DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2021

Administrator
Clara City Care Center
1012 North Division Street PO Box 797
Clara City, MN 56222

RE: CCN: 245573
Cycle Start Date: September 23, 2021

Dear Administrator:

On October 21, 2021, we informed you of imposed enforcement remedies.

On October 26, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey/revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effectiveDecember 5, 2021, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 5, 2021.

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.

As we notified you in our letter of October 21, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 5, 2021.

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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 December 23, 2021 (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

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222**

(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 10/25/21 and 10/26/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5573017C (MN77478), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure care planned	F 689	Resident 1 passed away 11/14/21.	11/23/21

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

Electronically Signed | 11/18/2021

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F 689	Continued From page 1 fall risk prevention interventions were followed when R1 was directed to walk without proper footwear and a gait belt was not placed for 1 of 3 residents reviewed for falls. This deficient practice led to R1 falling and sustaining skin tear. Findings include: R1's Face Sheet dated 10/6/21, indicated R1 was admitted to the facility on 10/6/21, with the following pertinent diagnosis:cerebral vascular accident (CVA), (stroke). R1's admission minimum data set (MDS) assessment dated 10/13/21, identified R1 as having a brief interview for mental status (BIMS) score of "15" (no impairment in cognition). R1 required extensive assistance with activities of daily living (ADL's) including dressing and personal hygiene. The MDS further indicated R1 required extensive assistance with bed mobility, transferring and limited assistance with walking in room. R1's care plan last revised on 10/6/21, indicated R1 was at high fall risk as evidenced by unsteady gait and balance, and history of falls. Interventions included ambulate with the assistance of one, use a transfer belt, ensure proper non-slip footwear, and notify the doctor if there is a fall. During an interview on 10/26/21, 9:29 a.m. R1 stated nursing assistant (NA)-A took off residents shoes, sweater, and shirt to help him get ready for bed on 10/7/21 . NA-A instructed R1 to use his walker and walk the few feet to his bed. R1 stated he did not have a gait belt on and without having non-slip footwear on, he slipped and fell onto the	F 689	All residents at risk for falls have the potential to be affected by this deficient practice. The DON or designee will review fall prevention and management program policy and procedure, update as needed and review with appropriate staff. The DON or designee, will in-service all nursing staff on fall prevention and management program policy and procedure including fall risk interventions and care plan implementation on 11/22/21. DON or designee will audit all residents at risk for falls for interventions being on the care plan and further audit that the interventions listed are being followed by staff on varying shifts daily x 5, then weekly x 4, and monthly x4 and report findings to the QAPI Committee for review and further action.	

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F 689	Continued From page 2	F 689		

wastebasket. R1 stated his left shoulder landed on the waste basket and the sharp edge of the wastebasket made a skin tear on his upper arm. R1 further stated his right upper arm hit the walker and sustained another skin tear on the right upper arm. R1 stated NA-A grabbed his right arm and pulled on the walker to get him to his feet. R1 pivoted and sat on the bed. Once R1 was on the bed, NA-A quickly left the room. A minute later LPN-A came in and asked R1 what happened. R1 stated he reported to LPN-A he fell onto the wastebasket with his shoulder on the wastebasket, his knees on the floor, and now has an injury on both arms.

A progress note dated 10/07/21, at 10:55 p.m. by licensed practical nurse (LPN)-A documented being informed by nursing assistant (NA)-A at 10:35 p.m. that R1 had a skin tear. LPN-A assessed the skin tear and documented finding a 2 cm x 0.8 cm wide skin tear. LPN-A cleansed the wound, completed skin preparation, applied steri strips and a 3 x 3" Mepilex bandage. LPN-A further documented R1 currently had a bruise in the same location as the skin tear. There was no documentation found in the medial record that a post fall assessment was completed to identify potential contributing factors and needed interventions.

A progress note dated 10/8/21, at 2:37 p.m. indicated that director of nursing (DON) documented R1's family was notified that he had a fall and sustained a skin tear.

A progress note dated 10/08/21, 3:57 p.m. documented registered nurse (RN)-A, was notified by staff at 6:00 a.m. that R1 reported having a fall last evening. R1 stated NA-A was

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F 689	Continued From page 3	F 689		

helping him get ready for bed and NA-A took R1's shoes, sweater and shirt off and directed R1 to walk to the bed. R1 stated he was walking unassisted to the bed and his socks were slippery and that fell after taking one step. R1 stated he fell and landed with his left arm/chest on the wastebasket, and his knees were on the floor.

A progress note dated 10/11/21, at 12:14 p.m. documented LPN-A created an updated note for the 10/07/21, skin tear. LPN-A documented asking R1 what happened, and his reply was he slipped on the edge of the recliner and sat on the edge of the recliner/garbage can, but at no point did his bottom touch the floor.

During an interview on 10/26/21, at 9:49 a.m. NA-A stated on 10/07/21, at approximately 10:30 p.m. he went to help R1 get ready for bed. NA-A stated he took R1's shoes off and that he only had socks on. NA-A indicated it was only a few feet from the recliner to the bed and thought R1 could walk to the bed without falling. NA-A stated he directed R1 to walk to the bed so he could continue to get R1 undressed. NA-A stated the recliner is approximately three feet from the bed and NA-A started walking with only his socks on, and that he did not place a gait belt on R1. NA-A stated R1 took a step, slipped and he tried to catch him. NA-A stated R1 fell to the left and landed on the wastebasket that is between and recliner and the bed, but he had a hold of R1's right arm. NA-A stated he is unsure if R1's knees were on the floor. NA-A then helped R1 to stand, pivot and sit on the bed. NA-A stated he immediately went to the charge nurse (does not remember her name - identified as LPN-A) and informed her that R1 fell and now has a skin tear. LPN-A immediately went to VA's room. NA-A

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F 689	Continued From page 4	F 689		

sated he did not return to R1's room as it was the end of his shift and he left the facility. NA-A stated he did not follow the care plan which directed him to use a gait belt and ensure proper footwear were on R1 during the transfer.

During an observation on 10/26/21, at 9:45 a.m. R1 was observed in a wheelchair being wheeled into his room by unknown name physical therapist (PT)-A. PT-A assisted R1 to stand and then pivot to the recliner. R1's gait was observed to be unsteady and required the assistance of PT-A to stand and pivot. R1 was observed while lowering to sit in the recliner to abruptly land due to lack of strength.

During an interview on 10/26/21, at 11:13 a.m. LPN-A stated NA-A was observed on 10/07/21, at approximately 11:00 p.m. going to the charting area and could be overheard reporting to NA-B that R1 has a skin tear. LPN-A further overheard NA-A state it happened while he was transferring R1 and that he sat on top of the garbage can next to the bed. LPN-A stated she asked NA-A what happened and then went to assess R1's wound. LPN-A stated she asked R1 what happened, and he indicated he did not fall but slipped and sat on the garbage can. LPN-A stated since R1 did not fall to the floor, she did not think it was a fall. LPN-A further stated R1 informed her that NA-A did not use a gait belt and directed him to walk only in his socks, which made him slip. LPN-A stated when she arrived to R1's room, he was sitting on the bed with only his tee shirt and underwear on, so she was able to assess his skin. LPN-A she did not see the right upper arm wound that night, but it was found by another nurse the next day.

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F 689	Continued From page 5 During an interview on 10/26/21, at 12:33 p.m. DON stated a fall is an unplanned rapid descent. DON stated the fall to the wastebasket is considered a fall and should have been reported immediately. The facility Fall Prevention and Management Program policy, last modified on 01/12/21, directed that any unintentional change in position is considered a fall and in the event of a fall, notify the charge nurse by using the walkie.	F 689		

Electronically delivered
November 17, 2021

Administrator
Clara City Care Center
1012 North Division Street PO Box 797
Clara City, MN 56222

Re: State Nursing Home Licensing Orders
Event ID: FYO311

Dear Administrator:

The above facility was surveyed on October 25, 2021 through October 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.usOffice:
(507) 344-2742 Mobile: (651) 368-3593

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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	00061	A. BUILDING: _____ B. WING _____	C 10/26/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/25/21 and 10/26/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5573017C (MN77478) with a licensing order issued at 4658.0520 Subp 1. 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00061	A. BUILDING: _____ B. WING _____	C 10/26/2021

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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 ensure care planned fall risk prevention interventions were followed when R1 was directed to walk without proper footwear and a gait belt was not placed for 1 of 3 residents reviewed for falls. This deficient practice led to R1 falling and sustaining skin tear. Findings include: R1's Face Sheet dated 10/6/21, indicated R1 was admitted to the facility on 10/6/21, with the following pertinent diagnosis:cerebral vascular accident (CVA), (stroke). R1's admission minimum data set (MDS) assessment dated 10/13/21, identified R1 as having a brief interview for mental status (BIMS) score of "15" (no impairment in cognition). R1 required extensive assistance with activities of	2 830	Corrected	11/23/21

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2 830	Continued From page 3	2 830		

daily living (ADL's) including dressing and personal hygiene. The MDS further indicated R1 required extensive assistance with bed mobility, transferring and limited assistance with walking in room.

R1's care plan last revised on 10/6/21, indicated R1 was at high fall risk as evidenced by unsteady gait and balance, and history of falls. Interventions included ambulate with the assistance of one, use a transfer belt, ensure proper non-slip footwear, and notify the doctor if there is a fall.

During an interview on 10/26/21, 9:29 a.m. R1 stated nursing assistant (NA)-A took off residents shoes, sweater, and shirt to help him get ready for bed on 10/7/21 . NA-A instructed R1 to use his walker and walk the few feet to his bed. R1 stated he did not have a gait belt on and without having non-slip footwear on, he slipped and fell onto the wastebasket. R1 stated his left shoulder landed on the waste basket and the sharp edge of the wastebasket made a skin tear on his upper arm. R1 further stated his right upper arm hit the walker and sustained another skin tear on the right upper arm. R1 stated NA-A grabbed his right arm and pulled on the walker to get him to his feet. R1 pivoted and sat on the bed. Once R1 was on the bed, NA-A quickly left the room. A minute later LPN-A came in and asked R1 what happened. R1 stated he reported to LPN-A he fell onto the wastebasket with his shoulder on the wastebasket, his knees on the floor, and now has an injury on both arms.

A progress note dated 10/07/21, at 10:55 p.m. by licensed practical nurse (LPN)-A documented being informed by nursing assistant (NA)-A at 10:35 p.m. that R1 had a skin tear. LPN-A

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2 830	Continued From page 4	2 830		

assessed the skin tear and documented finding a 2 cm x 0.8 cm wide skin tear. LPN-A cleansed the wound, completed skin preparation, applied steri strips and a 3 x 3" Mepilex bandage. LPN-A further documented R1 currently had a bruise in the same location as the skin tear. There was no documentation found in the medial record that a post fall assessment was completed to identify potential contributing factors and needed interventions.

A progress note dated 10/8/21, at 2:37 p.m. indicated that director of nursing (DON) documented R1's family was notified that he had a fall and sustained a skin tear.

A progress note dated 10/08/21, 3:57 p.m. documented registered nurse (RN)-A, was notified by staff at 6:00 a.m. that R1 reported having a fall last evening. R1 stated NA-A was helping him get ready for bed and NA-A took R1's shoes, sweater and shirt off and directed R1 to walk to the bed. R1 stated he was walking unassisted to the bed and his socks were slippery and that fell after taking one step. R1 stated he fell and landed with his left arm/chest on the wastebasket, and his knees were on the floor.

A progress note dated 10/11/21, at 12:14 p.m. documented LPN-A created an updated note for the 10/07/21, skin tear. LPN-A documented asking R1 what happened, and his reply was he slipped on the edge of the recliner and sat on the edge of the recliner/garbage can, but at no point did his bottom touch the floor.

During an interview on 10/26/21, at 9:49 a.m. NA-A stated on 10/07/21, at approximately 10:30 p.m. he went to help R1 get ready for bed. NA-A stated he took R1's shoes off and that he only

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2 830	Continued From page 5	2 830		

had socks on. NA-A indicated it was only a few feet from the recliner to the bed and thought R1 could walk to the bed without falling. NA-A stated he directed R1 to walk to the bed so he could continue to get R1 undressed. NA-A stated the recliner is approximately three feet from the bed and NA-A started walking with only his socks on, and that he did not place a gait belt on R1. NA-A stated R1 took a step, slipped and he tried to catch him. NA-A stated R1 fell to the left and landed on the wastebasket that is between and recliner and the bed, but he had a hold of R1's right arm. NA-A stated he is unsure if R1's knees were on the floor. NA-A then helped R1 to stand, pivot and sit on the bed. NA-A stated he immediately went to the charge nurse (does not remember her name - identified as LPN-A) and informed her that R1 fell and now has a skin tear. LPN-A immediately went to VA's room. NA-A sated he did not return to R1's room as it was the end of his shift and he left the facility. NA-A stated he did not follow the care plan which directed him to use a gait belt and ensure proper footwear were on R1 during the transfer.

During an observation on 10/26/21, at 9:45 a.m. R1 was observed in a wheelchair being wheeled into his room by unknown name physical therapist (PT)-A. PT-A assisted R1 to stand and then pivot to the recliner. R1's gait was observed to be unsteady and required the assistance of PT-A to stand and pivot. R1 was observed while lowering to sit in the recliner to abruptly land due to lack of strength.

During an interview on 10/26/21, at 11:13 a.m. LPN-A stated NA-A was observed on 10/07/21, at approximately 11:00 p.m. going to the charting area and could be overheard reporting to NA-B that R1 has a skin tear. LPN-A further overheard

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2 830	Continued From page 6 NA-A state it happened while he was transferring R1 and that he sat on top of the garbage can next to the bed. LPN-A stated she asked NA-A what happened and then went to assess R1's wound. LPN-A stated she asked R1 what happened, and he indicated he did not fall but slipped and sat on the garbage can. LPN-A stated since R1 did not fall to the floor, she did not think it was a fall. LPN-A further stated R1 informed her that NA-A did not use a gait belt and directed him to walk only in his socks, which made him slip. LPN-A stated when she arrived to R1's room, he was sitting on the bed with only his tee shirt and underwear on, so she was able to assess his skin. LPN-A she did not see the right upper arm wound that night, but it was found by another nurse the next day. During an interview on 10/26/21, at 12:33 p.m. DON stated a fall is an unplanned rapid descent. DON stated the fall to the wastebasket is considered a fall and should have been reported immediately. The facility Fall Prevention and Management Program policy, last modified on 01/12/21, directed that any unintentional change in position is considered a fall and in the event of a fall, notify the charge nurse by using the walkie. SUGGESTED METHOD OF CORRECTION: The DON or designee, could audit all current fall risk residents and resident falls to ensure care plan interventions are in place and acted upon toto help mitigate fall risk. The DON or designee could review polices and procedures for fall prevention, update as needed and review with appropriate staff. The DON or designee, could in-service staff on fall risk interventions and care plan implementation and audit for compliance.	2 830		

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2 830	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		