DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 3, 2024

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: May 24, 2024

Dear Administrator:

On July 1, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Administrator
Mahnomen Health Center
414 West Jefferson Avenue
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Re: Reinspection Results
Event ID: 87V112

Dear Administrator:

On July 1, 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 May 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/23/24 through 5/24/24, 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. HZ3003700C (MN00103097) As a result of the investigation a deficiency was 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=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	5/24/24: Hourly rounding was put into	6/27/24

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

Electronically Signed | 06/17/2024

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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F 689	Continued From page 1 review, the facility failed to develop and implement interventions to reduce fall risks for 1 of 3 residents (R3) reviewed for accidents. Findings include: R3's quarterly Minimum Data Set (MDS) dated 5/8/24, identified intact cognition, socially isolated self often, and no behaviors identified. R3 had functional impairment upper extremity on one side. R3 required supervision or touching assistance with personal hygiene, sit to stand, ambulation, toilet transfers, toileting hygiene, shower/bath, upper body dressing, and putting on and taking off footwear. R3 required partial to moderate assistance with lower body dressing. R3 was frequently incontinent of bladder and occasionally incontinent of bowel. R3 had diagnoses of anemia (low red blood cell that carry oxygen to the body and can cause fatigue and shortness of breath), CHF (congestive heart failure), diabetes mellitus (DM), depression, and asthma (chronic lung disease affecting of the lungs and can cause shortness of breath). R3 received restorative therapy, 6 out of 7 days, active range of motion and walking. R3 had a chair alarm on her recliner. R3's physician orders identified: -Date 9/12/24: Chair Alarm: Alarm is in her recliner to alert staff she is up and walking or attempting to transfer. Staff are to check functioning and placement every shift. Twice A Day; 07:00 a.m. - 6:00 p.m. and 6:00 p.m. - 06:00 a.m. Date 6/13/24: Behavior monitoring: Please document any behaviors that were noted on your	F 689	place for safety checks as well as any cares she may need assistance with. Orders were placed in the POC for the NAR□s to sign off as well as nursing orders in the MAR for hourly rounding, paper flow sheets were also placed on nursing desk for NARs to document every 1 hour. The communication book was updated to notify staff of hourly rounding, which included asking the resident if she needed to use the bathroom, join activities or any other needs she may have. Paper communication statements were placed on both medication carts for nurses, they were educated in real time of the updated interventions and reasoning for the hourly rounding and the info was passed on from shift to shift. 5/28/24 Hourly rounding sheets were reviewed, and it was determined that the hourly rounding will need to continue due to her continued self-transfers. 3-day toileting audit was started to determine any patterns for toilet use and incontinence issues. 6/4/24 Care conference held today with resident, her daughters, DON, unit manager and social service designee. The main objective for this meeting is to discuss resident□s fall risk, interventions and plans to keep her as safe as possible. Fall interventions were discussed in detail with resident and daughters that are currently in place and the newly added interventions; hourly rounding, PT EVAL and treatment working on Turning and sitting (Order approved by medical	

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F 689	Continued From page 2 shift. Please ask the staff if the resident had any behaviors. Twice A Day; 6:00 a.m. - 6:00 p.m. and 6:00 p.m. - 06:00 a.m. R3's care plan dated 5/23/26, identified R3 as a fall risk, has had many falls at home prior admission. R3 lost balance and all of a sudden fell. R3's past falls included: 10/29/23, self-transferred with no injuries, 11/20/23, fell in room self-transferred skin tears to both elbows, and 4/1/24, self-transferring to bathroom/witnessed fall. R3 hit head on heater sustained skin tear and large bruise on left hand. On 6/23/23, staff were directed to keep call light within reach, room free from clutter, fall risk assessment, and instruct R3 of safety measures: use call light. On 4/23/24, added to R3's care plan revealed chair alarm box place behind her recliner, moved out of the sight and hopefully will not turn off alarm and staff will know when she was ringing. R3 did not use her call light for assistance, would not wait for assistance, and used chair alarm as a call light. On 4/1/24, green tape was placed around call light. 8/8/23, signed placed in room after fall, Call don't fall. R3's care plan also identified ADL deficit as she remained short of breath with any activities and required more assistance. Staff were instructed to help with toileting due to her fall risk, not safe to walk by herself, and required staff to stabilize her. The facility nursing assistant (NA) activities of daily living (ADL) worksheet last updated 9/26/23, identified R3 required assist of one with gait belt and walker off unit, can be independent in room, assist of one for toilet use, and did not use an alarm. R3's special requests identified R3 got SOB with any ambulation, was deconditioned,	F 689	director 5/28/24). Resident and family agreed to the interventions. Resident specifically stated that she will use her call light and try to wait for staff. Daughters also verbalize understanding for the meeting and will continue to try to remind and educate their mother on the importance of waiting for help. Other social interventions such as other hobbies or things to take up more of her time were also discussed with resident and daughters and no new interests were found. Daughters and resident agreed that she is tired and does sleep most of the day. She attends the activities of her choosing and would rather not attend the 11am activities unless she enjoys that activity of the day. Resident does usually join the 2pm activities, staff will ask her to join. 3 day toilet audit review didn't reveal anything out of the norm. She tends to get up around 3-5 am to use the bathroom, up for the day around 8am, toilet before and after meals and then before bed. The staff were educated to toilet her at 3-5 am and her care plan was updated. Staff is already trying to assist or is assisting her to the bathroom at these other times of the day. Care plan and root cause were be updated. Fall□s and interventions will be reviewed monthly at the QAPI meeting and PRN. Toileting review will be done quarterly and PRN to look for any trends. All residents at risk for falls due to specifically self transfers and walking, who are care planned to need assistance	

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F 689	Continued From page 3 and needed to build her strength. R3 was alert and orientated, can use her call light appropriately, and liked to sleep in her recliner. R3's ADL worksheet 9/26/23 was not revised and current with care plan/assist date 5/23/24 and failed to identify and direct Nas on the level of care and assistance R3 required to stay safe and prevent falls. R3's Fall Risk assessment dated 5/2/24, identified impaired mobility, elimination status/continent and required assist with toileting. R3's medications included anticoagulants (blood thinner), antihypertensives (lowers blood pressure), and diuretics. R3 had one or two falls in the past three months. R3 had orthopedic joint pain: osteoarthritis. R3's fall risk score was 11 (10 or higher represents a high risk for falls) and determined a risk for falls. R3's Bowel and Bladder Retraining Potential dated 5/2/24, identified a urinary toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility. R3 was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). R2 was always continent of bowel. R3 wore incontinent pads/briefs and independent cognitive skills for daily decision making consistent/reasonable, and usually aware of mental awareness of toileting needs. R3 was identified as not a good candidate for retaining and summarization/explanation of that determination section was left blank. Plan of care for R3 was to continue current plan of care.	F 689	from staff, will be assessed by 6-21-24. Assessments will include and risk factors that are seen, interventions in place and new interventions added, root cause analysis will be updated if applicable. Fall risk assessments will continue Quarterly and PRN. Weekly IDT will address falls, residents at risk for falls, interventions/plans to prevent future falls and if the interventions are appropriate and working. Monthly falls meeting will be separated from the QAPI meeting to focus only on falls, residents at risk for falls and interventions in place. Monthly meeting for falls will take place the last Thursday of the month. QAPI audits will be completed weekly. Interviews of nurses and NARS will include: who are the residents at risk for self transferring, frequent fallers, non-complaint with call light use, ect. What are the interventions in place. Nurses will audit, hourly rounding and documentation from NAR's and nurses. Audits will be reviewed at monthly falls meeting. Monthly staff meetings will include education on all high fall risk resident and interventions. Staff will be able to discuss the interventions, if they are working and any other ideas for interventions. This months staff meeting will be June 27th.	

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F 689	Continued From page 4 R3's care plan lacked evidence of fall interventions related to frequent toileting and increased supervision despite R3 requiring assistance with mobility, toileting and having an order for a diuretic which had a common side effect of frequent urination. R3's physical therapy assessment dated 11/12/23, identified R3 had impulsive ambulation as a fall predictor. R3's physical therapy discharge summary dated 9/15/23, identified highest practical level achieved. R3 required minimum assistance with transfers, set up with restorative nursing program to facilitate functional abilities and increase safety and decrease need for assistance with carryover demonstrated 75% of therapeutic opportunities and required the need for further instruction for implementation of instructions/techniques. R3's physician visit dated 4/9/24, identified R3 was alert with mental status at baseline. R3's care conference notes dated 4/10/24, identified R3 stayed in her room most of the day and came out for bingo and exercises. R3 attended restorative nursing program six times a week for range of motion (ROM) and ambulation. Reviewed concerns of R3 not using her call light for help. She has a chair alarm because she gets up without calling for help. Educated R3 on the importance of using her call light and that she could seriously injure herself without help. R3 verbalized understanding but continued to get up without calling. On 4/1/24, R3 had a fall when she had gotten up to use the bathroom and did not use her call light. Staff was alerted from her chair alarm and once staff were able to assist, she was already on the floor.	F 689		

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F 689	Continued From page 5 Facility Event Report dated 4/10/24, identified R3's fall in bathroom self-transferring on 4/1/24. R3 hit back of head complained of pain 3/10, bruising, and skin tears noted. R3 had taken diuretics (increases urination). Immediate interventions taken by facility were chair alarm and placed green take around call light. R3 had witnessed fall in bathroom. R3's chair alarm alarmed, when staff got to her room, R3 was already in bathroom. Staff saw her turn around, lost her footing, and went backwards. R3 hit head on heat register, sustained a small bump, skin tear and bruises on left hand and wrist. R3 stated "this is why you guys always want someone with me, this one scared me, and would be calling more often for help. Evaluation: event still open. Review of R3's progress notes regarding self-transfers/behaviors shift (6 a.m. to 2:00 p.m., 2:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m.) documentation from 4/1/24, through 5/1/24, revealed: -4/1/24 at 5:22 a.m. behaviors. At 2:21 p.m. Writer heard R3 call light/ bed alarm going off, writer ran down to R3's room and found R3 already in restroom pulling up her bottoms. Grabbed R3 by the waist band to have a hold on her but fell back against the wall and had a hold of R3's arm, just slowly slid down on wall. R3 did her head and had a little bit of skin tear on top of hand. Help was called for immediately, 4/stayed with R3 until nurse arrive and assisted R3 up to his recliner. -4/2/24, 4/11/24, 4/18/24, and 4/28/24, no documentation on self-transfers or behaviors.	F 689		

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F 689	Continued From page 6 -4/3/24, at 9:01 p.m. R3 continued to self-transfer after being continuously reminded to call for assistance to prevent falls. -4/4/24, at 11:53 a.m. no behaviors. At 4:35 p.m. R3's chair alarm going off, R3 on toilet when staff arrived. Reminded R3 of using call light and wait for assist. R3 stated "I guess I don't listen well". Assisted R3 back to chair. At 9:44 p.m. no behaviors. 4/5/24 - 4/9/24, no behaviors noted. -4/12/2024At 8:45 p.m. Reminders to call for assistance. R3 has been pleasant this evening, continues to self-transfer. Chair alarm on bedroom recliner. 4/13/24 - 4/16/24, no behaviors noted. -4/17/24, at 3:10 p.m. Staff reported R3 was self-transferring independently to the bathroom in her room; chair alarm noted in place and in working order, alarming staff to assist. 4/18/24 - 4/19/24, no behaviors noted. -4/20/23, at 12:28 p.m. R3 had been self-transferring throughout the shift. R3 does not ring her call light before getting up. The only reason staff knows she was up because her chair alarms was sounding. R3 had been reminded to ring for help prior to getting up but she continued to self-transfer. 4/21/24 - 4/22/24, no behaviors noted. -4/23/24, at 1:53 p.m. R3 continued to self-transfer herself to the bathroom while in her	F 689		

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F 689	Continued From page 7 room; chair alarm noted in place and in working order, alarming staff to assist. -4/24/24, at 8:54 p.m. R3 continued to self-transfer self in room to bathroom and will not ring for help or wait for help chair alarm is in place and working. 4/25/24, at 12:34 p.m. R3 does self-transfer to use the bathroom. Chair alarms in place and working properly. 4/26/24 - 4/28/24, no behaviors noted. 4/29/24, at 12:55 a.m. R3 continued to self-transfer after continuously being reminded to call for assistance d/t previous falls. 4/30/24, no behaviors noted. 5/1/24, at 2:44 p.m. Staff reported R3 was self-transferring independently to the bathroom in her room; chair alarm noted in place and in working order, alarming staff to assist. Writer reminds resident to request assistance for transfers. During an interview on 5/23/24, at 2:00 p.m. nursing assistant (NA)-A stated R3 required assist of one to transfer and ambulate in her room and to the bathroom. NA-A indicated R3 had self-transferred herself into the bathroom and fell about a month ago. NA-A stated R3 had an alarm on her chair that sounded but not until she stood up and that type of situation happened many times a day. NA-A stated R3 usually made it to bathroom by herself prior to staff getting there.	F 689		

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F 689	Continued From page 8 During an interview/observation on 5/23/24, at 2:35 p.m. R3 sat in recliner in her bedroom alone with feet on the floor, shoes on, with door ½ way closed. R3 stated she tried to take the brakes off the wheelchair (located directly in front of her) and move it to the other side of the room. R3 had pushed herself to the edge of the recliner and started to stand up prior to start of interview, then remained in recliner. On wall behind the recliner was a sign LEAN FORWARD TO STAND UP. R3 stated she could use her call light (located next to her) when help was needed but usually took herself to the bathroom. R3 stated she could make it to the bathroom with her walker alone. R3 stated her chair had an alarm on it that beeped after she stood up, so cannot get away with anything, when staff hear it, they come and by then she is usually in the bathroom. R3 stated she had fallen in her apartment prior to her admission to the facility and that was the reason she lived there now. R3 stated she had gotten short of breath at times when up by herself and did not recall falling at the facility since she moved in. Additionally, signs were posted on R3's wall on each side of the bathroom door, stating "Remember to Call Don't Fall". R3 stated she used the walker to go to bathroom and could make it on her own, adding the walker was "pretty handy", and felt she could take off when she wanted to and that's what she did. R3 indicated there are times she got short of breath though but had exercises that helped keep her strong. During an interview on 5/23/24, at 2:55 p.m. registered nurse (RN)-A stated R3 required one on one assistance for getting up and going to the bathroom but was notorious for doing it alone. RN-A stated R3 has been given frequent reminders, had a chair alarm, and slept in her	F 689		

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F 689	Continued From page 9 recliner. RN-A stated R3's chair alarm went off when she would stand up and by the time staff arrived in her room to assist her, she had already made it to the bathroom by herself. RN-A indicated R3 was short of breath at times when up ambulating and was concerned when R3 would turn alarm off herself. RN-A stated the chair alarm was placed behind her recliner and she was unable to see it. During an interview on 5/23/24, at 4:30 p.m. NA-B stated R3 required assist of at least one to transfer from sit to stand and ambulate to bathroom. NA-B stated R3 had most of her falls when she had to go to the bathroom, tried to turn to shut the bathroom door, then lost her balance and fell. NA-B stated we wait for the chair alarm to go off then head to her room to assist her. NA-B also stated R3 preferred to toilet herself and that was the reason staff did not go in on a regular basis to assist her with toileting. NA-B indicated R3 was a risk for falls. During an interview on 5/24/24, at 9:44 a.m. licensed practical nurse (LPN)-B stated R3 was assist of one for transfers and ambulation, high risk for falls, and required reminders. LPN-B stated R3 had a chair alarm that went off yesterday and when she arrived to R3's room she had already taken herself to the bathroom, off the toilet, and was pulling up her pants. LPN-B verified the ADL care sheet was inaccurate and lacked updating. LPN-B indicated R3 was not on a toileting schedule and brought herself to the toilet. LPN-B stated at least four times a shift R3's alarm goes off, call light goes on, and was also displayed at nurse's station on a screen, and R3 was already up and out of the chair prior to when staff arrived. LPN-B stated staff were expected to	F 689		

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F 689	Continued From page 10 check on R3 at least every two hours. (R3's care plan lacked evidence of every two hour checks). During an interview on 5/24/24, at 10:07 a.m. LPN-A stated R3 was a high risk for falls and had a chair alarm that beeped when she stood up, staff were expected to get there as soon as possible due to her history of falls. LPN-A verified this morning (5/24/24) R3's alarm beeped for a while, no staff came and checked on her, when she entered R3's room she was already in the bathroom. LPN-A stated R3 was not independent in her room and the ADL sheet information was incorrect and had not been updated. LPN-A also stated R3 had gotten short of breath and required assistance especially to the bathroom to help prevent falls. LPN-A stated R3 needed more interventions such as a toileting assessment/schedule, reminders, a better approach, and offered the bathroom more frequently. During an interview on 5/24/24, at 10:28 a.m. NA-D stated checked communication book prior to starting shift for any changes and then relied solely on ADL care sheet to guide her on how to care for her assigned residents. NA-D stated R3 was not independent in her room and required assist of one to transfer and ambulate to bathroom. NA-D stated the ADL care sheet was not updated and identified incorrect information on R3. NA-D stated R3 liked to take herself to the bathroom, had an alarm on her chair, but usually on her way to or in the bathroom by the time she arrived in her room. NA-D stated had found R3 in the bathroom at least a couple of times, moved fast, and should have not transferred alone. NA-D indicated R3 usually used the walker when she transferred herself, became short of breath when	F 689		

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F 689	Continued From page 11 ambulating, losses her balance turning to come back out of bathroom or when she closed door placed her at risk for another fall. During an interview on 5/24/24, at 11:15 a.m. NA-C stated at start of shift checks the communication book to see if any changes in residents, then solely relied on the ADL care sheet when transferring and caring for each resident. NA-C stated R3 required extensive assistance for cares and minimum assistance and a transfer belt for transfers. NA-C stated R3 was not on a toileting schedule and was not independent in her room. NA-C verified checked on R3 every two hours, had a chair alarm that sounded as soon as she stood up which also triggered the call light to go off. NA-C stated R3 had taken herself to bathroom frequently and witnessed this at least three times a shift. NA-C stated R3 was impulsive, very quick, confused quite a bit, placed her at higher risk for more falls. During a telephone interview on 5/24/24, at 12:16 p.m. licensed practical nurse (LPN)-C stated R3 was high risk for falls and required assistance of one to transfer/ambulate. LPN-C stated R3 had a chair alarm that was set off frequently when R3 stood up and usually guaranteed she had already headed to the bathroom by herself. LPN-C indicated R3 used a walker to ambulate but was unsteady on her feet and short of breath. LPN-C verified R3 had a fall in the middle of her bedroom and another one in the bathroom. LPN-C stated this type of alarm set off when the resident was already standing was not an effective way to prevent falls or keep R3 safe. LPN-C stated R3 was confused, some days were worse than others and lacked short-and long-term memory. LPN-C stated had seen R3 at	F 689		

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F 689	Continued From page 12 least three times in an eight-hour shift where her chair alarm went off and she was found already in the bathroom alone. During an interview on 5/24/24, at 2:00 p.m. director of nursing (DON) stated R3's cognition included forgetfulness especially dates and was impulsive in her room. DON stated R3 was struggling to accept and come to terms she lived in the facility. DON stated R3 required assistance of one to be safe, her knees buckled up and became short of breath. DON indicated R3 was able to get up by herself out of the recliner and required assistance of at least one staff to be safe going to the bathroom. DON stated R3 did not have a three-day bowel and bladder assessment completed, more of a dribbler, and most likely would not benefit from that type of assessment. DON stated R3 would say no, she was fine then bolts to the bathroom by herself without assistance and was not placed on a toileting schedule. DON verified R3 was a high risk for falls. DON also verified the R3's ADL care sheet was not updated until today (5/24/24), she removed independent in room and added high risk for falls. DON indicated she expected staff to utilize the ADL sheet when unsure how to care for a resident as a guide. DON stated she checked on R3 this morning when alarm went off and R3 moved fast, was already halfway to the bathroom when arrived in her room. DON stated staff were expected to report to the nurse when R3 transferred on her own and the nurse would be expected to document in the progress notes every shift. DON stated R3 self-transferred so frequently, unsure it had been reported each shift. DON indicated R3 was so impulsive, she would eventually fall again. DON indicated green tape was placed on call light so that R3 would	F 689		

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F 689	Continued From page 13 hopefully recognize it was there and maybe use it, but she tends not to use the call light and the chair alarm was used as the call light instead. DON also stated staff were expected to check on R3 at least every two hours, encourage her to use call light so staff arrived before she got off the recliner and moved around by herself to help prevent falls. DON indicated additional interventions would need to be added to R3's care plan such as frequent checks, one on one activities, bowel and bladder audit/assessment, and a physical therapy assessment to possibly deter her from self-transferring. Facility policy titled Bed and Chair Alarms dated 1/30/24, identified alarms would be used on residents with confusion and dementia, demonstrate a potential for falling, history of falling, and have scored moderate to high fall risk should be assessed for the need for alarm. Alarms will be utilized for residents based on their individual care plan. Facility policy titled Care Planning Policy dated 2/1/24, identified care plans provide continuity of care, quality no life, and to meet the quality of life needs for the individual resident. As changes in the resident condition occur, the care plan will be updated in a timely manner to reflect the current plan of care. The care plan will address the resident's needs and include measurable goals and interventions specific to each resident.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/23/24, through 5/24/24, 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	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. HZ3003700C (MN00103097) with no licensing orders issued. As a result of the investigation a licensing order was issued at 830. 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to reduce fall risks for 1 of 3 residents (R3) reviewed for accidents. Findings include:	2 830	5/24/24: Hourly rounding was put into place for safety checks as well as any cares she may need assistance with. Orders were placed in the POC for the NAR's to sign off as well as nursing orders in the MAR for hourly rounding, paper flow	6/6/24

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2 830	Continued From page 3 R3's quarterly Minimum Data Set (MDS) dated 5/8/24, identified intact cognition, socially isolated self often, and no behaviors identified. R3 had functional impairment upper extremity on one side. R3 required supervision or touching assistance with personal hygiene, sit to stand, ambulation, toilet transfers, toileting hygiene, shower/bath, upper body dressing, and putting on and taking off footwear. R3 required partial to moderate assistance with lower body dressing. R3 was frequently incontinent of bladder and occasionally incontinent of bowel. R3 had diagnoses of anemia (low red blood cell that carry oxygen to the body and can cause fatigue and shortness of breath), CHF (congestive heart failure), diabetes mellitus (DM), depression, and asthma (chronic lung disease affecting of the lungs and can cause shortness of breath). R3 received restorative therapy, 6 out of 7 days, active range of motion and walking. R3 had a chair alarm on her recliner. R3's physician orders identified: -Date 9/12/24: Chair Alarm: Alarm is in her recliner to alert staff she is up and walking or attempting to transfer. Staff are to check functioning and placement every shift. Twice A Day; 07:00 a.m. - 6:00 p.m. and 6:00 p.m. - 06:00 a.m. Date 6/13/24: Behavior monitoring: Please document any behaviors that were noted on your shift. Please ask the staff if the resident had any behaviors. Twice A Day; 6:00 a.m. - 6:00 p.m. and 6:00 p.m. - 06:00 a.m. R3's care plan dated 5/23/26, identified R3 as a	2 830	sheets were also placed on nursing desk for NARs to document every 1 hour. The communication book was updated to notify staff of hourly rounding, which included asking the resident if she needed to use the bathroom, join activities or any other needs she may have. Paper communication statements were placed on both medication carts for nurses, they were educated in real time of the updated interventions and reasoning for the hourly rounding and the info was passed on from shift to shift. 5/28/24 Hourly rounding sheets were reviewed, and it was determined that the hourly rounding will need to continue due to her continued self-transfers. 3-day toileting audit was started to determine any patterns for toilet use and incontinence issues. 6/4/24 Care conference held today with resident, her daughters, DON, unit manager and social service designee. The main objective for this meeting is to discuss resident's fall risk, interventions and plans to keep her as safe as possible. Fall interventions were discussed in detail with resident and daughters that are currently in place and the newly added interventions; hourly rounding, PT EVAL and treatment working on Turning and sitting (Order approved by medical director 5/28/24). Resident and family agreed to the interventions. Resident specifically stated that she will use her call light and try to wait for staff. Daughters also verbalize understanding for the meeting and will continue to try to remind and	

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2 830	Continued From page 4 fall risk, has had many falls at home prior admission. R3 lost balance and all of a sudden fell. R3's past falls included: 10/29/23, self-transferred with no injuries, 11/20/23, fell in room self-transferred skin tears to both elbows, and 4/1/24, self-transferring to bathroom/witnessed fall. R3 hit head on heater sustained skin tear and large bruise on left hand. On 6/23/23, staff were directed to keep call light within reach, room free from clutter, fall risk assessment, and instruct R3 of safety measures: use call light. On 4/23/24, added to R3's care plan revealed chair alarm box place behind her recliner, moved out of the sight and hopefully will not turn off alarm and staff will know when she was ringing. R3 did not use her call light for assistance, would not wait for assistance, and used chair alarm as a call light. On 4/1/24, green tape was placed around call light. 8/8/23, signed placed in room after fall, Call don't fall. R3's care plan also identified ADL deficit as she remained short of breath with any activities and required more assistance. Staff were instructed to help with toileting due to her fall risk, not safe to walk by herself, and required staff to stabilize her. The facility nursing assistant (NA) activities of daily living (ADL) worksheet last updated 9/26/23, identified R3 required assist of one with gait belt and walker off unit, can be independent in room, assist of one for toilet use, and did not use an alarm. R3's special requests identified R3 got SOB with any ambulation, was deconditioned, and needed to build her strength. R3 was alert and orientated, can use her call light appropriately, and liked to sleep in her recliner. R3's ADL worksheet 9/26/23 was not revised and current with care plan/assist date 5/23/24 and failed to identify and direct Nas on the level of	2 830	educate their mother on the importance of waiting for help. Other social interventions such as other hobbies or things to take up more of her time were also discussed with resident and daughters and no new interests were found. Daughters and resident agreed that she is tired and does sleep most of the day. She attends the activities of her choosing and would rather not attend the 11am activities unless she enjoys that activity of the day. Resident does usually join the 2pm activities, staff will ask her to join. 3 day toilet audit review didn't reveal anything out of the norm. She tends to get up around 3-5 am to use the bathroom, up for the day around 8am, toilet before and after meals and then before bed. The staff were educated to toilet her at 3-5 am and her care plan was updated. Staff is already trying to assist or is assisting her to the bathroom at these other times of the day. Care plan and root cause were be updated. Fall's and interventions will be reviewed monthly at the QAPI meeting and PRN. Toileting review will be done quarterly and PRN to look for any trends.	

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2 830	Continued From page 5 care and assistance R3 required to stay safe and prevent falls. R3's Fall Risk assessment dated 5/2/24, identified impaired mobility, elimination status/continent and required assist with toileting. R3's medications included anticoagulants (blood thinner), antihypertensives (lowers blood pressure), and diuretics. R3 had one or two falls in the past three months. R3 had orthopedic joint pain: osteoarthritis. R3's fall risk score was 11 (10 or higher represents a high risk for falls) and determined a risk for falls. R3's Bowel and Bladder Retraining Potential dated 5/2/24, identified a urinary toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility. R3 was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). R2 was always continent of bowel. R3 wore incontinent pads/briefs and independent cognitive skills for daily decision making consistent/reasonable, and usually aware of mental awareness of toileting needs. R3 was identified as not a good candidate for retaining and summarization/explanation of that determination section was left blank. Plan of care for R3 was to continue current plan of care. R3's care plan lacked evidence of fall interventions related to frequent toileting and increased supervision despite R3 requiring assistance with mobility, toileting and having an order for a diuretic which had a common side effect of frequent urination. R3's physical therapy assessment dated	2 830		

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2 830	Continued From page 6 11/12/23, identified R3 had impulsive ambulation as a fall predictor. R3's physical therapy discharge summary dated 9/15/23, identified highest practical level achieved. R3 required minimum assistance with transfers, set up with restorative nursing program to facilitate functional abilities and increase safety and decrease need for assistance with carryover demonstrated 75% of therapeutic opportunities and required the need for further instruction for implementation of instructions/techniques. R3's physician visit dated 4/9/24, identified R3 was alert with mental status at baseline. R3's care conference notes dated 4/10/24, identified R3 stayed in her room most of the day and came out for bingo and exercises. R3 attended restorative nursing program six times a week for range of motion (ROM) and ambulation. Reviewed concerns of R3 not using her call light for help. She has a chair alarm because she gets up without calling for help. Educated R3 on the importance of using her call light and that she could seriously injure herself without help. R3 verbalized understanding but continued to get up without calling. On 4/1/24, R3 had a fall when she had gotten up to use the bathroom and did not use her call light. Staff was alerted from her chair alarm and once staff were able to assist, she was already on the floor. Facility Event Report dated 4/10/24, identified R3's fall in bathroom self-transferring on 4/1/24. R3 hit back of head complained of pain 3/10, bruising, and skin tears noted. R3 had taken diuretics (increases urination). Immediate interventions taken by facility were chair alarm and placed green take around call light. R3 had witnessed fall in bathroom. R3's chair alarm	2 830		

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2 830	Continued From page 7 alarmed, when staff got to her room, R3 was already in bathroom. Staff saw her turn around, lost her footing, and went backwards. R3 hit head on heat register, sustained a small bump, skin tear and bruises on left hand and wrist. R3 stated "this is why you guys always want someone with me, this one scared me, and would be calling more often for help. Evaluation: event still open. Review of R3's progress notes regarding self-transfers/behaviors shift (6 a.m. to 2:00 p.m., 2:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m.) documentation from 4/1/24, through 5/1/24, revealed: -4/1/24 at 5:22 a.m. behaviors. At 2:21 p.m. Writer heard R3 call light/ bed alarm going off, writer ran down to R3's room and found R3 already in restroom pulling up her bottoms. Grabbed R3 by the waist band to have a hold on her but fell back against the wall and had a hold of R3's arm, just slowly slid down on wall. R3 did her head and had a little bit of skin tear on top of hand. Help was called for immediately, 4/stayed with R3 until nurse arrive and assisted R3 up to his recliner. -4/2/24, 4/11/24, 4/18/24, and 4/28/24, no documentation on self-transfers or behaviors. -4/3/24, at 9:01 p.m. R3 continued to self-transfer after being continuously reminded to call for assistance to prevent falls. -4/4/24, at 11:53 a.m. no behaviors. At 4:35 p.m. R3's chair alarm going off, R3 on toilet when staff arrived. Reminded R3 of using call light and wait for assist. R3 stated "I guess I don't listen well". Assisted R3 back to chair. At 9:44 p.m. no behaviors.	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 4/5/24 - 4/9/24, no behaviors noted. -4/12/2024At 8:45 p.m. Reminders to call for assistance. R3 has been pleasant this evening, continues to self-transfer. Chair alarm on bedroom recliner. 4/13/24 - 4/16/24, no behaviors noted. -4/17/24, at 3:10 p.m. Staff reported R3 was self-transferring independently to the bathroom in her room; chair alarm noted in place and in working order, alarming staff to assist. 4/18/24 - 4/19/24, no behaviors noted. -4/20/23, at 12:28 p.m. R3 had been self-transferring throughout the shift. R3 does not ring her call light before getting up. The only reason staff knows she was up because her chair alarms was sounding. R3 had been reminded to ring for help prior to getting up but she continued to self-transfer. 4/21/24 - 4/22/24, no behaviors noted. -4/23/24, at 1:53 p.m. R3 continued to self-transfer herself to the bathroom while in her room; chair alarm noted in place and in working order, alarming staff to assist. -4/24/24, at 8:54 p.m. R3 continued to self-transfer self in room to bathroom and will not ring for help or wait for help chair alarm is in place and working. 4/25/24, at 12:34 p.m. R3 does self-transfer to use the bathroom. Chair alarms in place and working properly.	2 830		

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	00353	A. BUILDING: _____ B. WING _____	C 05/24/2024

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2 830	Continued From page 9 4/26/24 - 4/28/24, no behaviors noted. 4/29/24, at 12:55 a.m. R3 continued to self-transfer after continuously being reminded to call for assistance d/t previous falls. 4/30/24, no behaviors noted. 5/1/24, at 2:44 p.m. Staff reported R3 was self-transferring independently to the bathroom in her room; chair alarm noted in place and in working order, alarming staff to assist. Writer reminds resident to request assistance for transfers. During an interview on 5/23/24, at 2:00 p.m. nursing assistant (NA)-A stated R3 required assist of one to transfer and ambulate in her room and to the bathroom. NA-A indicated R3 had self-transferred herself into the bathroom and fell about a month ago. NA-A stated R3 had an alarm on her chair that sounded but not until she stood up and that type of situation happened many times a day. NA-A stated R3 usually made it to bathroom by herself prior to staff getting there. During an interview/observation on 5/23/24, at 2:35 p.m. R3 sat in recliner in her bedroom alone with feet on the floor, shoes on, with door ½ way closed. R3 stated she tried to take the brakes off the wheelchair (located directly in front of her) and move it to the other side of the room. R3 had pushed herself to the edge of the recliner and started to stand up prior to start of interview, then remained in recliner. On wall behind the recliner was a sign LEAN FORWARD TO STAND UP. R3 stated she could use her call light (located next to her) when help was needed but usually took	2 830		

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2 830	Continued From page 10 herself to the bathroom. R3 stated she could make it to the bathroom with her walker alone. R3 stated her chair had an alarm on it that beeped after she stood up, so cannot get away with anything, when staff hear it, they come and by then she is usually in the bathroom. R3 stated she had fallen in her apartment prior to her admission to the facility and that was the reason she lived there now. R3 stated she had gotten short of breath at times when up by herself and did not recall falling at the facility since she moved in. Additionally, signs were posted on R3's wall on each side of the bathroom door, stating "Remember to Call Don't Fall". R3 stated she used the walker to go to bathroom and could make it on her own, adding the walker was "pretty handy", and felt she could take off when she wanted to and that's what she did. R3 indicated there are times she got short of breath though but had exercises that helped keep her strong. During an interview on 5/23/24, at 2:55 p.m. registered nurse (RN)-A stated R3 required one on one assistance for getting up and going to the bathroom but was notorious for doing it alone. RN-A stated R3 has been given frequent reminders, had a chair alarm, and slept in her recliner. RN-A stated R3's chair alarm went off when she would stand up and by the time staff arrived in her room to assist her, she had already made it to the bathroom by herself. RN-A indicated R3 was short of breath at times when up ambulating and was concerned when R3 would turn alarm off herself. RN-A stated the chair alarm was placed behind her recliner and she was unable to see it. During an interview on 5/23/24, at 4:30 p.m. NA-B stated R3 required assist of at least one to transfer from sit to stand and ambulate to	2 830		

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2 830	Continued From page 11 bathroom. NA-B stated R3 had most of her falls when she had to go to the bathroom, tried to turn to shut the bathroom door, then lost her balance and fell. NA-B stated we wait for the chair alarm to go off then head to her room to assist her. NA-B also stated R3 preferred to toilet herself and that was the reason staff did not go in on a regular basis to assist her with toileting. NA-B indicated R3 was a risk for falls. During an interview on 5/24/24, at 9:44 a.m. licensed practical nurse (LPN)-B stated R3 was assist of one for transfers and ambulation, high risk for falls, and required reminders. LPN-B stated R3 had a chair alarm that went off yesterday and when she arrived to R3's room she had already taken herself to the bathroom, off the toilet, and was pulling up her pants. LPN-B verified the ADL care sheet was inaccurate and lacked updating. LPN-B indicated R3 was not on a toileting schedule and brought herself to the toilet. LPN-B stated at least four times a shift R3's alarm goes off, call light goes on, and was also displayed at nurse's station on a screen, and R3 was already up and out of the chair prior to when staff arrived. LPN-B stated staff were expected to check on R3 at least every two hours. (R3's care plan lacked evidence of every two hour checks). During an interview on 5/24/24, at 10:07 a.m. LPN-A stated R3 was a high risk for falls and had a chair alarm that beeped when she stood up, staff were expected to get there as soon as possible due to her history of falls. LPN-A verified this morning (5/24/24) R3's alarm beeped for a while, no staff came and checked on her, when she entered R3's room she was already in the bathroom. LPN-A stated R3 was not independent in her room and the ADL sheet information was incorrect and had not been updated. LPN-A also	2 830		

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2 830	Continued From page 12 stated R3 had gotten short of breath and required assistance especially to the bathroom to help prevent falls. LPN-A stated R3 needed more interventions such as a toileting assessment/schedule, reminders, a better approach, and offered the bathroom more frequently. During an interview on 5/24/24, at 10:28 a.m. NA-D stated checked communication book prior to starting shift for any changes and then relied solely on ADL care sheet to guide her on how to care for her assigned residents. NA-D stated R3 was not independent in her room and required assist of one to transfer and ambulate to bathroom. NA-D stated the ADL care sheet was not updated and identified incorrect information on R3. NA-D stated R3 liked to take herself to the bathroom, had an alarm on her chair, but usually on her way to or in the bathroom by the time she arrived in her room. NA-D stated had found R3 in the bathroom at least a couple of times, moved fast, and should have not transferred alone. NA-D indicated R3 usually used the walker when she transferred herself, became short of breath when ambulating, losses her balance turning to come back out of bathroom or when she closed door placed her at risk for another fall. During an interview on 5/24/24, at 11:15 a.m. NA-C stated at start of shift checks the communication book to see if any changes in residents, then solely relied on the ADL care sheet when transferring and caring for each resident. NA-C stated R3 required extensive assistance for cares and minimum assistance and a transfer belt for transfers. NA-C stated R3 was not on a toileting schedule and was not independent in her room. NA-C verified checked on R3 every two hours, had a chair alarm that	2 830		

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2 830	Continued From page 13 sounded as soon as she stood up which also triggered the call light to go off. NA-C stated R3 had taken herself to bathroom frequently and witnessed this at least three times a shift. NA-C stated R3 was impulsive, very quick, confused quite a bit, placed her at higher risk for more falls. During a telephone interview on 5/24/24, at 12:16 p.m. licensed practical nurse (LPN)-C stated R3 was high risk for falls and required assistance of one to transfer/ambulate. LPN-C stated R3 had a chair alarm that was set off frequently when R3 stood up and usually guaranteed she had already headed to the bathroom by herself. LPN-C indicated R3 used a walker to ambulate but was unsteady on her feet and short of breath. LPN-C verified R3 had a fall in the middle of her bedroom and another one in the bathroom. LPN-C stated this type of alarm set off when the resident was already standing was not an effective way to prevent falls or keep R3 safe. LPN-C stated R3 was confused, some days were worse than others and lacked short-and long-term memory. LPN-C stated had seen R3 at least three times in an eight-hour shift where her chair alarm went off and she was found already in the bathroom alone. During an interview on 5/24/24, at 2:00 p.m. director of nursing (DON) stated R3's cognition included forgetfulness especially dates and was impulsive in her room. DON stated R3 was struggling to accept and come to terms she lived in the facility. DON stated R3 required assistance of one to be safe, her knees buckled up and became short of breath. DON indicated R3 was able to get up by herself out of the recliner and required assistance of at least one staff to be safe going to the bathroom. DON stated R3 did not have a three-day bowel and bladder	2 830		

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2 830	Continued From page 14 assessment completed, more of a dribbler, and most likely would not benefit from that type of assessment. DON stated R3 would say no, she was fine then bolts to the bathroom by herself without assistance and was not placed on a toileting schedule. DON verified R3 was a high risk for falls. DON also verified the R3's ADL care sheet was not updated until today (5/24/24), she removed independent in room and added high risk for falls. DON indicated she expected staff to utilize the ADL sheet when unsure how to care for a resident as a guide. DON stated she checked on R3 this morning when alarm went off and R3 moved fast, was already halfway to the bathroom when arrived in her room. DON stated staff were expected to report to the nurse when R3 transferred on her own and the nurse would be expected to document in the progress notes every shift. DON stated R3 self-transferred so frequently, unsure it had been reported each shift. DON indicated R3 was so impulsive, she would eventually fall again. DON indicated green tape was placed on call light so that R3 would hopefully recognize it was there and maybe use it, but she tends not to use the call light and the chair alarm was used as the call light instead. DON also stated staff were expected to check on R3 at least every two hours, encourage her to use call light so staff arrived before she got off the recliner and moved around by herself to help prevent falls. DON indicated additional interventions would need to be added to R3's care plan such as frequent checks, one on one activities, bowel and bladder audit/assessment, and a physical therapy assessment to possibly deter her from self-transferring. Facility policy titled Bed and Chair Alarms dated 1/30/24, identified alarms would be used on residents with confusion and dementia,	2 830		

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2 830	Continued From page 15 demonstrate a potential for falling, history of falling, and have scored moderate to high fall risk should be assessed for the need for alarm. Alarms will be utilized for residents based on their individual care plan. Facility policy titled Care Planning Policy dated 2/1/24, identified care plans provide continuity of care, quality no life, and to meet the quality of life needs for the individual resident. As changes in the resident condition occur, the care plan will be updated in a timely manner to reflect the current plan of care. The care plan will address the resident's needs and include measurable goals and interventions specific to each resident. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		