Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 17, 2024

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: August 6, 2024

Dear Administrator:

On August 26, 2024, we notified you a remedy was imposed. On September 9, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 6, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 10, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 26, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 6, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 6, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2024

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: Reinspection Results
Event ID: UYGR12

Dear Administrator:

On September 9, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 26, 2024

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: August 6, 2024

Dear Administrator:

On August 6, 2024, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 3, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 10, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 10, 2024 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 10, 2024, (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 $12,924; 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 6, 2024. 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, Good Samaritan Society - Mary Jane Brown is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 6, 2024. 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" and/ or "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 February 6, 2025 (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:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding

this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2024

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: State Nursing Home Licensing Orders
Event ID: UYGR11

Dear Administrator:

The above facility was surveyed on August 1, 2024 through August 6, 2024 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING ______ B. WING ______	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

(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 8/1/24, 8/2/24, and 8/6/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 7/27/24, when the facility failed to comprehensively assess R1's falls for root cause annalysis and put interventions in place. The administrator and director of nursing (DON) were notified of the IJ on 8/6/24 at 1:50 pm. The IJ was removed on 8/3/24 at 12:00 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 8/6/24. The following complaints were reviewed: H55686422C (MN00105310) with a deficiency cited at F689 and F690. 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	Free of Accident Hazards/Supervision/Devices	F 689		9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/03/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

(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 SS=J	Continued From page 1 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 compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury 2 of 2 residents (R2 and R3) with history of falls. This resulted in immediate jeopardy (IJ) for R2 who sustained multiple left rib fractures, left clavicle fracture and a subdural hematoma (brain bleed). The IJ began on 7/27/24 when staff failed to implement R2's care plan for close supervision resulting in R2's fifth (5th) unwitnessed fall, major head injury, and intensive care unit (ICU) admission. The administrator, regional nurse manager, and director of nursing (DON) were notified of the IJ on 8/2/24 at 3:00 p.m. The IJ was removed on 8/3/24 at 12:00 p.m., when the facility had implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings included:	F 689	R2 and R3 are no longer resident in our facility. All residents at high risk of falls have the potential to be affected by the deficient practice. All residents were re-assessed for high risk of falls. Care plans updated if warranted based on a new Falls Tool being completed. All Licensed Nursing staff were educated by DNS and Clinical Learning and Development Specialist prior to their next working shift on how to assess falls for root cause analysis and to implement an appropriate intervention by reviewing our policy and Procedure. All nursing staff were educated prior to their next working shift on the need to follow the care plan to prevent falls with major injury. Audits will be completed by DNS or Designee on 3 falls per week if applicable, if applicable, to ensure a root cause	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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F 689	Continued From page 2 R2's admission Minimum Data Set (MDS) dated 7/15/24, identified R2 did not have cognitive impairment and had diagnoses of hip fracture, other fracture, osteoporosis, and dementia. R2 had a history of falls prior to admission to the facility and two falls with injury since admission on 7/1/24. R2 had functional range of motion impairment on one upper and lower extremity. R1 used a walker and wheelchair. R2 required partial to substantial assistant for all his activities of daily living (ADLs) and required moderate assist for transfers and did not walk more than 10 feet. R2 was frequently incontinent of bowel and bladder and did not have a toileting plan. Review of R2's Fall Tool admission assessment dated 7/2/24, R2 was at medium risk for falls. R2 had history of one or more falls in the last three months, was taking medications that put him at risk, and mildly impaired cognition status. R2 risk factor for falls included mobility/transfers due to changes in mobility related to muscles weakness or strength, impaired balance or coordination and pain. Although R2 had mild cognition he had reduced insight, difficulties in orientation on new admission, medical problems which affected changes in his orientation/level of consciousness and was incontinent. R2 was referred to therapy and care plan was updated. R2's care plan dated 7/2/24, included an ADL focus that indicated R2 had a deficit related to recent hip surgery with interventions that directed to use one staff assistance with pivot/transfers. Fall focus identified R2 had an actual fall on 7/1/24 (sic) and was at risk for falls related to falls prior to hospitalization with the intervention that directed staff to ensure R2 was wearing appropriate footwear when ambulating or	F 689	analysis was completed, appropriate intervention were added, and the care plan was followed. Data will be reviewed for at least 3 months at QAPI or until the QAPI committee has determined compliance has been sustained. September 6th, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING ______ B. WING ______	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

(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 3 mobilizing in wheelchair. The care plan also identified R2's preferred wake time was 5:00 a.m. and his bedtime was 10:00 p.m. The care plan did not identify a toileting routine or program even though R2 was frequently incontinent of urine. R2's late entry progress note dated 7/3/24 at 11:42 a.m., indicated R2 was heard yelling from hallway. R2 was found lying across the bedside table legs, R2's head was facing the door and head at the foot of the bed and nightstand. Water pitcher and water spilled on the floor. R2 did not have shoes on. Skin tear noted to left elbow with complaints of pain in left shoulder, unable to abduct without pain or calling out. Pillow placed under head and removed bedside stand from under body. Vital signs obtained and transfer to emergency department (ED) initiated. Ambulance arrived at 8:10 a.m. and left 8:15 a.m. Progress note at 11:20 a.m. indicated the hospital ED called the facility to notify R2 had fractured his left scapula and several ribs on the left side. R2's Fall Huddle Sheet dated 7/3/24 at 7:50 a.m., identified the fall with the additional information of- R2 was ambulating and attempting to self-transfer, slipped and lost his balance. R2's bed was higher than it should have been and R2 had bare feet. Last toileted at 1:43 a.m. six hours before R2's fall. R2's incident report dated 7/3/24 at 7:50 a.m., included the fall information identified in the progress note and Fall Huddle with the following additional information: R2 had on brief and t-shirt, R2 recently had right hip replacement, which he was able to move appropriately, and R2 stated that he was getting up to go take a shower initially and then later thought he was in the copy/print	F 689		

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room at his newspaper job in Colorado.

R2's records did not include a comprehensive fall analysis for root cause and interventions that identified risk factors from the incident and huddle reports such as (but not limited) to the bed height, self-transfers/impulsivity, and duration of time documented between toileting.

R2's progress note dated 7/9/24, identified R2 returned from the hospital and his care plan was updated with interventions to reduce the risk for falls.

R2's care plan was revised on 7/8/24 to reflect the following interventions, educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance.

R2's care plan was revised on 7/9/24 to reflect the following interventions: Make sure resident wears glasses when up/out of bed; Keep urinal within reach, check and empty frequently (frequency was not defined); Fall mat placed on floor next to bed; signs placed in room to remind R2 to use call light and wait for assistance. Staff to ask for OT to evaluate room arrangement and will trial non-spill cup that R2 can keep in bed with him. New focuses added included: R2 had sleep disturbance evidenced by complaints of feeling tired, change in ability to perform ADLs, and change in gait/falls with interventions that included follow R2's usual bedtime routine. New focus of R2 had behavior symptoms evidenced by impulsiveness and lack of safety awareness with interventions that included praise any indication of R2's progress/improvement in behavior and prefers the diversional activity of

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F 689	Continued From page 5 ready books. Review of R2's record between 7/9/24 to 7/22/24, did not indicate OT had completed an evaluation of R2's room arrangement. R2's progress note dated 7/10/24 at 7:00 p.m., identified background, assessment, and recommendation (SBAR) was sent to physician indicating R2 had fallen when he went to stand up. Was wearing appropriate footwear and had call light and personal items within reach. At 7:25 p.m. R2 was sent to the ED via ambulance. R2 had head computer tomography (CT) without evidence of injury or bleed and laceration on right side of forehead. R2's Fall Huddle Sheet dated 7/10/24 at 7:00 p.m., identified the fall information and included the additional information of- fall was unwitnessed. R2 reported he was trying to stand up to empty his urinal and lost his balance. Causal factors included the bed/chair height was not appropriate and R2 does not ask for assistance. R2's incident report dated 7/10/24 at 7:00 p.m., identified the aforementioned fall information from the Fall Huddle and progress notes. Additional information included: Urinal was of dresser and only 1/3 full; R2 seemed confused on where he was and what he was doing; impaired memory and lack of safety awareness put him at increased risk for falls. The incident report was updated on 7/15/24 included "Have been constantly reminding resident to wait for assistance, and this has been helping." R2's records did not identify a comprehensive fall	F 689		

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analysis for root cause that addressed risk factors identified on the incident and huddle reports such as (but not limited to) height of the bed, urinal usage, and self-transfers/impulsivity.

R2's ED notes dated 7/10/24, identified R2 presented after a fall with a laceration to his scalp that was 2 centimeters (cm) on his right forehead near the hairline that required sutures. "We recommend tabs alarm [a device that alarms audibly or silently (i.e. box at nursing desk) with movement of resident from a surface such as a bed or chair] or closer supervision to prevent falls."

R2's progress note dated 7/10/24 at 10:26 p.m. indicated director of nursing (DON) had concerns with R2 returning to the facility. "DON informed them [hospital] that nursing home unable to provide 1:1 supervision with resident d/t [do to] staffing and TABS are not appropriate in this setting. MD stated no medical reason for hospitalization, R2 would be returning to facility."

R2's progress note dated 7/10/24 at 11:30 p.m. indicated R2 arrived back to the facility from ED with no acute pathology and received orders for TABS alarm at all times if possible or supervision. "DON explained that TABS alarms are not used at the facility d/t it being considered a restraint ...actually create a fall ..." Facility to provide increased supervisor of resident by having resident in recliner chair out by nurse's station so his safety can be closely monitored by staff.

R2's care plan was revised on 7/11/24, to include Ensure/provide a safe environment: avoid isolation and place resident by chair by nurse's station to offer closer supervision as ordered by

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the physician.

R2's record did not identify an assessment that determined and/or defined frequency of checks/supervision R2 required based on his risk factors, mannerisms, and behaviors. Furthermore, there was no indication the medically recommended device (tabs) based on a physician's evaluation to prevent R2 falls was comprehensively assessed by the facility prior to the determining the device would not be effective.

Review of R2's record between 7/11/24 to 7/29/24, there was no indication R2's care plan interventions that directed staff to provide "closer supervision" and placing R2 by the nurse's stations were implemented and/or evaluated for effectiveness.

R2's progress note dated 7/14/24 at 3:00 p.m., indicated R2 had an unwitnessed fall in his room. Staff found R2 on the floor with head on dresser and feet towards bed. Staff assisted R2 to wheelchair and out to lounge area. R2 stated he wanted to go to the basement. R2 noted to transfer self during morning shift to bathroom and to recliner after dinner. R2 was asked if attempted to ambulate self and replied "yes, because I don't need any help."

Review of R2's Fall Huddle Sheet dated 7/14/24 at 3:00 p.m. identified the fall information with the additional information of- causal factors included R2 "gets more confused @ night" Corrective actions taken: Resident education/training or re-instruction. No care plan interventions were identified.

R2's incident report dated 7/14/24 at 3:00 p.m.,

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identified the fall information. Additional information included-Resident alert and orientated x 3 during the day but as time gets later, he gets more confused. The report was updated on 7/15/24 to include, the interdisciplinary team (IDT) reviewed Incident: Intervention will be to put a sign in his room. Resident loves to read, so we are thinking this will be a better intervention that constant telling him to "Wait for help"

In review of R2's records identified a comprehensive fall analysis for root cause and interventions was not completed that addressed risk factors included on the incident and huddle reports such as (but not limited to) even though the reports identified R2 had increased confusion at night, the intervention for closer supervision was not individualized and/or assessed to address that risk factor. Additionally, not evident the care plan was revised to include signage intervention.

R2's progress note dated 7/16/24 at 2:45 a.m., staff was going down hallway and noticed R2's door closed, stopped to open, and found R2 lying on the floor stretched out next to his bedside. Had a smile on his face and denied any new pain. R2 states he slipped off the edge of his bed. R2 was assisted off the floor. Bed was lowered to lowest position and fall mat applied to floor at bedside. Call light within reach.

Review of R2's Fall Huddle Sheet dated 7/16/24 3:19 a.m., identified fall information in addition to R2 stated he fell while trying to reach his water. Action taken was "water glass in bed no spill cup" No injuries.

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R2's incident report dated 7/16/24 at 3:19 a.m., identified fall information with no other additional information. The report was updated on 7/22/24 to include IDT reviewed Incident: Will attempt to give resident a new cup that won't spill and he can keep closer to himself in bed. Also, will talk to therapy to check out resident's room to see if we can rearrange to make it easier for Resident to navigate (according to the care plan both interventions were supposed to be already in place on 7/9/24).

Review of R2's record lacked a comprehensive analysis of causal factors that included if the intervention of "close supervision" was provided and was evaluated for effectiveness. Further not evident the care plan was revised to reduce R2's risk for falls and/or falls with major injury.

R2's progress note dated 7/27/24 at 6:00 p.m., nursing assistant observed R2 on floor by closet door with head towards his bed. ROM within normal limits, pupils equal and reactive to light, assist with two staff to wheelchair without difficulty and taken to lounge area to watch TV with other residents. Nurse noted a bump to left side of head in which R2 refused an ice pack, also noted a blood blister on left elbow, covered with band aid.

Facility surveillance video footage recorded on 7/27/24 from 5:55 p.m. to 6:19 p.m. was reviewed with the administrator.
-At 5:56 p.m. licensed practical nurse (LPN)-B walked by R2's room. LPN-B looked in the room but did not stop. LPN-B assisted a female resident to her room at the end of the hallway.
-At 5:59 p.m. LPN-B walked back up the hallway and entered R2's room for approximately 15

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F 689	Continued From page 10 seconds and then exits the room without R2. -At 6:09 p.m. NA-P walked down hallway and looked in R2's room, entered the room, and activated the emergency call light. NA-Z and LPN-B walked to and entered R2's room. -At 6:11 p.m., NA-Z left R2's room and walked towards the nursing station. NA-P left the room, got the standing mechanical lift from the other end of the hallway, and brought it back to R2's room along with wheelchair at 6:14 p.m. -At 6:16 p.m., NA-P exited R2's room with the standing lift. -At 6:19 p.m., LPN-K exited the room, looked to be prompting R2 to follow her, R2 self-propelled his wheelchair out of the room toward the nurse's station. Review of R2's Fall Huddle Sheet dated 7/27/24 at 6:00 p.m., R2 had an unwitnessed fall in his room when he was ambulating to bathroom using a device (not specified). Last seen by a staff member around 5:30 p.m. Causal factors included "resident left in room unattended." The form indicated the investigation was completed on 7/29/24. Corrective action taken was documented as the roommate moved to a different room to make R2's room private and staff suspension/terminated. R2's incident report dated 7/27/24 6:00 p.m., identified the fall information. In addition, R2 reported "I was just walking". The form was revised on 7/29/24 to include IDT Team reviewed incident: Noted that Roommates walker was next to him after fall. Intervention: Ensure roommate's walker is out of reach and out of the way to ensure R2 does not attempt to use it. R2's progress notes on 7/29/24 at 8:04 a.m.,	F 689		

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indicated a nurse was called to R2's room. R2 was orientated to self only. The physician and power of attorney were notified. Progress note at 8:16 a.m. indicated an order to send R2 to ED. Progress note at 12:29 p.m. indicated the hospital ED called to notify facility compressions (cardio pulmonary resuscitation) was started.

R2's hospital progress note dated 7/29/24 indicated that R2 was being evaluated for a fall with head injury that occurred 3 days prior and at 8:30 a.m. on 7/29/24, was noted to be more confused and not following commands. R2's last known well time was 11:00 p.m. on 7/28/24. R2 had a head CT that showed 1.) an acute right subdural hematoma over the right vertebral hemisphere which measures up to 10 millimeters (mm) in thickness. A mild localized mass effect without midline shift. 2.) Hemorrhagic contusion most notable in the right temporal lobe, with a smaller hemorrhagic contusion involving the inferior right frontal lobe. 3.) Left parietal scalp trauma without associated skull fracture. During his ER stay R2 was transferred to higher level of care hospital by ground ambulance.

R2's higher level hospital progress note dated 7/29/24, indicated R2 was admitted to the intensive Care Unit (ICU) with diagnoses of traumatic bran injury, sub dural hematoma, temporal contusion, seizure, encephalopathy and hyponatremia. R2 had a repeat head CT upon arrival that agreed with the first hospital but added but added a thin subdural blood product along posterior falx (curved shape) and right tentorial leaflet, up to 1mm. R2 received antiseizure medications.

During interview on 8/6/24 at 11:22, registered

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nurse (RN)-B reported R2 had been discharged from the hospital to a hospice facility however, was not aware of the date he was discharged.

During an interview on 8/1/24 at 1:52 p.m., trained medication assistant (TMA)-A stated R2 had fallen a lot since admission. There was one fall where he fell and broke his shoulder and some ribs. TMA-A stated R2 would attempt to self-transfer and forget to ask for help. TMA-S stated if R2 was in his room staff needed to visualize R2 and make sure he was "OK" or R2 needed to be in the common area by nurses' station, so staff could see him. TMA-A indicated the checks were not documented anywhere.

During an interview on 8/1/24 at 2:33 p.m., NA-B stated R2 had behaviors where he would get up by himself in his room then fall or wander around in his wheelchair. NA-B was not able to articulate R2's fall interventions.

During an interview on 8/2/24 at 11:20 a.m., TMA-D stated R2 was alert and oriented. TMA-D remembered R2 had two falls while she was worker but could not recall the dates of the falls. TM-D explained R2 had slid out of his recliner after he had used the remote to raise the chair up too high. TMA-D could not remember what caused the other fall, but neither fall resulted in injuries. TMA-D could not remember R2's fall interventions.

During an interview on 8/2/24 at 11:25 a.m., NA-J stated R2 would not listen; she would put R2 in his recliner with the reminder to use his call light however a few minutes later she would walk by his room to find R2 attempting to self transfer. NA-J remembered R2 had one fall while she was

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working. NA-J thought R2 was trying to self-transfer from his recliner to his wheelchair and got a "goose egg" on his forehead and a black eye.

During an interview of 8/1/24 at 2:59 p.m., LPN-A stated R2 was a frequent faller, and was to be in the commons area by the nurse' station so staff could supervise him. LPN-A indicated she had been working on evening when R2 fell, LPN-A could not recall the date, she had opened R2's door and found R2 on the floor beside his bed with things under his head, "like he had been there awhile." LPN-A stated R2 did not have any injuries with that fall and she had instructed staff working to leave R2's door open for closer monitoring when he was in bed. LPN-A indicated she had not added the intervention to R2's care plan.

During an interview of 8/1/24 at 3:20 p.m. NA-Z stated R2 was confused and did not use his call light and liked to be independent. NA-Z explained she had been working on 7/27/24, when R2 fall. NA-Z recalled the fall had happened and dinner and staff were busy with other residents. NA-Z had been talking with LPN-B by the dining room hallway when NA-P turned on the emergency call light. NA-Z got to R2's room with LPN-B and R2 had his head against the register under the window and R2's legs were entangled in a walker. NA-Z indicated she was not aware of how or why R2 was in his room unsupervised.

During an interview on 8/2/24 at 8:15 a.m., NA-S stated R2 was impulsive and would not use his call light. According to R2's care plan he was supposed to be out at the nurse's station when he was out of bed, especially after meals. NA-S

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thought staff would forget this because R2 seemed like he was alert. On 7/29/24, NA-S went into get R2 up for the day around 8:00 a.m., and he was not responding like himself. R2 would respond verbally with "yeah" to her questions but would not move. NA-S sent NA-T for the nurse and LPN-K came and brought RN-B. R2 was sent to the local ER and then airlifted to a higher level of care.

During interview on 8/2/24 at 11:51 a.m., LPN-B stated on 7/27/24, she was called to R2's room around 6:10 p.m. via the emergency staff alert. LPN-B entered R2's room and R2 was on the floor by the window and his head was not touching the wall or the floor. LPN-B stated she looked at R2's head and did not see any blood and R2 had answered her questions appropriately. LPN-B was not aware of how or why R2 was in his room alone. LPN-B stated on 7/29/24 at approximately 8:00 a.m., a nursing assistant had notified her R2 was not right. LPN-B went to R2's room, he was lying in bed in the fetal position facing towards the wall. LPN-B indicated she was unable to get R2 to open his eyes and notified RN-B and decided to send R2 to the emergency room for further evaluation.

During an interview on 8/2/24 at 1:44 p.m., RN-B stated she was called to R2's room on 7/29/24 because R2 was not responding per his normal. R2 was rigid, in a fetal position and pale in color. RN-B stated R2 needed to go to the ED immediately and helped initiate the transfer.

During an interview on 8/1/24 at 3:49 p.m., director of nursing (DON) explained after a fall occurs after each fall nursing staff were to implement immediate interventions to prevent

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F 689	Continued From page 15	F 689		

another fall. The IDT would then meet the following morning (Monday through Friday) to discuss the fall, try to determine what the cause was, and what appropriate interventions should be in place including the immediate intervention that had been immediately implemented. DON indicated R2's falls that happened after 7/11/24 happened because his care plan for supervision was not followed; All these falls took place in R2 ' s room and were unwitnessed. DON stated she had been made aware of R2's fall that occurred on 7/27/24 when she arrived to work on 7/29/24 and R2 was being transferred to the ED.

During an interview on 8/6/24 at 1:55 p.m., medical director (MD)-A, stated the R2 had a history of drug abuse, seemed forgetful, and did not always listen to staff. R2 had numerous falls while at the facility. MD-A could not say for sure when the brain bleed happened. R2 had a head CT on 7/3/24 and 7/10/24 that did not show a brain bleed but the head CT on 7/29/24 did.

R3
R3's admission Falls Tool dated 6/11/24, indicated R3 was at low risk for falls. R3 had no falls in the past 12 months, was taking medications that could cause falls and had mild cognitive impairment. Risk factors included cognitive status, reduced insight, and impulsiveness; environmental risk factors of difficulty with orientation and was a new admission. There was nothing checked under the action plan.

R3's admission MDS date 6/12/24, indicated R3 to have severely impaired cognition with diagnoses of atrial fibrillation, congestive heart failure, arthritis, osteoporosis, and Parkinson's

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F 689	Continued From page 16 disease. R3 was independent with transfers, walking and ADL's and used a walker for mobility. R3 had no history of falls. R3's ADL care plan dated 6/13/24, indicated R1 needed one staff assist with, gait belt and four wheeled walker (4WW) for ambulation, bed mobility, toilet use and transfers. Fall care plan indicated R3 had an actual fall with no injury with interventions dated 7/16/24, to provide activities that promote exercise and strength building where possible, consult physical therapy (PT) and occupational therapy (OT) for strength and mobility, and educate R3 and family on safe use of assistive devices. R3's progress notes dated 7/15/24 at 9:30 a.m., indicated a fax was sent to the provider to notify of R3's fall. R3's assessment, neuros, and vital signs were at baseline and denied pain. R3 thought it happened due to legs feeling weaker since R3 had worked with therapy. R3's Fall Huddle Worksheet dated 7/15/24 at 7:15 a.m., indicated R3 had an unwitnessed fall in the bathroom, after attempting to self-ambulate and last staff to see resident were NA-J and NA-K with no date and time listed. Did not identify the last time R3 was assisted with ADL's. R3's Incident Report dated 7/15/24 at 7:15 a.m., identified R3's fall information from the progress notes and fall Huddle with additional information of: R3 received an abrasion to left 2nd toe. Care plan and order were updated with providing activities to promote strength building, consult PT and OT for mobility and strength and to educate R3 and family on safe use of assistive devices.	F 689		

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F 689	Continued From page 17 R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury. R3's Fall Huddle Worksheet dated 7/16/24 at 7:34 a.m., indicated R3 had an unwitnessed fall in his room where he was found on his knees attempting to self-transfer, lost his strength/knees buckled while R3 used his walker. Did not identify the last time R3 was assisted with ADL's. R3's Incident Report dated 7/16/24 at 7:34 a.m., identified R3's fall information from the fall Huddle with the additional information of: R3 was holding onto his walker and had bumped his head on the walker while trying to stand. R3 stated he was trying to get up for breakfast. R3 was complaining of low back pain, was seen the week prior and noted to have compression fracture in low back. No care plan interventions noted. R3's progress note dated 7/16/24 at 9:38 a.m., indicated IDT reviewed R3's fall from 7/15/24 at 7:45 a.m. and 7/16/24 at 7:34 a.m., R3 was found on the bathroom floor on 7/15/24 and found on floor next to bed on 7/16/24. R3 was attempting to get up to go to breakfast. Will fax provider for a urinalysis related to back/flank pain and increased weakness and confusion. Will also ask for PT/OT orders for strengthening following fall. R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury while waiting for laboratory test results with any follow-up treatment and while	F 689		

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F 689	Continued From page 18 R3 gained strength from working with PT/OT. R3's progress note dated 7/20/24 at 8:22 a.m., indicated R3 was found on the floor in his room at 4:30 a.m., no injuries noted, see incident in risk management for details. Further noted at 8:33 a.m. a fax was sent to physician for R3's unwitnessed fall with no injury along with uncontrolled back pain and the scheduled Tylenol 1000 milligrams (mg) was ineffective. Staff requested stronger pain medication. R3's Fall Huddle Worksheet dated 7/20/24 at 4:30 a.m., indicated R3 had an unwitnessed fall in his room while R3 was attempting to self-ambulate, lost his balance while wearing slipper socks and using his walker. Last time staff saw R3 was 30 minutes prior to fall, when staff saw R3 in recliner. Did not identify the last time R3 was assisted with ADL's. R3's Incident report dated 7/20/24 at 4:30 a.m., indicated R3 was found on the floor in front of the recliner when the nurse arrived R3 was lying on floor holding his head up. R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury. R3's progress note dated 7/30/24 at 4:31 p.m., indicated nurse summoned to R3's room as laundry staff observed R3 seated on the floor in front of his recliner with one foot at his side and one foot on the chair. R3 then ambulated with FWW in his room to his wheelchair and was brought to lounge area with vital signs taken	F 689		

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frequently.

R3's Fall Huddle Worksheet dated 7/30/24 at 4:00 p.m., indicated R3 had an unwitnessed fall while reaching to move trash bucket out of the way and lost his balance, was wearing shoes and using his walker at time of the incident. Last staff to see resident, "resident ambulating per self with 4WW throughout facility, all staff allowing this to happen." No name of staff or date and time listed for last seen by. Does not identify the last time R3 was assisted with ADL's.

R3's Incident Report dated 7/30/24 at 4:00 p.m., indicated R3 was found sitting on floor in front of the recliner by the laundry. R3's feet were out in front of him and one at the side out of the chair. On 7/30/24, order received to discontinue the Oxycodone per R3's request and an order received for lidocaine external patch 4%, apply one patch a day for up to 12 hours.

R3's medical record lacked root cause analysis and implementation of prevention interventions for R3's numerous falls to mitigate the risk for future falls.

During an observation on 8/1/24 at 12:57 p.m., R3 was self-propelling his wheelchair from the dining room. At 4:00 p.m., R3 was seated in his wheelchair in the common area.

During an interview on 8/1/24 at 1:52 p.m., TMA-A stated R3 had a change in status over the past month, felt R3's memory was getting worse as R3 would not remember to ask for assistance or use his call light. TMA-A further stated that R3 was having more pain and nursing was working with the provider on this.

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F 689	Continued From page 20 During an interview on 8/1/24 at 2:25 p.m., NA-E stated R3 was not independent, used a wheelchair and staff were to leave his door open to watch in case he self-transferred. During an interview on 8/1/24 at 2:33 p.m., NA-B stated R3 was confused and attempted to self-transfer. R3 needed 1 staff assist with transfers with the use of a gait belt. During an interview on 8/1/24 at 3:20 p.m., NA-Z stated R3 was independent when he arrived about a month ago but has gone downhill lately. NA-Z further stated R3 had increased confusion, does not like to stay in his wheelchair, forgets to ask for assistance and gets frustrated quickly when staff remind him to ask for assistance or use his call light. During an interview on 8/2/24 at 8:15 a.m., NA-S stated R3 was admitted to the facility independent and continent, but after some falls, he was to use wheelchair and was needing more care from staff with his ADLs including going to the bathroom and changing his brief or pull up. R2 would let staff know when he had to go to the bathroom or the staff would catch him self transferring. During an interview on 8/1/24 at 3:49 p.m., DON indicated after reviewing R3's falls, a comprehensive analysis of the falls had not been completed for appropriate interventions. DON indicated the facility had identified gaps in the falls program with causal analysis to which the facility implemented a quality assurance performance improvement (QAPI) project in June 2024; the cause analysis was "a work in progress". DON stated she expected staff to	F 689		

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follow the resident's care plans and the fall policy and procedures.

Review of facility's policy entitled Fall Resource Packet - Rehab/Skilled, dated 5/7/24, indicated the following:
- refer to Fall Prevention and Management policy, INTERACT Fall- Care Path, AMDA clinical practice guideline (CPGs) and AMDA Know-it-All card for additional information regarding actions to take post-fall.
- Staff were to complete the following PCC:
-Falls Tool UDA
-Change in Condition (if applicable)
-neuro Check UDA (triggered from risk management incident types: slipped or fell, found on the floor, fall involving mechanical lift)
-pain evaluation
-vital signs
-risk management module- new incident, for the type of fall.
-Check the care plan to determine if the cause of the fall is addressed (to avoid additional falls from the same cause). Consider setting a short-term goal to assist with monitoring the fall interventions closely to determine effectiveness; if not effective, revise the care plan and set new short-term goal

The IJ was removed on 8/3/24 at 12:00 p.m., when it was verified the facility implemented the following corrective actions:
-Completed comprehensive fall assessments on all residents to identify those who were at high risk for falls and updated care plans appropriately.
-Educated all nursing staff on comprehensive fall assessment, root cause analysis and identifying potential effective interventions to decrease

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F 689	Continued From page 22 risk/actual falls for residents at high fall risk. Staff were also educated on how to update/revise care plans and Kardex's with potential effective fall interventions. -For every fall the IDT will do investigation using root cause analysis approach and update the care plan appropriately. -All nursing staff were re-educated on the facilities fall policy and procedure.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		9/6/24

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F 690	Continued From page 23 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete a comprehensive bladder assessment and develop an individualized toileting program to restore, maintain, or prevent a decline in continence for 2 of 2 residents; R3 who had a change in mobility and R2 who had a documented decline in continence. Findings include: R3's admission Minimum Data Set (MDS) dated 6/12/24, indicated severe cognitive impairment with diagnoses of cancer, heart failure, arthritis, and Parkinson's disease. R3 had no impairment of range of motion and used a walker. R3 was independent with his activities of daily living (ADLs) except needed supervision with eating and oral hygiene. R3 had no history of falls. R3 was always continent of bowel and bladder and did not have a toileting program. R3's bowel and bladder assessment from the Nursing Admit Re-Admit data collection (NARA) tool, dated 6/6/24, indicated R3 was continent of bowel and bladder. No other bowel and bladder information was included on the assessment. R3's care plan (current at the time of the suvey) did not identify bladder/bowel focus that identified	F 690	R2 and R3 are no longer resident in our facility. All residents with changes in continence or changes in mobility have the potential to be affected by this deficient practice. All residents were reviewed for changes in continence and/or mobility. Updates were made, a new Bladder assessment was completed, and care plans were updated if warranted to include a toileting program. All resident's bowel and bladder assessments will be reviewed quarterly and if a Change in Condition occurs. Care plans will be updated if warranted. IDT Team will review all residents for changes in Bowel and Bladder weekly during At Risk meeting. All Licensed Nursing staff were educated by DNS and Clinical Learning and Development Specialist on our policy of Bowel & Bladder: Evaluation, Assessment, Toileting Programs by having them review our Policy and	

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F 690	Continued From page 24 R3's toileting needs. The ADL care plan dated 7/23/24 identified the following: -ambulation with assist of one, gait belt and four wheeled walker (4WW), dated 7/23/24, -bed mobility with assist of one, gait belt and 4WW, date 7/23/24, -toilet use with assist of one, gait belt and 4WW, dated 7/23/24. During an interview on 8/2/24 at 8:15 a.m., nursing assistant (NA)-S stated R3 was admitted to the faciity independent and continent, but after some falls, he was to use wheelchair and was needing more care from staff with his ADLs including going to the bathroom and changing his brief or pull up. NA-S indicated R3 did not have a toileting program, R3 would let staff know when he had to go to the bathroom or the staff would catch him self- transferring to the bathroom. During an interview on 8/6/24 at 12:46 p.m., NA-D indicated R3 needed assistance to transfer, had confusion, would attempt to self-transfer, and did not have a toileting schedule. During an interview on 8/6/24 at 3:07 p.m., NA-P stated she would take R3 to the bathroom at least before and after supper. R3 did not have a toileting schedule. R2's bowel and bladder assessment from the NARA tool, dated 7/9/24, indicated R2 was continent of bowel and bladder, used a urinal, had urgency, and needed assistance with clothing management. The assessment did not include any other information. R2's care plan did not include identify a toileting program. The care plan included:	F 690	Procedure. Case Manager was educated on the need to review/complete bladder assessments quarterly and on Change in Condition. An audit will also be completed weekly x4 and then monthly x 3 for 3 residents who have had a change in Condition, if applicable, to ensure a comprehensive assessment was completed to develop an individualized toileting program. An audit will be completed on three residents weekly x 4 then monthly x 3 to ensure bladder assessments match the care planned interventions. Data will be reviewed for 3 months at QAPI or until the QAPI committee has determined compliance has been sustained. September 6th, 2024	

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- R2 required staff assist of one with clothing management, dated 7/9/24.
-Staff to keep urinal in reach, check and empty frequently, dated 7/9/24.

R2's admission MDS dated 7/15/24, indicated intact cognition with diagnoses of hip fracture, other fracture, osteoporosis, and dementia. R2 did not have a toileting program and was frequently incontinent of bowel and bladder. R2 had impairment on one upper and lower extremity range of motion (ROM). R2 used a walker and wheelchair. R2 required partial to substantial assistant for all his activities of daily living (ADLs). R2 required moderate assist for transfers and did not walk more than 10 feet.

R2's record did not include a comprehensive assessment in R2's change in level of continence nor physician notification of R2's bladder control changes. Further the care plan did not address individualized interventions to restore, maintain, or prevent worsening.

During an interview on 8/2/24 at 8:15 a.m., NA-S indicated R2 would use urinal if he remembered but wore brief and staff were responsible for changing. NA-S further stated R2 was not on scheduled toileting or check and change program.

During an interview on 8/6/24 at 12:46 p.m., NA-D stated R2 used a urinal and wore a brief. R2 was frequently incontinent and needed staff assist with managing his brief. NA-D was not aware if R2 was on a scheduled toileting or check and change program.

During an interview on 8/2/24, DON stated the

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F 690	Continued From page 26 bowel and bladder assessment was completed on admission. If the resident was continent it would not trigger a care plan focus for bowel and bladder. DON stated it was her expectation staff followed the facility's bowel and bladder evaluation policy. Review of facility's policy entitled Bowel and Bladder: Evaluation. Assessment, Toileting Programs- Rehab/Skilled, dated 5/21/24, did not identify timing of assessments outside completion of Care Area Assessment and/or protocals for when residents had a change in condition/function. The policy included the following: -Based on the resident's comprehensive assessment, the location will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. -Check and change every two hours would not be considered a scheduled toileting program on the MDS. -The type of incontinence should be identified based on information obtained and evaluated using the Bladder Evaluation UDS, and the Care Area Assessment (CAA). -Care plan interventions should be individualized based on the CAA and modified as appropriate based on an assessment/evaluation of the resident's response to the interventions and success with attaining/maintaining bladder continence. -individualized program will be communicated to staff members via PCC/POC-Kardex and the 24-hour Report and Shift Report in PCC.	F 690		

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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 8/1/24, 8/2/24 and 8/6/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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and identify the date when they will be completed.

The following complaints were reviewed: H55686422C (MN00105310) with a licensing order issued at 0830 and 0910.
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 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.

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2 000	Continued From page 2 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 compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury 2 of 2 residents (R2 and R3) with history of falls. This resulted in immediate jeopardy (IJ) for R2 who sustained multiple left rib fractures, left clavicle fracture and a subdural hematoma (brain bleed). The IJ began on 7/27/24 when staff failed to	2 830	Corrected.	9/6/24

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implement R2's care plan for close supervision resulting in R2's fifth (5th) unwitnessed fall, major head injury, and intensive care unit (ICU) admission. The administrator, regional nurse manager, and director of nursing (DON) were notified of the IJ on 8/2/24 at 3:00 p.m. The IJ was removed on 8/3/24 at 12:00 p.m., when the facility had implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy.

Findings included:

R2's admission Minimum Data Set (MDS) dated 7/15/24, identified R2 did not have cognitive impairment and had diagnoses of hip fracture, other fracture, osteoporosis, and dementia. R2 had a history of falls prior to admission to the facility and two falls with injury since admission on 7/1/24. R2 had functional range of motion impairment on one upper and lower extremity. R1 used a walker and wheelchair. R2 required partial to substantial assistant for all his activities of daily living (ADLs) and required moderate assist for transfers and did not walk more than 10 feet. R2 was frequently incontinent of bowel and bladder and did not have a toileting plan.

Review of R2's Fall Tool admission assessment dated 7/2/24, R2 was at medium risk for falls. R2 had history of one or more falls in the last three months, was taking medications that put him at risk, and mildly impaired cognition status. R2 risk factor for falls included mobility/transfers due to changes in mobility related to muscles weakness or strength, impaired balance or coordination and pain. Although R2 had mild cognition he had reduced insight, difficulties in orientation on new

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admission, medical problems which affected changes in his orientation/level of consciousness and was incontinent. R2 was referred to therapy and care plan was updated.

R2's care plan dated 7/2/24, included an ADL focus that indicated R2 had a deficit related to recent hip surgery with interventions that directed to use one staff assistance with pivot/transfers. Fall focus identified R2 had an actual fall on 7/1/24 (sic) and was at risk for falls related to falls prior to hospitalization with the intervention that directed staff to ensure R2 was wearing appropriate footwear when ambulating or mobilizing in wheelchair. The care plan also identified R2's preferred wake time was 5:00 a.m. and his bedtime was 10:00 p.m. The care plan did not identify a toileting routine or program even though R2 was frequently incontinent of urine.

R2's late entry progress note dated 7/3/24 at 11:42 a.m., indicated R2 was heard yelling from hallway. R2 was found lying across the bedside table legs, R2's head was facing the door and head at the foot of the bed and nightstand. Water pitcher and water spilled on the floor. R2 did not have shoes on. Skin tear noted to left elbow with complaints of pain in left shoulder, unable to abduct without pain or calling out. Pillow placed under head and removed bedside stand from under body. Vital signs obtained and transfer to emergency department (ED) initiated. Ambulance arrived at 8:10 a.m. and left 8:15 a.m. Progress note at 11:20 a.m. indicated the hospital ED called the facility to notify R2 had fractured his left scapula and several ribs on the left side.

R2's Fall Huddle Sheet dated 7/3/24 at 7:50 a.m., identified the fall with the additional information of- R2 was ambulating and attempting to

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self-transfer, slipped and lost his balance. R2's bed was higher than it should have been and R2 had bare feet. Last toileted at 1:43 a.m. six hours before R2's fall.

R2's incident report dated 7/3/24 at 7:50 a.m., included the fall information identified in the progress note and Fall Huddle with the following additional information: R2 had on brief and t-shirt, R2 recently had right hip replacement, which he was able to move appropriately, and R2 stated that he was getting up to go take a shower initially and then later thought he was in the copy/print room at his newspaper job in Colorado.

R2's records did not include a comprehensive fall analysis for root cause and interventions that identified risk factors from the incident and huddle reports such as (but not limited) to the bed height, self-transfers/impulsivity, and duration of time documented between toileting.

R2's progress note dated 7/9/24, identified R2 returned from the hospital and his care plan was updated with interventions to reduce the risk for falls.

R2's care plan was revised on 7/8/24 to reflect the following interventions, educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance.

R2's care plan was revised on 7/9/24 to reflect the following interventions: Make sure resident wears glasses when up/out of bed; Keep urinal within reach, check and empty frequently (frequency was not defined); Fall mat placed on floor next to bed; signs placed in room to remind R2 to use call light and wait for assistance. Staff

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to ask for OT to evaluate room arrangement and will trial non-spill cup that R2 can keep in bed with him. New focuses added included: R2 had sleep disturbance evidenced by complaints of feeling tired, change in ability to perform ADLs, and change in gait/falls with interventions that included follow R2's usual bedtime routine. New focus of R2 had behavior symptoms evidenced by impulsiveness and lack of safety awareness with interventions that included praise any indication of R2's progress/improvement in behavior and prefers the diversional activity of ready books.

Review of R2's record between 7/9/24 to 7/22/24, did not indicate OT had completed an evaluation of R2's room arrangement.

R2's progress note dated 7/10/24 at 7:00 p.m., identified background, assessment, and recommendation (SBAR) was sent to physician indicating R2 had fallen when he went to stand up. Was wearing appropriate footwear and had call light and personal items within reach. At 7:25 p.m. R2 was sent to the ED via ambulance. R2 had head computer tomography (CT) without evidence of injury or bleed and laceration on right side of forehead.

R2's Fall Huddle Sheet dated 7/10/24 at 7:00 p.m., identified the fall information and included the additional information of- fall was unwitnessed. R2 reported he was trying to stand up to empty his urinal and lost his balance. Causal factors included the bed/chair height was not appropriate and R2 does not ask for assistance.

R2's incident report dated 7/10/24 at 7:00 p.m., identified the aforementioned fall information from

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the Fall Huddle and progress notes. Additional information included: Urinal was of dresser and only 1/3 full; R2 seemed confused on where he was and what he was doing; impaired memory and lack of safety awareness put him at increased risk for falls. The incident report was updated on 7/15/24 included "Have been constantly reminding resident to wait for assistance, and this has been helping."

R2's records did not identify a comprehensive fall analysis for root cause that addressed risk factors identified on the incident and huddle reports such as (but not limited to) height of the bed, urinal usage, and self-transfers/impulsivity.

R2's ED notes dated 7/10/24, identified R2 presented after a fall with a laceration to his scalp that was 2 centimeters (cm) on his right forehead near the hairline that required sutures. "We recommend tabs alarm [a device that alarms audibly or silently (i.e. box at nursing desk) with movement of resident from a surface such as a bed or chair] or closer supervision to prevent falls."

R2's progress note dated 7/10/24 at 10:26 p.m. indicated director of nursing (DON) had concerns with R2 returning to the facility. "DON informed them [hospital] that nursing home unable to provide 1:1 supervision with resident d/t [do to] staffing and TABS are not appropriate in this setting. MD stated no medical reason for hospitalization, R2 would be returning to facility."

R2's progress note dated 7/10/24 at 11:30 p.m. indicated R2 arrived back to the facility from ED with no acute pathology and received orders for TABS alarm at all times if possible or supervision. "DON explained that TABS alarms are not used

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at the facility d/t it being considered a restraint ...actually create a fall ..." Facility to provide increased supervisor of resident by having resident in recliner chair out by nurse's station so his safety can be closely monitored by staff.

R2's care plan was revised on 7/11/24, to include Ensure/provide a safe environment: avoid isolation and place resident by chair by nurse's station to offer closer supervision as ordered by the physician.

R2's record did not identify an assessment that determined and/or defined frequency of checks/supervision R2 required based on his risk factors, mannerisms, and behaviors. Furthermore, there was no indication the medically recommended device (tabs) based on a physician's evaluation to prevent R2 falls was comprehensively assessed by the facility prior to the determining the device would not be effective.

Review of R2's record between 7/11/24 to 7/29/24, there was no indication R2's care plan interventions that directed staff to provide "closer supervision" and placing R2 by the nurse's stations were implemented and/or evaluated for effectiveness.

R2's progress note dated 7/14/24 at 3:00 p.m., indicated R2 had an unwitnessed fall in his room. Staff found R2 on the floor with head on dresser and feet towards bed. Staff assisted R2 to wheelchair and out to lounge area. R2 stated he wanted to go to the basement. R2 noted to transfer self during morning shift to bathroom and to recliner after dinner. R2 was asked if attempted to ambulate self and replied "yes, because I don't need any help."

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Review of R2's Fall Huddle Sheet dated 7/14/24 at 3:00 p.m. identified the fall information with the additional information of- causal factors included R2 "gets more confused @ night" Corrective actions taken: Resident education/training or re-instruction. No care plan interventions were identified.

R2's incident report dated 7/14/24 at 3:00 p.m., identified the fall information. Additional information included-Resident alert and orientated x 3 during the day but as time gets later, he gets more confused. The report was updated on 7/15/24 to include, the interdisciplinary team (IDT) reviewed Incident: Intervention will be to put a sign in his room. Resident loves to read, so we are thinking this will be a better intervention that constant telling him to "Wait for help"

In review of R2's records identified a comprehensive fall analysis for root cause and interventions was not completed that addressed risk factors included on the incident and huddle reports such as (but not limited to) even though the reports identified R2 had increased confusion at night, the intervention for closer supervision was not individualized and/or assessed to address that risk factor. Additionally, not evident the care plan was revised to include signage intervention.

R2's progress note dated 7/16/24 at 2:45 a.m., staff was going down hallway and noticed R2's door closed, stopped to open, and found R2 lying on the floor stretched out next to his bedside. Had a smile on his face and denied any new pain. R2 states he slipped off the edge of his bed. R2 was assisted off the floor. Bed was lowered to lowest position and fall mat applied to floor at bedside.

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2 830	Continued From page 10 Call light within reach. Review of R2's Fall Huddle Sheet dated 7/16/24 3:19 a.m., identified fall information in addition to R2 stated he fell while trying to reach his water. Action taken was "water glass in bed no spill cup" No injuries. R2's incident report dated 7/16/24 at 3:19 a.m., identified fall information with no other additional information. The report was updated on 7/22/24 to include IDT reviewed Incident: Will attempt to give resident a new cup that won't spill and he can keep closer to himself in bed. Also, will talk to therapy to check out resident's room to see if we can rearrange to make it easier for Resident to navigate (according to the care plan both interventions were supposed to be already in place on 7/9/24). Review of R2's record lacked a comprehensive analysis of causal factors that included if the intervention of "close supervision" was provided and was evaluated for effectiveness. Further not evident the care plan was revised to reduce R2's risk for falls and/or falls with major injury. R2's progress note dated 7/27/24 at 6:00 p.m., nursing assistant observed R2 on floor by closet door with head towards his bed. ROM within normal limits, pupils equal and reactive to light, assist with two staff to wheelchair without difficulty and taken to lounge area to watch TV with other residents. Nurse noted a bump to left side of head in which R2 refused an ice pack, also noted a blood blister on left elbow, covered with band aid. Facility surveillance video footage recorded on 7/27/24 from 5:55 p.m. to 6:19 p.m. was reviewed	2 830		

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with the administrator.
-At 5:56 p.m. licensed practical nurse (LPN)-B walked by R2's room. LPN-B looked in the room but did not stop. LPN-B assisted a female resident to her room at the end of the hallway.
-At 5:59 p.m. LPN-B walked back up the hallway and entered R2's room for approximately 15 seconds and then exits the room without R2.
-At 6:09 p.m. NA-P walked down hallway and looked in R2's room, entered the room, and activated the emergency call light. NA-Z and LPN-B walked to and entered R2's room.
-At 6:11 p.m., NA-Z left R2's room and walked towards the nursing station. NA-P left the room, got the standing mechanical lift from the other end of the hallway, and brought it back to R2's room along with wheelchair at 6:14 p.m.
-At 6:16 p.m., NA-P exited R2's room with the standing lift.
-At 6:19 p.m., LPN-K exited the room, looked to be prompting R2 to follow her, R2 self-propelled his wheelchair out of the room toward the nurse's station.

Review of R2's Fall Huddle Sheet dated 7/27/24 at 6:00 p.m., R2 had an unwitnessed fall in his room when he was ambulating to bathroom using a device (not specified). Last seen by a staff member around 5:30 p.m. Causal factors included "resident left in room unattended." The form indicated the investigation was completed on 7/29/24. Corrective action taken was documented as the roommate moved to a different room to make R2's room private and staff suspension/terminated.

R2's incident report dated 7/27/24 6:00 p.m., identified the fall information. In addition, R2 reported "I was just walking". The form was revised on 7/29/24 to include IDT Team reviewed

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incident: Noted that Roommates walker was next to him after fall. Intervention: Ensure roommate's walker is out of reach and out of the way to ensure R2 does not attempt to use it.

R2's progress notes on 7/29/24 at 8:04 a.m., indicated a nurse was called to R2's room. R2 was orientated to self only. The physician and power of attorney were notified. Progress note at 8:16 a.m. indicated an order to send R2 to ED. Progress note at 12:29 p.m. indicated the hospital ED called to notify facility compressions (cardio pulmonary resuscitation) was started.

R2's hospital progress note dated 7/29/24 indicated that R2 was being evaluated for a fall with head injury that occurred 3 days prior and at 8:30 a.m. on 7/29/24, was noted to be more confused and not following commands. R2's last known well time was 11:00 p.m. on 7/28/24. R2 had a head CT that showed 1.) an acute right subdural hematoma over the right vertebral hemisphere which measures up to 10 millimeters (mm) in thickness. A mild localized mass effect without midline shift. 2.) Hemorrhagic contusion most notable in the right temporal lobe, with a smaller hemorrhagic contusion involving the inferior right frontal lobe. 3.) Left parietal scalp trauma without associated skull fracture. During his ER stay R2 was transferred to higher level of care hospital by ground ambulance.

R2's higher level hospital progress note dated 7/29/24, indicated R2 was admitted to the intensive Care Unit (ICU) with diagnoses of traumatic bran injury, sub dural hematoma, temporal contusion, seizure, encephalopathy and hyponatremia. R2 had a repeat head CT upon arrival that agreed with the first hospital but added but added a thin subdural blood product along

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posterior falx (curved shape) and right tentorial leaflet, up to 1mm. R2 received antiseizure medications.

During interview on 8/6/24 at 11:22, registered nurse (RN)-B reported R2 had been discharged from the hospital to a hospice facility however, was not aware of the date he was discharged.

During an interview on 8/1/24 at 1:52 p.m., trained medication assistant (TMA)-A stated R2 had fallen a lot since admission. There was one fall where he fell and broke his shoulder and some ribs. TMA-A stated R2 would attempt to self-transfer and forget to ask for help. TMA-S stated if R2 was in his room staff needed to visualize R2 and make sure he was "OK" or R2 needed to be in the common area by nurses' station, so staff could see him. TMA-A indicated the checks were not documented anywhere.

During an interview on 8/1/24 at 2:33 p.m., NA-B stated R2 had behaviors where he would get up by himself in his room then fall or wander around in his wheelchair. NA-B was not able to articulate R2's fall interventions.

During an interview on 8/2/24 at 11:20 a.m., TMA-D stated R2 was alert and oriented. TMA-D remembered R2 had two falls while she was worker but could not recall the dates of the falls. TM-D explained R2 had slid out of his recliner after he had used the remote to raise the chair up too high. TMA-D could not remember what caused the other fall, but neither fall resulted in injuries. TMA-D could not remember R2's fall interventions.

During an interview on 8/2/24 at 11:25 a.m., NA-J stated R2 would not listen; she would put R2 in

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his recliner with the reminder to use his call light however a few minutes later she would walk by his room to find R2 attempting to self transfer. NA-J remembered R2 had one fall while she was working. NA-J thought R2 was trying to self-transfer from his recliner to his wheelchair and got a "goose egg" on his forehead and a black eye.

During an interview of 8/1/24 at 2:59 p.m., LPN-A stated R2 was a frequent faller, and was to be in the commons area by the nurse' station so staff could supervise him. LPN-A indicated she had been working on evening when R2 fell, LPN-A could not recall the date, she had opened R2's door and found R2 on the floor beside his bed with things under his head, "like he had been there awhile." LPN-A stated R2 did not have any injuries with that fall and she had instructed staff working to leave R2's door open for closer monitoring when he was in bed. LPN-A indicated she had not added the intervention to R2's care plan.

During an interview of 8/1/24 at 3:20 p.m. NA-Z stated R2 was confused and did not use his call light and liked to be independent. NA-Z explained she had been working on 7/27/24, when R2 fall. NA-Z recalled the fall had happened and dinner and staff were busy with other residents. NA-Z had been talking with LPN-B by the dining room hallway when NA-P turned on the emergency call light. NA-Z got to R2's room with LPN-B and R2 had his head against the register under the window and R2's legs were entangled in a walker. NA-Z indicated she was not aware of how or why R2 was in his room unsupervised.

During an interview on 8/2/24 at 8:15 a.m., NA-S stated R2 was impulsive and would not use his

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call light. According to R2's care plan he was supposed to be out at the nurse's station when he was out of bed, especially after meals. NA-S thought staff would forget this because R2 seemed like he was alert. On 7/29/24, NA-S went into get R2 up for the day around 8:00 a.m., and he was not responding like himself. R2 would respond verbally with "yeah" to her questions but would not move. NA-S sent NA-T for the nurse and LPN-K came and brought RN-B. R2 was sent to the local ER and then airlifted to a higher level of care.

During interview on 8/2/24 at 11:51 a.m., LPN-B stated on 7/27/24, she was called to R2's room around 6:10 p.m. via the emergency staff alert. LPN-B entered R2's room and R2 was on the floor by the window and his head was not touching the wall or the floor. LPN-B stated she looked at R2's head and did not see any blood and R2 had answered her questions appropriately. LPN-B was not aware of how or why R2 was in his room alone. LPN-B stated on 7/29/24 at approximately 8:00 a.m., a nursing assistant had notified her R2 was not right. LPN-B went to R2's room, he was lying in bed in the fetal position facing towards the wall. LPN-B indicated she was unable to get R2 to open his eyes and notified RN-B and decided to send R2 to the emergency room for further evaluation.

During an interview on 8/2/24 at 1:44 p.m., RN-B stated she was called to R2's room on 7/29/24 because R2 was not responding per his normal. R2 was rigid, in a fetal position and pale in color. RN-B stated R2 needed to go to the ED immediately and helped initiate the transfer.

During an interview on 8/1/24 at 3:49 p.m., director of nursing (DON) explained after a fall

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occurs after each fall nursing staff were to implement immediate interventions to prevent another fall. The IDT would then meet the following morning (Monday through Friday) to discuss the fall, try to determine what the cause was, and what appropriate interventions should be in place including the immediate intervention that had been immediately implemented. DON indicated R2's falls that happened after 7/11/24 happened because his care plan for supervision was not followed; All these falls took place in R2 's room and were unwitnessed. DON stated she had been made aware of R2's fall that occurred on 7/27/24 when she arrived to work on 7/29/24 and R2 was being transferred to the ED.

During an interview on 8/6/24 at 1:55 p.m., medical director (MD)-A, stated the R2 had a history of drug abuse, seemed forgetful, and did not always listen to staff. R2 had numerous falls while at the facility. MD-A could not say for sure when the brain bleed happened. R2 had a head CT on 7/3/24 and 7/10/24 that did not show a brain bleed but the head CT on 7/29/24 did.

R3
R3's admission Falls Tool dated 6/11/24, indicated R3 was at low risk for falls. R3 had no falls in the past 12 months, was taking medications that could cause falls and had mild cognitive impairment. Risk factors included cognitive status, reduced insight, and impulsiveness; environmental risk factors of difficulty with orientation and was a new admission. There was nothing checked under the action plan.

R3's admission MDS date 6/12/24, indicated R3 to have severely impaired cognition with diagnoses of atrial fibrillation, congestive heart

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failure, arthritis, osteoporosis, and Parkinson's disease. R3 was independent with transfers, walking and ADL's and used a walker for mobility. R3 had no history of falls.

R3's ADL care plan dated 6/13/24, indicated R1 needed one staff assist with, gait belt and four wheeled walker (4WW) for ambulation, bed mobility, toilet use and transfers. Fall care plan indicated R3 had an actual fall with no injury with interventions dated 7/16/24, to provide activities that promote exercise and strength building where possible, consult physical therapy (PT) and occupational therapy (OT) for strength and mobility, and educate R3 and family on safe use of assistive devices.

R3's progress notes dated 7/15/24 at 9:30 a.m., indicated a fax was sent to the provider to notify of R3's fall. R3's assessment, neuros, and vital signs were at baseline and denied pain. R3 thought it happened due to legs feeling weaker since R3 had worked with therapy.

R3's Fall Huddle Worksheet dated 7/15/24 at 7:15 a.m., indicated R3 had an unwitnessed fall in the bathroom, after attempting to self-ambulate and last staff to see resident were NA-J and NA-K with no date and time listed. Did not identify the last time R3 was assisted with ADL's.

R3's Incident Report dated 7/15/24 at 7:15 a.m., identified R3's fall information from the progress notes and fall Huddle with additional information of: R3 received an abrasion to left 2nd toe. Care plan and order were updated with providing activities to promote strength building, consult PT and OT for mobility and strength and to educate R3 and family on safe use of assistive devices.

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R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury.

R3's Fall Huddle Worksheet dated 7/16/24 at 7:34 a.m., indicated R3 had an unwitnessed fall in his room where he was found on his knees attempting to self-transfer, lost his strength/knees buckled while R3 used his walker. Did not identify the last time R3 was assisted with ADL's.

R3's Incident Report dated 7/16/24 at 7:34 a.m., identified R3's fall information from the fall Huddle with the additional information of: R3 was holding onto his walker and had bumped his head on the walker while trying to stand. R3 stated he was trying to get up for breakfast. R3 was complaining of low back pain, was seen the week prior and noted to have compression fracture in low back. No care plan interventions noted.

R3's progress note dated 7/16/24 at 9:38 a.m., indicated IDT reviewed R3's fall from 7/15/24 at 7:45 a.m. and 7/16/24 at 7:34 a.m., R3 was found on the bathroom floor on 7/15/24 and found on floor next to bed on 7/16/24. R3 was attempting to get up to go to breakfast. Will fax provider for a urinalysis related to back/flank pain and increased weakness and confusion. Will also ask for PT/OT orders for strengthening following fall.

R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury while waiting for laboratory test results with any follow-up treatment and while R3 gained strength from working with PT/OT.

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2 830	Continued From page 19 R3's progress note dated 7/20/24 at 8:22 a.m., indicated R3 was found on the floor in his room at 4:30 a.m., no injuries noted, see incident in risk management for details. Further noted at 8:33 a.m. a fax was sent to physician for R3's unwitnessed fall with no injury along with uncontrolled back pain and the scheduled Tylenol 1000 milligrams (mg) was ineffective. Staff requested stronger pain medication. R3's Fall Huddle Worksheet dated 7/20/24 at 4:30 a.m., indicated R3 had an unwitnessed fall in his room while R3 was attempting to self-ambulate, lost his balance while wearing slipper socks and using his walker. Last time staff saw R3 was 30 minutes prior to fall, when staff saw R3 in recliner. Did not identify the last time R3 was assisted with ADL's. R3's Incident report dated 7/20/24 at 4:30 a.m., indicated R3 was found on the floor in front of the recliner when the nurse arrived R3 was lying on floor holding his head up. R3's record did not identify a completed comprehensive analysis of causal factors and/root cause to determine appropriate interventions to prevent falls or reduce the risk of falls with major injury. R3's progress note dated 7/30/24 at 4:31 p.m., indicated nurse summoned to R3's room as laundry staff observed R3 seated on the floor in front of his recliner with one foot at his side and one foot on the chair. R3 then ambulated with FWW in his room to his wheelchair and was brought to lounge area with vital signs taken frequently.	2 830		

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R3's Fall Huddle Worksheet dated 7/30/24 at 4:00 p.m., indicated R3 had an unwitnessed fall while reaching to move trash bucket out of the way and lost his balance, was wearing shoes and using his walker at time of the incident. Last staff to see resident, "resident ambulating per self with 4WW throughout facility, all staff allowing this to happen." No name of staff or date and time listed for last seen by. Does not identify the last time R3 was assisted with ADL's.

R3's Incident Report dated 7/30/24 at 4:00 p.m., indicated R3 was found sitting on floor in front of the recliner by the laundry. R3's feet were out in front of him and one at the side out of the chair. On 7/30/24, order received to discontinue the Oxycodone per R3's request and an order received for lidocaine external patch 4%, apply one patch a day for up to 12 hours.

R3's medical record lacked root cause analysis and implementation of prevention interventions for R3's numerous falls to mitigate the risk for future falls.

During an observation on 8/1/24 at 12:57 p.m., R3 was self-propelling his wheelchair from the dining room. At 4:00 p.m., R3 was seated in his wheelchair in the common area.

During an interview on 8/1/24 at 1:52 p.m., TMA-A stated R3 had a change in status over the past month, felt R3's memory was getting worse as R3 would not remember to ask for assistance or use his call light. TMA-A further stated that R3 was having more pain and nursing was working with the provider on this.

During an interview on 8/1/24 at 2:25 p.m., NA-E stated R3 was not independent, used a

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wheelchair and staff were to leave his door open to watch in case he self-transferred.

During an interview on 8/1/24 at 2:33 p.m., NA-B stated R3 was confused and attempted to self-transfer. R3 needed 1 staff assist with transfers with the use of a gait belt.

During an interview on 8/1/24 at 3:20 p.m., NA-Z stated R3 was independent when he arrived about a month ago but has gone downhill lately. NA-Z further stated R3 had increased confusion, does not like to stay in his wheelchair, forgets to ask for assistance and gets frustrated quickly when staff remind him to ask for assistance or use his call light.

During an interview on 8/2/24 at 8:15 a.m., NA-S stated R3 was admitted to the facility independent and continent, but after some falls, he was to use wheelchair and was needing more care from staff with his ADLs including going to the bathroom and changing his brief or pull up. R2 would let staff know when he had to go to the bathroom or the staff would catch him self transferring.

During an interview on 8/1/24 at 3:49 p.m., DON indicated after reviewing R3's falls, a comprehensive analysis of the falls had not been completed for appropriate interventions. DON indicated the facility had identified gaps in the falls program with causal analysis to which the facility implemented a quality assurance performance improvement (QAPI) project in June 2024; the cause analysis was "a work in progress". DON stated she expected staff to follow the resident's care plans and the fall policy and procedures.

Review of facility's policy entitled Fall Resource

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Packet - Rehab/Skilled, dated 5/7/24, indicated the following:
- refer to Fall Prevention and Management policy, INTERACT Fall- Care Path, AMDA clinical practice guideline (CPGs) and AMDA Know-it-All card for additional information regarding actions to take post-fall.
- Staff were to complete the following PCC:
-Falls Tool UDA
-Change in Condition (if applicable)
-neuro Check UDA (triggered from risk management incident types: slipped or fell, found on the floor, fall involving mechanical lift)
-pain evaluation
-vital signs
-risk management module- new incident, for the type of fall.
-Check the care plan to determine if the cause of the fall is addressed (to avoid additional falls from the same cause). Consider setting a short-term goal to assist with monitoring the fall interventions closely to determine effectiveness; if not effective, revise the care plan and set new short-term goal

The IJ was removed on 8/3/24 at 12:00 p.m., when it was verified the facility implemented the following corrective actions:
-Completed comprehensive fall assessments on all residents to identify those who were at high risk for falls and updated care plans appropriately.
-Educated all nursing staff on comprehensive fall assessment, root cause analysis and identifying potential effective interventions to decrease risk/actual falls for residents at high fall risk. Staff were also educated on how to update/revise care plans and Kardex's with potential effective fall interventions.
-For every fall the IDT will do investigation using

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2 830	Continued From page 23 root cause analysis approach and update the care plan appropriately. -All nursing staff were re-educated on the facilities fall policy and procedure. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		9/6/24

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2 910	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to complete a comprehensive bladder assessment and develop an individualized toileting program to restore, maintain, or prevent a decline in continence for 2 of 2 residents; R3 who had a change in mobility and R2 who had a documented decline in continence. Findings include: R3's admission Minimum Data Set (MDS) dated 6/12/24, indicated severe cognitive impairment with diagnoses of cancer, heart failure, arthritis, and Parkinson's disease. R3 had no impairment of range of motion and used a walker. R3 was independent with his activities of daily living (ADLs) except needed supervision with eating and oral hygiene. R3 had no history of falls. R3 was always continent of bowel and bladder and did not have a toileting program. R3's bowel and bladder assessment from the Nursing Admit Re-Admit data collection (NARA) tool, dated 6/6/24, indicated R3 was continent of bowel and bladder. No other bowel and bladder information was included on the assessment. R3's care plan (current at the time of the suvey) did not identify bladder/bowel focus that identified R3's toileting needs. The ADL care plan dated 7/23/24 identified the following: -ambulation with assist of one, gait belt and four wheeled walker (4WW), dated 7/23/24, -bed mobility with assist of one, gait belt and 4WW, date 7/23/24, -toilet use with assist of one, gait belt and 4WW,	2 910	Corrected.	

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	00575	A. BUILDING: ______ B. WING ______	08/06/2024

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2 910	Continued From page 25	2 910		

dated 7/23/24.

During an interview on 8/2/24 at 8:15 a.m., nursing assistant (NA)-S stated R3 was admitted to the faciity independent and continent, but after some falls, he was to use wheelchair and was needing more care from staff with his ADLs including going to the bathroom and changing his brief or pull up. NA-S indicated R3 did not have a toileting program, R3 would let staff know when he had to go to the bathroom or the staff would catch him self- transferring to the bathroom.

During an interview on 8/6/24 at 12:46 p.m., NA-D indicated R3 needed assistance to transfer, had confusion, would attempt to self-transfer, and did not have a toileting schedule.

During an interview on 8/6/24 at 3:07 p.m., NA-P stated she would take R3 to the bathroom at least before and after supper. R3 did not have a toileting schedule.

R2's bowel and bladder assessment from the NARA tool, dated 7/9/24, indicated R2 was continent of bowel and bladder, used a urinal, had urgency, and needed assistance with clothing management. The assessment did not include any other information.

R2's care plan did not include identify a toileting program. The care plan included:
- R2 required staff assist of one with clothing management, dated 7/9/24.
-Staff to keep urinal in reach, check and empty frequently, dated 7/9/24.

R2's admission MDS dated 7/15/24, indicated intact cognition with diagnoses of hip fracture, other fracture, osteoporosis, and dementia. R2

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2 910	Continued From page 26	2 910		

did not have a toileting program and was frequently incontinent of bowel and bladder. R2 had impairment on one upper and lower extremity range of motion (ROM). R2 used a walker and wheelchair. R2 required partial to substantial assistant for all his activities of daily living (ADLs). R2 required moderate assist for transfers and did not walk more than 10 feet.

R2's record did not include a comprehensive assessment in R2's change in level of continence nor physician notification of R2's bladder control changes. Further the care plan did not address individualized interventions to restore, maintain, or prevent worsening.

During an interview on 8/2/24 at 8:15 a.m., NA-S indicated R2 would use urinal if he remembered but wore brief and staff were responsible for changing. NA-S further stated R2 was not on scheduled toileting or check and change program.

During an interview on 8/6/24 at 12:46 p.m., NA-D stated R2 used a urinal and wore a brief. R2 was frequently incontinent and needed staff assist with managing his brief. NA-D was not aware if R2 was on a scheduled toileting or check and change program.

During an interview on 8/2/24, DON stated the bowel and bladder assessment was completed on admission. If the resident was continent it would not trigger a care plan focus for bowel and bladder. DON stated it was her expectation staff followed the facility's bowel and bladder evaluation policy.

Review of facility's policy entitled Bowel and Bladder: Evaluation. Assessment, Toileting

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Programs- Rehab/Skilled, dated 5/21/24, did not identify timing of assessments outside completion of Care Area Assessment and/or protocals for when residents had a change in condition/function. The policy included the following:
-Based on the resident's comprehensive assessment, the location will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible.
-Check and change every two hours would not be considered a scheduled toileting program on the MDS.
-The type of incontinence should be identified based on information obtained and evaluated using the Bladder Evaluation UDS, and the Care Area Assessment (CAA).
-Care plan interventions should be individualized based on the CAA and modified as appropriate based on an assessment/evaluation of the resident's response to the interventions and success with attaining/maintaining bladder continence.
-individualized program will be communicated to staff members via PCC/POC-Kardex and the 24-hour Report and Shift Report in PCC.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all policies and procedures for bowel and bladder comprehensive assessment. The director of nursing or designee, could conduct random audits of residents bowel and bladder status to ensure appropriate care and services are implemented.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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