DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 4, 2020

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: June 12, 2020

Dear Administrator:

On June 26, 2020, we notified you a remedy was imposed. On July 10, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 8, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 11, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 26, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 11, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 8, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 26, 2020

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: June 21, 2020

Dear Administrator:

On June 12, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 11, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 11, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 11, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 11, 2020., the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Neilson Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 11, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 12, 2020 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	**1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601**

(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 6/11/20, and 6/12/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance wit the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be substantiated with deficiencies cited. H5039038C: Deficiencies issues at F684 and F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		7/8/20

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

Electronically Signed | 07/01/2020

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 684	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and provide ongoing treatment including medical attention for 1 of 3 residents reviewed who had sustained a significant skin injury following a fall. This failure resulted in actual harm due to identification of the wound requiring sutures which could not be applied due to the delayed identification of the significance of the wound. Findings include: R3's undated face sheet indicated R3's diagnoses included neurodegenerative disease, dementia, anxiety disorder, repeated falls-high risk for falls, and overactive bladder. R3's quarterly Minimum Data Set (MDS) dated 3/27/20, indicated R3 had moderate cognitive impairment and was independent with all activities of daily living (ADLs) with setup help from staff. The MDS indicated R3's skin was intact. R3's care plan dated 4/5/19, identified a self care deficit and directed the staff to supervise R3 with dressing and one staff to physically assist with bathing, pivot transfers, and ambulation with a wheeled walker. The care plan also indicated R3 had no skin issues. R3's Progress Note (PN) dated 6/5/20, at 4:01 a.m. indicated a "V" shaped skin tear was noted on R3's right elbow that measured 1.5	F 684	On 6/12/2020 R3's physician assessed, and provided orders for monitoring and ongoing treatment of the skin injury. On 6/19/2020 R3 had a follow up appointment with their physician who provided orders for monitoring and ongoing treatment of the skin injury. In order to minimize the risk for falls and injury for R3 the following actions were taken: On 6/12/2020 fall interventions were updated on the care plan. On 6/15/2020 a referral to occupational therapy was made. On 6/26/20 a falls risk observation was completed. On 6/29/2020 a comprehensive assessment was done of R3's falls to ensure the care plan and fall interventions were appropriate. By 7/8/2020 the Nurse Manager's/designee will review all current residents care and treatment plans to ensure that they include care and treatment in accordance with the comprehensive assessment, professional standards of practice, and the residents' choices. This will include comprehensive assessment, monitoring and providing ongoing treatment including medical attention for skin injuries. By 7/8/2020 the Director of Nursing/designee will review and update as necessary facility policies regarding comprehensive assessment, professional standards of practice and the residents' choices. The interdisciplinary members of the care plan team and nursing staff will	

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F 684	Continued From page 2 centimeters (cm). R3 stated he had fallen down onto the toilet hitting his elbow on the bar. The area was cleansed and covered with a 2 X 2 gauze and transparent dressing. However, R3's treatment record lacked information related to the skin injury and need for follow up/treatment. On 6/11/20, at 3:00 p.m. R3 was observed in his room, seated in the wheelchair with his right arm bent and resting on his lap. R3 lifted his right arm up with his left hand and stated he was not doing so good. "It's my arm, I fell in the bathroom and hit it on the rail in there." R3 stated he wanted to go to the doctor, but the staff had taped it up, bandaged and wrapped his arm. R3 added, "I think I need stitches." R3 stated the injury occurred about a week ago and verified that he did not ask for help with mobility into the bathroom because, "I just go myself." "If you are from the department of health, maybe you can look into it." On 6/12/20, at 8:15 a.m. R3 was observed seated in the wheelchair, in his bathroom facing the sink. -At 8:31 a.m. R3 was observed seated on his bathroom toilet. No staff entered the room. -At 8:35 a.m. staff entered the room and reminded R3 of the need to call for assistance in order to prevent falls. R3 refused assistance and remained sitting on the toilet. Staff exited the room. -At 8:37 a.m. staff entered R3's room and assisted him to finish toileting. -At 9:30 a.m. R3 stated, "My elbow hurts, would you like to see it?" and proceeded to remove the Kerlix wrap which was covering his right elbow wound. The wound appeared to have an open area that was approximately 2.0 cm in length and when R3 lifted up his elbow, the wound gaped	F 684	be educated on those policies, which will include documented assessment, monitoring and ongoing treatment of skin injuries. Beginning 7/8/2020 the Director of Nursing/designee will audit 3 resident care and treatment plans weekly for 6 weeks to ensure they include care and treatment in accordance with the comprehensive assessment, professional standards of practice and the residents' choices. Results will be forwarded to the QAPI committee for further recommendation.	

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F 684	Continued From page 3	F 684		

open approximately 1.0 cm with an observable, undetermined depth. R3 stated he had asked the nurse for a new dressing, but she said he was not on her list of dressing changes to be completed that day.
-At 9:35 a.m. the surveyor (SA) requested that RN-A notify the SA when she performed R3's right elbow dressing change so that the SA could observe it.
-At 9:37 RN-B approached the SA and stated R3 did not have a dressing change ordered. When RN-B was informed R3 had an open area on his right elbow, RN-B stated there was no documented evidence of a dressing change order for R3's wound on the medication or treatment record. RN-B stated typically if a resident had an open area/wound, it would be identified on the treatment record and would include treatment orders. At this time, RN-B stated she was going to go look at R3's wound. Upon nearing R3's room, RN-A was observed exiting R3's room and stated to RN-B, "yeah it is bad, it should have had stitches. I don't work here that often, so I was not aware of it." RN-A stated it was too late to send R3 into the clinic for stitches, therefore, RN-B directed RN-A to apply Steri-strips to the wound and to notify the physician for further orders.
-At 9:44 a.m. a telemed visit was conducted with R3's primary physician who prescribed treatment orders, a wound program, and a follow up evaluation to be done in one week.

R3's Physician Office Visit Note dated 6/12/20, indicated R3 had been evaluated for a skin tear on his right elbow following a fall in 6/5/20, and staff were wondering if the wound needed to be pulled together, but a week had past. The note indicated R3's elbow appeared to have a 2.0 cm length by a 0.5 cm width, triangular shaped skin

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F 684	Continued From page 4	F 684		

tear directly over the olecranon prominence of the right elbow. The skin edges are withdrawn about a 1.0 to 1.5 cm and 0.5 cm depth at the worst midpoint of the triangle. There is no drainage. At this late juncture it is not worth placing sutures rather a Q-tip was to be used to lift the skin edge to try to approximate the tear a little better then to secure and place Steri-strips in an attempt to bring the wound edges together a little. Antibiotic ointment and a Tegaderm (a transparent dressing) to be applied for one week at which time the physician would discuss proper removal of the Tegaderm and replacement with the facility.

On 6/12/20, at 1:30 p.m. a telephone interview was attempted with R3's unit manager, without success.

On 6/12/20, at 3:30 p.m. during a telephone interview, the director of nursing (DON) stated she had only been in her position for four weeks, but had been aware of R3's right elbow skin wound as a result of a fall on 6/5/20. The DON stated the interdisciplinary team (IDT) had discussed the incident the next day and was told R3 had denied falling and would not allow staff to look at his arm. The DON stated she, herself had not visualized the wound as she had been told R3 would not allow the wound to be looked at. The DON acknowledged R3's documentation indicated the nurse had assessed and treated the skin injury as soon as it was identified, but had not noted the wound or treatment provided onto R3's treatment record in order to alert the staff that he had the wound and the need to continue monitoring it. In addition, the DON stated she would have expected there to have been more documentation related to R3's wound in his clinical record.

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F 684	Continued From page 5 The facility's Skin Risk Assessment Interventions policy revised on 4/25/19, indicated if a resident had a pressure injury or skin breakdown to complete the treatment as ordered, monitor area daily, conduct a weekly comprehensive assessment, document, and to monitor the wound for signs of infection.	F 684		
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: Based on interview and document review, the facility failed to comprehensively assess and/or develop and implement fall interventions in order to minimize the risk for falls and injury for 2 of 3 residents (R1, R3) identified at risk for falls. This failure resulted in actual harm when R1 was not provided timely toileting assistance and her wheelchair had not been positioned by the bed, as directed, resulting in a fall and subsequent sacral fracture. This failure also resulted in actual harm when R3 did not receive comprehensive assessments and implementations of new fall interventions following each falls per the facility fall policy resulting in a significant skin injury which would have required the application of sutures.	F 689	The following actions were taken in order to minimize the risk for falls and injury for R1: on 6/2/2020 a Fall Risk observation was completed including a care plan review and update of fall interventions with family, and care plan interventions updated again on 6/5/2020. On 5/30/2020 the DON provided education to nursing staff on following the care sheets for fall interventions. In order to minimize the risk for falls and injury for R3 the following actions were taken: On 6/12/2020 fall interventions were updated on the care plan. On 6/15/2020 a referral to occupational therapy was made. On 6/26/20 a falls risk observation was completed. On 6/29/2020 a	7/8/20

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F 689	Continued From page 6 Findings include: R1's admission Minimum Data Set (MDS) dated 5/24/20, indicated R1's diagnoses included a displaced fracture of the base of the neck of the left femur, osteoporosis, left artificial hip joint, diabetes, kidney disease, and mild cognitive impairment. The MDS also indicated R1 required limited assistance with transfers, dressing, and personal hygiene and extensive assistance with bed mobility and toileting. R1 had not ambulated and required assistance with mobility in her wheelchair. R1 had a history of falls within the month prior to admission which included a fall with a fracture. R1's Activities of Daily Living (ADL) Functional Status Care Area Assessment (CAA) dated 5/26/20, indicated R1 had fallen at home and sustained a left hip fracture with surgical repair. R1's nurses noted reflected forgetfulness and confusion at times and indicated R1 required ADL assistance. R1's Fall CAA dated 5/26/20, indicated R1 was at risk for falls related to her history of falls, medications, slight cognitive impairment, incontinence and pain. The undated, personal care sheet, a pocket care plan utilized by the nursing assistant's, indicated R1 had a left hip fracture with surgical repair and was partial weight bearing to left leg, had bouts of confusion, was at risk for falls, and directed the staff to provide every 30 minutes rounding checks, assist of one to transfer with a walker and gait belt, a low bed, pendant call light, hip protectors to be worn, wheelchair to be at bedside, signage in room to remind to call for	F 689	comprehensive assessment was done of R3's falls to ensure the care plan and fall interventions were appropriate. By 7/8/2020 the Nurse Managers/designee will review all current residents with a history of falls to ensure their falls have been comprehensively assessed and interventions were implemented in order to minimize the risk for falls and injury. By 7/8/2020 the Director of Nursing/designee will review and revise as necessary the facility's policy on falls and educate all nursing staff on the facility's fall policy, and to ensure residents are comprehensively assessed and interventions are implemented in order to minimize the risk for falls and injury. Beginning 7/8/2020 the Director of Nursing/designee will audit all residents weekly for 6 weeks who have fallen to ensure they are comprehensively assessed and interventions are implemented in order to minimize the risk for falls and injury. Results will be forwarded to the QAPI committee for further recommendations.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	**1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601**

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assistance, and to toilet every two hours and at 4:00 a.m. and 6:00 a.m.

R1's comprehensive care plan created 5/26/20, indicated R1 had mild cognitive impairment, had a potential for falls due to a history of falls, medication use, limited mobility, incontinence, and cognitive deficit. The care plan directed the staff to keep assistive devices and call light within reach, hip protectors on when awake, 30 minute rounding (visual checks), frequent reminders to use call light, signage for reminders to call for assistance, offer toileting every two hours and at 4:00 a.m. and 6:00 a.m., assist of one with a front wheeled walker and gait belt for transfers, low bed, bed to be at transfer height for all transfers, pendant call light, and to initiate and reinforce safety teaching. The care plan also indicated R1 was at risk for potential complications related to anticoagulant (blood thinner) therapy and directed the staff to protect R1 from injury/trauma.

R1's Fall Risk Assessment, dated 6/2/20, identified R1 was at risk for falls. R1's clinical record lacked any previous fall risk assessments.

R1's 5/30/20, incident report submitted to the State Agency (SA) indicated on 5/30/20, R1 was found on the floor, in her room. R1 stated she was trying to ambulate to the bathroom when she fell.

R1's Nurse Progress Note (PN) dated 5/28/20, indicated R1 was alert and orientated with confusion at times. She was able to use the call light appropriately most times, was continent of bowel and bladder, and required assistance of one with ADL's and to pivot transfer.

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R1's PN dated 5/29/20, indicated R1 required extensive assistance of one for wheelchair locomotion on the unit.

R1's PN dated 5/30/20, at 12:06 a.m. indicated staff had heard R1 yelling for help. R1 was found seated on the floor, in her room. Staff assessed R1 and with the assistance of three staff and a gait belt, assisted R1 up off the floor. Upon rising, R1 immediately complained of pain in her left and was assisted to sit in her wheelchair then pivot transferred to her bed. Upon transfer, R1 again complained of increased pain in her left leg. Staff assessed R1's left hip area and noted deformity to the upper left leg and swelling. The on call provider was contacted.

R1's PN dated 5/30/20, at 12:42 a.m. indicated an ambulance was called to transfer R1 to the emergency room. A subsequent PN at 3:51 a.m. indicated the emergency room staff called and notified the facility that R1 had re-fractured her left hip and world be admitted to the hospital for further care.

R1's 6/5/20, 5 day investigation report submitted to the SA indicated R1 had sustained a fall with significant injury due to staff not following R1's care plan, as directed. The report indicated the care plan directed the staff to keep R1's wheelchair at bedside and to toilet R1 every two hours. The investigation revealed R1's wheelchair was not positioned at her bedside rather was positioned across the room, and R1 had not been toileted every two hours as directed. The facility re-educated the staff on the importance of following care plan directives and were directed to review the personal care attendant (PCA) sheets (pocket care plans which identified each resident

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care needs) at the start of every shift. The report also indicated R1 had not sustained a hip re-fracture, but did sustained a sacral fracture as a result of the fall.

On 6/12/20, at 3:30 p.m. the director of nursing (DON) stated R1's care plan indicated a fall prevention program was in place which would refer the reader to the PCA for the individualized interventions implemented. The DON stated during the investigation of R1's fall, it was discovered that the staff did not follow R1's care plan regarding placing the wheelchair by the bed and toileting R1 every two hours as R1 had not been assisted with toileting since 8:00 p.m. the previous evening (approximately four hours prior to the fall).

R3's undated face sheet indicated R3's diagnoses included neurodegenerative disease, dementia, anxiety disorder, repeated falls-high risk for falls, and overactive bladder

R3's quarterly MDS dated 3/27/20, indicated R3 had moderate cognitive impairment and was independent with all ADLs with setup help from staff. The MDS also indicated R3 was occasionally incontinent of bowel and bladder and had experienced two or more falls since his last assessment.

R3's care plan dated 4/5/19, identified a self care deficit and directed the staff to supervise R3 with dressing and one staff to physically assist with bathing, pivot transfers, and ambulation with a wheeled walker. The care plan indicated R3 often transferred himself and did not ask for help. The care plan also indicated R3 had occasional incontinence and directed the staff to offer

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toileting every two hours when awake to help avoid self transfers. The care plan indicated R3 was at risk for falls and directed the staff to place R3 on a fall prevention plan, provide a walker, encourage R3 to sit while praying, to not give R3 powder, to encourage use of gripper socks at all times, encourage to call staff for assist, conduct frequent and purposeful rounding, offer and assist as he would allow with showers, provide a longer phone cord and a one way glide and anti roll back on wheelchair.

Review of R3's PN revealed the following:

-On 2/21/20, at 3:20 a.m. R3 was found sitting on the bathroom floor. His brief and pants were lying on the floor next to him with the wheelchair nearby with the brakes engaged. No injuries were noted. R3's clinical record lacked evidence of a root cause analysis and interventions implemented.

-On 3/15/20, at 6:31 a.m. R3 was found on the shower floor. He stated he purposely got down on the floor and was wiping up excess water but could not get himself back up. R3's clinical record lacked evidence of a root cause analysis and interventions implemented to prevent future occurrences. The record also indicated R3 would independently take a shower in his bathroom shower.

-On 3/29/20, R3 rang his call light and was found sitting on the bathroom floor. R3 stated he had lost his footing on the slippery bathroom floor and went down, landing on his buttocks. R3 had had a bowel movement which was noted on the floor, R3's shoes, and on the toilet seat and bowl. R3's clinical record lacked evidence of a root cause

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analysis and interventions implemented.

-On 4/1/20, at 9:17 a.m. indicated R3's care plan was reviewed. A subsequent note dated 4/2/20, at 9:02 a.m. indicated care plan review directed staff to increase scheduled toileting, to offer toileting every two hours while awake with a goal of one or less incontinent voids per week. However, the note did not identify the effectiveness of the current fall interventions nor any new fall interventions implemented.

-On 6/5/20, at 4:01 a.m. a "V" shaped skin tear was noted on R3's right elbow that measured 1.5 centimeters (cm). R3 stated he had fallen down onto the toilet hitting his elbow on the bar. The area was cleansed and covered with a 2 X 2 gauze and transparent dressing. An incident report was completed, however, did not include a root cause analysis or evaluation of the bathroom to ascertain how R3 obtained the injury.

-On 6/12/20, at 9:50 a.m. staff entered R3's room to assist R3 as he had transferred himself to the toilet. R3 was very resistive with staff. R3 was reminded to use call light to ask for assistance. R3 stated he did not need help. R3 was reminded of his previous falls and was asked to use his call light in order to prevent future falls. Writer indicated this conversation with R3 would be discussed with the nurse manager on her return.

R3's clinical record lacked evidence of a comprehensive assessment of the aforementioned fall incidents which would have included a root cause analysis. The record also lacked an assessment on how R3 sustained a skin tear on his right elbow from the toilet grab

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bars following a fall.

On 6/11/20, at 3:00 p.m. R3 was observed in his room, seated in the wheelchair with his right arm bent and resting on his lap. R3 lifted his right arm up with his left hand and stated he was not doing so good. "It's my arm, I fell in the bathroom and hit it on the rail in there."At this time, two U-shaped metal bars were observed bolted to floor on both sides of the toilet. The bars had a smooth surface with no sharp edges noted. R3 stated he wanted to go to the doctor, but the staff had taped it up, bandaged and wrapped his arm. R3 added, "I think I need stitches." R3 stated the injury occurred about a week ago and verified that he did not ask for help with mobility into the bathroom because, "I just go myself." "If you are from the department of health, maybe you can look into it."

On 6/12/20, at 8:15 a.m. R3 was observed seated in the wheelchair, in his bathroom facing the sink.
-At 8:31 a.m. R3 was observed seated on his bathroom toilet. No staff have entered the room.
-At 8:35 a.m. staff entered the room and reminded R3 of the need to call for assistance in order to prevent falls. R3 refused assistance and remained sitting on the toilet. Staff exited the room.
-At 8:37 a.m. staff entered R3's room and assisted him to finish toileting.
-At 9:30 a.m. R3 stated, "My elbow hurts, would you like to see it?" and proceeded to remove the Kerlix wrap which was covering his right elbow wound. The wound appeared to have an open area that was approximately 2.0 cm in length and when R3 lifted up his elbow, the wound gaped open approximately 1.0 cm with an observable, undetermined depth. R3 stated he had asked the

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nurse for a new dressing, but she said he was not on her list of dressing changes to complete that day.
-At 9:35 a.m. the SA requested that RN-A notify the SA when she performed R3's right elbow dressing change so that the SA could observe it.
-At 9:37 RN-B approached the SA and stated R3 did not have a dressing change ordered. When RN-B was informed R3 had an open area on his right elbow, RN-B stated there was no documented evidence of a dressing change order for R3's wound on the medication or treatment record. RN-B stated typically if a resident had an open area/wound, it would be identified on the treatment record and include dressing change orders. At this time, RN-B stated she was going to go look at R3's wound, however, upon nearing R3's room, RN-A was observed exiting R3's room and stated to RN-B "yeah it is bad, it should have had stitches. I don't work here that often, so I was not aware of it." RN-A stated it was too late to send R3 into the clinic for stitches therefore RN-B directed RN-A to apply Steri strips to the wound and notify the physician for further orders.
-At 9:44 a.m. a telemed visit was conducted with R3's primary physician who described and prescribed orders for a wound program, with a follow up evaluation to be done in one week.

R3's Physician Office Visit note dated 6/12/20, indicated R3 had been evaluated for a skin tear on his right elbow following a fall in 6/5/20, and staff were wondering if the wound needed to be pulled together, but noted a week had already past. The note indicated R3's elbow appeared to have a 2.0 cm by 0.5 cm triangular shaped skin tear directly over the olecranon prominence. The skin edges are withdrawn about a 1.0 cm to 1.5 cm and 0.5 cm depth at the worst midpoint of the

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triangle. There is no drainage. At this late juncture, it is not worth placing sutures and directed the staff to use a Q-tip to lift the skin edge to try to approximate the tear a little better then to secure and place Steri-strips in an attempt to bring the wound edges together a little. Antibiotic ointment and a Tegaderm (a transparent dressing) to be applied for one week at which time the physician would discuss proper removal of the Tegaderm and replacement with the facility.

On 6/12/20, at 1:00 p.m. RN-B stated she was not aware that the facility's fall policy directed RN or physical therapist (PT) to observe a resident transfer following each fall and confirmed this evaluation had not been completed. RN-B verified the staff were not completing fall risk assessments and developing and implementing new interventions after each fall, rather would complete a fall risk assessment only if something had changed with the resident. In addition, RN-B stated she would have expected the nurse to have assessed the bathroom to investigate how R3 had cut his elbow on the toilet grab bar and document that assessment in R3's PN's. RN-B stated there would have been plenty of other interventions to implement in an attempt to minimize falls and/or injury.

On 6/12/20, at 1:30 p.m. a telephone interview was attempted with R3's unit manager, without success.

On 6/12/20, at 1:38 p.m. occupational therapist (OT)-A stated the head therapist attended the facility's interdisciplinary meetings meetings (IDT), but she did not think on a daily basis. OT-A stated the occupational therapy department would

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receive referrals for evaluations following a resident's fall and verified a referral had not been received following R3's falls.

On 6/12/20, at 3:30 p.m. during a telephone interview, the director of nursing (DON) stated she had only been in her position for four weeks therefore was not familiar with R3's March 2020, falls. However, the DON stated she had been aware of R3's right elbow skin tear wound as a result of landing on the toilet hard on 6/5/20. The DON stated the IDT had discussed the incident the next day and was told R3 had denied falling and would not allow staff to look at his arm. The DON verified R3's falls had not been comprehensively assessed which would have included the identification and potential elimination of the cause of the elbow injury, and a RN or physical therapist evaluation of R3's transfer abilities in order to identify a need for therapy and/or new interventions to be implemented. The DON stated the IDT as well as nursing staff should have attempted to identify and implement alternative interventions for safe transferring techniques for R3.

The facility's Fall Management Program policy and procedure revised 12/10/18, indicated after each fall, staff were to implement immediate interventions to prevent another fall and identify possible or likely causes. Staff were to evaluate the chain of events or circumstances preceding a fall and continue to collect and evaluate information until they either identified the root cause of the fall, or determined the cause could not be found. The policy also directed the staff to complete a post fall evaluation which consisted of a nurse or physical therapist observation of the resident transferring and if had difficulty

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F 689	Continued From page 16 transferring, an additional evaluation may be initiated. The policy directed the staff to ensure the post fall assessment and interventions implemented were documented.	F 689		

Electronically delivered
June 26, 2020

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: RN7S11

Dear Administrator:

The above facility was surveyed on June 11, 2020 through June 12, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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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 6/11/20, and 6/12/20, a surveyor of this Department's staff visited the above provider for a complaint investigation to investigate complaint H5039038C. The complaint was substantiated. Correction order issued at State Licensing 4658.0520	2 000	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.	

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	00823	A. BUILDING: _____ B. WING _____	C 06/12/2020

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	2 830		7/8/20

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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and/or develop and implement fall interventions in order to minimize the risk for falls and injury for 2 of 3 residents (R1, R3) identified at risk for falls. This failure resulted in actual harm when R1 was not provided timely toileting assistance and her wheelchair had not been positioned by the bed, as directed, resulting in a fall and subsequent sacral fracture. This failure also resulted in actual harm when R3 did not receive comprehensive assessments and implementations of new fall interventions following each falls per the facility fall policy resulting in a significant skin injury which would have required the application of sutures. Findings include: R1's admission Minimum Data Set (MDS) dated 5/24/20, indicated R1's diagnoses included a displaced fracture of the base of the neck of the left femur, osteoporosis, left artificial hip joint, diabetes, kidney disease, and mild cognitive impairment. The MDS also indicated R1 required limited assistance with transfers, dressing, and personal hygiene and extensive assistance with bed mobility and toileting. R1 had not ambulated and required assistance with mobility in her wheelchair. R1 had a history of falls within the month prior to admission which included a fall	2 830	Will be corrected per POC outlined in the Federal Deficiencies F684 and F689	

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2 830	Continued From page 3 with a fracture. R1's Activities of Daily Living (ADL) Functional Status Care Area Assessment (CAA) dated 5/26/20, indicated R1 had fallen at home and sustained a left hip fracture with surgical repair. R1's nurses noted reflected forgetfulness and confusion at times and indicated R1 required ADL assistance. R1's Fall CAA dated 5/26/20, indicated R1 was at risk for falls related to her history of falls, medications, slight cognitive impairment, incontinence and pain. The undated, personal care sheet, a pocket care plan utilized by the nursing assistant's, indicated R1 had a left hip fracture with surgical repair and was partial weight bearing to left leg, had bouts of confusion, was at risk for falls, and directed the staff to provide every 30 minutes rounding checks, assist of one to transfer with a walker and gait belt, a low bed, pendant call light, hip protectors to be worn, wheelchair to be at bedside, signage in room to remind to call for assistance, and to toilet every two hours and at 4:00 a.m. and 6:00 a.m. R1's comprehensive care plan created 5/26/20, indicated R1 had mild cognitive impairment, had a potential for falls due to a history of falls, medication use, limited mobility, incontinence, and cognitive deficit. The care plan directed the staff to keep assistive devices and call light within reach, hip protectors on when awake, 30 minute rounding (visual checks), frequent reminders to use call light, signage for reminders to call for assistance, offer toileting every two hours and at 4:00 a.m. and 6:00 a.m., assist of one with a front wheeled walker and gait belt for transfers, low	2 830		

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2 830	Continued From page 4	2 830		

bed, bed to be at transfer height for all transfers, pendant call light, and to initiate and reinforce safety teaching. The care plan also indicated R1 was at risk for potential complications related to anticoagulant (blood thinner) therapy and directed the staff to protect R1 from injury/trauma.

R1's Fall Risk Assessment, dated 6/2/20, identified R1 was at risk for falls. R1's clinical record lacked any previous fall risk assessments.

R1's 5/30/20, incident report submitted to the State Agency (SA) indicated on 5/30/20, R1 was found on the floor, in her room. R1 stated she was trying to ambulate to the bathroom when she fell.

R1's Nurse Progress Note (PN) dated 5/28/20, indicated R1 was alert and orientated with confusion at times. She was able to use the call light appropriately most times, was continent of bowel and bladder, and required assistance of one with ADL's and to pivot transfer.

R1's PN dated 5/29/20, indicated R1 required extensive assistance of one for wheelchair locomotion on the unit.

R1's PN dated 5/30/20, at 12:06 a.m. indicated staff had heard R1 yelling for help. R1 was found seated on the floor, in her room. Staff assessed R1 and with the assistance of three staff and a gait belt, assisted R1 up off the floor. Upon rising, R1 immediately complained of pain in her left and was assisted to sit in her wheelchair then pivot transferred to her bed. Upon transfer, R1 again complained of increased pain in her left leg. Staff assessed R1's left hip area and noted deformity to the upper left leg and swelling. The on call provider was contacted.

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2 830	Continued From page 5 R1's PN dated 5/30/20, at 12:42 a.m. indicated an ambulance was called to transfer R1 to the emergency room. A subsequent PN at 3:51 a.m. indicated the emergency room staff called and notified the facility that R1 had re-fractured her left hip and world be admitted to the hospital for further care. R1's 6/5/20, 5 day investigation report submitted to the SA indicated R1 had sustained a fall with significant injury due to staff not following R1's care plan, as directed. The report indicated the care plan directed the staff to keep R1's wheelchair at bedside and to toilet R1 every two hours. The investigation revealed R1's wheelchair was not positioned at her bedside rather was positioned across the room, and R1 had not been toileted every two hours as directed. The facility re-educated the staff on the importance of following care plan directives and were directed to review the personal care attendant (PCA) sheets (pocket care plans which identified each resident care needs) at the start of every shift. The report also indicated R1 had not sustained a hip re-fracture, but did sustained a sacral fracture as a result of the fall. On 6/12/20, at 3:30 p.m. the director of nursing (DON) stated R1's care plan indicated a fall prevention program was in place which would refer the reader to the PCA for the individualized interventions implemented. The DON stated during the investigation of R1's fall, it was discovered that the staff did not follow R1's care plan regarding placing the wheelchair by the bed and toileting R1 every two hours as R1 had not been assisted with toileting since 8:00 p.m. the previous evening (approximately four hours prior to the fall).	2 830		

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2 830	Continued From page 6 R3's undated face sheet indicated R3's diagnoses included neurodegenerative disease, dementia, anxiety disorder, repeated falls-high risk for falls, and overactive bladder R3's quarterly MDS dated 3/27/20, indicated R3 had moderate cognitive impairment and was independent with all ADLs with setup help from staff. The MDS also indicated R3 was occasionally incontinent of bowel and bladder and had experienced two or more falls since his last assessment. R3's care plan dated 4/5/19, identified a self care deficit and directed the staff to supervise R3 with dressing and one staff to physically assist with bathing, pivot transfers, and ambulation with a wheeled walker. The care plan indicated R3 often transferred himself and did not ask for help. The care plan also indicated R3 had occasional incontinence and directed the staff to offer toileting every two hours when awake to help avoid self transfers. The care plan indicated R3 was at risk for falls and directed the staff to place R3 on a fall prevention plan, provide a walker, encourage R3 to sit while praying, to not give R3 powder, to encourage use of gripper socks at all times, encourage to call staff for assist, conduct frequent and purposeful rounding, offer and assist as he would allow with showers, provide a longer phone cord and a one way glide and anti roll back on wheelchair. Review of R3's PN revealed the following: -On 2/21/20, at 3:20 a.m. R3 was found sitting on the bathroom floor. His brief and pants were lying on the floor next to him with the wheelchair nearby with the brakes engaged. No injuries	2 830		

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2 830	Continued From page 7 were noted. R3's clinical record lacked evidence of a root cause analysis and interventions implemented. -On 3/15/20, at 6:31 a.m. R3 was found on the shower floor. He stated he purposely got down on the floor and was wiping up excess water but could not get himself back up. R3's clinical record lacked evidence of a root cause analysis and interventions implemented to prevent future occurrences. The record also indicated R3 would independently take a shower in his bathroom shower. -On 3/29/20, R3 rang his call light and was found sitting on the bathroom floor. R3 stated he had lost his footing on the slippery bathroom floor and went down, landing on his buttocks. R3 had had a bowel movement which was noted on the floor, R3's shoes, and on the toilet seat and bowl. R3's clinical record lacked evidence of a root cause analysis and interventions implemented. -On 4/1/20, at 9:17 a.m. indicated R3's care plan was reviewed. A subsequent note dated 4/2/20, at 9:02 a.m. indicated care plan review directed staff to increase scheduled toileting, to offer toileting every two hours while awake with a goal of one or less incontinent voids per week. However, the note did not identify the effectiveness of the current fall interventions nor any new fall interventions implemented. -On 6/5/20, at 4:01 a.m. a "V" shaped skin tear was noted on R3's right elbow that measured 1.5 centimeters (cm). R3 stated he had fallen down onto the toilet hitting his elbow on the bar. The area was cleansed and covered with a 2 X 2 gauze and transparent dressing. An incident report was completed, however, did not include a	2 830		

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2 830	Continued From page 8 root cause analysis or evaluation of the bathroom to ascertain how R3 obtained the injury. -On 6/12/20, at 9:50 a.m. staff entered R3's room to assist R3 as he had transferred himself to the toilet. R3 was very resistive with staff. R3 was reminded to use call light to ask for assistance. R3 stated he did not need help. R3 was reminded of his previous falls and was asked to use his call light in order to prevent future falls. Writer indicated this conversation with R3 would be discussed with the nurse manager on her return. R3's clinical record lacked evidence of a comprehensive assessment of the aforementioned fall incidents which would have included a root cause analysis. The record also lacked an assessment on how R3 sustained a skin tear on his right elbow from the toilet grab bars following a fall. On 6/11/20, at 3:00 p.m. R3 was observed in his room, seated in the wheelchair with his right arm bent and resting on his lap. R3 lifted his right arm up with his left hand and stated he was not doing so good. "It's my arm, I fell in the bathroom and hit it on the rail in there."At this time, two U-shaped metal bars were observed bolted to floor on both sides of the toilet. The bars had a smooth surface with no sharp edges noted. R3 stated he wanted to go to the doctor, but the staff had taped it up, bandaged and wrapped his arm. R3 added, "I think I need stitches." R3 stated the injury occurred about a week ago and verified that he did not ask for help with mobility into the bathroom because, "I just go myself." "If you are from the department of health, maybe you can look into it."	2 830		

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2 830	Continued From page 9 On 6/12/20, at 8:15 a.m. R3 was observed seated in the wheelchair, in his bathroom facing the sink. -At 8:31 a.m. R3 was observed seated on his bathroom toilet. No staff have entered the room. -At 8:35 a.m. staff entered the room and reminded R3 of the need to call for assistance in order to prevent falls. R3 refused assistance and remained sitting on the toilet. Staff exited the room. -At 8:37 a.m. staff entered R3's room and assisted him to finish toileting. -At 9:30 a.m. R3 stated, "My elbow hurts, would you like to see it?" and proceeded to remove the Kerlix wrap which was covering his right elbow wound. The wound appeared to have an open area that was approximately 2.0 cm in length and when R3 lifted up his elbow, the wound gaped open approximately 1.0 cm with an observable, undetermined depth. R3 stated he had asked the nurse for a new dressing, but she said he was not on her list of dressing changes to complete that day. -At 9:35 a.m. the SA requested that RN-A notify the SA when she performed R3's right elbow dressing change so that the SA could observe it. -At 9:37 RN-B approached the SA and stated R3 did not have a dressing change ordered. When RN-B was informed R3 had an open area on his right elbow, RN-B stated there was no documented evidence of a dressing change order for R3's wound on the medication or treatment record. RN-B stated typically if a resident had an open area/wound, it would be identified on the treatment record and include dressing change orders. At this time, RN-B stated she was going to go look at R3's wound, however, upon nearing R3's room, RN-A was observed exiting R3's room and stated to RN-B "yeah it is bad, it should have had stitches. I don't work here that often, so I was not aware of it." RN-A stated it was too late to	2 830		

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send R3 into the clinic for stitches therefore RN-B directed RN-A to apply Steri strips to the wound and notify the physician for further orders.
-At 9:44 a.m. a telemed visit was conducted with R3's primary physician who described and prescribed orders for a wound program, with a follow up evaluation to be done in one week.

R3's Physician Office Visit note dated 6/12/20, indicated R3 had been evaluated for a skin tear on his right elbow following a fall in 6/5/20, and staff were wondering if the wound needed to be pulled together, but noted a week had already past. The note indicated R3's elbow appeared to have a 2.0 cm by 0.5 cm triangular shaped skin tear directly over the olecranon prominence. The skin edges are withdrawn about a 1.0 cm to 1.5 cm and 0.5 cm depth at the worst midpoint of the triangle. There is no drainage. At this late juncture, it is not worth placing sutures and directed the staff to use a Q-tip to lift the skin edge to try to approximate the tear a little better then to secure and place Steri-strips in an attempt to bring the wound edges together a little. Antibiotic ointment and a Tegaderm (a transparent dressing) to be applied for one week at which time the physician would discuss proper removal of the Tegaderm and replacement with the facility.

On 6/12/20, at 1:00 p.m. RN-B stated she was not aware that the facility's fall policy directed RN or physical therapist (PT) to observe a resident transfer following each fall and confirmed this evaluation had not been completed. RN-B verified the staff were not completing fall risk assessments and developing and implementing new interventions after each fall, rather would complete a fall risk assessment only if something had changed with the resident. In addition, RN-B

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stated she would have expected the nurse to have assessed the bathroom to investigate how R3 had cut his elbow on the toilet grab bar and document that assessment in R3's PN's. RN-B stated there would have been plenty of other interventions to implement in an attempt to minimize falls and/or injury.

On 6/12/20, at 1:30 p.m. a telephone interview was attempted with R3's unit manager, without success.

On 6/12/20, at 1:38 p.m. occupational therapist (OT)-A stated the head therapist attended the facility's interdisciplinary meetings meetings (IDT), but she did not think on a daily basis. OT-A stated the occupational therapy department would receive referrals for evaluations following a resident's fall and verified a referral had not been received following R3's falls.

On 6/12/20, at 3:30 p.m. during a telephone interview, the director of nursing (DON) stated she had only been in her position for four weeks therefore was not familiar with R3's March 2020, falls. However, the DON stated she had been aware of R3's right elbow skin tear wound as a result of landing on the toilet hard on 6/5/20. The DON stated the IDT had discussed the incident the next day and was told R3 had denied falling and would not allow staff to look at his arm. The DON verified R3's falls had not been comprehensively assessed which would have included the identification and potential elimination of the cause of the elbow injury, and a RN or physical therapist evaluation of R3's transfer abilities in order to identify a need for therapy and/or new interventions to be implemented. The DON stated the IDT as well as nursing staff should have attempted to identify

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2 830	Continued From page 12 and implement alternative interventions for safe transferring techniques for R3. The facility's Fall Management Program policy and procedure revised 12/10/18, indicated after each fall, staff were to implement immediate interventions to prevent another fall and identify possible or likely causes. Staff were to evaluate the chain of events or circumstances preceding a fall and continue to collect and evaluate information until they either identified the root cause of the fall, or determined the cause could not be found. The policy also directed the staff to complete a post fall evaluation which consisted of a nurse or physical therapist observation of the resident transferring and if had difficulty transferring, an additional evaluation may be initiated. The policy directed the staff to ensure the post fall assessment and interventions implemented were documented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures related to falls and educate all staff. The DON or designee could conduct audits to ensure compliance and report the findings to the quality improvement committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		