Electronically Submitted
January 13, 2020

Administrator
Olivia Rehabilitation & Healthcare Center
1003 West Maple
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: December 26, 2019

Dear Administrator:

On December 26, 2019, survey was completed at your facility by the Minnesota Department 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.

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 December 26, 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 15, 2020.

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 March 15, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 15, 2020, (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 December 26, 2019. This prohibition is not subject to appeal. 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 with one or more of the following: §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, Olivia Rehabilitation & Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 26, 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:

Gail Anderson, Unit Supervisor

Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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 June 26, 2020 (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: 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 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,

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
	245290	A. BUILDING _____ B. WING _____	C 12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA REHABILITATION & HEALTHCARE CENTER	**1003 WEST MAPLE OLIVIA, MN 56277**

(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 12/23/19 through 12/26/19, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. At the time of the abbreviated survey, onsite investigation was completed and the following complaints were found to be SUBSTANTIATED: H5290018C with deficiencies cited at F684. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F684 began on 12/9/19, when the facility failed to appropriately assess, monitor, intervene, and notify physician and family after a fall with known head injury with decreased mental status, resulting in the death of 1 of 1 resident (R1). The administrator, and DON were notified of the IJ on 12/24/19 at 12:35 p.m. The IJ was removed on 12/26/19 p.m. at 12:40 p.m., when the facility took steps to remove the immediacy. Non-compliance remained at the scope and severity of G, isolated-actual harm that is not immediate jeopardy. The above findings constituted substandard quality of care (SQC), and an extended survey was conducted on 12/26/19. 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	F 000		

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

Electronically Signed | 01/22/2020

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 000	Continued From page 1 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=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, and monitor 1 of 1 resident (R1) who had a fall with a head injury resulting in subsequent mental and physical decline leading to his death. The survey resulted in an immediate jeopardy (IJ) that began on 12/9/19, when the facility failed to appropriately assess, monitor, intervene, and notify physician and family after a fall with known head injury with decreased mental status, resulting in the death of R1. The administrator, and DON were notified of the IJ for R1 on 12/24/19 at 12:35 p.m.	F 684	R1 is no longer a resident at the facility. All other residents who fell with head injury from 12/23/19 to present were reviewed, with care plans adjusted as needed. Resident incidents from 12/23/19 to present were reviewed for timely notification of resident responsible party and physician. R2 and R3 will be reviewed to ensure proper assessing, monitoring, and notification of responsible party and physician in accordance with our current change in condition policy.	1/24/20

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F 684	Continued From page 2 The IJ was removed on 12/26/19 p.m. at 12:40 p.m., when it could be verified by interview and document review, the facility took steps to remove the immediacy by revising policies and procedures, and educating licensed nursing staff in the event change of condition were to occur with any hospice residents residing at the facility. Non-compliance remained at the scope and severity of G, isolated-actual harm that is not immediate jeopardy. Findings include: Review of the 12/20/19, report filed to the State Agency (SA) identified on 12/09/2019, between 3:00 a.m. and 4:00 a.m., staff heard R1 fall in his room. R1 was found on floor and placed back in bed. R1 hit his head on left side receiving a bruise which was red in color approximately two inches in diameter. R1's family had been notified around 9:30 a.m.. Upon arrival at the facility, the family found R1 unresponsive, never regained consciousness. R1 passed away on 12/10/2019, at 9:55 pm. The complainant was aware R1 was on hospice care and had orders to do not resuscitate (DNR). The complainant identified had R1 not fallen, he would have not passed away at that time. Interview on 12/23/19 3:10 p.m., with the complainant (C)-A identified she was made aware of the incident until "hours later". When family arrived at about 9:00 a.m., R1 was comatose. Family member (FM)-A asked her R1 if ok and never responded. Staff advised family R1 had fallen while self-toileting. R1 had been using urinal, spilled some, and slipped hitting his head. C-A was upset staff took so long to contact family. R1 was receiving hospice care for chronic	F 684	Residents who score as high risk for falls assessments will be reviewed and care plans interventions adjusted. Nursing staff were in-serviced on 12/24 and again on 1/8 on change of condition policy and procedure, proper responsible party and physician notification, and post fall documentation. Nursing staff will also be in-serviced at the next nurse meeting on neurological assessments after falls with head injury. DNS and/or designee will review falls every week day during morning meeting to ensure timely notification and appropriate interventions are in place. DNS and/or designee will be responsible for compliance. Audits on notification and neurological flow sheet post falls with head injury, will begin daily x 5 working days, weekly x 2 weeks then monthly to ensure compliance. All audits will be reviewed by the administrator and taken to QAPI for review and recommendation.	

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F 684	Continued From page 3	F 684		

obstructive pulmonary disease (COPD). The family was not notified by hospice or facility staff of the incident immediately after it occurred. R1 had been cognitive the day and evening before, and had called his family member A (FM)-A to wish her goodnight as he advised her he was going to get ready for bed. C-A was unsure of the events surrounding R1's fall. C-A reported FM-A had asked staff why R1 was never taken to the emergency room (ER). An unidentified nurse stated, "He was going downhill for several days anyway."

Review of R1's 12/9/19, Incident Report identified R1 fell on 12/9/19 at 3:15 a.m. while using his urinal. A nursing assistant (NA) heard a loud noise coming from his room. Staff found him lying next to his bed. R1 had hit his head. Neurological (neuro) checks were started. Immediately R1 was assessed to have decreased level of consciousness (LOC). R1 was lethargic and responded slowly to verbal stimuli, and his pupils were sluggish to react (normal is brisk). R1 sustained scrapes and bruising under his right eye, bruising on his left ear, and skin tears to his elbow and left upper arm. R1 was very short of breath (SOB). Immediately after the fall, his oxygen saturation (SpO2) was 46%. Staff took initial set of vitals BP 155/82, HR 110, RR 28. (R1's normal SpO2 were averaging 86-96% prior to his fall.) R1 was very slow to respond and confused. He was able to move all extremities without difficulty. R1 advised staff he had been using his urinal, spilled it and slipped and fell onto the floor. Hospice nurse (RN)-A was notified R1 had fallen. RN-A advised staff to continue with nebulizer treatments to open R1's airways, continue to monitor, and keep the head of the bed elevated. Staff were to urge R1 to use his call

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F 684	Continued From page 4	F 684		

light when he needed toileting. There was no mention RN-A was notified of R1's abnormal neuro signs or known head injury. R1 was not taken to the emergency room (ER). R1 was noted to be lethargic, have labored breathing. His mental status was documented as alert but confused. Staff check-marked "no injuries post incident". Staff identified predisposing factors to the fall were a wet floor, confusion, incontinence, recent changes to medications or new sedative medication. The report noted the director of nursing (DON) was called on 12/9/19 at 5:55 a.m., FM-A was documented as having been notified at 7:18 a.m., RN-A at 5:55 a.m., and R1's medical doctor (MD)-B was notified at 5:54 a.m.

Review of R1's 12/9/19 at 3:15 a.m., SBAR-Change of Condition note identified R1 fell on 12/9/19 at 3:15 a.m. while using his urinal. A NA heard a loud noise coming from his room. Staff found him lying next to his bed. R1 had hit his head. R1 was on hospice care and his condition had declined with increased SOB. Nursing assessment identified R1 was lethargic and slow to respond to staff and more confused. Staff documented they were awaiting a response from MD-B as they had faxed him regarding R1's fall but had not heard back yet. They would continue to do neuro checks and monitor his condition. Staff documented no level of urgency on the form as they were indicated to do. There was no mention R1's family had been called to identify if they wanted R1 sent to the ER immediately after the incident.

Review of the time-stamped 12/9/19, fax to R1's primary care physician (MD)-B was 8:08 a.m., almost 5 hours after the incident occurred.

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F 684	Continued From page 5 Interview on 12/23/19 at 3:10 p.m., with FM-A identified she had not been called at the time of the incident and was not notified until over 4 hrs. later. She unaware R1 had declined. When she arrived at the facility at approximately 9:00 a.m., R1 was completely non-responsive. FM-A felt she should have been notified of R1's fall immediately. She would have like him to have been evaluated at the ER. "This was not a result of the COPD, but a direct result of the fall. He could have lived longer." R1's 11/29/19, admission Minimum Data Set (MDS), identified R1 had intact cognition, only required supervision with oversight or cueing for transfers, walking in his room and toileting. R1 was always continent of urine. R1 was administered antianxiety medication, antidepressants, and diuretics ("water pills" to assist with urination). R1 was receiving hospice, and had desires and expectations to return to the community. R1's Care Area Assessment (CAA) identified he triggered for falls. R1 had diagnoses of congestive heart failure (CHF) pain in his lower leg, insomnia, and COPD. R1 required O2 therapy via continuous positive airway pressure (CPAP). Review of R1's Medication Administration record identified he received: 1) Duloxetine (antidepressant) related to pain in his lower leg. 2) Furosemide (water pill) for CHF. 3) Spironolactone (water pill) for CHF. 4) Lorazepam (antianxiety) twice daily. 5) Pulmicort (inhaler medication) for COPD, gabapentin (neuroleptic used to treat pain), 6) Duo-neb (ipratropium/Albuterol) inhaled nebulizer (neb) treatments 4 x daily for COPD.	F 684		

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F 684	Continued From page 6 7) Morphine (pain medication) 0.5 milliliters (ml) by mouth every 4 hours for pain and comfort care (given in the overnight hours of midnight and again at 4 am). 8) Albuterol neb every 2 hours as needed for SOB. R1 received a neb treatment on 12/8/19 at 6:30 p.m. prior to his fall, and had not received any additional treatment until 12/9/19 at 9:35 a.m., even though staff reported R1 was SOB after his fall. Review of R1's printed 12/24/19, care plan active at the time of his admission, identified he used psychotropic medications related to an end stage disease process (COPD) as evidenced by air hunger. R1 received hospice services and preferred to spend his day visiting with his spouse who was there much of each day. Staff were to call hospice when new medication was needed or R1's condition changed. There was no mention staff were to call R1's family or physician with changes. Review of R1's 12/9/19, Neurological Flow Sheet identified staff began neurological (neuro) checks at 3:15 a.m. The neuro checks showed: 1) Between 3:15 a.m. and 4:00 a.m., R1 was lethargic and responded slowly to staff. His pupils were sluggish to respond. At 3:15 a.m., R1's vital signs (blood pressure (BP), heart rate (HR) and SpO2 were abnormal. His BP ranged 136/75 to 155/82 millimeters of mercury (mm/hg) (normal 120/80), HR ranged from 95 beats per minute (bpm) to 110 bpm (normal 60-100), and his SpO2 ranged from 46% to 53% (R1's normal was 88-96%) during that time. 2) On 12/9/19 from 4:15 a.m. on through 12/10/19 at 5:15 p.m., R1 was reported to vary from conscious and awake to lethargic and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 7 responding slowly, then asleep during the last 2 entries of 9:15 p.m. and 1:15 a.m., where staff had not woken R1 to assess his neuro status. His BP ranged from 146/73 mm/hg trending down to 124/56 mm/hg. His SpO2 had increased from 67% up to 93% with oxygen via CPAP during that time. The flow sheet denoted on the top right corner staff were to notify the medical doctor (MD) immediately if there were signs or symptoms of intracranial pressure, such as difficulty speaking or a change in the level of alertness. R1's progress notes identified on: 1) 12/8/19 at 4:06 p.m., RN-A had been to the facility to visit R1. R1's wife was in attendance. R1 had increasing periods of SOB, with some relief from nebulizer treatments. There was no indication R1 had any LOC changes at that time. 2) 12/9/19 at 3:15 a.m., R1 fell next to bed. A NA heard R1 fall and found him lying on his left side on the floor next to his bed. R1 had hit his head. Neuros were started. R1 had been sitting up in bed using his urinal, spilled the urinal and slipped on urine on the floor. R1 was on hospice and had been declining with increased SOB. R1's vitals at the time of the fall were BP 155/72 mm/hg, HR 100 bpm, and SpO2 46% on 4 liters of oxygen via CPAP. R1 hit his head and neuros were started. R1 had a small abrasion and bruise under his right eye and bruising on his left. R1 was lethargic and slow to respond and was more confused. MD-B was faxed regarding the fall and RN-A was called. Staff were told by RN-A to elevate R1's head of his bed and to continue to give nebulizer treatments while awake. Staff were to remind R1 to use his call light when needing assistance with his urinal and to keep his gripper socks on when in bed. There was no mention family or the ER	F 684		

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F 684	Continued From page 8	F 684		

was called, nor had staff identified abnormal vitals as potential head injury complications.
3) 12/09/19 at 6:30 a.m., R1 was sitting on the edge of his bed using his urinal, unable to sit up on his own. R1 had voided a large amount of urine. His color was dusky (dark) and his SpO2 was 72% with O2 at 4 liters per minute, per nasal cannula. R1 refused breakfast. Staff applied his CPAP mask and his SpO2 rose to 92%. At 10:00 a.m., RN-A was notified of R1's condition and his wife was called and updated. At 10:00 a.m., RN-A was at the facility and FM-A was there to visit. R1 refused lunch, had difficulty swallowing, and confusion was noted. R1 had been in bed all day and repositioned per staff.
4) 12/10/19 at 6:27 a.m., Post fall: R1 had been quiet all night. He received Morphine per order. SpO2's were 90% via mask. 12/10/19 at 7:48 p.m., R1 had been "resting comfortably in bed all day. Non- responsive." R1 had been taking nothing by mouth (food or medication). Staff were unable to insert a urinary catheter after multiple attempts that day. R1 had moderate amounts of secretions coming out of his mouth and nose several times that day. Staff started Tylenol for pain and were to continue to monitor. There was no mention what the secretions were or if staff had identified if they were related to his head injury.
5) 12/10/19 at 10:08 p.m., R1's vital signs ceased at 9:55 p.m.. A call was placed to family and hospice. There was no mention MD-B had been notified of R1's decline after his fall up to the point of his death.

Interview on 12/24/19 at 8:20 a.m., with MD-B's clinic registered nurse (RN)-B identified if a resident fell the facility would normally send a fax alerting whichever clinic provider had oversight of

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the resident, notifying them of a fall with no injury. The clinic's after-hours number was answered by the local hospital ER, and was to be used for any incidents or injuries after hours or urgent needs by residents. The faxed notifications were to be used only to notify the physician for routine concerns. RN-B remembered the fax received regarding R1. There was no indication R1 had sustained any injuries after his fall. The facility's expected process was to call the after-hours number for a fall with a head injury. MD-B was unavailable for interview at that time as he would not be resuming work until after the holidays. A message was left requesting MD-B to call back.

No call was received after the survey from MD-B.

Interview and document review, on 12/24/19 at 9:00 a.m., with licensed practical nurse (LPN)-A identified she had worked the day shift on 12/10/19, and began her shift at 6:00 a.m. that day. She was made aware of R1's fall and had reviewed the assessment data on the neuro sheet. She notified family via telephone after report, sometime around 7:30 a.m. on 12/9/19. LPN-A had also sent a fax to R1's primary physician, MD-B. She verified the time on the fax to be the time she had sent the faxed notification. LPN-A had reviewed R1's neuros recorded on the flow sheet that morning at the beginning of her shift and had contributed to the assessments thereafter. She identified R1 had abnormal neuro check data. She agreed looking back at the neuro flow sheet, his neuro data was consistent with a head injury and signs and symptoms of head trauma. LPN-A verified there was no call made to the after-hours clinic for MD-B, which was forwarded to the ER, to identify if R1 should be seen for treatment for a fall they attributed to

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slipping on urine on the floor with head injury. FM-A was not notified of R1's change of condition until approximately 7:18 am, per documentation when LPN-A called. MD-B was never updated to R1's declining condition after fax notification had been sent. LPN-A identified she had not felt R1's mental status changes or level of alertness would be urgent to intervene because he was on hospice. The hospice nurse made all the decisions. "Hospice drives the care. They tell us what to do." LPN-A identified the facility procedure for a patient on hospice was to notify hospice for anything that happened with a hospice resident. Hospice was to call the MD and family at their discretion and advise facility staff what steps to take. LPN-A identified she had not called the ER once she was made aware of his abnormal neuros, as hospice already knew about the situation. The night nurse (LPN-B) had advised her she called hospice and they dictated to facility staff what measures were to be taken. LPN-A knew R1 was on hospice for COPD. He fell after he slipped in his urine. When LPN-A was asked if the fall would be related to COPD exacerbation, she replied "No. He fell because he slipped." LPN-A stated, had R1 not been on hospice, she would have called the after-hours number to see what direction staff should take with a R1's care.

Interview and document review on 12/24/19 at 9:38 a.m., with the hospice nurse (RN-A) identified she was notified of R1's fall approximately ½ hr. after the incident. The incident report identified staff had documented she was not notified until 5:55 a.m.. RN-A thought that may be when staff documented the notification into the electronic form and was not accurate. She was advised R1 had fallen but not

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of his head injury. She was advised R1 had slipped on urine and fell. RN-A advised LPN-B to make R1 comfortable, provide oxygen and elevate the head of his bed. Staff were to notify her with any new changes. RN-A expected the facility to call the family and physician. Not knowing details of an incident, RN-A stated it would be impossible to accurately depict the events surrounding R1's fall. RN-A had no idea R1 had hit his head and was not informed of that by LPN-B. Had she been informed, she would have come to the facility right away to assess R1. She was not allowed access to facility incident reports on a routine basis to assist with root cause analysis for appropriate care planning and treatment. She was unaware of the neuro assessments that had been performed. RN-A agreed R1 had changes in his level of consciousness that could be contributed to head trauma. She agreed there was no indication in R1's medical record to support his fall and subsequent death was related to a sudden exacerbation of R1's COPD.

Review of the March 2017, Hospice Services agreement, identified hospice was to assume full responsibility for professional management of terminal care. The facility was to provide care to each hospice resident to keep him reasonably protected from accident or injury. Facility staff were to call hospice immediately if they observed a significant change to the resident's physical and mental status, or clinical complications that suggest a need to alter the plan of care, a life threatening condition, or the need to transfer the resident.

Interview and document review, on 12/24/19 at 11:04 a.m., with the director of nursing (DON)

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identified if a resident is on hospice care, hospice decides what care that resident was to receive. She was unaware of R1's neuro changes and immediately after the fall. R1 had been slowly declining related to his COPD. She agreed his SpO2's immediately leading up to the fall were 88-96% and fell to 46% after the fall. Nursing staff's assessment of changes in neuros were consistent with head injury. She was aware of the notation on the Neuro Flow Sheet directing staff to immediately call the physician with signs and symptoms of LOC changes. In R1's case, he was a hospice patient so she had expected staff to call hospice to identify what measures were to be taken. Nursing was to contact the after-hours number linked to the ER for all other patients. She was not aware the family had not been called, nor that hospice had not been advised of R1's head injury. She was unaware MD-B had not been called as indicated, but had been faxed hours later at 8:-08 a.m., per timestamp from the fax machine. After review of the information, the DON agreed she would expect staff to follow facility policies for non-hospice related incidents, such as falling after slipping on urine. The DON and interdisciplinary team reviewed all falls daily and bi-weekly. That information was to have been brought to Quality Assurance Performance Improvement (QAPI) during the last meeting on 12/12/19. She cannot recall if R1's fall had been discussed in depth. In review of the QAPI meeting minutes, she could not identify R1's fall had been documented as discussed. She could not recall any measures formulated by QAPI regarding R1.

Interview on 12/24/19 at 11:30 a.m., with the medical director (MD)-A identified he had no knowledge of R1's fall. To his knowledge, that

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was not discussed at the QAPI meeting on 12/12/19, nor was he notified after the fall. No falls were discussed at QAPI related to R1 that either he, or his wife, who attends meetings with him, had any knowledge of. The MD agreed a fall related to slipping on urine on the floor with no documented decline in LOC or COPD exacerbation symptoms hours before the incident, would lead him to believe the fall was not caused by R1's COPD hospice diagnosis. R1's immediate LOC changes and decline could be contributed to the fall itself related to head injury. His expectation was staff should have followed all policies and procedures and sent R1 to the ER for evaluation for head injury with LOC changes.

Review of the 12/12/19, QAPI Meeting Agenda identified MD-A, the DON, and the administrator were present as well as other members. Discussion of falls identified 8 of 20 falls happened with 1 repeat fall upon waking or going to bed. 4 falls were with a repeat fall who has been declining. Medications were reviewed and changes were made for that resident. 3 falls were isolated incidents. 2 falls were from 1 resident self-transferring from a recliner to the wheelchair. There was no mention of R1's fall or subsequent death identified in the QAPI meeting minutes as a fall for R1 who slipped on urine resulting in head injury and subsequent death.

Interview on 12/24/19 at 2:38 p.m., with LPN-B identified she was working the night R1 had fallen. A nursing assistant (NA) heard R1 fall. R1 had toilet himself using a urinal and had slipped and fell on spilt urine hitting his head. R1 was able to use the urinal himself. Staff only emptied it after he was finished. LPN-A indicated R1's LOC

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earlier that evening before he went to bed, was normal. She agreed he had LOC changes after the fall consistent with documented assessment. LPN-B believed she advised RN-A R1 had received a head injury, but had not documented what RN-A had been notified of in her notes. R1 was on hospice, so any injuries or changes of condition were to be handled by hospice to drive care. Normally, for non-hospice patients, she would have called the after-hours number to alert medical staff at the hospital of the events surrounding an incident. LPN-B had not called MD-B. She thought staff had sent a fax. She agreed LOC changes directly after a fall were indicative of potential head trauma. Facility procedure identified hospice was to identify what measures were to be taken, if any. Hospice was responsible to call family and the provider. She was aware of the notation to call the provider on the Neuro Flow Sheet for signs and symptoms of abnormal neurological status. LPN-B perceived this to not apply to any hospice patients.

The IJ was removed on 12/26/19 p.m. at 12:40 p.m., when it could be verified by interview and document review on 12/26/19 between 10:00 a.m. and 12:40 p.m. the facility revised policies and procedures, educated licensed nursing staff on how to identify a change in condition and whom to contact when this occurs. The immediacy was removed and non-compliance remained at the scope and severity of G, isolated-actual harm that is not immediate jeopardy.

Review of the current undated, current Falls Clinical Protocol policy identified nursing shall assess, document and report vital signs, recent injury especially a head injury, change of

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F 684	Continued From page 15 condition (COD) or LOC, and neuro status. Staff with physician guidance, were to follow up on any fall associated fall with injury until the resident was stable and delayed complications, such as fracture or brain bleed had been ruled out or resolved. Review of the current undated, Change in a Resident's Condition or Status policy identified the nurse supervisor or charge nurse were to notify the physician or on-call physician when there had been an accident or incident involving the resident, a significant change in a resident's physical and mental condition, and the need to alter treatment or transfer to the hospital. Unless instructed by the resident, the nursing supervisor or charge nurse were to notify the resident's family of any incident that results in injury, when there was a significant change in physical or mental status, or if it was necessary to transfer the resident to the hospital.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 13, 2020

Administrator
Olivia Rehabilitation & Healthcare Center
1003 West Maple
Olivia, MN 56277

Re: State Nursing Home Licensing Orders
Event ID: YIUX11

Dear Administrator:

The above facility was surveyed on December 23, 2019 through December 26, 2019 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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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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: A complaint investigation was conducted on 12/23/19 through 12/26/19, to investigate complaint H5290018C. As a result the following was identified: The complaint was found to be SUBSTANTIATED, with licensing orders issued.	2 000		

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OLIVIA REHABILITATION & HEALTHCARE CEN	1003 WEST MAPLE OLIVIA, MN 56277

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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. Although no plan of correction is required, it is required that you 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, and monitor 1 of 1 resident (R1) who had a fall with a head injury resulting in subsequent mental and physical decline leading to his death. The survey resulted in an immediate jeopardy (IJ) that began on 12/9/19, when the facility failed to appropriately assess, monitor, intervene, and notify physician and family after a fall with known head injury with decreased mental status,	2 830	R1 is no longer a resident at the facility. All other residents who fell with head injury from 12/23/19 to present were reviewed, with care plans adjusted as needed. Resident incidents from 12/23/19 to present were reviewed for timely notification of resident responsible party and physician. R2 and R3 will be reviewed to ensure	1/24/20

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2 830	Continued From page 2 resulting in the death of R1. The administrator, and DON were notified of the IJ for R1 on 12/24/19 at 12:35 p.m. The IJ was removed on 12/26/19 p.m. at 12:40 p.m., when it could be verified by interview and document review, the facility took steps to remove the immediacy by revising policies and procedures, and educating licensed nursing staff in the event change of condition were to occur with any hospice residents residing at the facility. Non-compliance remained at the scope and severity of G, isolated-actual harm that is not immediate jeopardy. Findings include: Review of the 12/20/19, report filed to the State Agency (SA) identified on 12/09/2019, between 3:00 a.m. and 4:00 a.m., staff heard R1 fall in his room. R1 was found on floor and placed back in bed. R1 hit his head on left side receiving a bruise which was red in color approximately two inches in diameter. R1's family had been notified around 9:30 a.m.. Upon arrival at the facility, the family found R1 unresponsive, never regained consciousness. R1 passed away on 12/10/2019, at 9:55 pm. The complainant was aware R1 was on hospice care and had orders to do not resuscitate (DNR). The complainant identified had R1 not fallen, he would have not passed away at that time. Interview on 12/23/19 3:10 p.m., with the complainant (C)-A identified she was made aware of the incident until "hours later". When family arrived at about 9:00 a.m., R1 was comatose. Family member (FM)-A asked her R1 if ok and never responded. Staff advised family R1 had fallen while self-toileting. R1 had been using	2 830	proper assessing, monitoring, and notification of responsible party and physician in accordance with our current change in condition policy. Residents who score as high risk for falls assessments will be reviewed and care plans interventions adjusted. Nursing staff were in-serviced on 12/24 and again on 1/8 on change of condition policy and procedure, proper responsible party and physician notification, and post fall documentation. Nursing staff will also be in-serviced at the next nurse meeting on neurological assessments after falls with head injury. DNS and/or designee will review falls every week day during morning meeting to ensure timely notification and appropriate interventions are in place. DNS and/or designee will be responsible for compliance. Audits on notification and neurological flow sheet post falls with head injury, will begin daily x 5 working days, weekly x 2 weeks then monthly to ensure compliance. All audits will be reviewed by the administrator and taken to QAPI for review and recommendation.	

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2 830	Continued From page 3 urinal, spilled some, and slipped hitting his head. C-A was upset staff took so long to contact family. R1 was receiving hospice care for chronic obstructive pulmonary disease (COPD). The family was not notified by hospice or facility staff of the incident immediately after it occurred. R1 had been cognitive the day and evening before, and had called his family member A (FM)-A to wish her goodnight as he advised her he was going to get ready for bed. C-A was unsure of the events surrounding R1's fall. C-A reported FM-A had asked staff why R1 was never taken to the emergency room (ER). An unidentified nurse stated, "He was going downhill for several days anyway." Review of R1's 12/9/19, Incident Report identified R1 fell on 12/9/19 at 3:15 a.m. while using his urinal. A nursing assistant (NA) heard a loud noise coming from his room. Staff found him lying next to his bed. R1 had hit his head. Neurological (neuro) checks were started. Immediately R1 was assessed to have decreased level of consciousness (LOC). R1 was lethargic and responded slowly to verbal stimuli, and his pupils were sluggish to react (normal is brisk). R1 sustained scrapes and bruising under his right eye, bruising on his left ear, and skin tears to his elbow and left upper arm. R1 was very short of breath (SOB). Immediately after the fall, his oxygen saturation (SpO2) was 46%. Staff took initial set of vitals BP 155/82, HR 110, RR 28. (R1's normal SpO2 were averaging 86-96% prior to his fall.) R1 was very slow to respond and confused. He was able to move all extremities without difficulty. R1 advised staff he had been using his urinal, spilled it and slipped and fell onto the floor. Hospice nurse (RN)-A was notified R1 had fallen. RN-A advised staff to continue with nebulizer treatments to open R1's airways,	2 830		

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2 830	Continued From page 4 continue to monitor, and keep the head of the bed elevated. Staff were to urge R1 to use his call light when he needed toileting. There was no mention RN-A was notified of R1's abnormal neuro signs or known head injury. R1 was not taken to the emergency room (ER). R1 was noted to be lethargic, have labored breathing. His mental status was documented as alert but confused. Staff check-marked "no injuries post incident". Staff identified predisposing factors to the fall were a wet floor, confusion, incontinence, recent changes to medications or new sedative medication. The report noted the director of nursing (DON) was called on 12/9/19 at 5:55 a.m., FM-A was documented as having been notified at 7:18 a.m., RN-A at 5:55 a.m., and R1's medical doctor (MD)-B was notified at 5:54 a.m. Review of R1's 12/9/19 at 3:15 a.m., SBAR-Change of Condition note identified R1 fell on 12/9/19 at 3:15 a.m. while using his urinal. A NA heard a loud noise coming from his room. Staff found him lying next to his bed. R1 had hit his head. R1 was on hospice care and his condition had declined with increased SOB. Nursing assessment identified R1 was lethargic and slow to respond to staff and more confused. Staff documented they were awaiting a response from MD-B as they had faxed him regarding R1's fall but had not heard back yet. They would continue to do neuro checks and monitor his condition. Staff documented no level of urgency on the form as they were indicated to do. There was no mention R1's family had been called to identify if they wanted R1 sent to the ER immediately after the incident. Review of the time-stamped 12/9/19, fax to R1's primary care physician (MD)-B was 8:08 a.m., almost 5 hours after the incident occurred.	2 830		

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2 830	Continued From page 5 Interview on 12/23/19 at 3:10 p.m., with FM-A identified she had not been called at the time of the incident and was not notified until over 4 hrs. later. She unaware R1 had declined. When she arrived at the facility at approximately 9:00 a.m., R1 was completely non-responsive. FM-A felt she should have been notified of R1's fall immediately. She would have like him to have been evaluated at the ER. "This was not a result of the COPD, but a direct result of the fall. He could have lived longer." R1's 11/29/19, admission Minimum Data Set (MDS), identified R1 had intact cognition, only required supervision with oversight or cueing for transfers, walking in his room and toileting. R1 was always continent of urine. R1 was administered antianxiety medication, antidepressants, and diuretics ("water pills" to assist with urination). R1 was receiving hospice, and had desires and expectations to return to the community. R1's Care Area Assessment (CAA) identified he triggered for falls. R1 had diagnoses of congestive heart failure (CHF) pain in his lower leg, insomnia, and COPD. R1 required O2 therapy via continuous positive airway pressure (CPAP). Review of R1's Medication Administration record identified he received: 1) Duloxetine (antidepressant) related to pain in his lower leg. 2) Furosemide (water pill) for CHF. 3) Spironolactone (water pill) for CHF. 4) Lorazepam (antianxiety) twice daily. 5) Pulmicort (inhaler medication) for COPD, gabapentin (neuroleptic used to treat pain), 6) Duo-neb (ipratropium/Albuterol) inhaled nebulizer (neb) treatments 4 x daily for COPD.	2 830		

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2 830	Continued From page 6 7) Morphine (pain medication) 0.5 milliliters (ml) by mouth every 4 hours for pain and comfort care (given in the overnight hours of midnight and again at 4 am). 8) Albuterol neb every 2 hours as needed for SOB. R1 received a neb treatment on 12/8/19 at 6:30 p.m. prior to his fall, and had not received any additional treatment until 12/9/19 at 9:35 a.m., even though staff reported R1 was SOB after his fall. Review of R1's printed 12/24/19, care plan active at the time of his admission, identified he used psychotropic medications related to an end stage disease process (COPD) as evidenced by air hunger. R1 received hospice services and preferred to spend his day visiting with his spouse who was there much of each day. Staff were to call hospice when new medication was needed or R1's condition changed. There was no mention staff were to call R1's family or physician with changes. Review of R1's 12/9/19, Neurological Flow Sheet identified staff began neurological (neuro) checks at 3:15 a.m. The neuro checks showed: 1) Between 3:15 a.m. and 4:00 a.m., R1 was lethargic and responded slowly to staff. His pupils were sluggish to respond. At 3:15 a.m., R1's vital signs (blood pressure (BP), heart rate (HR) and SpO2 were abnormal. His BP ranged 136/75 to 155/82 millimeters of mercury (mm/hg) (normal 120/80), HR ranged from 95 beats per minute (bpm) to 110 bpm (normal 60-100), and his SpO2 ranged from 46% to 53% (R1's normal was 88-96%) during that time. 2) On 12/9/19 from 4:15 a.m. on through 12/10/19 at 5:15 p.m., R1 was reported to vary from conscious and awake to lethargic and responding slowly, then asleep during the last 2	2 830		

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2 830	Continued From page 7 entries of 9:15 p.m. and 1:15 a.m., where staff had not woken R1 to assess his neuro status. His BP ranged from 146/73 mm/hg trending down to 124/56 mm/hg. His SpO2 had increased from 67% up to 93% with oxygen via CPAP during that time. The flow sheet denoted on the top right corner staff were to notify the medical doctor (MD) immediately if there were signs or symptoms of intracranial pressure, such as difficulty speaking or a change in the level of alertness. R1's progress notes identified on: 1) 12/8/19 at 4:06 p.m., RN-A had been to the facility to visit R1. R1's wife was in attendance. R1 had increasing periods of SOB, with some relief from nebulizer treatments. There was no indication R1 had any LOC changes at that time. 2) 12/9/19 at 3:15 a.m., R1 fell next to bed. A NA heard R1 fall and found him lying on his left side on the floor next to his bed. R1 had hit his head. Neuros were started. R1 had been sitting up in bed using his urinal, spilled the urinal and slipped on urine on the floor. R1 was on hospice and had been declining with increased SOB. R1's vitals at the time of the fall were BP 155/72 mm/hg, HR 100 bpm, and SpO2 46% on 4 liters of oxygen via CPAP. R1 hit his head and neuros were started. R1 had a small abrasion and bruise under his right eye and bruising on his left. R1 was lethargic and slow to respond and was more confused. MD-B was faxed regarding the fall and RN-A was called. Staff were told by RN-A to elevate R1's head of his bed and to continue to give nebulizer treatments while awake. Staff were to remind R1 to use his call light when needing assistance with his urinal and to keep his gripper socks on when in bed. There was no mention family or the ER was called, nor had staff identified abnormal vitals as potential head injury complications.	2 830		

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2 830	Continued From page 8 3) 12/09/19 at 6:30 a.m., R1 was sitting on the edge of his bed using his urinal, unable to sit up on his own. R1 had voided a large amount of urine. His color was dusky (dark) and his SpO2 was 72% with O2 at 4 liters per minute, per nasal cannula. R1 refused breakfast. Staff applied his CPAP mask and his SpO2 rose to 92%. At 10:00 a.m., RN-A was notified of R1's condition and his wife was called and updated. At 10:00 a.m., RN-A was at the facility and FM-A was there to visit. R1 refused lunch, had difficulty swallowing, and confusion was noted. R1 had been in bed all day and repositioned per staff. 4) 12/10/19 at 6:27 a.m., Post fall: R1 had been quiet all night. He received Morphine per order. SpO2's were 90% via mask. 12/10/19 at 7:48 p.m., R1 had been "resting comfortably in bed all day. Non- responsive." R1 had been taking nothing by mouth (food or medication). Staff were unable to insert a urinary catheter after multiple attempts that day. R1 had moderate amounts of secretions coming out of his mouth and nose several times that day. Staff started Tylenol for pain and were to continue to monitor. There was no mention what the secretions were or if staff had identified if they were related to his head injury. 5) 12/10/19 at 10:08 p.m., R1's vital signs ceased at 9:55 p.m.. A call was placed to family and hospice. There was no mention MD-B had been notified of R1's decline after his fall up to the point of his death. Interview on 12/24/19 at 8:20 a.m., with MD-B's clinic registered nurse (RN)-B identified if a resident fell the facility would normally send a fax alerting whichever clinic provider had oversight of the resident, notifying them of a fall with no injury. The clinic's after-hours number was answered by the local hospital ER, and was to be used for any	2 830		

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2 830	Continued From page 9 incidents or injuries after hours or urgent needs by residents. The faxed notifications were to be used only to notify the physician for routine concerns. RN-B remembered the fax received regarding R1. There was no indication R1 had sustained any injuries after his fall. The facility's expected process was to call the after-hours number for a fall with a head injury. MD-B was unavailable for interview at that time as he would not be resuming work until after the holidays. A message was left requesting MD-B to call back. No call was received after the survey from MD-B. Interview and document review, on 12/24/19 at 9:00 a.m., with licensed practical nurse (LPN)-A identified she had worked the day shift on 12/10/19, and began her shift at 6:00 a.m. that day. She was made aware of R1's fall and had reviewed the assessment data on the neuro sheet. She notified family via telephone after report, sometime around 7:30 a.m. on 12/9/19. LPN-A had also sent a fax to R1's primary physician, MD-B. She verified the time on the fax to be the time she had sent the faxed notification. LPN-A had reviewed R1's neuros recorded on the flow sheet that morning at the beginning of her shift and had contributed to the assessments thereafter. She identified R1 had abnormal neuro check data. She agreed looking back at the neuro flow sheet, his neuro data was consistent with a head injury and signs and symptoms of head trauma. LPN-A verified there was no call made to the after-hours clinic for MD-B, which was forwarded to the ER, to identify if R1 should be seen for treatment for a fall they attributed to slipping on urine on the floor with head injury. FM-A was not notified of R1's change of condition until approximately 7:18 am, per documentation when LPN-A called. MD-B was never updated to	2 830		

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2 830	Continued From page 10 R1's declining condition after fax notification had been sent. LPN-A identified she had not felt R1's mental status changes or level of alertness would be urgent to intervene because he was on hospice. The hospice nurse made all the decisions. "Hospice drives the care. They tell us what to do." LPN-A identified the facility procedure for a patient on hospice was to notify hospice for anything that happened with a hospice resident. Hospice was to call the MD and family at their discretion and advise facility staff what steps to take. LPN-A identified she had not called the ER once she was made aware of his abnormal neuros, as hospice already knew about the situation. The night nurse (LPN-B) had advised her she called hospice and they dictated to facility staff what measures were to be taken. LPN-A knew R1 was on hospice for COPD. He fell after he slipped in his urine. When LPN-A was asked if the fall would be related to COPD exacerbation, she replied "No. He fell because he slipped." LPN-A stated, had R1 not been on hospice, she would have called the after-hours number to see what direction staff should take with a R1's care. Interview and document review on 12/24/19 at 9:38 a.m., with the hospice nurse (RN-A) identified she was notified of R1's fall approximately ½ hr. after the incident. The incident report identified staff had documented she was not notified until 5:55 a.m.. RN-A thought that may be when staff documented the notification into the electronic form and was not accurate. She was advised R1 had fallen but not of his head injury. She was advised R1 had slipped on urine and fell. RN-A advised LPN-B to make R1 comfortable, provide oxygen and elevate the head of his bed. Staff were to notify her with any new changes. RN-A expected the	2 830		

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2 830	Continued From page 11 facility to call the family and physician. Not knowing details of an incident, RN-A stated it would be impossible to accurately depict the events surrounding R1's fall. RN-A had no idea R1 had hit his head and was not informed of that by LPN-B. Had she been informed, she would have come to the facility right away to assess R1. She was not allowed access to facility incident reports on a routine basis to assist with root cause analysis for appropriate care planning and treatment. She was unaware of the neuro assessments that had been performed. RN-A agreed R1 had changes in his level of consciousness that could be contributed to head trauma. She agreed there was no indication in R1's medical record to support his fall and subsequent death was related to a sudden exacerbation of R1's COPD. Review of the March 2017, Hospice Services agreement, identified hospice was to assume full responsibility for professional management of terminal care. The facility was to provide care to each hospice resident to keep him reasonably protected from accident or injury. Facility staff were to call hospice immediately if they observed a significant change to the resident's physical and mental status, or clinical complications that suggest a need to alter the plan of care, a life threatening condition, or the need to transfer the resident. Interview and document review, on 12/24/19 at 11:04 a.m., with the director of nursing (DON) identified if a resident is on hospice care, hospice decides what care that resident was to receive. She was unaware of R1's neuro changes and immediately after the fall. R1 had been slowly declining related to his COPD. She agreed his SpO2's immediately leading up to the fall were	2 830		

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	00939	A. BUILDING: _____ B. WING _____	C 12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 12 88-96% and fell to 46% after the fall. Nursing staff's assessment of changes in neuros were consistent with head injury. She was aware of the notation on the Neuro Flow Sheet directing staff to immediately call the physician with signs and symptoms of LOC changes. In R1's case, he was a hospice patient so she had expected staff to call hospice to identify what measures were to be taken. Nursing was to contact the after-hours number linked to the ER for all other patients. She was not aware the family had not been called, nor that hospice had not been advised of R1's head injury. She was unaware MD-B had not been called as indicated, but had been faxed hours later at 8:-08 a.m., per timestamp from the fax machine. After review of the information, the DON agreed she would expect staff to follow facility policies for non-hospice related incidents, such as falling after slipping on urine. The DON and interdisciplinary team reviewed all falls daily and bi-weekly. That information was to have been brought to Quality Assurance Performance Improvement (QAPI) during the last meeting on 12/12/19. She cannot recall if R1's fall had been discussed in depth. In review of the QAPI meeting minutes, she could not identify R1's fall had been documented as discussed. She could not recall any measures formulated by QAPI regarding R1. Interview on 12/24/19 at 11:30 a.m., with the medical director (MD)-A identified he had no knowledge of R1's fall. To his knowledge, that was not discussed at the QAPI meeting on 12/12/19, nor was he notified after the fall. No falls were discussed at QAPI related to R1 that either he, or his wife, who attends meetings with him, had any knowledge of. The MD agreed a fall related to slipping on urine on the floor with no documented decline in LOC or COPD	2 830		

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2 830	Continued From page 13 exacerbation symptoms hours before the incident, would lead him to believe the fall was not caused by R1's COPD hospice diagnosis. R1's immediate LOC changes and decline could be contributed to the fall itself related to head injury. His expectation was staff should have followed all policies and procedures and sent R1 to the ER for evaluation for head injury with LOC changes. Review of the 12/12/19, QAPI Meeting Agenda identified MD-A, the DON, and the administrator were present as well as other members. Discussion of falls identified 8 of 20 falls happened with 1 repeat fall upon waking or going to bed. 4 falls were with a repeat fall who has been declining. Medications were reviewed and changes were made for that resident. 3 falls were isolated incidents. 2 falls were from 1 resident self-transferring from a recliner to the wheelchair. There was no mention of R1's fall or subsequent death identified in the QAPI meeting minutes as a fall for R1 who slipped on urine resulting in head injury and subsequent death. Interview on 12/24/19 at 2:38 p.m., with LPN-B identified she was working the night R1 had fallen. A nursing assistant (NA) heard R1 fall. R1 had toilet himself using a urinal and had slipped and fell on spilt urine hitting his head. R1 was able to use the urinal himself. Staff only emptied it after he was finished. LPN-A indicated R1's LOC earlier that evening before he went to bed, was normal. She agreed he had LOC changes after the fall consistent with documented assessment. LPN-B believed she advised RN-A R1 had received a head injury, but had not documented what RN-A had been notified of in her notes. R1 was on hospice, so any injuries or changes of condition were to be handled by hospice to drive	2 830		

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2 830	Continued From page 14 care. Normally, for non-hospice patients, she would have called the after-hours number to alert medical staff at the hospital of the events surrounding an incident. LPN-B had not called MD-B. She thought staff had sent a fax. She agreed LOC changes directly after a fall were indicative of potential head trauma. Facility procedure identified hospice was to identify what measures were to be taken, if any. Hospice was responsible to call family and the provider. She was aware of the notation to call the provider on the Neuro Flow Sheet for signs and symptoms of abnormal neurological status. LPN-B perceived this to not apply to any hospice patients. The IJ was removed on 12/26/19 p.m. at 12:40 p.m., when it could be verified by interview and document review on 12/26/19 between 10:00 a.m. and 12:40 p.m. the facility revised policies and procedures, educated licensed nursing staff on how to identify a change in condition and whom to contact when this occurs. The immediacy was removed and non-compliance remained at the scope and severity of G, isolated-actual harm that is not immediate jeopardy. Review of the current undated, current Falls Clinical Protocol policy identified nursing shall assess, document and report vital signs, recent injury especially a head injury, change of condition (COD) or LOC, and neuro status. Staff with physician guidance, were to follow up on any fall associated fall with injury until the resident was stable and delayed complications, such as fracture or brain bleed had been ruled out or resolved. Review of the current undated, Change in a Resident's Condition or Status policy identified	2 830		

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2 830	Continued From page 15 the nurse supervisor or charge nurse were to notify the physician or on-call physician when there had been an accident or incident involving the resident, a significant change in a resident's physical and mental condition, and the need to alter treatment or transfer to the hospital. Unless instructed by the resident, the nursing supervisor or charge nurse were to notify the resident's family of any incident that results in injury, when there was a significant change in physical or mental status, or if it was necessary to transfer the resident to the hospital. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for nursing change of condition for neurological status. Nursing staff could be educated as necessary to the importance of monitoring neuro changes and updated the physician when needed. The DON or designee, could audit any/all resident's with neuro changes to ensure compliance. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: (21) days.	2 830		