Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25613	A. BUILDING: ______ B. WING ______	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GABLES OF BOUTWELLS LANDING	13575 58TH STREET NORTH OAK PARK HEIGHTS, MN 55082

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2 000	Initial Comments	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 5/29/24 through 5/30/24, 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

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H56154106C (MN00103651, MN00103478) with a licensing order issued at (0830). 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	2 000		

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2 000	Continued From page 2 Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement assessed and directed fall prevention techniques for 2 of 3 residents (R1,R2) reviewed for falls. This resulted in actual harm for R1 who had an assisted fall to the floor when staff were not utilizing a gait belt during a transfer as assessed and R1 sustained a right ankle fracture.	2 830	Corrected	7/9/24

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2 830	Continued From page 3	2 830		

Findings include:

R1's annual Minimal Data Set (MDS) dated 5/6/24, indicated R1 had diagnoses which included osteoporosis, Alzheimer's disease, and R1 had moderately impaired cognition.

R1's care plan revised on 5/26/24, identified R1 had limited physical mobility related to muscle weakness and impaired gait/balance, chronic shoulder pain, dementia with memory loss and required a front wheeled walker and assistance by staff when transferring and ambulating. Further, R1's care plan identified R1 was at risk for falls.

Review of facility's Summit 3 Communication Sheet dated 5/16/24, identified R1 was a fall risk and directed staff to assist R1 with transfers utilizing a front wheeled walker and a gait belt. Further, facility document revealed standard safety measures and directed staff to assure call light was within reach and gait belt was to be used when assisting with all transfers and ambulating.

Review of facility report to the State Agency (SA) dated 5/20/24, indicated staff was assisting R1 to get ready for the day and ambulating R1 to the toilet. R1 was about to pass out while ambulating and assisted R1 to the floor. R1 complained of pain on her left side of the body and her right ankle, but was able to move all extremities. Review of facility's 5-day investigation to the SA revealed R1 was confirmed to have sustained a right bimalleolar fracture with mortise displacement. In addition, the staff did not follow the company's standard safety practice of utilizing a gait belt when transferring or ambulating a

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2 830	Continued From page 4 resident and facility wide education to ensure staff would follow plan of care and compliance with the company's standard safety practices was the action taken to prevent reoccurrence. R1's Final Report dated 5/19/24, completed by Dispatch Health Imagining, revelaed the findings of R1's x-rays was a fracture of the distal fibula and a chip fracture of the medial malleolus. R2's entry MDS dated 5/17/24, indicated R2 had diagnoses which included Alzheimer's disease, anxiety disorder and urgency of urination. R2's care plan as of 5/29/24, identified R2 as at risk for falls related to cognitive impairment, gait/balance problems, history of falls, poor communication/comprehension, and unaware of safety needs. R2's fall interventions included a toileting plan in place and directed staff to reference the communication sheet for details. Review of facility's Trolley 3 Communication Sheet dated 5/24/24, identified R2 was a fall risk and directed staff to keep bedroom door open for safety due to frequent self-transfers and toilet upon rising, before meals, at hour of sleep and every 3 hours during the night. R2's Resident Occurrence Report dated 5/26/24, indicated R2 had an unwitnessed fall in room at 3:50 a.m. and R2 did not sustain any injuries. R2 reported she was attempting to get out of bed to use the bathroom. R2 was last observed by nursing assistant (NA)-B at 3:30 a.m. and R2 was noted to be in her room laying in bed. R2 was last assisted to the bathroom at approximately 12:00 a.m. However, document lacked evidence of interdisciplinary team (IDT) addressing R2's toileting care plan was not followed at the time of	2 830		

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2 830	Continued From page 5	2 830		

the fall and what had been done to correct.

Review of facility document titled Falls Tracking as of 5/29/24, revealed R2 had a fall on 5/26/24 and IDT intervention implemented based on root cause was identified as staff coaching.

Review of facility document titled Gables Care Center dated 5/21/24, and name of education was identified as Communication Protocol and Gait Belts for Transfers and Ambulation directing staff to sign the document to verify staff were present and understood to follow policies and practices outlined within the presentation. Further, education provided included when providing cares to residents or responding to resident requests, all staff need to be aware of the individualized interventions for each resident and resident care specific information could be found on the Communication Sheet. Staff were directed to review the Communication Sheet each time they work with residents due to constant changes and adjustments made to the resident's cares. Also, education included Communication Sheet Guideline which included toileting schedule and transfer for staff to review. In addition, document revealed NA-B had not reviewed the document as evidenced by NA-B's signature was not on the document.

On 5/29/24 at 2:49 p.m., R2 was observed in her room sitting in a standard wheelchair, slippers on and call light was within reach. R2 appeared comfortable and was drinking a cup of coffee. At 3:14 p.m., R2 was assisted to a table in the commons area with other female residents and an unidentified female staff remained in the area.

On 5/30/24 at 8:51 a.m., registered nurse (RN)-A indicated R2 was at risk for falls and interventions

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2 830	Continued From page 6	2 830		

Continued From page 6

included keeping R2's door open for staff to monitor her closely as well as toileting program every 2-3 hours and as needed. Further, RN-A stated fall interventions were located on the Communication Sheets which are available to staff and updated daily and with any changes.

On 5/30/24 at 10:24 a.m., NA-C stated R2 requires staff assistance with transfers using a gait belt and she was at risk for falls due to self-transferring, adding R2's fall interventions included frequent glances into R2's room, keep door open, and toileting every 2-3 hours as well as upon rising, and before meals. Further, NA-C stated fall interventions were listed on each resident's care plan as well as the Communication Sheets.

On 5/30/24 at 10:59 a.m., NA-A stated she was assisting R1 to get up in the morning on 5/19/24. NA-A stated R1 stood up from her bed and NA-A was supporting her but did not use a gait belt as required because NA-A stated she did not know she required one at that time. NA-A stated R1 expressed feeling lightheaded and NA-A offered her the wheelchair to which R1 declined. R1 then began falling forward and NA-A gently assisted her to the ground. Following the incident, NA-A stated management had called her and informed her she did not follow R1's care plan and NA-A should have used a gait belt. NA-A stated she resigned from the position and was no longer employed with the facility.

On 5/30/24 at 1:31 p.m., RN-B stated following each fall she would review the form that was completed by the floor nurse at the time of the fall and bring it to the IDT meeting every weekday at 9:00 a.m. RN-B stated the IDT then goes through the fall and interventions and ideas are discussed

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as a team, and if the fall required follow up with the floor staff RN-B would do that within the same day or the next day depending on significance. RN-A stated interventions are determined based on the root cause analysis of the fall and what could staff do differently to prevent another fall, and the new intervention would then be communicated to the staff verbally on shift and updated the resident's care plan and staff Communication sheets that they are expected to review before every shift. RN-B stated R1 required assist of one staff with a gait belt and front wheeled walker for transfers and had been identified as a fall risk. RN-B indicated on 5/19/24, when R1 had a fall resulting in an ankle fracture, through the facility's investigation it was determined R1's care plan was not followed at the time of the fall due to NA-A not utilizing a gait belt while transferring R1 and the facility immediately implemented education to all staff on utilizing the Communication Sheet and all resident's require a gait belt to transfer. Further, RN-B stated R2 was a new admission and had only been at the facility approximately a week but was identified as a high fall risk with intervention that included wheelchair for mobility, toileting plan every three hours, upon rising, before meals and bed as well. RN-B stated on 5/26/24 R2 had an unwitnessed fall in her room and IDT determined the root cause of the fall to be R2's toileting program had not been followed on the overnight as R2 would have been due for toileting at time of the fall. R2 did not sustain any injuries from the fall and RN-B stated coaching to NA-B had not occurred yet but planned on completing today (5/30/24). RN-B confirmed NA-B had worked since the fall occurred and education could have been done prior to 5/30/24.

On 5/30/24 at 1:55 p.m., director of nursing

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2 830	Continued From page 8	2 830		

(DON) stated staff were expected to implement immediate interventions following a fall on the weekend and the IDT would review the next business day to provide an intervention. At 3:16 p.m., DON stated she was aware R2's care plan related to toileting was not followed at the time of R2's fall on 5/26/24 and confirmed NA-B had not been educated or re-trained but messages had been left for NA-B since the incident with no call back. DON stated NA-B worked at the facility on 5/27/24, 5/28/24 and 5/29/24 but no attempts were made to connect with NA-B while at work. At 4:10 p.m., DON stated the all-staff education for R1's fall should be completed by all staff within two weeks and for those who have not completed the education would be contacted by leadership. DON confirmed neither NA-B nor all facility staff had been re-educated at time of survey entrance for the R1's incident.

On 5/30/24 at 2:36 p.m., family member (FM)-A stated she had received a call from the facility staff following R1's fall on 5/19/24, and staff informed FM-A they had called the physician to get orders to obtain an x-ray. FM-A stated she was agreeable to have R1 remain in the facility following the confirmation of R1's fracture, declining hospitalization, and FM-A stated she was concerned about R1's pain management, which the physician was involved and ordering medication. FM-A stated the facility scheduled an orthopedic appointment related to R1's fracture for the following week.

On 5/30/24 at 3:46 p.m., an attempt to interview NA-B was made by phone but unsuccessful.

Review of facility policy titled Fall Prevention and Management Program Policy modified 4/2021, indicated the clinical coordinator was responsible

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2 830	Continued From page 9 for implementation and oversight of individualized residents fall prevention care and supervising personnel in delivering safe and personalized care. Further, policy indicated members of the IDT are responsible for assessing, treating, and implementing strategies for the prevention of resident falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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F 000	INITIAL COMMENTS On 5/29/24 through 5/30/24, 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. The following complaint was reviewed: H56154106C (MN00103651, MN00103478) with a deficiency issued 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=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		7/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 06/18/2024

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

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Based on observation, interview and document review, the facility failed to implement assessed and directed fall prevention techniques for 2 of 3 residents (R1,R2) reviewed for falls. This resulted in actual harm for R1 who had an assisted fall to the floor when staff were not utilizing a gait belt during a transfer as assessed and R1 sustained a right ankle fracture.

Findings include:

R1's annual Minimal Data Set (MDS) dated 5/6/24, indicated R1 had diagnoses which included osteoporosis, Alzheimer's disease, and R1 had moderately impaired cognition.

R1's care plan revised on 5/26/24, identified R1 had limited physical mobility related to muscle weakness and impaired gait/balance, chronic shoulder pain, dementia with memory loss and required a front wheeled walker and assistance by staff when transferring and ambulating. Further, R1's care plan identified R1 was at risk for falls.

Review of facility's Summit 3 Communication Sheet dated 5/16/24, identified R1 was a fall risk and directed staff to assist R1 with transfers utilizing a front wheeled walker and a gait belt. Further, facility document revealed standard safety measures and directed staff to assure call light was within reach and gait belt was to be used when assisting with all transfers and ambulating.

Review of facility report to the State Agency (SA) dated 5/20/24, indicated staff was assisting R1 to get ready for the day and ambulating R1 to the toilet. R1 was about to pass out while ambulating

This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited to maintain certification in the Medicare and Medicaid programs and constitutes a credible allegation of compliance. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.
It is the policy of The Gables Care Center of Boutwells Landing to comply with F689-G. To assure continued compliance, the following plan has been put into place:
1) Regarding cited residents, R1 was on hospice and passed away on 5/26/24 unrelated to the concerns noted during the survey. NA-A received written corrective action for not following the plan of care for R1 and has since resigned and no longer employed at the facility. R2 has been observed to have no adverse impact from the observations documented during survey. R2 remains at their functional, cognitive, and psychosocial baselines. NA-B received suspension level correction and documented in their employee file for not following the plan of care R2.

2) Measures put in place to ensure deficient practice does not recur: Review of the Care Plan Policy and Procedure has taken place and has been reviewed and remains current. All nursing staff are being re-educated regarding the importance of following the communication sheets for the care of all

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and assisted R1 to the floor. R1 complained of pain on her left side of the body and her right ankle, but was able to move all extremities. Review of facility's 5-day investigation to the SA revealed R1 was confirmed to have sustained a right bimalleolar fracture with mortise displacement. In addition, the staff did not follow the company's standard safety practice of utilizing a gait belt when transferring or ambulating a resident and facility wide education to ensure staff would follow plan of care and compliance with the company's standard safety practices was the action taken to prevent reoccurrence.

R1's Final Report dated 5/19/24, completed by Dispatch Health Imagining, revelaed the findings of R1's x-rays was a fracture of the distal fibula and a chip fracture of the medial malleolus.

R2's entry MDS dated 5/17/24, indicated R2 had diagnoses which included Alzheimer's disease, anxiety disorder and urgency of urination.

R2's care plan as of 5/29/24, identified R2 as at risk for falls related to cognitive impairment, gait/balance problems, history of falls, poor communication/comprehension, and unaware of safety needs. R2's fall interventions included a toileting plan in place and directed staff to reference the communication sheet for details.

Review of facility's Trolley 3 Communication Sheet dated 5/24/24, identified R2 was a fall risk and directed staff to keep bedroom door open for safety due to frequent self-transfers and toilet upon rising, before meals, at hour of sleep and every 3 hours during the night.

R2's Resident Occurrence Report dated 5/26/24,

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our residents.

3) Actions taken to identify other potential residents having similar occurrences: All like residents fall risk will be reviewed to ensure they are up to date and documented correctly in their care plan and communication sheet.

4) Effective implementation of actions will be monitored by: The clinical managers will audit 10% of all residents care weekly x4 weeks and then monthly x2 months to ensure facility maintains compliance with the care plan policy and procedure. Results of these audits will be reviewed by the facility Quality Assurance and Performance Improvement (QAPI) committee for ongoing compliance.

5) The Director of Nursing is responsible for ongoing compliance.

6) Date of Correction: 7/15/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. BUILDING ______ B. WING ______	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GABLES OF BOUTWELLS LANDING	**13575 58TH STREET NORTH OAK PARK HEIGHTS, MN 55082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3 indicated R2 had an unwitnessed fall in room at 3:50 a.m. and R2 did not sustain any injuries. R2 reported she was attempting to get out of bed to use the bathroom. R2 was last observed by nursing assistant (NA)-B at 3:30 a.m. and R2 was noted to be in her room laying in bed. R2 was last assisted to the bathroom at approximately 12:00 a.m. However, document lacked evidence of interdisciplinary team (IDT) addressing R2's toileting care plan was not followed at the time of the fall and what had been done to correct. Review of facility document titled Falls Tracking as of 5/29/24, revealed R2 had a fall on 5/26/24 and IDT intervention implemented based on root cause was identified as staff coaching. Review of facility document titled Gables Care Center dated 5/21/24, and name of education was identified as Communication Protocol and Gait Belts for Transfers and Ambulation directing staff to sign the document to verify staff were present and understood to follow policies and practices outlined within the presentation. Further, education provided included when providing cares to residents or responding to resident requests, all staff need to be aware of the individualized interventions for each resident and resident care specific information could be found on the Communication Sheet. Staff were directed to review the Communication Sheet each time they work with residents due to constant changes and adjustments made to the resident's cares. Also, education included Communication Sheet Guideline which included toileting schedule and transfer for staff to review. In addition, document revealed NA-B had not reviewed the document as evidenced by NA-B's signature was not on the document.	F 689		

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F 689	Continued From page 4 On 5/29/24 at 2:49 p.m., R2 was observed in her room sitting in a standard wheelchair, slippers on and call light was within reach. R2 appeared comfortable and was drinking a cup of coffee. At 3:14 p.m., R2 was assisted to a table in the commons area with other female residents and an unidentified female staff remained in the area. On 5/30/24 at 8:51 a.m., registered nurse (RN)-A indicated R2 was at risk for falls and interventions included keeping R2's door open for staff to monitor her closely as well as toileting program every 2-3 hours and as needed. Further, RN-A stated fall interventions were located on the Communication Sheets which are available to staff and updated daily and with any changes. On 5/30/24 at 10:24 a.m., NA-C stated R2 requires staff assistance with transfers using a gait belt and she was at risk for falls due to self-transferring, adding R2's fall interventions included frequent glances into R2's room, keep door open, and toileting every 2-3 hours as well as upon rising, and before meals. Further, NA-C stated fall interventions were listed on each resident's care plan as well as the Communication Sheets. On 5/30/24 at 10:59 a.m., NA-A stated she was assisting R1 to get up in the morning on 5/19/24. NA-A stated R1 stood up from her bed and NA-A was supporting her but did not use a gait belt as required because NA-A stated she did not know she required one at that time. NA-A stated R1 expressed feeling lightheaded and NA-A offered her the wheelchair to which R1 declined. R1 then began falling forward and NA-A gently assisted her to the ground. Following the incident, NA-A	F 689		

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F 689	Continued From page 5	F 689		

stated management had called her and informed her she did not follow R1's care plan and NA-A should have used a gait belt. NA-A stated she resigned from the position and was no longer employed with the facility.

On 5/30/24 at 1:31 p.m., RN-B stated following each fall she would review the form that was completed by the floor nurse at the time of the fall and bring it to the IDT meeting every weekday at 9:00 a.m. RN-B stated the IDT then goes through the fall and interventions and ideas are discussed as a team, and if the fall required follow up with the floor staff RN-B would do that within the same day or the next day depending on significance. RN-A stated interventions are determined based on the root cause analysis of the fall and what could staff do differently to prevent another fall, and the new intervention would then be communicated to the staff verbally on shift and updated the resident's care plan and staff Communication sheets that they are expected to review before every shift. RN-B stated R1 required assist of one staff with a gait belt and front wheeled walker for transfers and had been identified as a fall risk. RN-B indicated on 5/19/24, when R1 had a fall resulting in an ankle fracture, through the facility's investigation it was determined R1's care plan was not followed at the time of the fall due to NA-A not utilizing a gait belt while transferring R1 and the facility immediately implemented education to all staff on utilizing the Communication Sheet and all resident's require a gait belt to transfer. Further, RN-B stated R2 was a new admission and had only been at the facility approximately a week but was identified as a high fall risk with intervention that included wheelchair for mobility, toileting plan every three hours, upon rising, before meals and bed as well. RN-B stated

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F 689	Continued From page 6 on 5/26/24 R2 had an unwitnessed fall in her room and IDT determined the root cause of the fall to be R2's toileting program had not been followed on the overnight as R2 would have been due for toileting at time of the fall. R2 did not sustain any injuries from the fall and RN-B stated coaching to NA-B had not occurred yet but planned on completing today (5/30/24). RN-B confirmed NA-B had worked since the fall occurred and education could have been done prior to 5/30/24. On 5/30/24 at 1:55 p.m., director of nursing (DON) stated staff were expected to implement immediate interventions following a fall on the weekend and the IDT would review the next business day to provide an intervention. At 3:16 p.m., DON stated she was aware R2's care plan related to toileting was not followed at the time of R2's fall on 5/26/24 and confirmed NA-B had not been educated or re-trained but messages had been left for NA-B since the incident with no call back. DON stated NA-B worked at the facility on 5/27/24, 5/28/24 and 5/29/24 but no attempts were made to connect with NA-B while at work. At 4:10 p.m., DON stated the all-staff education for R1's fall should be completed by all staff within two weeks and for those who have not completed the education would be contacted by leadership. DON confirmed neither NA-B nor all facility staff had been re-educated at time of survey entrance for the R1's incident. On 5/30/24 at 2:36 p.m., family member (FM)-A stated she had received a call from the facility staff following R1's fall on 5/19/24, and staff informed FM-A they had called the physician to get orders to obtain an x-ray. FM-A stated she was agreeable to have R1 remain in the facility	F 689		

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F 689	Continued From page 7 following the confirmation of R1's fracture, declining hospitalization, and FM-A stated she was concerned about R1's pain management, which the physician was involved and ordering medication. FM-A stated the facility scheduled an orthopedic appointment related to R1's fracture for the following week. On 5/30/24 at 3:46 p.m., an attempt to interview NA-B was made by phone but unsuccessful. Review of facility policy titled Fall Prevention and Management Program Policy modified 4/2021, indicated the clinical coordinator was responsible for implementation and oversight of individualized residents fall prevention care and supervising personnel in delivering safe and personalized care. Further, policy indicated members of the IDT are responsible for assessing, treating, and implementing strategies for the prevention of resident falls.	F 689		