Electronically delivered
December 1, 2021

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

RE: CCN: 245560
Cycle Start Date: November 10, 2021

Dear Administrator:

On November 10, 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 actual harm that was not immediate jeopardy (Level G), 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 February 10, 2022 (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 May 10, 2022 (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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
December 1, 2021

Administrator
Edgebrook Care Center
505 Trosky Road West
Edgerton, MN 56128

Re: State Nursing Home Licensing Orders
Event ID: BQCI11

Dear Administrator:

The above facility was surveyed on November 9, 2021 through November 10, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00454	A. BUILDING: _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEBROOK CARE CENTER	505 TROSKY ROAD WEST EDGERTON, MN 56128

(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
2 000	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 11/9/21 through 11/10/21, 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 these orders and identify the date when they will be completed.	2 000		

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

Electronically Signed | 12/09/21

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2 000	Continued From page 1 The following complaints was found to be SUBSTANTIATED: H5560021C (MN78281), H5560022C (MN76617), H5560023C (MN76616) and H5560024C (MN76131), with a licensing order issued at 830. The following complaint was also found to be SUBSTANTIATED: H5560020C (MN78236) however, NO licensing orders were issued due to actions implemented by the facility prior to the survey. 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 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	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
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 provide adequate supervision for 1 of 1 resident (R5), who was left	2 830	Corrected	12/10/21

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2 830	Continued From page 3 unsupervised and fell after attempting to stand, resulting in actual harm to R5 when R5 suffered a neck fracture as a result of the fall. Findings include: Review of the 8/24/21 at 9:28 p.m., report to the State Agency (SA) identified R5 was left in the dining room unattended following the supper meal on 8/24/21 at 6:44 p.m. and experienced a fall. A large hematoma was noted on the right side of R5's forehead on assessment. R5 was sent to the local emergency room where it was discovered she had a neck fracture. R5's recent significant change Minimum Data Set (MDS), dated 9/2/21, identified R5 had severe cognitive impairment, verbal and physical behaviors directed toward others, and rejection of care with diagnoses of osteoporosis, generalized weakness, anxiety disorder, and difficulty walking. R5 required extensive assistance with bed mobility, transfers, locomotion on/off unit, dressing, eating, toileting and personal hygiene. The Care Area Assessment (CAA) identified R5 had falls secondary to impaired gait and mobility and the level of assistance required with transfers. R5 had a history of falls, weakness and physical performance limitations affecting balance, gait, strength and muscle endurance. R5's current, undated care plan identified she was at risk for falls. R5 was known to bend forward to pick up items from the floor and needed to be reminded to use a grabber device. R5 had a terminal diagnosis of Alzheimer's disease with decline in Activities of Daily Living (ADLs, and increased irritability and combativeness. The care plan failed to identify the need for increased supervision due to	2 830		

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2 830	Continued From page 4 unsteadiness and risk for falls. R5's 8/24/21 at 9:04 p.m., progress note identified R5 was found on the floor in the dining room at 6:44 p.m. with a 5 centimeter (CM) bruise located on the right side of her forehead. R5 was upset and yelling but due to extent of dementia, staff were not able to get accurate information. R5 did report her neck and head hurt. Staff noted R5 had poor-safety awareness and often would get up on her own and had poor balance. Interview and video footage review on 11/10/21 at 1:53 p.m., with the administrator of the incident on 8/24/21, at 6:44 p.m. R5 was observed in her wheelchair as she moved herself around tables in the dining room. No staff were observed in the dining room during this time and all tables had been cleared. R5 bent forward at the waist and raised the left foot pedal while holding onto the arm of her chair, sat back upright and then bent forward and rocked back and forth and slowly stood up. R5 took a couple of steps forward, turned to the right and fell face forward onto the floor beside the table. The table blocked view of how R5 landed or if she struck any objects as she fell. The administrator stated staff noted R5 had refused to leave the dining room following the supper meal. Staff left R5 unattended in the dining room to assist other residents. At the time of the fall, R5 did not have a pressure alarm on her wheelchair (w/c) which would have alerted staff of an attempt to self transfer. The administrator was not certain how long it was before staff responded, as staff reported they heard R5 yelling for help to get up. The administrator confirmed R5 should have been supervised for safety and placed in an area where staff would have been able to monitor her activities.	2 830		

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2 830	Continued From page 5 Review of the 6/24/20, Fall Prevention and Management policy identified after a fall, a root cause analysis was to be performed to identify solutions to be put into place. Staff were to communicate a fall had occurred during stand-up and shift change, report to the SA, and monitor for effectiveness of interventions. There was no mention of a review to ensure appropriate supervision was in place or education to staff was to occur when it was discovered staff failed to appropriately supervise a resident. R5's physician wasn't available for interview at the time of the survey. SUGGESTED METHOD OF CORRECTION: The DON or designee should review all residents at risk for falls, ensure appropriate measure are care planned and those interventions followed. The DON or designee could ensure all staff are educated on policies and procedures to keep residents safe including providing appropriate supervision. The DON or designee should have measurable audits to ensure residents recieve appropriate care, services and supervision. Results of those audits should go to the Quality Assurance Performance Improvement (QAPI) to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	2 830		

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	245560	A. BUILDING _____ B. WING _____	C 11/10/2021

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F 000	INITIAL COMMENTS On 11/9/21 through 11/10/21, 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 was found to be SUBSTANTIATED: H5560021C (MN78281), H5560022C (MN76617), H5560023C (MN76616) and H5560024C (MN76131), with a deficiency cited at F689. The following complaint was also found to be SUBSTANTIATED: H5560020C (MN78236) however NO deficiencies were cited due to actions implemented by the facility prior to survey. 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. 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=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/10/21

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

Electronically Signed | 12/09/2021

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

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F 689	Continued From page 1 §483.25(d)(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 provide adequate supervision for 1 of 1 resident (R5), who was left unsupervised and fell after attempting to stand, resulting in actual harm to R5 when R5 suffered a neck fracture as a result of the fall. Findings include: Review of the 8/24/21 at 9:28 p.m., report to the State Agency (SA) identified R5 was left in the dining room unattended following the supper meal on 8/24/21 at 6:44 p.m. and experienced a fall. A large hematoma was noted on the right side of R5's forehead on assessment. R5 was sent to the local emergency room where it was discovered she had a neck fracture. R5's recent significant change Minimum Data Set (MDS), dated 9/2/21, identified R5 had severe cognitive impairment, verbal and physical behaviors directed toward others, and rejection of care with diagnoses of osteoporosis, generalized weakness, anxiety disorder, and difficulty walking. R5 required extensive assistance with bed mobility, transfers, locomotion on/off unit, dressing, eating, toileting and personal hygiene. The Care Area Assessment (CAA) identified R5 had falls secondary to impaired gait and mobility and the level of assistance required with transfers. R5 had a history of falls, weakness and physical performance limitations affecting balance, gait, strength and muscle endurance.	F 689	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. R5's direct care staff were immediately reeducated by DON or designee on providing adequate supervision to all residents within the dining room. The care plan is updated to include when R5 does not wish to leave the dining room than 15 minutes checks are implemented until R5 wishes to relocate. 2. All residents with a history of attempting to self-transfer in the dining room were reviewed to ensure appropriate interventions are reviewed and in place. 3. To ensure systemic changes all staff involved will be reeducated by the DNS or	

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EDGEBROOK CARE CENTER	**505 TROSKY ROAD WEST EDGERTON, MN 56128**

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F 689	Continued From page 2 R5's current, undated care plan identified she was at risk for falls. R5 was known to bend forward to pick up items from the floor and needed to be reminded to use a grabber device. R5 had a terminal diagnosis of Alzheimer's disease with decline in Activities of Daily Living (ADLs), and increased irritability and combativeness. The care plan failed to identify the need for increased supervision due to unsteadiness and risk for falls. R5's 8/24/21 at 9:04 p.m., progress note identified R5 was found on the floor in the dining room at 6:44 p.m. with a 5 centimeter (CM) bruise located on the right side of her forehead. R5 was upset and yelling but due to extent of dementia, staff were not able to get accurate information. R5 did report her neck and head hurt. Staff noted R5 had poor-safety awareness and often would get up on her own and had poor balance. Interview and video footage review of the incident on 8/24/21, at 6:44 p.m. was conducted on 11/10/21 at 1:53 p.m., with the administrator present. R5 was observed in her wheelchair as she moved herself around tables in the dining room. No staff were observed in the dining room during this time and all tables had been cleared. R5 bent forward at the waist and raised the left foot pedal while holding onto the arm of her chair, sat back upright and then bent forward and rocked back and forth and slowly stood up. R5 took a couple of steps forward, turned to the right and fell face forward onto the floor beside the table. The table blocked view of how R5 landed or if she struck any objects as she fell. The administrator stated staff noted R5 had refused to leave the dining room following the supper meal. Staff left R5 unattended in the dining room to	F 689	designee on 12/8/2021 on how to monitor residents at risk of self-transferring when they wish to remain in the dining room after meals or activities have ended. Staff will refer to the Kardex/Care plan to ensure they know the interventions to be implemented for this resident and any others that are at risk of attempting self-transfer when not supervised. 4. Observation audits will be conducted by the Quality Assurance Coordinator or designee for (R5) and (2) other random residents for resident supervision in the dining room. Audits will be done weekly x 4 and every other week x 2 and monthly x 1. Audit results will be brought to the monthly QA meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Completion date: December 9, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245560	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 3 assist other residents. At the time of the fall, R5 did not have a pressure alarm on her wheelchair (w/c) which would have alerted staff of an attempt to self transfer. The administrator was not certain how long it was before staff responded, as staff reported they heard R5 yelling for help to get up. The administrator confirmed R5 should have been supervised for safety and placed in an area where staff would have been able to monitor her activities. Review of the 6/24/20, Fall Prevention and Management policy identified after a fall, a root cause analysis was to be performed to identify solutions to be put into place. Staff were to communicate a fall had occurred during stand-up and shift change, report to the SA, and monitor for effectiveness of interventions. There was no mention of a review to ensure appropriate supervision was in place or education to staff was to occur when it was discovered staff failed to appropriately supervise a resident. R5's physician wasn't available for interview at the time of the survey.	F 689		