Electronically delivered
March 16, 2021

Administrator
Fair Meadow Nursing Home
300 Garfield Avenue Southeast
Fertile, MN 56540

RE: CCN: 245545
Cycle Start Date: March 2, 2021

Dear Administrator:

On March 2, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 2, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 2, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	C 03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	**300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540**

(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 3/1/21, through 3/3/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5545008C (MN70250) with deficiency cited at F689 H5545009C (MN63160) H5545010C (MN55991, MN56001) H5545011C (MN62578) H5545014C (MN56737) H5545012C (MN57907) H5545013C (MN56607) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=D	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	F 689	DON and nursing team reviewed policies	3/30/21

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

Electronically Signed | 03/17/2021

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F 689	Continued From page 1 review the facility failed to implement assessed interventions used to reduce the risk for falls for 1 of 6 (R7) residents reviewed for falls. Findings include: R7's quarterly Minimum Data Set (MDS) dated 11/11/20, identified R1 had severe cognitive impairment and required assistance with transfers, toileting, bed mobility and locomotion on/off the unit. R7's diagnoses included repeated falls, dementia, anxiety disorder, generalized weakness, syncope and collapse (diagnosis with symptoms of dizziness and collapsing). Further, R7 had two or more falls since the last assessment period dated 8/26/20, which included one fall with injury. Further, R7 was receiving medications for anxiety and depression. R7's Fall Risk Assessment dated 2/10/21, identified R7 had a history of three or more falls in the past three months, was chair bound, had balance problems while standing and walking, and had jerking movements or was unstable when making turns. R7's care plan, reviewed on 2/18/21, identified R7 was at risk for falls related to repeated falls prior to and since admit, had an unsteady gait, attempted to self-transfer, did not remember to use the call light for assistance and received high risk medications. Interventions included: ensure R7 was wearing non-skid socks and shoes when walking or mobilizing in wheelchair; sensor pad alarm on bed, on recliner in room and on wheelchair; and tab alarm in recliner chair at the front nurse's station. R7's facility Fall Reports indicated R7 had 11 falls	F 689	and procedures related to falls and resident supervision to assure proper assessment and interventions are being implemented. DON and nursing team reviewed R7's care plan and fall interventions. The tab alarm was removed from the recliner at the front desk. Staff were instructed that R7 should not be placed in the recliner in the evenings when staff are not present. A new, wider, low bed was put in R7's room to encourage her to sleep in her bed. Essential oils will be used at bedtime to promote relaxation and sleep. Care plan updated. All nursing staff will be re-educated on fall policy, interventions, and the importance of following the care plan. Staff meeting is scheduled for March 30. Random shift audits for monitoring consistent intervention implementation will be completed by DON or designee 3x/wk for 1 month, then 2x/wk for 2 weeks, and then 1x/wk for 1 week. QAA was made aware of the deficiency. The audit results will be brought to QAA for input on need to increase, decrease or discontinue audits based on findings. RN's performed fall assessments on those at risk for falls and the DON, primary RN's and IDT reviewed care plans for those residents. A "Fall log" addressing time of fall, location of fall, interventions in place, and root cause analysis was started and reviewed qd at morning IDT meeting. Every fall is	

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F 689	Continued From page 2 from 9/9/20, through 2/20/21. The facility identified two falls where R7's care plan was not being followed to reduce the risk of falls. On 11/1/20, R7 was found on the floor next to her bed and the sensor pad was found unplugged. On 2/20/21, R7 was found on the floor in her room next to her recliner and after investigation the facility determined that R7's chair sensor pad was not placed under resident. During observation on 3/3/21, at 11:15 a.m. R7 was seated in the recliner near the front nurses station, in a reclined position. The chair tab alarm was attached to upper left corner of the recliner with the clip end dangling down towards floor and not connected to R7. -At 1:41 p.m. R7 was seated in her wheelchair next to the recliner near the nurses station. R7's chair pad sensor was on the seat of the recliner. Activity aide (AA)-A assisted R7 into the recliner and proceeded to place R7 in a reclined position. The tab alarm was dangling from the left side of the recliner and was not attached to resident. -At 1:46 p.m. R7 continued to sit in same recliner near the nurse's station with the tab alarm still hanging from the left side of the chair and still not clipped to R7. Staff were not near the nurse's station where R7 was seated. On 3/3/21, at 11:15 a.m. trained medication assistant (TMA)-A stated R7 used a chair alarm pad when seated in the recliner in her room and when she was in her wheelchair. R7 usually had a tab alarm clipped to her while seated in the recliner near the nurses station, and was uncertain why or who placed R7 on the chair alarm pad and didn't clip the tab alarm to her.	F 689	recorded and evaluated for any patterns for effectiveness of interventions in place. Individualized care plans updated to reflect any changes. In addition, for future monitoring, prior to ARD, IDT will meet and review care plans and interventions quarterly. The random audits mentioned above are completed on all residents at risk for falls, not just R7. Compliance monitored by DON and primary RN.	

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F 689	Continued From page 3	F 689		

Further, R7 was observed by staff when she was seated in the recliner at the nurses station and the alarms were used to alert staff that a resident was moving and not to prevent falls. At 11:15 a.m. staff were not present near the nurses station where R7 was seated, to intervene if R7 attempted to self transfer.

During interview on 3/3/21, at 1:52 p.m. AA-A stated when R7 was left unattended in their room or while seated in the recliner near the nurses station R7 would at times become antsy, scoot forward and attempt to transfer themselves. R7's increased activity was random and AA-A not aware of how frequently R7 made attempts to self transfer. Further, staff should attach the tab alarm to R7 when she was seated in the recliner at the nurses station to alert staff of R7's movement.

When interviewed on 3/3/21, at 2:43 p.m. the director of nursing (DON) stated R7 was admitted to the facility for frequent falls and had multiple falls since admission. Staff were identified in the past to not follow the care plans and the DON did not know why the staff were not following the care plan. She had tried to re-educate staff on the importance of following the care plans. This worked for a while and then staff would fall back into their old ways. The charge nurses were responsible to ensure the staff on their shift were following the care plan, and ultimately, the DON was responsible to ensure staff were following the care plan.

The facilities Facility Accident Prevention - Fall Risk Assessment policy and procedure, reviewed 1/16/20, indicated licensed nursing staff were responsible for identifying each at risk resident for accidents and/or falls and implementation of

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F 689	Continued From page 4 interventions to prevent accidents.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2021

Administrator
Fair Meadow Nursing Home
300 Garfield Avenue Southeast
Fertile, MN 56540

Re: State Nursing Home Licensing Orders
Event ID: TXFW11

Dear Administrator:

The above facility was surveyed on March 2, 2021 through March 2, 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:

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

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
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
	00460	A. BUILDING: _____ B. WING _____	C 03/02/2021

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FAIR MEADOW NURSING HOME	**300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540**

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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 3/1/210, through 3/3/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID	

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5545008C (MN70250) with state licensing order issued at MN Rule 4658.0520 Subp. 1 0830 H5545009C (MN63160) H5545010C (MN55991, MN56001) H5545011C (MN62578) H5545014C (MN56737) H5545012C (MN57907) H5545013C (MN56607) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to 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	2 000	Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
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 implement assessed interventions used to reduce the risk for falls for 1 of 6 (R7) residents reviewed for falls. Findings include:	2 830	Corrected.	3/30/21

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	00460	A. BUILDING: _____ B. WING _____	C 03/02/2021

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FAIR MEADOW NURSING HOME	300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540

(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) COMPLETE DATE
2 830	Continued From page 3 R7's quarterly Minimum Data Set (MDS) dated 11/11/20, identified R1 had severe cognitive impairment and required assistance with transfers, toileting, bed mobility and locomotion on/off the unit. R7's diagnoses included repeated falls, dementia, anxiety disorder, generalized weakness, syncope and collapse (diagnosis with symptoms of dizziness and collapsing). Further, R7 had two or more falls since the last assessment period dated 8/26/20, which included one fall with injury. Further, R7 was receiving medications for anxiety and depression. R7's Fall Risk Assessment dated 2/10/21, identified R7 had a history of three or more falls in the past three months, was chair bound, had balance problems while standing and walking, and had jerking movements or was unstable when making turns. R7's care plan, reviewed on 2/18/21, identified R7 was at risk for falls related to repeated falls prior to and since admit, had an unsteady gait, attempted to self-transfer, did not remember to use the call light for assistance and received high risk medications. Interventions included: ensure R7 was wearing non-skid socks and shoes when walking or mobilizing in wheelchair; sensor pad alarm on bed, on recliner in room and on wheelchair; and tab alarm in recliner chair at the front nurse's station. R7's facility Fall Reports indicated R7 had 11 falls from 9/9/20, through 2/20/21. The facility identified two falls where R7's care plan was not being followed to reduce the risk of falls. On 11/1/20, R7 was found on the floor next to her bed and the sensor pad was found unplugged. On 2/20/21, R7 was found on the floor in her	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 room next to her recliner and after investigation the facility determined that R7's chair sensor pad was not placed under resident. During observation on 3/3/21, at 11:15 a.m. R7 was seated in the recliner near the front nurses station, in a reclined position. The chair tab alarm was attached to upper left corner of the recliner with the clip end dangling down towards floor and not connected to R7. -At 1:41 p.m. R7 was seated in her wheelchair next to the recliner near the nurses station. R7's chair pad sensor was on the seat of the recliner. Activity aide (AA)-A assisted R7 into the recliner and proceeded to place R7 in a reclined position. The tab alarm was dangling from the left side of the recliner and was not attached to resident. -At 1:46 p.m. R7 continued to sit in same recliner near the nurse's station with the tab alarm still hanging from the left side of the chair and still not clipped to R7. Staff were not near the nurse's station where R7 was seated. On 3/3/21, at 11:15 a.m. trained medication assistant (TMA)-A stated R7 used a chair alarm pad when seated in the recliner in her room and when she was in her wheelchair. R7 usually had a tab alarm clipped to her while seated in the recliner near the nurses station, and was uncertain why or who placed R7 on the chair alarm pad and didn't clip the tab alarm to her. Further, R7 was observed by staff when she was seated in the recliner at the nurses station and the alarms were used to alert staff that a resident was moving and not to prevent falls. At 11:15 a.m. staff were not present near the nurses station where R7 was seated, to intervene if R7 attempted to self transfer.	2 830		

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2 830	Continued From page 5 During interview on 3/3/21, at 1:52 p.m. AA-A stated when R7 was left unattended in their room or while seated in the recliner near the nurses station R7 would at times become antsy, scoot forward and attempt to transfer themselves. R7's increased activity was random and AA-A not aware of how frequently R7 made attempts to self transfer. Further, staff should attach the tab alarm to R7 when she was seated in the recliner at the nurses station to alert staff of R7's movement. When interviewed on 3/3/21, at 2:43 p.m. the director of nursing (DON) stated R7 was admitted to the facility for frequent falls and had multiple falls since admission. Staff were identified in the past to not follow the care plans and the DON did not know why the staff were not following the care plan. She had tried to re-educate staff on the importance of following the care plans. This worked for a while and then staff would fall back into their old ways. The charge nurses were responsible to ensure the staff on their shift were following the care plan, and ultimately, the DON was responsible to ensure staff were following the care plan. The facilities Facility Accident Prevention - Fall Risk Assessment policy and procedure, reviewed 1/16/20, indicated licensed nursing staff were responsible for identifying each at risk resident for accidents and/or falls and implementation of interventions to prevent accidents. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the	2 830		

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2 830	Continued From page 6 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		