Electronically Submitted

April 9, 2019

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Numbers S5228030, H5228016C

Dear Administrator:

On February 15, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E).

On March 8, 2019, an abbreviated standard 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 8, 2019, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 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:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 15, 2019, (42 CFR 488.417 (b)).

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective, May 15, 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 15, 2019, (42 CFR 488.417 (b)).

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 8, 2019. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and

Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Avera Morningside Heights Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 8, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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, Licensing and Certification Program 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 August 15, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of

substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an

initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

(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 3/6/19 through 3/8/19, an abbreviated survey was completed at your facility to conduct a complaint investigations(s). Your facility was found NOT to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated: H5228016C Deficiency issued at F684. An Immediate Jeopardy (IJ) at F684 isolated/pattern J was identified, which began on 2/21/19, when it was determined the facility failed to ensure nursing staff used appropriate critical thinking and assessment, communication, and followed policies and procedures after a fall with facial fractures was not identified as emergent, resulting in delayed treatment and identification and subsequent death of a resident. The IJ was removed on 3/8/19 at 1:35 p.m.when the facility took steps to remove the immediate situation. Non-compliance remained at the lower scope and severity level of G, which identified actual harm. An extended survey was conducted by the Minnesota Department of Health on 3/8/19. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/12/2019

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 000	Continued From page 1 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=J	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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to appropriately assess, monitor, and intervene for 1 of 1 resident (R2) who sustained an unwitnessed fall with facial fractures resulting in serious harm and eventual death. Additionally, 2 of 2 residents (R1 and R3) whom sustained an unwitnessed fall did not receive consistent neurological monitoring from nursing staff. The survey resulted in an Immediate Jeopardy (IJ) at F684 J- isolated related to the facility's failure to appropriately assess, monitor, and intervene, with immediate risk to resident health and safety. The IJ began on 2/21/19 at 7:15 p.m. the facility administration were notified of the IJ on 3/7/19 at 4:35 p.m. Non-compliance remained at the lower scope and severity of G, actual harm, that was not Immediate Jeopardy. The IJ that began on 2/21/19 was removed on	F 684	Policy review: " DON/Administrator/Quality reviewed and revised the Fall prevention and management policy on 3/8/19 and added verbiage on purposeful hourly rounding to be completed on all new admits for the first two weeks of admission. Also added to the fall prevention policy that internal reporting will occur to the director of nursing, nurse supervisor, LTC administrator or the administrator on call for any resident who is exhibiting signs or symptoms of injury, or a change in condition from the residents baseline. " Post fall process map was reviewed and revised on 3/8/19 by the DON/Administrator/Quality to add thirty minute neurological checks to the current process for neuro assessment. " Physician medical services process	4/15/19

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F 684	Continued From page 2 3/8/19 at 1:35 p.m., when it could be verified by observation, document review and staff interview, the facility had implemented their plan of correction by educating and training all nursing staff, and reviewing and updating policies. Findings include: R2's significant change Minimum Data Set (MDS), dated 1/18/19 identified R2 had diagnosis of Alzheimer's dementia, severe cognitive impairment and a severe decline in weight and nutritional status and was admitted to hospice care. The MDS also identified R2 required extensive assistance for walking in her room and down the unit at that time. R2's 1/8/18, care plan identified R2 was a do not resuscitate (DNR) and had not wished to receive feeding tubes, IV fluids, mechanical breathing assistance, or cardiopulmonary resuscitation. The care plan identified R2 was steady on her feet for transfers, required only 1 assist for ambulation and required either a cane or walker. R2 was at risk for falls due to dementia and her inability to recall safety. If R2 was unsteady or weaker, staff were to offer assistance. R2's nutrition goal was to maintain weight with no significant weight loss. R2's nursing progress notes revealed on 2/21/19: (1) At 7:25 p.m., R2 fell on her face at 7:15 p.m., and had a laceration to the bridge of her nose with crooked in appearance. Her top and bottom lips were swollen, she had a forehead hematoma (large collection of blood under skin) and knee bruising to both knees. Her oxygen saturation of her blood (SPO2) was 95% (normal 95-100%). Her Glasgow Coma Scale (GCS) at that time was 15, identifying mild head injury. Her pupils were	F 684	map revised on 3/8/19 to include any suspected head injury or change in level of consciousness as an emergent situation. " Administrator/DON met with hospice manager on 3/13/19 and updated the Hospice contact process map updates include collaboration between LTC, hospice, provider, and family to discuss direction of care for hospice residents presenting with a change in condition. " LTC administrator and Director of Nursing met with eCare team on 3/13/19 to review current contract and expectations around utilization of camera with telemed visits. eCare Senior Care staff were provided education on the requirement to utilize camera to visualize residents during telemed visits. Staff education: Education provided to nursing staff on the above changes, including: " recognition of a change in condition, appropriate neurological assessments, fall follow ups, contact process for changes in condition/major injuries " updates to falls policy, post fall process map, physician medical services process map, hospice contact process map, and use of telemed camera for visits. " Nurses also received copies of Interact Care Pathways to assist in appropriate recognition of urgent vs. non urgent changes in condition. This education was completed by 3/8/19 for all licensed nurses. All scheduled nursing assistants for the	

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F 684	Continued From page 3 sluggish (normal reaction to light is brisk) and 3 millimeters (mm) in size, immediately after the fall R2 had no facial pain, but complained of right shoulder pain. R2's blood pressure (BP) was 153/78 millimeters of mercury (mm/hg) (normal 120/80 mm/hg). The Family, telemedicine (e-LTC) and hospice were notified of the fall. There was no mention staff identified R2's sluggish pupils as a concern for head trauma even though this was a change from her baseline December 2018 neurological assessment which identified her pupils normal reaction to light was brisk. (2) At 7:40 p.m., R2's pupils remained sluggish and her GCS was again 15. (3) At 7:45, R2's family member (FM) was contacted about the fall and a request was made for R2 to see the medical doctor (MD) through tele-medicine (e-LTC) for potential X-rays needed. The FM advised nursing "Yes, we need to fix what we can and keep her comfortable." (4) At 7:45 p.m., staff documented R2 was found on floor in hallway outside her room earlier at approximately 7:15 p.m. Staff had been in her room 15 minutes earlier and had helped R2 to bed. There was no indication R2 exhibited any abnormal behavior immediately before her fall that was reported by nurse aides (NA) to the nurse on duty. (5) At 7:55 p.m., R2's pupils remained sluggish. (6) At 8:10 p.m., R2 was "resting" and medications were given. No neurological (neuro) checks were performed at that time. (7) At 8:33 p.m., e-LTC was contacted regarding R2's fall via telephone only. No video assessment was completed. (8) At 9:00 p.m., R2 was "sleeping". No neurological checks were completed. (9) At 10:00 p.m., R2 responded to pain in her	F 684	dates of 3/7 and 3/8 received education on hourly rounding, falls, injury, recognition of a change in condition and appropriate follow up. All staff scheduled after 3/8/19 received education from DON/Nurse supervisor prior to their next scheduled shift. Quality Monitoring " Audits will be created to monitor for appropriate neurological assessments post fall. Audits to be completed by DON/Nursing Supervisor. DON/Nursing supervisors to follow up with counseling for nurses who do not complete neuro assessments accurately. Audits of neuro completion post fall will be added to the quality scorecard and results reviewed/reported at the LTC monthly quality committee meetings. Audits and scorecard additions will be implemented by 4/15/19 " LTC quality committee will review monthly, the eCARE utilization reports for use of the camera during visits and appropriate transfer to emergency department for emergent needs. " All ED transfers, beginning 4/15/19 will be reviewed by DON for timely treatment. These reviews will be discussed daily with administrator during tier 2 safety huddles.	

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F 684	Continued From page 4 shoulder. Staff noted they spoke with the X-ray department. X-ray department advised nursing the x-rays would not reveal any internal injuries from a fall to the face, and a CT should be ordered. The e-LTC provider was called and a recommendation made to forego the Ct scan as R2 had pain with movement in her shoulder which could wait until the morning. There was no indication staff notified the e-LTC MD about R2's abnormal sluggish pupils, decreased level of consciousness (LOC), or lack of pain with potential nasal fracture. R2 only responded to touch and pain during this time. (10) At 10:23 p.m., R2 was able to consume 600 milliliters (ml) of fluid. No neuro checks were documented as performed at that time. Staff were to give R2 pain medication every 2 hrs as needed, and check on her frequently. (11) At 11:00 p.m. R2 was sleeping. There was no indication staff woke R2 to appropriately assess her neurological function. Pain medication was given for moaning with movement. R2's nursing progress notes revealed on 2/22/19: (1) At 12:05 a.m., R2 was "resting". No neurological checks were noted at that time. (2) At 3:50 a.m., almost 4 hours later, staff documented R2 was responsive to pain and was given additional pain medication. No neurological checks or physical assessment were documented as performed. (3) At 10:42 a.m., 7 hours later, staff identified hospice registered nurse (RN)-B advised facility nursing staff she had transported R2 to the emergency department per FM's request and was looking for a medication list for R2. At that time, an unidentified ER nurse came to the facility requesting a medication list, advanced directives, code status, and power of attorney (POA)	F 684		

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F 684	Continued From page 5 information. Staff provided the ER nurse with the requested information. (4) At 10:45 a.m., staff documented R2 had passed away in the ER at 9:38 a.m. R2's 2/21/19 midnight, e-LTC documentation identified the provider, doctorate of nurse practitioner (DNP)-C identified R2 was not seen via camera video assessment. DNP-C diagnosed R2 with unspecified fall, unspecified injury of the nose, and pain in her right shoulder. DNP-C documented she called the facility and spoke with registered nurse (RN)-A, who reported family requested X-rays of R2's nose. Discussed calling hospice regarding goal of obtaining X-ray since treatment will most likely not change other than immobilization. Hospice nurse, RN-B spoke with FM and identified they were okay with not obtaining X-rays, however they would like R2's nose straightened manually. FM had wanted a shoulder X-ray and immobilization. DNP-C recommended R2 be seen by a provider in person for re-alignment. If FM wanted an accurate diagnosis, a head CT would be needed of R2's face. DNP-C identified R2 had an unwitnessed fall where resident "probably" hit her head, may have a broken nose, and hurt her right shoulder. R2 had hit her head on the railing in the hall and landed face down. Her face and knees hit the floor first before the rest of her body. DNP-C reported neuro's were within normal limits for R2. DPN-C's documentation identified R2 had hit her head, had a swollen bump over her right eye, and her lips and nose were swollen as well. R2's knees were swollen and bluish in color. Staff were ordered to follow facility fall protocol with vitals and neuro's. Fall was not related to R2's hospice diagnosis and hospice approved the	F 684		

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nose and shoulder X-ray. There is no mention RN-A reported R2's abnormal neuro's or the extent of potential injuries and seriousness to DNP-C.

R2's 2/21/19, 2:09 p.m. hospice note identified R2 was at the lunch table when RN-B arrived at the facility. R2's SPO2 was 94%, RR at 18, and BP was 108/72. R2 was able to make her wishes known to lie down at that time. No abnormalities of R2's health were noted.

R2's 2/22/19, 8:08 a.m. hospice note identified RN-B had been notified 2/21/19 at 8:00 p.m. of R2's fall. RN-B notified the family of a "nose and shoulder injury". FM wanted R2's nose straightened. The e-LTC advised RN-B R2's nose could be straightened in the morning. RN-B noted she had arrived at the facility earlier that a.m. and found R2 in bed with "some blood on her cheek which appears to be coming from her mouth." R2 had "snorous respirations and was very pale. R2's fingers were dusky. RN-B measured R2's SPO2 with her O2 monitor and found R2's SPO2 was at 17%. She then retrieved the facility's SPO2 monitor which calculated R2's O2 at 30%. RN-B placed a nasal cannula on R2's mouth and administered 5 L oxygen. RN-B placed a call to R2's FM and advised her of R2's health deterioration. FM wanted R2 to be seen immediately in the ER. R2 was discharged from hospice and transported to the ER.

R2's 2/22/19 ER record indicated she was brought to the ER:
(1) At 7:28 a.m., by RN-B after RN-B had arrived at the facility that morning. RN-B checked R2's SPO2 and identified as 35% on room air. RN-B notified FM of R2's condition and FM told RN-B to

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F 684	Continued From page 7 take R2 off hospice and bring R2 to the ER. Upon arrival to the ER, R2's SPO2 was 34% on 5 liters (L)/minute (min) of oxygen via mask. ER staff noted bruising around both eyes and behind R2's left ear with an abrasion (scrape) to her right forehead and shoulder. R2's vital signs were identified as temperature, 99.5 degrees Fahrenheit (F) (slightly elevated), heart rate (HR) 81 beats per minute (bpm), a fast respiratory rate of 24 breaths per minute (bpm) (normal 16-20 bpm), and a lowered BP of 110/58 mm/hg. R2's GCS was 3, identifying severe neurological damage if less than 8. An IV was started, and R2 was seen by the physician (MD)-A at 7:35 a.m. (2) At 7:35 a.m., R2's oxygen was increased to 15 L/min and her SPO2 increased to 68%. After IV initiation, R2's BP increased to 135/72. Staff attempted to wake R2 using a sternal (chest bone) rub in attempt to wake or get a response from R2. R2 made no response. (3) At 7:40 a.m., R2's GCS remained at 3, with her pupil diameter smaller at 2 mm and sluggish. R2 remained unresponsive at that time and displayed agonal breathing (abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, and accompanied by strange vocalizations and involuntary muscle jerking). R2's skin was dusky and cool to the touch. (4) At 7:45 a.m., R2 was started on a Bi-Pap machine (pushes air into lungs to assist with breathing). R2's SPO2 increased to 72%. R2's HR was 78 bpm and her BP was 152/76. Her GCS and pupil reaction remained unchanged. (5) At 8:03 a.m., R2 was positioned to sitting up in bed to attempt to increase her SPO2. R2's SPO2 increased to 88%, BP increased to 154/84, but her GCS and pupil reaction remained the same. (6) At 8:10 a.m., R2's SPO2 increased to 92%.	F 684		

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F 684	Continued From page 8 The director of nursing (DON) for the facility was called regarding potential comfort care for R2. (7) At 9:18 a.m., R2 was switched to another breathing machine, a more aggressive (AVAP) as her SPO2 declined to 60 %. (8) At 9:32 a.m., staff documented R2's continuing decline in SPO2, in spite of the use of an AVAP machine. (9) At 9:33 a.m., R2's HR was abnormally low at 55 bpm, her respirations decreased to 4 bpm, and her SPO2 was at 53%. There was no change to her GCS. (10) At 9:34 a.m., R2's heart rate went to asystole (absence of heart beat). (11) At 9:38 a.m., R2 was pronounced dead. Interview and document review on 3/7/19 at 8:00 a.m., with RN-A identified she was the nurse on duty who assisted R2 on 2/21/19 after her fall. R2 had walked out into the hallway and fell face first at approximately 7:15 p.m.. RN-A performed an immediate assessment on R2. Her face was "banged up". R2's neuro's immediately after the fall were sluggish. Staff were to perform neuro's every 15 min x 4, every hour x 4, then every 4 x 6. RN-A had thought R2's sluggish neuro's were her normal. Staff would check back in electronic medical record at the previous neuro documentation to see if anything had changed. RN-A identified on 12/8/18, a neuro assessment was performed on R2 and her pupils were brisk at that time. RN-A agreed sluggish pupils would not be normal for R2. RN-A had not performed neuro checks according to policy as R2 was sleeping at times and she had not wanted to wake her. RN-A agreed that was not according to facility policy. Staff wouldn't normally wake residents if they appeared to be sleeping. RN-A was unsure how staff would be able to determine	F 684		

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a decrease in level of consciousness or changes to neuro status without performing appropriate assessments. E-LTC would be responsible to order X-Rays if needed after a fall. RN-A brought the e-LTC monitor into R2's room for DNP-C to do a visual assessment. DNP-C declined. DNP-C went off the report from the nurses who made the assessment. RN-A was not sure if she advised DNP-C about the potential severity of R2's injuries or abnormal neuro status. In the past, e-LTC would need to give orders to take a resident to the ER for evaluation. R2's family member had requested the facility take R2 to [ER] to straighten her nose. RN-A wasn't sure why staff had not taken R2 to the emergency room that night for assessment of her nose at the family's request. DNP-C felt the shoulder X-ray could be completed in the morning. R2 was moaning with movement and had had a "snoring" breathing pattern that was not her normal throughout the night of 2/21/19. RN-A was unaware R2 had the potential for facial fractures that could cause a brain bleed. RN-A was unsure if the director of nursing (DON) had been called right away after the fall. RN-A stated the facility had a post fall huddle a few days later and went over the events of the fall. No re-education was given at that time. RN-A agreed potential facial fractures would be an emergent situation, now that she looked back at the events surrounding R2's fall.

Interview on 3/7/19 at 9:10 a.m. with the DON regarding R2's fall identified staff were to call her if a significant injury happened at the facility. She was not notified of R2's fall until the next day after R2 went to the ER. If a resident was on hospice, typically the hospice MD-B (also the medical director) is called but he was on vacation at that

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time, so staff called the e-LTC. E-LTC is contracted for urgent care needs only. Her expectation staff were to perform assessments as dictated in the policy. Staff should have woken R2 to perform neuro assessments. Staff were to use critical thinking in assessment of injuries and identify abnormal vita signs and potential serious injuries. Staff should have communicated the potential seriousness of R2's injuries to the MD and family so all options were given to make the best judgement on care of a resident. The DON performed a post fall huddle and went over the events of R2's fall with staff. Her expectation was hospice should have been alerted to the seriousness of R2's injuries to determine what may need to be done with higher level of care. The DON had set expectation of vitals and policies and procedures were to be followed, but had not re-educated the nursing staff on communication, clinical assessment or policies and procedures. She planned on addressing this individually with staff at a later date. The nurse practitioner (NP) who worked for the MD also reviewed R2's chart and had serious concerns of how staff handled the situation. RN-A advised the DON because R2 was hospice, her fall was not serious. The DON agreed R2's fall was an emergent situation and should have had immediate evaluation.

Interview on 3/7/19 at 11:20 A.M., with the emergency room doctor (MD)-A, regarding the events surrounding R2's fall. MD-A agreed if e-LTC would have visually assessed the resident, they could have seen the potential extent of her injuries. Facial fractures commonly have no pain associated with them as nerve damage is common. MD-A suspected a brain bleed, but was not sure if it was related to Alzheimer or the fall.

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If R2 had no symptoms or abnormalities immediately before the fall, he would associate the bleed with the injury vs Alzheimers. MD-A stated staff should have taken R2 to the ER immediately for evaluation of her obvious facial fractures. There may have been preventative measures ER staff could have taken to prevent the death of R2 if caught early. MD-A agreed staff failed to recognize the serious extent of R2's injuries, causing delay in treatment.

Interview on 3/7/19 at 11:42 a.m., with RN-B (hospice nurse) regarding R2's fall. RN-B had seen R2 earlier that day on 2/21/19. R2 was alert, but confused related to Alzheimers. That was her normal. R2 was placed on hospice related to her nutritional decline earlier that month. RN-B was notified of a probably nose fracture and a potential shoulder injury. RN-B was not made aware of the extent of R2's facial injuries or her abnormal neuro's and vital signs. She spoke with the e-LTC doctor, who reported R2's shoulder x-ray could wait until morning. R2 should have been seen in person at the ER to assess and manually straighten R2's nose. RN-B was not aware the facility staff had not taken R2 to the ER for evaluation. R2's fall injuries were not related to her Alzheimers disease process. RN-B was never advised of the seriousness of R2's injuries that included orbital (eye) bruising with the high potential of facial fracture, R2's hematoma, or abnormal vitals. RN-B arrived to the facility early on 2/22/19 as another hospice resident had passed away. RN-B came to see how R2 was doing and found her to have ineffectual snored breathing and was pale in color. She immediately assessed R2 and took her SPO2. When her machine said R2 had 17% SPO2, she retrieved the facility monitor. That was a bit higher but

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F 684	Continued From page 12 seriously low. RN-B immediately called R2's FM and conveyed the seriousness of the situation. At that time, R2's FM decided to remove R2 from hospice and have her transferred to the ER for evaluation. R2 died shortly after in the ER. Had RN-B known the potential seriousness of R2's injuries and abnormal vitals, she would have recommended immediate evaluation at the ER. Interview and competency document review on 3/7/19 at 12:30 p.m. with RN-D regarding RN-A's competencies and training identified staff meetings and training were held every month. RN-A had not attended either December of January 2019 trainings as she usually had not attended onsite trainings as she works nights. RN-A was required to sign an email stating she read the training that was provided. No competencies or training were done for RN-A related to falls since February 2016. RN-E had not had any current fall and injury prevention. her last training was on 9/25/2017. The IJ that began on 2/21/19 was removed on 3/8/19 at 1:35 p.m., when it could be verified by observation, document review and staff interview, the facility had implemented their plan of correction by educating and training all nursing staff, and reviewing and updating policies related to emergency procedures, signs and symptoms of head injury, and fall prevention. R1's 2/6/19, Significant Change (SC) MDS identified she was severely cognitively impaired and totally dependent on staff for mobility. R1 had an unwitnessed fall on 2/25/19. She was	F 684		

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F 684	Continued From page 13 found lying on her left side of her body on the fall matt beside her bed. R1 pointed to the other side of the room and said "red drawer". R1 denied pain at that time. R1's first 4 neuro assessments were performed the first hour at approximately every 15 min followed by every hour x 4. R1's neuro's after 2:30 a.m. were not performed until 10:30 a.m. the next day 8 hours later as R1 had been asleep. R3's quarterly 1/15/19, MDS assessment identified she had mild cognitive impairment and would forget things easily and had a history of falls. R3's 2/11/19 care plan identified she was at risk for falls related to her inability to recall she needed assistance when up related to poor balance that varied with memory problems. R3 had an unwitnessed fall on 2/20/19 at 3:40 a.m. R3 stated she was reaching for her call light that was not beside her in bed, but left in the recliner. R3 had a touchpad call light on her railing, but had forgotten to use it. R3's neuro's were completed at 3:40 a.m. and again at 3:55 a.m. and 4:10 a.m. At 4:23 a.m. and 5:25 a.m., staff noted R3 was resting and had not performed any neurological assessment as indicated per policy for an unwitnessed fall until 6:25 a.m.. Neuro's were then checked at 7:40 a.m. and 8:40 a.m., and not checked again until 12:35 p.m. later that day. The last neuro check was at 4:30 p.m. Interview on 3/8/19 at 11:15 a.m. with the DON identified she agreed R1 and R3's neuro checks for unwitnessed falls were not completed according to policy and procedure. She agreed nursing staff were not completing these timely or were not performing the assessments if residents	F 684		

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were sleeping and should have. Neuros should be completed initially, then every 15 minutes x 4, then every 1 hour x 4 and every 4 hours x 6. This information was not written into any facility policy or procedure, but was expected to be performed as a nursing standard.

Review of the August 2018 Fall Prevention and management policy identified nursing staff were to follow the post fall process map. An assessment of a resident was to include vitals signs and neuro checks if a resident struck their head or it was an unwitnessed fall. The nurse was to notify the family and physician of the fall, sequence of events, and patient condition. There was no mention of how long or at what interval neuro assessments were to be made.

Review of the 8/1/18, Avera Senior Care Services Agreement identified e-LTC was to be used for urgent care services 24 hours per day/7 days per week /365 days per year. The facility and e-LTC agreed to collect and provide current vital signs for residents. E-LTC was to participate in a video encounter when requested by the Avera RN. the RN was to provide an accurate, brief synopsis of the presenting problem, including vital signs that will allow the MD to triage.

Review of the undated Physician/medical Services LTC algorithm identified e-LTC was to provide services for residents when the MD or his designee were not onsite. A change in a resident's medical condition requiring physician information identified emergent, life-threatening medical conditions were to be evaluated in the ER immediately.

Electronically delivered
April 9, 2019

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: State Nursing Home Licensing Orders - Project Number H5228016C

Dear Administrator:

The above facility was surveyed on March 6, 2019 through March 8, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5228016C. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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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 3/6/19 through 3/8/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint(s) were found to be substantiated: H5228016C correction order was issued at 0830. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to appropriately assess, monitor, and intervene for 1 of 1 resident (R2) who sustained an unwitnessed fall with facial fractures resulting in serious harm and eventual death. Additionally, 2 of 2 residents (R1 and R3) whom sustained an unwitnessed fall did not receive consistent neurological monitoring from nursing staff.	2 830	Corrected	4/15/19

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2 830	Continued From page 2 The survey resulted in an Immediate Jeopardy (IJ) at F684 J- isolated related to the facility's failure to appropriately assess, monitor, and intervene, with immediate risk to resident health and safety. The IJ began on 2/21/19 at 7:15 p.m. the facility administration were notified of the IJ on 3/7/19 at 4:35 p.m. Non-compliance remained at the lower scope and severity of G, actual harm, that was not Immediate Jeopardy. The IJ that began on 2/21/19 was removed on 3/8/19 at 1:35 p.m., when it could be verified by observation, document review and staff interview, the facility had implemented their plan of correction by educating and training all nursing staff, and reviewing and updating policies. Findings include: R2's significant change Minimum Data Set (MDS), dated 1/18/19 identified R2 had diagnosis of Alzheimer's dementia, severe cognitive impairment and a severe decline in weight and nutritional status and was admitted to hospice care. The MDS also identified R2 required extensive assistance for walking in her room and down the unit at that time. R2's 1/8/18, care plan identified R2 was a do not resuscitate (DNR) and had not wished to receive feeding tubes, IV fluids, mechanical breathing assistance, or cardiopulmonary resuscitation. The care plan identified R2 was steady on her feet for transfers, required only 1 assist for ambulation and required either a cane or walker. R2 was at risk for falls due to dementia and her inability to recall safety. If R2 was unsteady or weaker, staff were to offer assistance. R2's nutrition goal was to maintain weight with no significant weight loss.	2 830		

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2 830	Continued From page 3 R2's nursing progress notes revealed on 2/21/19: (1) At 7:25 p.m., R2 fell on her face at 7:15 p.m., and had a laceration to the bridge of her nose with crooked in appearance. Her top and bottom lips were swollen, she had a forehead hematoma (large collection of blood under skin) and knee bruising to both knees. Her oxygen saturation of her blood (SPO2) was 95% (normal 95-100%). Her Glasgow Coma Scale (GCS) at that time was 15, identifying mild head injury. Her pupils were sluggish (normal reaction to light is brisk) and 3 millimeters (mm) in size, immediately after the fall R2 had no facial pain, but complained of right shoulder pain. R2's blood pressure (BP) was 153/78 millimeters of mercury (mm/hg) (normal 120/80 mm/hg). The Family, telemedicine (e-LTC) and hospice were notified of the fall. There was no mention staff identified R2's sluggish pupils as a concern for head trauma even though this was a change from her baseline December 2018 neurological assessment which identified her pupils normal reaction to light was brisk. (2) At 7:40 p.m., R2's pupils remained sluggish and her GCS was again 15. (3) At 7:45, R2's family member (FM) was contacted about the fall and a request was made for R2 to see the medical doctor (MD) through tele-medicine (e-LTC) for potential X-rays needed. The FM advised nursing "Yes, we need to fix what we can and keep her comfortable." (4) At 7:45 p.m., staff documented R2 was found on floor in hallway outside her room earlier at approximately 7:15 p.m. Staff had been in her room 15 minutes earlier and had helped R2 to bed. There was no indication R2 exhibited any abnormal behavior immediately before her fall that was reported by nurse aides (NA) to the nurse on duty. (5) At 7:55 p.m., R2's pupils remained sluggish.	2 830		

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2 830	Continued From page 4 (6) At 8:10 p.m., R2 was "resting" and medications were given. No neurological (neuro) checks were performed at that time. (7) At 8:33 p.m., e-LTC was contacted regarding R2's fall via telephone only. No video assessment was completed. (8) At 9:00 p.m., R2 was "sleeping". No neurological checks were completed. (9) At 10:00 p.m., R2 responded to pain in her shoulder. Staff noted they spoke with the X-ray department. X-ray department advised nursing the x-rays would not reveal any internal injuries from a fall to the face, and a CT should be ordered. The e-LTC provider was called and a recommendation made to forego the Ct scan as R2 had pain with movement in her shoulder which could wait until the morning. There was no indication staff notified the e-LTC MD about R2's abnormal sluggish pupils, decreased level of consciousness (LOC), or lack of pain with potential nasal fracture. R2 only responded to touch and pain during this time. (10) At 10:23 p.m., R2 was able to consume 600 milliliters (ml) of fluid. No neuro checks were documented as performed at that time. Staff were to give R2 pain medication every 2 hrs as needed, and check on her frequently. (11) At 11:00 p.m. R2 was sleeping. There was no indication staff woke R2 to appropriately assess her neurological function. Pain medication was given for moaning with movement. R2's nursing progress notes revealed on 2/22/19: (1) At 12:05 a.m., R2 was "resting". No neurological checks were noted at that time. (2) At 3:50 a.m., almost 4 hours later, staff documented R2 was responsive to pain and was given additional pain medication. No neurological checks or physical assessment were documented as performed.	2 830		

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2 830	Continued From page 5 (3) At 10:42 a.m., 7 hours later, staff identified hospice registered nurse (RN)-B advised facility nursing staff she had transported R2 to the emergency department per FM's request and was looking for a medication list for R2. At that time, an unidentified ER nurse came to the facility requesting a medication list, advanced directives, code status, and power of attorney (POA) information. Staff provided the ER nurse with the requested information. (4) At 10:45 a.m., staff documented R2 had passed away in the ER at 9:38 a.m. R2's 2/21/19 midnight, e-LTC documentation identified the provider, doctorate of nurse practitioner (DNP)-C identified R2 was not seen via camera video assessment. DNP-C diagnosed R2 with unspecified fall, unspecified injury of the nose, and pain in her right shoulder. DNP-C documented she called the facility and spoke with registered nurse (RN)-A, who reported family requested X-rays of R2's nose. Discussed calling hospice regarding goal of obtaining X-ray since treatment will most likely not change other than immobilization. Hospice nurse, RN-B spoke with FM and identified they were okay with not obtaining X-rays, however they would like R2's nose straightened manually. FM had wanted a shoulder X-ray and immobilization. DNP-C recommended R2 be seen by a provider in person for re-alignment. If FM wanted an accurate diagnosis, a head CT would be needed of R2's face. DNP-C identified R2 had an unwitnessed fall where resident "probably" hit her head, may have a broken nose, and hurt her right shoulder. R2 had hit her head on the railing in the hall and landed face down. Her face and knees hit the floor first before the rest of her body. DNP-C reported neuro's were within normal limits	2 830		

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2 830	Continued From page 6 for R2. DPN-C's documentation identified R2 had hit her head, had a swollen bump over her right eye, and her lips and nose were swollen as well. R2's knees were swollen and bluish in color. Staff were ordered to follow facility fall protocol with vitals and neuro's. Fall was not related to R2's hospice diagnosis and hospice approved the nose and shoulder X-ray. There is no mention RN-A reported R2's abnormal neuro's or the extent of potential injuries and seriousness to DNP-C. R2's 2/21/19, 2:09 p.m. hospice note identified R2 was at the lunch table when RN-B arrived at the facility. R2's SPO2 was 94%, RR at 18, and BP was 108/72. R2 was able to make her wishes known to lie down at that time. No abnormalities of R2's health were noted. R2's 2/22/19, 8:08 a.m. hospice note identified RN-B had been notified 2/21/19 at 8:00 p.m. of R2's fall. RN-B notified the family of a "nose and shoulder injury". FM wanted R2's nose straightened. The e-LTC advised RN-B R2's nose could be straightened in the morning. RN-B noted she had arrived at the facility earlier that a.m. and found R2 in bed with "some blood on her cheek which appears to be coming from her mouth." R2 had "snorous respirations and was very pale. R2's fingers were dusky. RN-B measured R2's SPO2 with her O2 monitor and found R2's SPO2 was at 17%. She then retrieved the facility's SPO2 monitor which calculated R2's O2 at 30%. RN-B placed a nasal cannula on R2's mouth and administered 5 L oxygen. RN-B placed a call to R2's FM and advised her of R2's health deterioration. FM wanted R2 to be seen immediately in the ER. R2 was discharged from hospice and transported to the ER.	2 830		

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2 830	Continued From page 7 R2's 2/22/19 ER record indicated she was brought to the ER: (1) At 7:28 a.m., by RN-B after RN-B had arrived at the facility that morning. RN-B checked R2's SPO2 and identified as 35% on room air. RN-B notified FM of R2's condition and FM told RN-B to take R2 off hospice and bring R2 to the ER. Upon arrival to the ER, R2's SPO2 was 34% on 5 liters (L)/minute (min) of oxygen via mask. ER staff noted bruising around both eyes and behind R2's left ear with an abrasion (scrape) to her right forehead and shoulder. R2's vital signs were identified as temperature, 99.5 degrees Fahrenheit (F) (slightly elevated), heart rate (HR) 81 beats per minute (bpm), a fast respiratory rate of 24 breaths per minute (bpm) (normal 16-20 bpm), and a lowered BP of 110/58 mm/hg. R2's GCS was 3, identifying severe neurological damage if less than 8. An IV was started, and R2 was seen by the physician (MD)-A at 7:35 a.m. (2) At 7:35 a.m., R2's oxygen was increased to 15 L/min and her SPO2 increased to 68%. After IV initiation, R2's BP increased to 135/72. Staff attempted to wake R2 using a sternal (chest bone) rub in attempt to wake or get a response from R2. R2 made no response. (3) At 7:40 a.m., R2's GCS remained at 3, with her pupil diameter smaller at 2 mm and sluggish. R2 remained unresponsive at that time and displayed agonal breathing (abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, and accompanied by strange vocalizations and involuntary muscle jerking). R2's skin was dusky and cool to the touch. (4) At 7:45 a.m., R2 was started on a Bi-Pap machine (pushes air into lungs to assist with breathing). R2's SPO2 increased to 72%. R2's HR was 78 bpm and her BP was 152/76. Her GCS and pupil reaction remained unchanged.	2 830		

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2 830	Continued From page 8 (5) At 8:03 a.m., R2 was positioned to sitting up in bed to attempt to increase her SPO2. R2's SPO2 increased to 88%, BP increased to 154/84, but her GCS and pupil reaction remained the same. (6) At 8:10 a.m., R2's SPO2 increased to 92%. The director of nursing (DON) for the facility was called regarding potential comfort care for R2. (7) At 9:18 a.m., R2 was switched to another breathing machine, a more aggressive (AVAP) as her SPO2 declined to 60 %. (8) At 9:32 a.m., staff documented R2's continuing decline in SPO2, in spite of the use of an AVAP machine. (9) At 9:33 a.m., R2's HR was abnormally low at 55 bpm, her respirations decreased to 4 bpm, and her SPO2 was at 53%. There was no change to her GCS. (10) At 9:34 a.m., R2's heart rate went to asystole (absence of heart beat). (11) At 9:38 a.m., R2 was pronounced dead. Interview and document review on 3/7/19 at 8:00 a.m., with RN-A identified she was the nurse on duty who assisted R2 on 2/21/19 after her fall. R2 had walked out into the hallway and fell face first at approximately 7:15 p.m.. RN-A performed an immediate assessment on R2. Her face was "banged up". R2's neuro's immediately after the fall were sluggish. Staff were to perform neuro's every 15 min x 4, every hour x 4, then every 4 x 6. RN-A had thought R2's sluggish neuro's were her normal. Staff would check back in electronic medical record at the previous neuro documentation to see if anything had changed. RN-A identified on 12/8/18, a neuro assessment was performed on R2 and her pupils were brisk at that time. RN-A agreed sluggish pupils would not be normal for R2. RN-A had not performed neuro checks according to policy as R2 was sleeping at times and she had not wanted to	2 830		

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2 830	Continued From page 9 wake her. RN-A agreed that was not according to facility policy. Staff wouldn't normally wake residents if they appeared to be sleeping. RN-A was unsure how staff would be able to determine a decrease in level of consciousness or changes to neuro status without performing appropriate assessments. E-LTC would be responsible to order X-Rays if needed after a fall. RN-A brought the e-LTC monitor into R2's room for DNP-C to do a visual assessment. DNP-C declined. DNP-C went off the report from the nurses who made the assessment. RN-A was not sure if she advised DNP-C about the potential severity of R2's injuries or abnormal neuro status. In the past, e-LTC would need to give orders to take a resident to the ER for evaluation. R2's family member had requested the facility take R2 to [ER] to straighten her nose. RN-A wasn't sure why staff had not taken R2 to the emergency room that night for assessment of her nose at the family's request. DNP-C felt the shoulder X-ray could be completed in the morning. R2 was moaning with movement and had had a "snoring" breathing pattern that was not her normal throughout the night of 2/21/19. RN-A was unaware R2 had the potential for facial fractures that could cause a brain bleed. RN-A was unsure if the director of nursing (DON) had been called right away after the fall. RN-A stated the facility had a post fall huddle a few days later and went over the events of the fall. No re-education was given at that time. RN-A agreed potential facial fractures would be an emergent situation, now that she looked back at the events surrounding R2's fall. Interview on 3/7/19 at 9:10 a.m. with the DON regarding R2's fall identified staff were to call her if a significant injury happened at the facility. She was not notified of R2's fall until the next day after	2 830		

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2 830	Continued From page 10 R2 went to the ER. If a resident was on hospice, typically the hospice MD-B (also the medical director) is called but he was on vacation at that time, so staff called the e-LTC. E-LTC is contracted for urgent care needs only. Her expectation staff were to perform assessments as dictated in the policy. Staff should have woken R2 to perform neuro assessments. Staff were to use critical thinking in assessment of injuries and identify abnormal vita signs and potential serious injuries. Staff should have communicated the potential seriousness of R2's injuries to the MD and family so all options were given to make the best judgement on care of a resident. The DON performed a post fall huddle and went over the events of R2's fall with staff. Her expectation was hospice should have been alerted to the seriousness of R2's injuries to determine what may need to be done with higher level of care. The DON had set expectation of vitals and policies and procedures were to be followed, but had not re-educated the nursing staff on communication, clinical assessment or policies and procedures. She planned on addressing this individually with staff at a later date. The nurse practitioner (NP) who worked for the MD also reviewed R2's chart and had serious concerns of how staff handled the situation. RN-A advised the DON because R2 was hospice, her fall was not serious. The DON agreed R2's fall was an emergent situation and should have had immediate evaluation. Interview on 3/7/19 at 11:20 A.M., with the emergency room doctor (MD)-A, regarding the events surrounding R2's fall. MD-A agreed if e-LTC would have visually assessed the resident, they could have seen the potential extent of her injuries. Facial fractures commonly have no pain associated with them as nerve damage is	2 830		

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2 830	Continued From page 11	2 830		

common. MD-A suspected a brain bleed, but was not sure if it was related to Alzheimer or the fall. If R2 had no symptoms or abnormalities immediately before the fall, he would associate the bleed with the injury vs Alzheimers. MD-A stated staff should have taken R2 to the ER immediately for evaluation of her obvious facial fractures. There may have been preventative measures ER staff could have taken to prevent the death of R2 if caught early. MD-A agreed staff failed to recognize the serious extent of R2's injuries, causing delay in treatment.

Interview on 3/7/19 at 11:42 a.m., with RN-B (hospice nurse) regarding R2's fall. RN-B had seen R2 earlier that day on 2/21/19. R2 was alert, but confused related to Alzheimers. That was her normal. R2 was placed on hospice related to her nutritional decline earlier that month. RN-B was notified of a probably nose fracture and a potential shoulder injury. RN-B was not made aware of the extent of R2's facial injuries or her abnormal neuro's and vital signs. She spoke with the e-LTC doctor, who reported R2's shoulder x-ray could wait until morning. R2 should have been seen in person at the ER to assess and manually straighten R2's nose. RN-B was not aware the facility staff had not taken R2 to the ER for evaluation. R2's fall injuries were not related to her Alzheimers disease process. RN-B was never advised of the seriousness of R2's injuries that included orbital (eye) bruising with the high potential of facial fracture, R2's hematoma, or abnormal vitals. RN-B arrived to the facility early on 2/22/19 as another hospice resident had passed away. RN-B came to see how R2 was doing and found her to have ineffectual snored breathing and was pale in color. She immediately assessed R2 and took her SPO2. When her machine said R2 had 17% SPO2, she retrieved

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	00343	A. BUILDING: _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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 12 the facility monitor. That was a bit higher but seriously low. RN-B immediately called R2's FM and conveyed the seriousness of the situation. At that time, R2's FM decided to remove R2 from hospice and have her transferred to the ER for evaluation. R2 died shortly after in the ER. Had RN-B known the potential seriousness of R2's injuries and abnormal vitals, she would have recommended immediate evaluation at the ER. Interview and competency document review on 3/7/19 at 12:30 p.m. with RN-D regarding RN-A's competencies and training identified staff meetings and training were held every month. RN-A had not attended either December of January 2019 trainings as she usually had not attended onsite trainings as she works nights. RN-A was required to sign an email stating she read the training that was provided. No competencies or training were done for RN-A related to falls since February 2016. RN-E had not had any current fall and injury prevention. her last training was on 9/25/2017. The IJ that began on 2/21/19 was removed on 3/8/19 at 1:35 p.m., when it could be verified by observation, document review and staff interview, the facility had implemented their plan of correction by educating and training all nursing staff, and reviewing and updating policies related to emergency procedures, signs and symptoms of head injury, and fall prevention. R1's 2/6/19, Significant Change (SC) MDS identified she was severely cognitively impaired and totally dependent on staff for mobility. R1 had an unwitnessed fall on 2/25/19. She was	2 830		

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2 830	Continued From page 13 found lying on her left side of her body on the fall matt beside her bed. R1 pointed to the other side of the room and said "red drawer". R1 denied pain at that time. R1's first 4 neuro assessments were performed the first hour at approximately every 15 min followed by every hour x 4. R1's neuro's after 2:30 a.m. were not performed until 10:30 a.m. the next day 8 hours later as R1 had been asleep. R3's quarterly 1/15/19, MDS assessment identified she had mild cognitive impairment and would forget things easily and had a history of falls. R3's 2/11/19 care plan identified she was at risk for falls related to her inability to recall she needed assistance when up related to poor balance that varied with memory problems. R3 had an unwitnessed fall on 2/20/19 at 3:40 a.m. R3 stated she was reaching for her call light that was not beside her in bed, but left in the recliner. R3 had a touchpad call light on her railing, but had forgotten to use it. R3's neuro's were completed at 3:40 a.m. and again at 3:55 a.m. and 4:10 a.m. At 4:23 a.m. and 5:25 a.m., staff noted R3 was resting and had not performed any neurological assessment as indicated per policy for an unwitnessed fall until 6:25 a.m.. Neuro's were then checked at 7:40 a.m. and 8:40 a.m., and not checked again until 12:35 p.m. later that day. The last neuro check was at 4:30 p.m. Interview on 3/8/19 at 11:15 a.m. with the DON identified she agreed R1 and R3's neuro checks for unwitnessed falls were not completed according to policy and procedure. She agreed nursing staff were not completing these timely or were not performing the assessments if residents were sleeping and should have. Neuros should	2 830		

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2 830	Continued From page 14 be completed initially, then every 15 minutes x 4, then every 1 hour x 4 and every 4 hours x 6. This information was not written into any facility policy or procedure, but was expected to be performed as a nursing standard. Review of the August 2018 Fall Prevention and management policy identified nursing staff were to follow the post fall process map. An assessment of a resident was to include vitals signs and neuro checks if a resident struck their head or it was an unwitnessed fall. The nurse was to notify the family and physician of the fall, sequence of events, and patient condition. There was no mention of how long or at what interval neuro assessments were to be made. Review of the 8/1/18, Avera Senior Care Services Agreement identified e-LTC was to be used for urgent care services 24 hours per day/7 days per week /365 days per year. The facility and e-LTC agreed to collect and provide current vital signs for residents. E-LTC was to participate in a video encounter when requested by the Avera RN. the RN was to provide an accurate, brief synopsis of the presenting problem, including vital signs that will allow the MD to triage. Review of the undated Physician/medical Services LTC algorithm identified e-LTC was to provide services for residents when the MD or his designee were not onsite. A change in a resident's medical condition requiring physician information identified emergent, life-threatening medical conditions were to be evaluated in the ER immediately. Suggested Method of Correction: The Directior of	2 830		

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2 830	Continued From page 15 Nursing or designee could review policies and procedures, train staff, to ensure staff were able to perform assessment and neurological testing to identify any change in neurological symptoms. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		