call light that is why [R1] was on the floor so many times." On 8/27/21, at 9:22 a.m. when interviewing family member (FM)-A on what the facility had put into place for fall interventions to prevent future falls and injury, FM-A stated "This is so touchy. They [staff] said [R1] is on 15-minute checks, but there is no way they can do that, they lowered the bed to the floor and put a mat next to the floor to prevent injury and we have moved rooms." Further, I really have not got anything on how	F 689		

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they are preventing falls honestly. I know from being there that the 15-minute checks are not being done when family is there and they don't know when I am there or when I leave."

On 8/27/21, at 9:40 a.m. when asked about the facility fall procedure, LPN-A stated, "we [staff] try to figure out what happened and try to put an intervention in place. For example, if they [residents] are falling in their room out of bed, we would put a pad down or call don't fall signs if appropriate." When asked when placing a call don't fall sign would not be an appropriate intervention for a resident post fall, LPN-A stated "it wouldn't be appropriate if they can't see or if they are not cognitively intact. We will try it, but they usually don't help." Further, LPN-A identified R1 was a high fall risk and had dementia behaviors. In addition, when asked what interventions were in place to prevent R1 from falling, LPN-A stated, "we keep an eye on him between everyone in the building, 15-minute checks, and he has a wander guard on, that is all I can think of."

On 8/27/21, at 10:26 a.m. when asked about the facility fall procedure, registered nurse (RN)-A indicated "we [staff] investigate and find out more. We put immediate interventions in and assess it [fall] the next day in IDT and come up with a better plan if there is one." RN-A indicated R1 showed some confusion related to his dementia and was a fall risk. Further, RN-A indicated after R1's fall on 7/26/21, there were no interventions placed in R1's care plan but the immediate interventions were frequent checks and TLC (tender loving care). RN-A then stated for 7/31/21, post fall interventions were remained free of clutter, sign posted, frequent checks,

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reorientation to call light and reorientation to staff transfer assistance with staff present. Further, RN-A indicated 8/2/21, post fall immediate intervention was sending R1 to the emergency room and when R1 returned from the hospital interventions placed were "again reorientation to call light, staff assistance, free of clutter, sign in room, frequent checks already had all that in place but the immediate was the ER evaluation and when he came back, we were trying to re-educate him." However, RN-A stated, "I think [R1] will sometimes remember to use the call light, but there was no new intervention added." RN-A continued to review R1's fall on 8/2/21, stated "this fall he got the skull fracture, that is why he spent the night in the ER, when he came back, we did not place a new intervention to prevent falls." RN-A stated referring to fall on 8/6/21, "immediate intervention was reeducation on the call light. IDT meeting there was nothing new added for an intervention. We made sure there was a night light on in his room, but that night light was placed on 8/13/21 so that was not immediate, it was after." Referring to R1's fall on 8/16/21, RN-A stated, "there was no new intervention" placed and "IDT meeting stated to continue to re-educate." Referring to R1's fall on 8/17/21, RN-A indicated the immediate intervention was being sent to the ER for evaluation due to hitting his head, however, "there is no intervention listed when he came back from the hospital on 8/17/21" but in IDT meeting a fall mat was placed. Further, RN-A referring to fall on 8/18/21, stated the immediate intervention was "gave call light, bed lowered, mat of floor and educated to use the call light. IDT met that day and there was no new intervention stated we just talked about proper footwear, clutter in room and reeducation to use the call light." Referring to the

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fall on 8/19/21, RN-A stated R1's immediate intervention was R1 was sent to the ER and returned on 8/20/21, "there was nothing new put into place" after discovery that R1 had a hand fracture. Referring to two falls on 8/23/21, the first one R1 had got outside and fell in the grass with an immediate intervention of R1 being sent to the ER for further evaluation and upon return was found on the floor in his room. RN-A stated "nothing new for interventions. IDT meeting regards to both elopement and fall was a stop sign was placed in room, call light was switched to a flat button. It's a touch pad for when he rolls." At this time, RN-A and surveyor went to R1's room to look at the flat button call light. RN-A stated "I have not seen one like it, it is new to myself and I am not sure if they [staff] have used it before. It is not an alarm or anything like that." RN-A correctly placed call light which appeared to be the shape of a teepee on top of R1's mattress and the button of the call light was to be placed on the side closest to the resident, not hanging off the bed and upside down like previously observed. RN-A stated she was not sure if the staff have been trained on how to properly place the flat button call light.

During interview on 8/27/21, at 11:13 a.m. with the Director of Nursing (DON) when asked what the facility procedure was for a fall, the DON stated staff "should check the room, check the situation wherever they fall to make sure nothing is out of place. Assess the situation and resident and put a new intervention if there is a new one. There is not always a new intervention, there is only so much you can do. Sometimes all you can do is reeducate." Further, DON indicate IDT meet the next business day "review it [fall] again and determine a root cause, if we [staff] determine

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one, address that issue and go from there and care plan it." When going through R1's 11 falls since admission, DON stated "we are doing the IDT and we are doing the things like basic root cause analysis, but we are not documenting it. But it should absolutely be on the care plan and it should be documented in IDT." DON also confirmed the same information as RN-A had. In addition, DON stated staff were expected "to check on [R1] more frequently and think outside of the box if they can't think of a new intervention after a fall. If they [staff] can't think of a new intervention, then more frequent checks and remind him to use the fall light if there is a fall with injury they call the directors otherwise we review it in IDT." Further, DON stated after the fall on 8/23/21, a flat call light was placed because "he would be more likely to slap than squeeze. We trained staff on the call light. I understand NA-B said it was a bed alarm. I am not sure if [staff] have used this call light here before. Not all staff were educated on the call light." At approximately 2:38 p.m. DON stated R1's "cognition is not good. I don't think he [R1] would be able to use his call light consistently. I think for the most part he knew what it was for, but I can't say that 100 percent of the time he would use it if he needed to. I think it's important to keep trying so it become engrained, and they understand that."

On 8/27/21, at 3:21 p.m. administrator stated, "after a fall we [staff] get together a root cause analysis and put interventions during IDT and keep putting interventions in place if the family agrees to the interventions." Further, administrator stated, "it is hard to determine the root cause with dementia." Administrator stated R1's "BIMS [brief interview for mental status] was low but he was still able to say what he needed

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and what he wanted. [R1] is able to use a call light. We [staff] were rounding on him frequently because he would not know he put on the call light and that is why he has a touch pad call light. We trained staff to the call light however, the older staff thought it was an alarm pad because they look very similar. Every single nursing staff that worked from my understanding was aware. He moved from one unit to the other to have better eye on him and I am unsure if all staff were cross trained in that form."

On 8/30/21, at 4:52 p.m. Administrator provided surveyor with a toileting program R1 started on day of admission 7/21/21, "to determine how often they [residents] go to the bathroom." However, the information did not affect R1's falls and no interventions were added from the results of the toileting program. Administrator also provided surveyor with results of R1's sleep watch which determined R1 was not sleeping much. Administrator stated, "we tried to adjust his bedtime and no napping during the day trying to get the restful sleep to prevent falls but none of it worked." However, that had not been communicated to the rest of the staff and was not in R1's record.

Review of facility policy titled Fall Prevention Program Policy dated 6/1/21, indicated if a resident is determined a high risk the resident will be placed on the facility's fall prevention program. In addition, residents will be provided interventions that address unique risk factor measured by the risk assessment tool: medications psychological, cognitive status, or recent change in functional status. As well as provide additional interventions as directed by the resident's assessment. Further review of policy,

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F 689	Continued From page 14 "each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care: interventions will be monitored for effectiveness, and the plan of care will be revised as needed." In addition, "when any resident experiences a fall, the facility will assess the resident, complete a post fall assessment, complete an incident report, notify physician and family, review the resident's care plan and update as indicated, document all assessments and actions and obtain witness statements in the care of injury." The IJ which began on 8/17/21, was removed on 8/31/21, at 5:06 p.m. after the facility successfully implemented a removal plan which included the following: -R1's care plan was revised for at risk for falls with a new intervention that included "the facility will collaborate with family to provide 1-1 supervision. the facility will re-evaluate the 1-1 status upon readmission to facility after comprehensive assessments are completed." -IDT completed a root cause analysis for all 11 of R1's falls. -Education was provided to staff related to resident who have a BIMS score of 12 or lower and a list of examples provided to staff that would be appropriate interventions to implement after a fall. -Education provided to all licensed nursing staff on resident fall prevention program/protocol.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 22, 2021

Administrator
Minnewaska Community Health Services
605 Main Street, Po Box 40
Starbuck, MN 56381

Re: State Nursing Home Licensing Orders
Event ID: PORK11

Dear Administrator:

The above facility was surveyed on August 26, 2021 through August 31, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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	00477	A. BUILDING: _____ B. WING _____	C 08/31/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/26/21 through 8/31/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5537038C (MN76099) H5537034C (MN76019) H5537033C (MN75436 with a licensing order issued at S0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State	2 000		

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	00477	A. BUILDING: _____ B. WING _____	C 08/31/2021

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2 000	Continued From page 2 licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a root cause analysis and develop interventions to prevent reoccurring falls for 1 of 3 residents (R1) which resulted in R1 falling 11 times causing one fracture, and minor injuries that required first aid.	2 830	Preparation, submission and implementation of this plan of correction does not constitute an admission or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies	8/31/21

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2 830	Continued From page 3 This resulted in an immediate jeopardy (IJ) situation for R1 who remained at risk for serious injury from frequent falls. The IJ began on 8/17/21, when R1 had 3 falls requiring emergency services in 48 hours which resulted in a wound over his eyebrow requiring Steri-Strips, a new bruise on right shoulder, right eye was still bruised and swollen and was admitted to the hospital and determined to have a right hand, 5th metacarpal fracture. The facility had no evidence of completing post fall root cause analysis or developing and implementing new interventions as a response to the falls. On 8/27/21, at 3:49 p.m. the director of nursing (DON) and administrator were notified of IJ for R1. The IJ was removed on 8/30/21, at 5:06 p.m., however non-compliance remained at an isolated scope and severity of a G, actual harm that is not immediate jeopardy. Findings include: R1's admission minimal data set (MDS) dated 7/27/21, indicated R1 had diagnoses which included hip fracture, anxiety disorder and had severely impaired cognition. Further review of MDS, indicated R1 required extensive assistance of one staff member for most activities of daily living which included bed mobility, ambulation in room, dressing, and toileting. R1's care plan dated 8/27/21, indicated R1 was at risk for falls related to diagnosis of history of falls and right hip fracture. Interventions for R1's falls included stop sign placed in room 8/24/21, fall mats at bedside 8/18/21, night light 8/13/21, frequent reminders for resident to use call light and ask for assistance before ambulation/transfers 8/3/21, re-orientate resident	2 830	and licensing violations stated herein This plan of correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. Resident identified has been transferred and has yet to return from hospital. Upon readmission a full comprehensive assessment will be conducted, and a new fall risk assessment will be completed with care planned interventions as appropriate for falls to decrease risk of harm. 1. Fall Prevention Program Policy a. Each resident of Minnewaska Lutheran Home will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 2. IDT Process (Post-Fall) a. IDT meetings are completed every business date. b. Nursing Management will utilize Post-Fall Assessment Form (See attachment) to identify RCA. i. Individual who observes resident post-apparent fall will complete witness statement to be included in the determination of RCA. c. Fall Tracking Log will be utilized to assess trends and aid in the RCA. d. RCA will be reviewed next business date by IDT. i. Nurse Management will complete temporary RCA via Post-Fall Assessment Form if post-fall does not occur on business day and is to be reviewed on next IDT meeting. 3. Nursing Staff Education	

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2 830	Continued From page 4 to call light use and safe transfers 8/2/21, call don't fall sign placed in resident's room 7/22/21, and 7/21/21, assist with mobility, medications as ordered, anticipate needs, call light within reach, adequate lighting allowed, room free from clutter. Review of R1's progress notes are as follows: On 7/22/21, R1 had unwitnessed fall at approximately 7:00 a.m. this morning. Immediate intervention of call don't fall sign put in R1's room. On 7/22/21, interdisciplinary team (IDT): R1's fall from 7/21/21, was discussed during meeting. R1 is on 15-minute checks and interventions will be to place call don't fall signs in R1's room. On 7/26/21, certified nursing assistant reported that she was ambulating R1 to bed from recliner and resident became weak and was eased to the floor. R1 did not sustain injury. Immediate intervention placed included staff will continue to do frequent checks on R1 and provide "tender loving care" (TLC). On 7/27/21, IDT meeting to discuss 7/26/21, fall concluded "will continue with current fall preventions. Will also continue with PT [physical therapy]/OT [occupational therapy] as ordered to aid in transfers/ambulation." On 7/31/21, R1 had unwitnessed fall in room. R1 self-ambulated over to his closet using his walker and then fell into the closet "breaking the door". "Abrasion noted to right arm, cleansed and Tegaderm applied." Immediate intervention implemented "resident re-educated to call light." On 8/2/21, IDT met to discuss 7/31/21, fall "interventions will remain, in addition to	2 830	a. Licensed Nursing Staff will be provided education on appropriate interventions for fall prevention. i. Appropriate interventions for individuals who had cognitive impairment as evidence by BIMs assessment that is completed by facility. ii. Intervention example list will be provided within Fall Prevention Program b. All staff will be provided education on Fall Prevention Program (see attachment). 4. Director of nursing as well as Quality Assurance nurse will audit to ensure that policy and procedure are being followed and that RCA's are being completed the first business day after every fall at the daily IDT meeting. Administrator will audit the DON and QA nurse once a week for 3 months then bring to quality assurance committee for review.	

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reorientation to use of call light, and transfer assistance with staff present. Approximate 15-minute checks will continue with documentation to be done via paper."

On 8/2/21, R1 had unwitnessed fall in his room. R1 reported hitting his head, back of head swollen. R1 had complaints of headache. "911 called and resident sent to ER [emergency room] for further evaluation for immediate intervention." R1 will be "spending at least one night d/t [due to] a skull fracture."

On 8/4/21, IDT met to discuss R1's fall on 8/2/21, "Resident's room remains free of clutter, appropriate footwear worn and on during time of fall, and call don't fall signs were in place. Nursing order discharged for 15-minute checks due to intervention not being effective. Interventions will remain, in addition to reorientation of use of call light, and transfer assistance with staff present."

On 8/6/21, R1 had unwitnessed fall in bedroom. R1 did not sustain an injury. Immediate intervention implemented included "will continue to monitor resident. Re-educated resident on use of call light."

No progress notes for the IDT meeting to discuss R1's fall on 8/6/21.

On 8/16/21, R1 had witnessed fall while self-ambulating unattended in the hallway. R1 was witnessed to bump his head, but no injuries noted at this time. Progress note lacked evidence that an immediate intervention was implemented to prevent future falls.

On 8/17/21, IDT met to discuss R1's 8/16/21, fall "Intervention put into place is to continue to

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educate resident to ask for assistance. It was also discussed that resident will be transitioning to memory care unit when opening is available. Resident is out of isolation and will be able to participate in activities and come out to meals."

On 8/17/21, R1 had unwitnessed fall in R1's room. R1 was face down alongside R1's bed. R1 was noted to have "blood coming from right eyebrow line. Pressure immediately placed. Wound cleaned and Steri-Strips placed over eyebrow. 911 called and updated hospital on transfer." R1 left facility at 7:00 p.m. via ambulance.

On 8/17/21, R1 returned to the facility at 10:40 p.m.

On 8/18/21, R1 had unwitnessed fall at 5:15 a.m. in the morning. R1 was found sitting on the floor mat that was placed on the evening of 8/17/21, after fall. R1 was noted to have a new bruise on right shoulder, right eye was still bruised and swollen no other injuries were noted. Immediate intervention was "call light given to resident and reminded him to use call light. Floor mat back in place and bed lowered."

On 8/18/21, IDT met to discuss R1's two falls within the last 24 hours. "he did sustain a small laceration near right eyebrow and has bruising to right hand, right shoulder, and right eye. Room was uncluttered, fall mats at bedside, proper footwear in place. IDT review and intervention is to continue with frequent reminders and re-education for call light use,"

On 8/19/21, R1 had unwitnessed fall at 10:00 p.m., in bathroom near the front of the facility. There was no injury observed. Ambulance arrived

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2 830	Continued From page 7 at 10:45 p.m. to pick up R1. On 8/20/21, R1 was admitted to the hospital for an "infection of unknown origin" and R1 had a "boxer's fracture" in his right hand. Resident's right hand, 5th metacarpal is fractured, and he is being fitted for a splint." On 8/20/21, IDT met related to "fall, medication changes at hospital, Amiodarone was decreased, with blood pressure parameters. No other recommendations at this point." No additional notes were included as to the cause or incident related to fracture. On 8/23/21, "family declines the need for Memory Clinic at this time and would like no changes to occur with his psychotropic medications at this time. Discussion of bladder training, and family declined this due to resident not being successful in the past. Will continue to revisit at a later date." On 8/23/21, R1 was observed in the grass at the building next door to the facility. R1 was transferred by ambulance for further evaluation. On 8/23/21, R1 had unwitnessed fall in his room. R1 was found on the floor mat laying on his right side. R1 sustained skin tear to both elbows. Progress note lacked evidence of an immediate intervention to prevent future fall and injuries. On 8/24/21, IDT met to discuss previous falls from 8/23/21. "WanderGuard was placed on resident. Stop signs placed in resident room. Call light will be switched to a flat bottom. Family declines the need for a pendant call light, stating they felt resident would not understand how to use it."	2 830		

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2 830	Continued From page 8 During observation on 8/27/21, at 7:43 a.m. R1 was lying in bed on his right side. R1's bed was lower to the floor and floor mat was next to bed. On R1's left side of the bed, there was a silver triangle call system. The call light was observed hanging from the left side of R1's bed and was upside down. This call light was placed as a fall intervention after R1's latest fall on 8/24/21, however this call light would not have notified staff as intended by the way it was hanging upside down off the bed rendering it in operable. In addition, there were two paper signs taped to R1's bathroom door one being a stop sign and the other said Call Don't Fall despite R1's cognition status being severely impaired. On 8/27/21, 7:46 a.m. licensed practical nurse (LPN)-A poked her head into R1's room and continues to walk down the hall. R1's call light continued in the same position. On 8/27/21, at 7:48 a.m. DON entered R1's room and stated, "sound asleep". R1's call light continued in the same position. On 8/27/21, at 8:04 a.m. LPN-A again poked her head into R1's room and continued to walk down the hall. R1's call light continued the same. On 8/27/21, at 8:20 a.m. nursing assistant (NA)-A and NA-B enter R1's room to assist with morning cares. When asked about the call light hanging upside down off R1's bed, NA-A stated "if he moves or stands up it is motion censored, so it alerts staff quickly" and placed it back as before hanging off the bed upside down on the left side. On 8/27/21, at 3:21 p.m. LPN-B indicated the fall procedure included "looking at the situation and see what we could have been done to prevent the	2 830		

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fall. We [staff] place an immediate intervention usually in the notes and it is care planned for what we did." Further, LPN-B indicated R1 was a high fall risk and had poor cognition. When asked what interventions were in place for R1's falls, LPN-B responded, "15-minute checks, call don't fall sign, and floor mat."

On 8/27/21, at 8:55 a.m. when asked what the facility's fall procedure was, NA-B stated "we [staff] set a protocol to keep them [residents] from falling again. We think what will prevent another fall, so it doesn't happen again. Sometimes it's a little tricky. We try to keep them safe like a floor mat or monitoring them one on one if we have to sit there we do. We try to take every step we can keep them safe." Further, NA-B indicated R1 was a high fall risk and is beginning to have "sun-downers [state of confusion that occurs later in the afternoon and into the night most often found in patients who have dementia or Alzheimer's disease.] in the evenings and that is when he has taken a tumble usually." NA-B stated R1 has had "a lot of falls" and indicated R1's fall interventions included the floor mat, monitor R1 every 10 minutes at least, sensor on his bed and low bed. In addition, when asked about the sensor on his bed NA-B stated, R1 is not able to use the call light appropriately and that is another reason why they moved to the bed sensor as it will detect any movement and senses his body moving or getting out of bed and will make a beeping noise to alert staff he is moving. However, NA-B continued to state, "I don't think [R1] would know how to use his call light that is why [R1] was on the floor so many times."

On 8/27/21, at 9:22 a.m. when interviewing family member (FM)-A on what the facility had put into place for fall interventions to prevent future falls

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and injury, FM-A stated "This is so touchy. They [staff] said [R1] is on 15-minute checks, but there is no way they can do that, they lowered the bed to the floor and put a mat next to the floor to prevent injury and we have moved rooms." Further, I really have not got anything on how they are preventing falls honestly. I know from being there that the 15-minute checks are not being done when family is there and they don't know when I am there or when I leave."

On 8/27/21, at 9:40 a.m. when asked about the facility fall procedure, LPN-A stated, "we [staff] try to figure out what happened and try to put an intervention in place. For example, if they [residents] are falling in their room out of bed, we would put a pad down or call don't fall signs if appropriate." When asked when placing a call don't fall sign would not be an appropriate intervention for a resident post fall, LPN-A stated "it wouldn't be appropriate if they can't see or if they are not cognitively intact. We will try it, but they usually don't help." Further, LPN-A identified R1 was a high fall risk and had dementia behaviors. In addition, when asked what interventions were in place to prevent R1 from falling, LPN-A stated, "we keep an eye on him between everyone in the building, 15-minute checks, and he has a wander guard on, that is all I can think of."

On 8/27/21, at 10:26 a.m. when asked about the facility fall procedure, registered nurse (RN)-A indicated "we [staff] investigate and find out more. We put immediate interventions in and assess it [fall] the next day in IDT and come up with a better plan if there is one." RN-A indicated R1 showed some confusion related to his dementia and was a fall risk. Further, RN-A indicated after R1's fall on 7/26/21, there were no interventions

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placed in R1's care plan but the immediate interventions were frequent checks and TLC (tender loving care). RN-A then stated for 7/31/21, post fall interventions were remained free of clutter, sign posted, frequent checks, reorientation to call light and reorientation to staff transfer assistance with staff present. Further, RN-A indicated 8/2/21, post fall immediate intervention was sending R1 to the emergency room and when R1 returned from the hospital interventions placed were "again reorientation to call light, staff assistance, free of clutter, sign in room, frequent checks already had all that in place but the immediate was the ER evaluation and when he came back, we were trying to re-educate him." However, RN-A stated, "I think [R1] will sometimes remember to use the call light, but there was no new intervention added." RN-A continued to review R1's fall on 8/2/21, stated "this fall he got the skull fracture, that is why he spent the night in the ER, when he came back, we did not place a new intervention to prevent falls." RN-A stated referring to fall on 8/6/21, "immediate intervention was reeducation on the call light. IDT meeting there was nothing new added for an intervention. We made sure there was a night light on in his room, but that night light was placed on 8/13/21 so that was not immediate, it was after." Referring to R1's fall on 8/16/21, RN-A stated, "there was no new intervention" placed and "IDT meeting stated to continue to re-educate." Referring to R1's fall on 8/17/21, RN-A indicated the immediate intervention was being sent to the ER for evaluation due to hitting his head, however, "there is no intervention listed when he came back from the hospital on 8/17/21" but in IDT meeting a fall mat was placed. Further, RN-A referring to fall on 8/18/21, stated the immediate intervention was "gave call light, bed lowered, mat of floor and

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educated to use the call light. IDT met that day and there was no new intervention stated we just talked about proper footwear, clutter in room and reeducation to use the call light." Referring to the fall on 8/19/21, RN-A stated R1's immediate intervention was R1 was sent to the ER and returned on 8/20/21, "there was nothing new put into place" after discovery that R1 had a hand fracture. Referring to two falls on 8/23/21, the first one R1 had got outside and fell in the grass with an immediate intervention of R1 being sent to the ER for further evaluation and upon return was found on the floor in his room. RN-A stated "nothing new for interventions. IDT meeting regards to both elopement and fall was a stop sign was placed in room, call light was switched to a flat button. It's a touch pad for when he rolls." At this time, RN-A and surveyor went to R1's room to look at the flat button call light. RN-A stated "I have not seen one like it, it is new to myself and I am not sure if they [staff] have used it before. It is not an alarm or anything like that." RN-A correctly placed call light which appeared to be the shape of a teepee on top of R1's mattress and the button of the call light was to be placed on the side closest to the resident, not hanging off the bed and upside down like previously observed. RN-A stated she was not sure if the staff have been trained on how to properly place the flat button call light.

During interview on 8/27/21, at 11:13 a.m. with the Director of Nursing (DON) when asked what the facility procedure was for a fall, the DON stated staff "should check the room, check the situation wherever they fall to make sure nothing is out of place. Assess the situation and resident and put a new intervention if there is a new one. There is not always a new intervention, there is only so much you can do. Sometimes all you can

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	00477	A. BUILDING: _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICE	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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do is reeducate." Further, DON indicate IDT meet the next business day "review it [fall] again and determine a root cause, if we [staff] determine one, address that issue and go from there and care plan it." When going through R1's 11 falls since admission, DON stated "we are doing the IDT and we are doing the things like basic root cause analysis, but we are not documenting it. But it should absolutely be on the care plan and it should be documented in IDT." DON also confirmed the same information as RN-A had. In addition, DON stated staff were expected "to check on [R1] more frequently and think outside of the box if they can't think of a new intervention after a fall. If they [staff] can't think of a new intervention, then more frequent checks and remind him to use the fall light if there is a fall with injury they call the directors otherwise we review it in IDT." Further, DON stated after the fall on 8/23/21, a flat call light was placed because "he would be more likely to slap than squeeze. We trained staff on the call light. I understand NA-B said it was a bed alarm. I am not sure if [staff] have used this call light here before. Not all staff were educated on the call light." At approximately 2:38 p.m. DON stated R1's "cognition is not good. I don't think he [R1] would be able to use his call light consistently. I think for the most part he knew what it was for, but I can't say that 100 percent of the time he would use it if he needed to. I think it's important to keep trying so it become engrained, and they understand that."

On 8/27/21, at 3:21 p.m. administrator stated, "after a fall we [staff] get together a root cause analysis and put interventions during IDT and keep putting interventions in place if the family agrees to the interventions." Further, administrator stated, "it is hard to determine the root cause with dementia." Administrator stated

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2 830	Continued From page 14 R1's "BIMS [brief interview for mental status] was low but he was still able to say what he needed and what he wanted. [R1] is able to use a call light. We [staff] were rounding on him frequently because he would not know he put on the call light and that is why he has a touch pad call light. We trained staff to the call light however, the older staff thought it was an alarm pad because they look very similar. Every single nursing staff that worked from my understanding was aware. He moved from one unit to the other to have better eye on him and I am unsure if all staff were cross trained in that form." On 8/30/21, at 4:52 p.m. Administrator provided surveyor with a toileting program R1 started on day of admission 7/21/21, "to determine how often they [residents] go to the bathroom." However, the information did not affect R1's falls and no interventions were added from the results of the toileting program. Administrator also provided surveyor with results of R1's sleep watch which determined R1 was not sleeping much. Administrator stated, "we tried to adjust his bedtime and no napping during the day trying to get the restful sleep to prevent falls but none of it worked." However, that had not been communicated to the rest of the staff and was not in R1's record. Review of facility policy titled Fall Prevention Program Policy dated 6/1/21, indicated if a resident is determined a high risk the resident will be placed on the facility's fall prevention program. In addition, residents will be provided interventions that address unique risk factor measured by the risk assessment tool: medications psychological, cognitive status, or recent change in functional status. As well as provide additional interventions as directed by the	2 830		

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2 830	Continued From page 15 resident's assessment. Further review of policy, "each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care: interventions will be monitored for effectiveness, and the plan of care will be revised as needed." In addition, "when any resident experiences a fall, the facility will assess the resident, complete a post fall assessment, complete an incident report, notify physician and family, review the resident's care plan and update as indicated, document all assessments and actions and obtain witness statements in the care of injury." The IJ which began on 8/17/21, was removed on 8/31/21, at 5:06 p.m. after the facility successfully implemented a removal plan which included the following: -R1's care plan was revised for at risk for falls with a new intervention that included "the facility will collaborate with family to provide 1-1 supervision. the facility will re-evaluate the 1-1 status upon readmission to facility after comprehensive assessments are completed." -IDT completed a root cause analysis for all 11 of R1's falls. -Education was provided to staff related to resident who have a BIMS score of 12 or lower and a list of examples provided to staff that would be appropriate interventions to implement after a fall. -Education provided to all licensed nursing staff on resident fall prevention program/protocol. 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	2 830		

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2 830	Continued From page 16 policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		