



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2024

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 21, 2024, we notified you a remedy was imposed. On March 7, 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 March 5, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 7, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 21, 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 March 7, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 5, 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 Therefore, the NATCEP prohibition is rescinded.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,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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



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March 13, 2024

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Re: Reinspection Results
Event ID: XWZI12

Dear Administrator:

On March 7, 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 February 7, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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
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February 21, 2024

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 7, 2024, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 March 7, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 7, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 7, 2024.

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.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; 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.

If you have not achieved substantial compliance by March 7, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Presbyterian Homes Of North Oaks will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 7, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

Presbyterian Homes Of North Oaks

February 21, 2024

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 - 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 7, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

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.

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

Presbyterian Homes Of North Oaks

February 21, 2024

Page 5

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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



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Electronically delivered
February 21, 2024

Administrator
Presbyterian Homes Of North Oaks
5919 Centerville Road
North Oaks, MN 55127

Re: State Nursing Home Licensing Orders
Event ID: XWZI11

Dear Administrator:

The above facility was surveyed on February 5, 2024 through February 7, 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.

Presbyterian Homes Of North Oaks

February 21, 2024

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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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2024
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NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF NORTH OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD NORTH OAKS, MN 55127
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 2/5/24, 2/6/24, and 2/7/24 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H56139329C (MN100370), H56139525C (MN97786), and H56139524C (MN96643) with a deficiency cited at F689.</p> <p>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.</p> <p>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.</p>	F 000		
F 689 SS=G	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 interview and document review, the</p>	F 689	" Facility will provide a 1:1 staff	3/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/27/2024
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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF NORTH OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD NORTH OAKS, MN 55127		
(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	<p>Continued From page 1</p> <p>facility failed to comprehensively assess and provide the provision of supervision of self transfer to prevent and/or mitigate the risk of falls for 1 of 3 residents (R2) who had a history of falls. This resulted in actual harm for R2 who fell and sustained back and rib fractures.</p> <p>Findings include:</p> <p>R2's Minimum Data Set (MDS) dated 1/23/24, indicated R2 was a 93-year-old admitted on 6/2/23 with diagnoses including dementia, diabetes, history of transient ischemic attack (temporary disruption of blood flow to the brain), muscle weakness, difficulty in walking, unsteadiness on feet, other abnormalities of gait and mobility, weakness, and repeated falls. R2's Brief Interview for Mental Status score was 11, indicating moderate cognitive impairment. R2 utilized a wheelchair, required substantial assistance with toileting hygiene, and moderate assistance with bed mobility and transfers. Walking was not attempted due to medical condition or safety concerns. R2 was frequently incontinent of bowel and bladder.</p> <p>R2's care plan dated 1/4/24, identified a focus on falls and noted resident is at risk for falls related to impaired cognition secondary to dementia, impaired balance during transitions, impaired gait, and history of repeated falls, activity intolerance secondary to chronic lung disease and hypertension, potential medication side effects. Other contributing factors noted were lower back pain, sleeplessness, frequently waking up to use the bathroom, and frequent independent transfers. Current fall interventions included: -alert/orient resident to changes in environment routine and caregivers,</p>	F 689	<p>supervision for R2 for 24 hours to determine patterns and level of supervision needed through activities of daily living and current care planned interventions.</p> <p>" Facility completed a comprehensive fall risk assessment for R2.</p> <p>" Facility comprehensively assessed R2 for bowel and bladder and results were care planned.</p> <p>" Facility continues to monitor the effectiveness of plan of care for R2 for falls to ensure supervision</p> <p>" 100% audit of all falls that have occurred in the last 30 days will be reviewed by the Clinical team to determine an appropriate level of supervision for the affected residents.</p> <p>" The clinical team completed an audit on all residents to determine if the level of supervision provided for each resident remains appropriate. All falls are reviewed every day by the interdisciplinary team during the week</p> <p>" The facility will continue to assess all new residents for fall risk and/or supervision needs as per policy and implement appropriate care plan interventions. The interdisciplinary team also meets weekly to review new residents for falls risk and past falls from the previous week for effectiveness of implemented interventions.</p> <p>" The facility will also continue to provide hourly safety checks for 48 hours on all new residents to establish on going safety and/or supervision needs are met.</p> <p>" The facility has reviewed the Fall Prevention and Management Program</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2024
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F 689	<p>Continued From page 2</p> <ul style="list-style-type: none"> -keep call light within reach and encourage use as needed, -complete fall risk assessment/evaluation quarterly and as needed, -check post-void residual as needed (amount of urine still in bladder after urinating), -encourage participation in activities that promote exercise and physical activity for strengthening and improved mobility such a physical and occupational therapies, ensure proper footwear is worn, -evaluate effectiveness of interventions on an ongoing basis, follow facility fall protocol, -give pain medication as ordered, -put motion sensor light in bathroom, -monitor for acute illness, -no repositioning sheet in bed, -pharmacy consultant review of medications at least monthly, -put night light near bed, -answer call light promptly, -place wheelchair with wheels locked next to bed when resident in bed, -physical therapy evaluation and treatment as needed, -remove clutter from room and keep a clear path to the bathroom, and noted to also see R2's care plan for activities of daily living (ADLs), mobility, and toileting. -Related ADL interventions included assist of one with dressing grooming and hygiene, and encourage/remind resident to use call light. -Related mobility interventions included active range of motion exercises of both lower extremities daily, resident preference to get up and do morning ADLs between 6:00 a.m. and 7:00 a.m., use of regular draw sheets on bed to prevent sliding off bed, and assistance of one with a gait belt for all transfers. 	F 689	<p>Policy, and it remains effective. All nursing staff were reeducated on the policy.</p> <p>" All staff training was completed on falls preventions and best practices.</p> <p>" The facility will audit 100% of falls for compliance on the first week, followed by 50% audit on the second week and 25% on the third week The Quality Assurance team will review the audit results daily at the Inter Disciplinary Team meetings. The results will be reported to the QA team, which they will determine the frequency of ongoing audits during the next QAPI meeting.</p> <p>" The Clinical Administrator or designee will be responsible for ongoing compliance.</p> <p>" Family and facility agree that may benefit from a small environment with more tactile activities geared towards residents with memory loss and/or close supervision needs. The facility is in the process assisting the resident in finding appropriate placement that may meet these needs.</p> <p>" The facility will collaborate with family of R2 to identify previous daily living patterns to continue to mitigate risks.</p> <p>" Date of compliance 3/5/2024.</p>	

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F 689	<p>Continued From page 3</p> <p>-Related toileting interventions included assistance with toileting and repositioning every two to three hours during waking hours and on all overnight rounds, last revised on 11/9/23.</p> <p>R2's electronic health record (EHR) included documentation of repeated falls since admission. R2's EHR included Falls Follow Up Forms from 6/3/23, 6/6/23, 6/22/23, 7/16/23, 7/17/23, 8/3/23, 9/16/23, 9/27/23, 10/1/23, 10/9/23, 10/28/23, 11/9/23, 11/28/23, 12/11/23, 12/14/23, 1/9/24, and 1/13/24. A progress note dated 12/31/23 at 12:04 p.m. indicated an additional fall on that date.</p> <p>In review of R2's fall records at least 7 of the falls involved toileting; 6/3/23, 7/16/23, 8/3/23, 9/27/23, 10/9/23, 11/9/23, and 1/9/24.</p> <p>R2's Resident Occurrence Report completed by registered nurse (RN)-A and licensed practical nurse (LPN)-A dated 12/14/23, indicated R2 was found on the floor in her room at 1:10 p.m. on 12/14/23. R2 was last observed at 1:00 p.m. when transferred from bed to chair by RN-A. The last time R2 was toileted was unknown. The resident statement indicated R2 was trying to reach the remote control. The analysis of the cause of the occurrence was R2 was unable to demonstrate call light use. The action to minimize reoccurrence was checking on R2 every 15 minutes. Suggestions to prevent this from occurring again noted the resident may benefit from having one-to-one assistance.</p> <p>R2's Falls Follow Up Form completed by registered nurse (RN)-A and licensed practical nurse (LPN)-A dated 12/14/23, indicated R2 fell on 12/14/23. The analysis and summary of causal factors noted R2 continued to self-transfer.</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>RN-A's short-term intervention was to check on R2 every 15 minutes. The long-term intervention noted by the director of nursing (DON) on 1/8/24 after inter-disciplinary team (IDT) review was rearrangement of R2's room to create a clear path to the bathroom.</p> <p>A progress note by RN-A dated 12/14/23 at 2:11 p.m., indicated the intervention based on root cause analysis of the fall was the resident is unable to follow directions for call light use. Frequent checks (was not defined) continued with resident to be brought to the bathroom. .</p> <p>A fall follow up progress note for R2's fall on 12/14/23 dated 12/17/23 at 7:28 a.m., indicated R2 continued to self-transfer and attempted to self-transfer three times during the night. R2 was rounded on frequently (was not defined) to monitor for safety and needs.</p> <p>A progress note dated 12/18/23 at 5:10 a.m., indicated R2 attempted to self-transfer four times during the writer's shift and was rounded on frequently to monitor for safety and needs.</p> <p>A provider note by nurse practitioner (NP)-A dated 12/19/23, indicated R2 has a history of multiple falls, likely multifactorial and usually when R2 is attempting to self-transfer. The plan directed staff to continue to assist with ambulation to and from the dining room and bathroom and transfers, to continue frequent check-ins, and to monitor for falls.</p> <p>R1's care plan was not revised to include "frequent check-in's" per NP note on 12/19/24.</p> <p>R2's record did not indicate an assessment or</p>	F 689		

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F 689	<p>Continued From page 5</p> <p>evaluation to determine interventions to reduce R2's self-transfers thereby reducing R2's risk for falls. Additionally, the record did not include completed evaluation of the effectiveness of the 15-minute checks and/or the "frequent" monitoring that was not individualized or determined to identify how often R2 required increased supervision.</p> <p>A progress note dated 12/20/23 at 1:35 p.m., indicated the resident is unable to demonstrate call light use.</p> <p>A progress note dated 12/22/23 at 6:22 a.m., indicated R2 attempted to self-transfer to the bathroom three times during the writer's shift, was assisted to the bathroom, and was rounded on frequently (was not defined) to monitor for needs and safety.</p> <p>A progress note dated 12/26/23 at 12:29 p.m., indicated R2 was unable to demonstrate call light use.</p> <p>A progress note dated 12/26/23 at 10:13 p.m., indicated R2 self-transferred twice during the writer's shift and does not use the call light.</p> <p>A progress note dated 12/27/23 at 11:50 p.m., indicated R2 self-transferred three times during the shift and did not use the call light.</p> <p>A progress note dated 12/28/23 at 11:18 p.m., indicated R2 was found self-transferring four times and "does NOT understand the call light."</p> <p>A progress note dated 12/31/23 at 12:04 p.m., indicated R2 attempted to use the restroom independently and fell in the morning. She did not</p>	F 689		

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F 689	<p>Continued From page 6</p> <p>use the call light for help and was found on the floor between her bed and armoire with her pants around her ankles. A Fall Follow Up Form for R2's 12/31/23 fall was not located in R2's EHR and no causal analysis of the fall was evident.</p> <p>A progress note dated 1/2/24 at 2:05 p.m., noted the resident has a diagnosis of dementia with a poor ability to recall new learning or follow call light use directions. New interventions related to mobility and/or fall risk included frequent checks and offering toileting every two to three hours, checking on R2 on all rounds overnight and offering toileting when awake, putting wheelchair with brakes on next to bed, rearranging bedroom, and placing bed closer to the bathroom.</p> <p>A progress note dated 1/3/24 at 12:17 p.m., indicated R2 remained impulsive and did not demonstrate the ability to identify the need for call light use.</p> <p>An IDT follow up progress note dated 1/3/24 at 3:25 p.m., indicated a root cause analysis of resident fall in the bathroom with intervention of occupational therapy evaluating for bars from a commode base to be placed on R2's toilet to use for balance and to push up on when R2 self-transfers to the toilet. The date of the fall was not indicated and not evident R1's toileting schedule was re-evaluated for appropriateness.</p> <p>A progress note dated 1/8/24 at 3:59 p.m., indicated R2 self-transferred once during the writer's shift and interventions were minimally effective as the resident was not dissuaded from self-transferring.</p> <p>A progress note dated 1/8/24 at 9:50 p.m.,</p>	F 689		

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F 689	<p>Continued From page 7</p> <p>indicated R2 self-transferred multiple times during the writer's shift and does not use call light despite continuing education and reminders.</p> <p>A fall progress note dated 1/9/24 at 7:23 a.m., indicated R2 was found on the floor returning from the bathroom without a wheelchair after self-transfer to the bathroom with a wheelchair. The intervention based on root cause analysis was "1:1 STAFFING WOULD BE MOST USEFUL - NOT AVAILABLE AT THIS TIME." An alternative intervention was not identified.</p> <p>R2's Resident Occurrence Report completed by RN-A dated 1/9/24, indicated R2 was found on the floor in her room on 1/9/24 at 6:45 a.m. The last observation of R2 prior to the fall was by nursing assistant (NA)-A at 6:30 a.m. when R2 was sleeping in bed with a wheelchair next to the bed. The last time R2 was toileted was not noted. The resident statement indicated R2 was trying to go to the bathroom and back to bed. The analysis of the cause of the occurrence was self-transfer to the toilet. The action to minimize reoccurrence noted new strategies were unable to be identified outside of one-to-one staff supervision. Suggestions to prevent this from occurring again were one-to-one staffing and noted frequent checks were inadequate and R2 was unable to follow directions.</p> <p>R2's Falls Follow Up Form completed by RN-A dated 1/9/24, indicated R2 fell on 1/9/24. The analysis and summary of causal factors noted R2 self-transferred for purpose of toileting without alerting staff, using a wheelchair to get to the bathroom and ambulating out of the bathroom without a wheelchair. RN-A's short-term intervention recommended one-to-one staff</p>	F 689		

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F 689	<p>Continued From page 8</p> <p>supervision. The long-term intervention noted by the director of nursing (DON) on 1/22/24 after IDT review was to continue to offer morning cares between 6:00 a.m. and 7:00 a.m. per resident preference.</p> <p>R1's record did not indicate an assessment or evaluation to determine interventions to reduce R1's self-transfers including re-assessment of R1's toileting time.</p> <p>A fall progress note by LPN-B dated 1/13/24 at 5:21 p.m., indicated R2 was found on the floor in her room between her bed and the bathroom on her left side with her left arm and leg underneath her body. Upon assessment R2 complained of pain, had unequal grip strength, could not move her left leg off the ground, and could not move her toes. R2 was sent to the hospital for further evaluation and treatment.</p> <p>R2's Resident Occurrence Report completed by LPN-B dated 1/13/24, indicated R2 was found on the ground between her bed and the bathroom at 4:40 p.m. on 1/13/24. Prior to the fall, R2 was last observed at 4:00 p.m. sleeping in bed when NA-B checked on R2 after R2 refused toileting offered at 3:30 p.m. The resident statement indicated R2 was going to the bathroom when she fell. The action to minimize reoccurrence and suggestions to prevent this from occurring again sections were not completed.</p> <p>R2's Falls Follow Up Form by LPN-B dated 1/13/24, indicated R2 fell at 4:40 p.m. on 1/13/24. The analysis and summary of causal factors noted R2 self-transferred, had no grippy socks, and did not use the call light. The short-term intervention was sending R2 to the hospital. A</p>	F 689		

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F 689	<p>Continued From page 9</p> <p>note dated 2/5/24 on the form from the DON after IDT review indicated R2 returned from the hospital with orders for physical and occupational therapies. The IDT would continue to evaluate R2's progress with therapy and update the plan of care as appropriate.</p> <p>A provider note dated 1/18/24, indicated R2 was admitted to Hospital on 1/13/24 for evaluation after an unwitnessed fall at the facility. Imaging revealed a lumbar vertebral fracture and two rib fractures. R2 transferred back to the facility on 1/17/24 and was discharged from the hospital with a thoracic lumbar sacral orthosis (TLSO) (a mid to lower back brace) to wear for three months.</p> <p>R2's NA care sheet for 2/7/24, indicated that R2 was a fall risk and instructed NAs to perform safety checks at the beginning and end of their shifts, take R2 to the bathroom every two to three hours while awake and on all overnight rounds, and to leave wheelchair with wheels locked next to R2's bed when in bed for self-transfers/falls.</p> <p>In an interview on 2/5/24 at 12:40 p.m., trained medication aide (TMA)-A stated R2 self-transfers and is a fall risk, so staff put her call light right next to her in bed and put her wheelchair next to her bed with the brakes locked. TMA-A stated R2's care plan was to offer toileting every two hours and he tried to monitor R2 "more frequently" because R2 is a fall risk. TMA-A did not articulate how frequent was frequent.</p> <p>In an interview on 2/5/24 at 1:05 p.m., NA-C stated R2 fell a lot and did not say when she needed to be changed or toileted. R2 did not know how to use the call light at all and tried to</p>	F 689		

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F 689	<p>Continued From page 10</p> <p>self-transfer when in her room. NA-C stated R2's wheelchair was placed at bedside with the bed in low position in case R2 tried to get up.</p> <p>In an interview on 2/5/24 at 2:01 p.m., family member (FM)-A stated R2 had fallen in the past while trying to go to the bathroom. Sometimes R2 had to wait to go to the bathroom and tried to go by herself. R2 did not like to wait, she goes when she wanted to go. When R2 was asked if she needed to go to the bathroom she might say yes and might say no, sometimes she said no and then had to go a few minutes later.</p> <p>In an interview on 2/7/24 at 9:21 a.m., RN-A stated R2 has an inability to retain new learning and education and reminders about using the call light have not been effective. RN-A stated she did not believe it was appropriate to have call light use as a fall intervention because it was not effective, and education was not an appropriate intervention if R2 was unable to learn. R2 could not use it and did not use it. R2 did not refuse cares when offered but was impulsive and had toileting every two hours in her care plan. RN-A stated she wrote R2 needs one-to-one staff supervision on a recent fall report. RN-A reported that she had not seen any changes in how R2 was monitored or supervised since completing the report and believed R2's fall with injury on 1/13/24 could have been prevented with more supervision.</p> <p>In an interview on 2/7/24 at 9:40 a.m., NA-D stated R2 ambulated with extensive assistance and transferred with an assist of one with a gait belt. R2 was a fall risk and interventions were on her care plan such as putting R2's wheelchair at bedside and the call light right next to her. NA-D</p>	F 689		

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F 689	<p>Continued From page 11</p> <p>stated toileting was offered to R2 every two to three hours and NA-D tried to check on R2 every hour. NA-D noted frequent checks would be considered checking on R2 hourly.</p> <p>In an interview on 2/7/24 at 9:50 a.m., TMA-A stated the frequency of checks on a resident depends on the resident's care plan. For R2, the toileting care plan said to check every two hours.</p> <p>In an interview on 2/7/24 at 9:57 a.m., NA-C stated frequent checks meant checking on a resident every half hour or so, at least every hour, but more if possible. Checking on a resident was looking at them to be sure they were okay and safe.</p> <p>In an interview on 2/7/24 at 10:28 a.m., NA-A stated R2 was a "big fall risk" and tends to self-transfer from her bed to the bathroom all the time. Staff tried to toilet her as much as possible so she did not self-transfer, R2 needed to be toileted every three to four hours. Staff kept R2's call light close by, wheelchair at bedside with brakes locked, and placed a motion sensor light in R2's bathroom. NA-A stated she had never seen R2 hold or push her call light, R2 did not refuse cares, R2 would get up and used the bathroom when she needed to.</p> <p>In an interview on 2/7/24 at 11:42 a.m., director of nursing (DON) stated when a resident had a fall with an injury the first question was to see if the plan of care was followed. The IDT met to review falls and made sure the plan of care was followed. If it was followed the IDT looked at what else could prevent the fall. The team considers what the recommendations were from the nurse and as a team we come up with interventions.</p>	F 689		

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F 689	Continued From page 12 Then after two weeks we review the fall again at the IDT meeting, go over what interventions were put in place, see if they are effective, and decide how to proceed. The fall risk assessment was the comprehensive assessment completed when the the resident was admitted. We review that as we get to know the resident and develop the care plan. If someone was a fall risk, we add the risks and interventions to the care plan and do the assessment every three months. DON stated R2 had approximately 14 to 15 falls since admission and fell frequently. For R2, nursing recommended one-to-one supervision, but DON did not offer that as an intervention because knew R2's family did not have resources. DON noted that the last revision to R2's toileting care plan was on 11/9/23 with the addition of an intervention to toilet R2 every two to three hours and on overnight rounds. DON stated the falls form from R2's 7/16/23 had a short-term intervention to continue hourly safety checks which staff could do but was not added to R2's care plan. DON explained there was an assessment of safety which included meeting a resident's needs but there was no separate assessment that determined supervision. To determine R2's level of supervision DON thought a sleep log was completed, pain management assessment, and the nurses and aides did safety checks at the beginning of their shifts. DON explained there were repeated recommendations from nursing to increase R2's supervision. DON stated "I don't think it is practical to say someone will go in every half hour or every hour to check on [R2], it is not realistic." Checking on a resident frequently is not on care plans because if you say frequently you have to say how often, "I can't tell the aides to check on the residents frequently without giving a time frame." DON believed the toileting every two to three hours that was	F 689		

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F 689	<p>Continued From page 13</p> <p>currently in place was appropriate. After R2's fall on 1/9/24, the intervention was continuing the plan of care, DON was not sure why. We can continue the plan of care but continue to also reapproach the resident when offering toileting if they say they do not need to toilet at the time. DON believed R2 has used the call light or but not aware of how frequently she used it. DON stated an awareness R2's cognition was continuing to decline.</p> <p>In an interview on 2/7/24 at 3:45 p.m., NP-A stated numerous interventions have been tried regarding R2's falls but it seems like every intervention tried helps for a short period of time and R2 continues to not use the call light. R2 often says she wants to go back to bed, and "it is tough to keep her up". NP-A thought trying to keep R2 in the common area more, having eyes on her more so R2 can't just climb out of bed would help. NP-A stated she could talk to R2's care team about how to have more eyes on her and not have R2 in bed the majority of the day so when R2 feels the need to get up she can be watched more closely by staff. NP-A stated staff do check-ins on R2 every two hours and believed staff should lay eyes on R2 every hour at least and make sure her basic needs are being met, especially during the day when she is more up and active. NP-A was not sure of the facility's availability but thought the facility was able to do that and it would be a good idea to step up those checks on R2.</p> <p>The facility's Fall Prevention and Management Program Policy dated April 2021 included the following:</p> <p>"Clinical Coordinator or designee is responsible</p>	F 689		

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F 689	<p>Continued From page 14</p> <p>for implementation and oversight of individualized residents fall prevention care as follows: a.) Assessing fall risk upon admission, quarterly, with significant change in condition. b.) Determining risk for fall and establishing appropriate interventions in the care plan related to fall risk in the plan of care. c.) Implementing the interventions specific to fall risk data collection. d.) Supervising personnel in delivering safe and personalized care. e.) Evaluating the effectiveness of interventions in relation to the resident specific plan of care. f.) Collaborating with the interdisciplinary team in the prevention of falls. g.) Appropriately managing residents who experience a fall by implementing interventions to prevent further falls. h.) Complete and update fall tracking.</p> <p>Prevention Interventions/Strategies: a.) Environmental Safety - Environmental rounds will be completed monthly. b.) Nursing staff will implement interventions according to resident specific risk factors. c.) Medications will be reviewed monthly by the consulting pharmacist and quarterly by nursing staff. d.) Care plans will indicate the resident specific interventions to prevent falls.</p> <p>Post Fall Management: The staff nurse will review the Occurrence Report and will: i.) Assess all factors contributing to the fall event including intrinsic and extrinsic factors and which interventions were in place at the time of the fall using Falls Follow Up Form as a guideline. ii.) Recommend interventions and changes to plan of care to prevent a repeat fall. iii.) Communicate and document results."</p>	F 689		

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/5/24, 2/6/24, and 2/7/24, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/27/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2024
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NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF NORTH OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD NORTH OAKS, MN 55127
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed H56139329C (MN100370), H56139525C (MN97786), and H56139524C (MN96643) with a licensing order issued at 830.</p> <p>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.</p> <p>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</p>	2 000		
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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and provide the provision of supervision of self transfer to prevent and/or mitigate the risk of falls for 1 of 3 residents (R2) who had a history of falls. This resulted in actual harm for R2 who fell and sustained back and rib fractures. Findings include:	2 830	corrected	3/4/24

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2 830	<p>Continued From page 3</p> <p>R2's Minimum Data Set (MDS) dated 1/23/24, indicated R2 was a 93-year-old admitted on 6/2/23 with diagnoses including dementia, diabetes, history of transient ischemic attack (temporary disruption of blood flow to the brain), muscle weakness, difficulty in walking, unsteadiness on feet, other abnormalities of gait and mobility, weakness, and repeated falls. R2's Brief Interview for Mental Status score was 11, indicating moderate cognitive impairment. R2 utilized a wheelchair, required substantial assistance with toileting hygiene, and moderate assistance with bed mobility and transfers. Walking was not attempted due to medical condition or safety concerns. R2 was frequently incontinent of bowel and bladder.</p> <p>R2's care plan dated 1/4/24, identified a focus on falls and noted resident is at risk for falls related to impaired cognition secondary to dementia, impaired balance during transitions, impaired gait, and history of repeated falls, activity intolerance secondary to chronic lung disease and hypertension, potential medication side effects. Other contributing factors noted were lower back pain, sleeplessness, frequently waking up to use the bathroom, and frequent independent transfers. Current fall interventions included:</p> <ul style="list-style-type: none"> -alert/orient resident to changes in environment routine and caregivers, -keep call light within reach and encourage use as needed, -complete fall risk assessment/evaluation quarterly and as needed, -check post-void residual as needed (amount of urine still in bladder after urinating), -encourage participation in activities that promote exercise and physical activity for strengthening and improved mobility such a physical and occupational therapies, ensure proper footwear is 	2 830		

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2 830	<p>Continued From page 4</p> <p>worn, -evaluate effectiveness of interventions on an ongoing basis, follow facility fall protocol, -give pain medication as ordered, -put motion sensor light in bathroom, -monitor for acute illness, -no repositioning sheet in bed, -pharmacy consultant review of medications at least monthly, -put night light near bed, -answer call light promptly, -place wheelchair with wheels locked next to bed when resident in bed, -physical therapy evaluation and treatment as needed, -remove clutter from room and keep a clear path to the bathroom, and noted to also see R2's care plan for activities of daily living (ADLs), mobility, and toileting. -Related ADL interventions included assist of one with dressing grooming and hygiene, and encourage/remind resident to use call light. -Related mobility interventions included active range of motion exercises of both lower extremities daily, resident preference to get up and do morning ADLs between 6:00 a.m. and 7:00 a.m., use of regular draw sheets on bed to prevent sliding off bed, and assistance of one with a gait belt for all transfers. -Related toileting interventions included assistance with toileting and repositioning every two to three hours during waking hours and on all overnight rounds, last revised on 11/9/23.</p> <p>R2's electronic health record (EHR) included documentation of repeated falls since admission. R2's EHR included Falls Follow Up Forms from 6/3/23, 6/6/23, 6/22/23, 7/16/23, 7/17/23, 8/3/23, 9/16/23, 9/27/23, 10/1/23, 10/9/23, 10/28/23, 11/9/23, 11/28/23, 12/11/23, 12/14/23, 1/9/24, and</p>	2 830		
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2 830	<p>Continued From page 5</p> <p>1/13/24. A progress note dated 12/31/23 at 12:04 p.m. indicated an additional fall on that date.</p> <p>In review of R2's fall records at least 7 of the falls involved toileting; 6/3/23, 7/16/23, 8/3/23, 9/27/23, 10/9/23, 11/9/23, and 1/9/24.</p> <p>R2's Resident Occurrence Report completed by registered nurse (RN)-A and licensed practical nurse (LPN)-A dated 12/14/23, indicated R2 was found on the floor in her room at 1:10 p.m. on 12/14/23. R2 was last observed at 1:00 p.m. when transferred from bed to chair by RN-A. The last time R2 was toileted was unknown. The resident statement indicated R2 was trying to reach the remote control. The analysis of the cause of the occurrence was R2 was unable to demonstrate call light use. The action to minimize reoccurrence was checking on R2 every 15 minutes. Suggestions to prevent this from occurring again noted the resident may benefit from having one-to-one assistance.</p> <p>R2's Falls Follow Up Form completed by registered nurse (RN)-A and licensed practical nurse (LPN)-A dated 12/14/23, indicated R2 fell on 12/14/23. The analysis and summary of causal factors noted R2 continued to self-transfer. RN-A's short-term intervention was to check on R2 every 15 minutes. The long-term intervention noted by the director of nursing (DON) on 1/8/24 after inter-disciplinary team (IDT) review was rearrangement of R2's room to create a clear path to the bathroom.</p> <p>A progress note by RN-A dated 12/14/23 at 2:11 p.m., indicated the intervention based on root cause analysis of the fall was the resident is unable to follow directions for call light use. Frequent checks (was not defined) continued with</p>	2 830		

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2 830	<p>Continued From page 6</p> <p>resident to be brought to the bathroom. .</p> <p>A fall follow up progress note for R2's fall on 12/14/23 dated 12/17/23 at 7:28 a.m., indicated R2 continued to self-transfer and attempted to self-transfer three times during the night. R2 was rounded on frequently (was not defined) to monitor for safety and needs.</p> <p>A progress note dated 12/18/23 at 5:10 a.m., indicated R2 attempted to self-transfer four times during the writer's shift and was rounded on frequently to monitor for safety and needs.</p> <p>A provider note by nurse practitioner (NP)-A dated 12/19/23, indicated R2 has a history of multiple falls, likely multifactorial and usually when R2 is attempting to self-transfer. The plan directed staff to continue to assist with ambulation to and from the dining room and bathroom and transfers, to continue frequent check-ins, and to monitor for falls.</p> <p>R1's care plan was not revised to include "frequent check-in's" per NP note on 12/19/24.</p> <p>R2's record did not indicate an assessment or evaluation to determine interventions to reduce R2's self-transfers thereby reducing R2's risk for falls. Additionally, the record did not include completed evaluation of the effectiveness of the 15-minute checks and/or the "frequent" monitoring that was not individualized or determined to identify how often R2 required increased supervision.</p> <p>A progress note dated 12/20/23 at 1:35 p.m., indicated the resident is unable to demonstrate call light use.</p>	2 830		

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2 830	<p>Continued From page 7</p> <p>A progress note dated 12/22/23 at 6:22 a.m., indicated R2 attempted to self-transfer to the bathroom three times during the writer's shift, was assisted to the bathroom, and was rounded on frequently (was not defined) to monitor for needs and safety.</p> <p>A progress note dated 12/26/23 at 12:29 p.m., indicated R2 was unable to demonstrate call light use.</p> <p>A progress note dated 12/26/23 at 10:13 p.m., indicated R2 self-transferred twice during the writer's shift and does not use the call light.</p> <p>A progress note dated 12/27/23 at 11:50 p.m., indicated R2 self-transferred three times during the shift and did not use the call light.</p> <p>A progress note dated 12/28/23 at 11:18 p.m., indicated R2 was found self-transferring four times and "does NOT understand the call light."</p> <p>A progress note dated 12/31/23 at 12:04 p.m., indicated R2 attempted to use the restroom independently and fell in the morning. She did not use the call light for help and was found on the floor between her bed and armoire with her pants around her ankles. A Fall Follow Up Form for R2's 12/31/23 fall was not located in R2's EHR and no causal analysis of the fall was evident.</p> <p>A progress note dated 1/2/24 at 2:05 p.m., noted the resident has a diagnosis of dementia with a poor ability to recall new learning or follow call light use directions. New interventions related to mobility and/or fall risk included frequent checks and offering toileting every two to three hours, checking on R2 on all rounds overnight and offering toileting when awake, putting wheelchair</p>	2 830		
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2 830	<p>Continued From page 8</p> <p>with brakes on next to bed, rearranging bedroom, and placing bed closer to the bathroom.</p> <p>A progress note dated 1/3/24 at 12:17 p.m., indicated R2 remained impulsive and did not demonstrate the ability to identify the need for call light use.</p> <p>An IDT follow up progress note dated 1/3/24 at 3:25 p.m., indicated a root cause analysis of resident fall in the bathroom with intervention of occupational therapy evaluating for bars from a commode base to be placed on R2's toilet to use for balance and to push up on when R2 self-transfers to the toilet. The date of the fall was not indicated and not evident R1's toileting schedule was re-evaluated for appropriateness.</p> <p>A progress note dated 1/8/24 at 3:59 p.m., indicated R2 self-transferred once during the writer's shift and interventions were minimally effective as the resident was not dissuaded from self-transferring.</p> <p>A progress note dated 1/8/24 at 9:50 p.m., indicated R2 self-transferred multiple times during the writer's shift and does not use call light despite continuing education and reminders.</p> <p>A fall progress note dated 1/9/24 at 7:23 a.m., indicated R2 was found on the floor returning from the bathroom without a wheelchair after self-transfer to the bathroom with a wheelchair. The intervention based on root cause analysis was "1:1 STAFFING WOULD BE MOST USEFUL - NOT AVAILABLE AT THIS TIME." An alternative intervention was not identified.</p> <p>R2's Resident Occurrence Report completed by RN-A dated 1/9/24, indicated R2 was found on</p>	2 830		

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2 830	<p>Continued From page 9</p> <p>the floor in her room on 1/9/24 at 6:45 a.m. The last observation of R2 prior to the fall was by nursing assistant (NA)-A at 6:30 a.m. when R2 was sleeping in bed with a wheelchair next to the bed. The last time R2 was toileted was not noted. The resident statement indicated R2 was trying to go to the bathroom and back to bed. The analysis of the cause of the occurrence was self-transfer to the toilet. The action to minimize reoccurrence noted new strategies were unable to be identified outside of one-to-one staff supervision. Suggestions to prevent this from occurring again were one-to-one staffing and noted frequent checks were inadequate and R2 was unable to follow directions.</p> <p>R2's Falls Follow Up Form completed by RN-A dated 1/9/24, indicated R2 fell on 1/9/24. The analysis and summary of causal factors noted R2 self-transferred for purpose of toileting without alerting staff, using a wheelchair to get to the bathroom and ambulating out of the bathroom without a wheelchair. RN-A's short-term intervention recommended one-to-one staff supervision. The long-term intervention noted by the director of nursing (DON) on 1/22/24 after IDT review was to continue to offer morning cares between 6:00 a.m. and 7:00 a.m. per resident preference.</p> <p>R1's record did not indicate an assessment or evaluation to determine interventions to reduce R1's self-transfers including re-assessment of R1's toileting time.</p> <p>A fall progress note by LPN-B dated 1/13/24 at 5:21 p.m., indicated R2 was found on the floor in her room between her bed and the bathroom on her left side with her left arm and leg underneath her body. Upon assessment R2 complained of</p>	2 830		
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2 830	<p>Continued From page 10</p> <p>pain, had unequal grip strength, could not move her left leg off the ground, and could not move her toes. R2 was sent to the hospital for further evaluation and treatment.</p> <p>R2's Resident Occurrence Report completed by LPN-B dated 1/13/24, indicated R2 was found on the ground between her bed and the bathroom at 4:40 p.m. on 1/13/24. Prior to the fall, R2 was last observed at 4:00 p.m. sleeping in bed when NA-B checked on R2 after R2 refused toileting offered at 3:30 p.m. The resident statement indicated R2 was going to the bathroom when she fell. The action to minimize reoccurrence and suggestions to prevent this from occurring again sections were not completed.</p> <p>R2's Falls Follow Up Form by LPN-B dated 1/13/24, indicated R2 fell at 4:40 p.m. on 1/13/24. The analysis and summary of causal factors noted R2 self-transferred, had no grippy socks, and did not use the call light. The short-term intervention was sending R2 to the hospital. A note dated 2/5/24 on the form from the DON after IDT review indicated R2 returned from the hospital with orders for physical and occupational therapies. The IDT would continue to evaluate R2's progress with therapy and update the plan of care as appropriate.</p> <p>A provider note dated 1/18/24, indicated R2 was admitted to Hospital on 1/13/24 for evaluation after an unwitnessed fall at the facility. Imaging revealed a lumbar vertebral fracture and two rib fractures. R2 transferred back to the facility on 1/17/24 and was discharged from the hospital with a thoracic lumbar sacral orthosis (TLSO) (a mid to lower back brace) to wear for three months.</p>	2 830		

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2 830	<p>Continued From page 11</p> <p>R2's NA care sheet for 2/7/24, indicated that R2 was a fall risk and instructed NAs to perform safety checks at the beginning and end of their shifts, take R2 to the bathroom every two to three hours while awake and on all overnight rounds, and to leave wheelchair with wheels locked next to R2's bed when in bed for self-transfers/falls.</p> <p>In an interview on 2/5/24 at 12:40 p.m., trained medication aide (TMA)-A stated R2 self-transfers and is a fall risk, so staff put her call light right next to her in bed and put her wheelchair next to her bed with the brakes locked. TMA-A stated R2's care plan was to offer toileting every two hours and he tried to monitor R2 "more frequently" because R2 is a fall risk. TMA-A did not articulate how frequent was frequent.</p> <p>In an interview on 2/5/24 at 1:05 p.m., NA-C stated R2 fell a lot and did not say when she needed to be changed or toileted. R2 did not know how to use the call light at all and tried to self-transfer when in her room. NA-C stated R2's wheelchair was placed at bedside with the bed in low position in case R2 tried to get up.</p> <p>In an interview on 2/5/24 at 2:01 p.m., family member (FM)-A stated R2 had fallen in the past while trying to go to the bathroom. Sometimes R2 had to wait to go to the bathroom and tried to go by herself. R2 did not like to wait, she goes when she wanted to go. When R2 was asked if she needed to go to the bathroom she might say yes and might say no, sometimes she said no and then had to go a few minutes later.</p> <p>In an interview on 2/7/24 at 9:21 a.m., RN-A stated R2 has an inability to retain new learning and education and reminders about using the call light have not been effective. RN-A stated she did</p>	2 830		

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NAME OF PROVIDER OR SUPPLIER PRESBYTERIAN HOMES OF NORTH OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD NORTH OAKS, MN 55127
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2 830	<p>Continued From page 12</p> <p>not believe it was appropriate to have call light use as a fall intervention because it was not effective, and education was not an appropriate intervention if R2 was unable to learn. R2 could not use it and did not use it. R2 did not refuse cares when offered but was impulsive and had toileting every two hours in her care plan. RN-A stated she wrote R2 needs one-to-one staff supervision on a recent fall report. RN-A reported that she had not seen any changes in how R2 was monitored or supervised since completing the report and believed R2's fall with injury on 1/13/24 could have been prevented with more supervision.</p> <p>In an interview on 2/7/24 at 9:40 a.m., NA-D stated R2 ambulated with extensive assistance and transferred with an assist of one with a gait belt. R2 was a fall risk and interventions were on her care plan such as putting R2's wheelchair at bedside and the call light right next to her. NA-D stated toileting was offered to R2 every two to three hours and NA-D tried to check on R2 every hour. NA-D noted frequent checks would be considered checking on R2 hourly.</p> <p>In an interview on 2/7/24 at 9:50 a.m., TMA-A stated the frequency of checks on a resident depends on the resident's care plan. For R2, the toileting care plan said to check every two hours.</p> <p>In an interview on 2/7/24 at 9:57 a.m., NA-C stated frequent checks meant checking on a resident every half hour or so, at least every hour, but more if possible. Checking on a resident was looking at them to be sure they were okay and safe.</p> <p>In an interview on 2/7/24 at 10:28 a.m., NA-A stated R2 was a "big fall risk" and tends to</p>	2 830		
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2 830	<p>Continued From page 13</p> <p>self-transfer from her bed to the bathroom all the time. Staff tried to toilet her as much as possible so she did not self-transfer, R2 needed to be toileted every three to four hours. Staff kept R2's call light close by, wheelchair at bedside with brakes locked, and placed a motion sensor light in R2's bathroom. NA-A stated she had never seen R2 hold or push her call light, R2 did not refuse cares, R2 would get up and used the bathroom when she needed to.</p> <p>In an interview on 2/7/24 at 11:42 a.m., director of nursing (DON) stated when a resident had a fall with an injury the first question was to see if the plan of care was followed. The IDT met to review falls and made sure the plan of care was followed. If it was followed the IDT looked at what else could prevent the fall. The team considers what the recommendations were from the nurse and as a team we come up with interventions. Then after two weeks we review the fall again at the IDT meeting, go over what interventions were put in place, see if they are effective, and decide how to proceed. The fall risk assessment was the comprehensive assessment completed when the the resident was admitted. We review that as we get to know the resident and develop the care plan. If someone was a fall risk, we add the risks and interventions to the care plan and do the assessment every three months. DON stated R2 had approximately 14 to 15 falls since admission and fell frequently. For R2, nursing recommended one-to-one supervision, but DON did not offer that as an intervention because knew R2's family did not have resources. DON noted that the last revision to R2's toileting care plan was on 11/9/23 with the addition of an intervention to toilet R2 every two to three hours and on overnight rounds. DON stated the falls form from R2's 7/16/23 had a short-term intervention to continue hourly safety</p>	2 830		
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2 830	<p>Continued From page 14</p> <p>checks which staff could do but was not added to R2's care plan. DON explained there was an assessment of safety which included meeting a resident's needs but there was no separate assessment that determined supervision. To determine R2's level of supervision DON thought a sleep log was completed, pain management assessment, and the nurses and aides did safety checks at the beginning of their shifts. DON explained there were repeated recommendations from nursing to increase R2's supervision. DON stated "I don't think it is practical to say someone will go in every half hour or every hour to check on [R2], it is not realistic." Checking on a resident frequently is not on care plans because if you say frequently you have to say how often, "I can't tell the aides to check on the residents frequently without giving a time frame." DON believed the toileting every two to three hours that was currently in place was appropriate. After R2's fall on 1/9/24, the intervention was continuing the plan of care, DON was not sure why. We can continue the plan of care but continue to also reapproach the resident when offering toileting if they say they do not need to toilet at the time. DON believed R2 has used the call light or but not aware of how frequently she used it. DON stated an awareness R2's cognition was continuing to decline.</p> <p>In an interview on 2/7/24 at 3:45 p.m., NP-A stated numerous interventions have been tried regarding R2's falls but it seems like every intervention tried helps for a short period of time and R2 continues to not use the call light. R2 often says she wants to go back to bed, and "it is tough to keep her up". NP-A thought trying to keep R2 in the common area more, having eyes on her more so R2 can't just climb out of bed would help. NP-A stated she could talk to R2's</p>	2 830		
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2 830	<p>Continued From page 15</p> <p>care team about how to have more eyes on her and not have R2 in bed the majority of the day so when R2 feels the need to get up she can be watched more closely by staff. NP-A stated staff do check-ins on R2 every two hours and believed staff should lay eyes on R2 every hour at least and make sure her basic needs are being met, especially during the day when she is more up and active. NP-A was not sure of the facility's availability but thought the facility was able to do that and it would be a good idea to step up those checks on R2.</p> <p>The facility's Fall Prevention and Management Program Policy dated April 2021 included the following:</p> <p>"Clinical Coordinator or designee is responsible for implementation and oversight of individualized residents fall prevention care as follows: a.) Assessing fall risk upon admission, quarterly, with significant change in condition. b.) Determining risk for fall and establishing appropriate interventions in the care plan related to fall risk in the plan of care. c.) Implementing the interventions specific to fall risk data collection. d.) Supervising personnel in delivering safe and personalized care. e.) Evaluating the effectiveness of interventions in relation to the resident specific plan of care. f.) Collaborating with the interdisciplinary team in the prevention of falls. g.) Appropriately managing residents who experience a fall by implementing interventions to prevent further falls. h.) Complete and update fall tracking.</p> <p>Prevention Interventions/Strategies: a.) Environmental Safety - Environmental rounds will be completed monthly. b.) Nursing staff will implement interventions according to resident</p>	2 830		

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2 830	<p>Continued From page 16</p> <p>specific risk factors. c.) Medications will be reviewed monthly by the consulting pharmacist and quarterly by nursing staff. d.) Care plans will indicate the resident specific interventions to prevent falls.</p> <p>Post Fall Management: The staff nurse will review the Occurrence Report and will: i.) Assess all factors contributing to the fall event including intrinsic and extrinsic factors and which interventions were in place at the time of the fall using Falls Follow Up Form as a guideline. ii.) Recommend interventions and changes to plan of care to prevent a repeat fall. iii.) Communicate and document results."</p> <p>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 ensure proper assessment and interventions 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.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		