Certified Mail #7016 2070 0000 7235 1409

March 6, 2020

Administrator
The Estates At Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

RE: CCN 245298
Cycle Start Date: February 21, 2020

Dear Administrator:

On February 21, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## REMEDIES

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

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

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

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by May 11, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Twin Rivers Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 11, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

## DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 21, 2020 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

## APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245298 | A. BUILDING _____ B. WING _____ | C 02/21/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **THE ESTATES AT TWIN RIVERS LLC** | **305 FREMONT STREET ANOKA, MN 55303** |

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| F 000 | INITIAL COMMENTS<br><br>On 2/20/20 to 2/21/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. The Estates of Twin Rivers was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>H5298089C was investigated and found to be substantiated with a deficiency issued at F689.<br><br>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.<br><br>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 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 689 | | |

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

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review, the facility failed to comprehensively assess and implement interventions to reduce the risk of falls for 2 of 3 residents (R1, R3) reviewed for accidents. This resulted in actual harm for R1 who fell multiple times without being assessed, and obtained a head laceration which required emergency medical care.

Findings include:

R1's Hospital Discharge Summary printed 1/13/20, identified R1 was being discharged from the hospital to the nursing home with a principle diagnosis listed as, "Fall with left hip fracture." R1's fracture had been deemed as a non-operative fracture, and R1 was sent to the nursing home with pain medication and orders for physical therapy. A section labeled, "After Discharge Orders and Instructions," was listed which identified R1 had orders for activity and weight bearing as tolerated with dictation reading, "Nursing staff to re-evaluate and modify as appropriate." Further, the summary identified R1 had been assessed as being at high risk for falls while admitted to the hospital.

R1's 5-Day Minimum Data Set (MDS) dated 2/10/20, identified R1 had intact cognition, and required extensive assistance with his activities of daily living (ADLs). Further, R1 had sustained falls within the month prior to his admission to the nursing home, however, had sustained no falls since his admission.

A telephone call was placed to R1's family member (FM)-A on 2/20/20, at 11:51 a.m. A return call was provided on 2/20/20, at 4:12 p.m. from FM-A who explained R1 had admitted to the nursing home from the hospital after he fell and

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sustained a left hip fracture. FM-A expressed significant concern as after R1 admitted to the nursing home, he proceeded to fall several times and, at times, sustained injuries including hitting his head where he "cracked it open" and had to be sent to the hospital, where he received treatment and a CT scan. FM-A stated she kept voicing concerns to the facility about R1 and his safety, however, the facility was "just not very responsive," so FM-A voiced she visited R1 frequently as she "didn't feel like he was safe there." R1 spent a majority of his time in his room and in his wheelchair, and FM-A expressed the facility would call her after R1 would fall and just kept voicing to her there "was nothing to worry about," and never really did update her with their new interventions or actions to help keep R1 safe until she was able to get hold of the director of nursing (DON). The DON explained different things which were being done which included hipsters (cushioned briefs) and anti-roll brakes on R1's wheelchair, however, at no time had there been discussion about increasing R1's supervision (i.e. safety checks, one to one). FM-A stated the supervision of R1 was important as he had paralysis on one side of his body, and if his call light was not answered timely, he would attempt to do things on his own. FM-A explained R1 never had any type of grab bar or bed rail attached to his bed, which FM-A stated she had requested, however, was told it was considered a restraint and was not allowed. FM-A voiced she was frustrated with that response, as a grab bar or rail would have helped make sure R1 didn't fall from bed and would "help him stay stable" while he stood at the bedside to void using his urinal.

R1's initial MHM Fall Review Evaluation dated 1/11/20, identified R1 had sustained falls within

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the past six months prior to admission. R1's medication use was reviewed which included hypoglycemics, antihypertensives, narcotics and sedatives, and R1 was recorded as being alert and orientated to person, place and time. R1 had no sensory deficits identified and no orthostasis (sudden change in blood pressure with position change) present, however, R1 was identified as being unable to independently come to a standing position. The assessment identified two additional sections to be completed which included "Environmental Factors" and "Summary/Interventions." However, these sections were left blank.

R1's subsequent MHM 48-hour Baseline Care Plan V-2, dated 1/14/20, identified a section labeled "Fall Risk," along with options to select to identify R1's needs. The plan identified a checkmark placed next to "Focus: Fall Risk related to," and "Goal: Resident will be safe and free from falls," which identified the section would be applicable to R1, however, the remainder of the section, including areas to write out and checkmark subsequent interventions, were all left blank and not completed. There were no recorded fall interventions on the temporary, baseline care plan to help ensure R1 remained safe and free of falls until his comprehensive care plan (completed within 21 days after admission) would be completed. However, an electronic care plan initiated 1/14/20, identified R1 as a fall risk due to his left hip fracture, and listed out three falls which happened on 1/15/20, 1/18/20, and 1/20/20. A goal was listed which identified, "[R1] will be safe and free from falls," and listed four interventions including anti slip grips to the floor by his bed (initiated 1/15/20), anti tips to his wheelchair (initiated 1/18/20), gripper socks

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(initiated 1/18/20), and hipsters at all times except bathing (initiated 1/21/20). Both care plans lacked information or interventions which had been assessed or implemented upon R1's admission to the nursing home, despite being hospitalized for a fall and fracture.

R1's progress note(s) and medical record identified the following recorded entries:

On 1/11/20, a progress note identified R1 admitted to the nursing home from Mercy hospital where he had been due to a left hip fracture.

On 1/13/20, a progress note identified R1 as being alert and orientated to time, person, and situation. The note continued, "[R1] able to move about in bed and get up to sitting position on his own. He is using the urinal to void. Stand up at bedside to useit [sic] and wants to be as independent as he is able." A subsequent note on 1/13/20, identified R1 had met with members of the interdisciplinary team (IDT) to review his care needs. R1 declined a copy of their initial care plan. However, the note lacked any dictation or evidence R1's fall risk had been reviewed and discussed with him, nor did the note contain any evidence of which fall interventions, if any, were in place after R1 had been admitted to the nursing home for two days.

On 1/14/20, a progress note recorded R1 as being up in his wheelchair for several hours and, "Attempting to transfer self onto toilet, but is unsteady-became upset when writer attempted to assist him." Further, R1 was recorded as appearing unhappy and complained of different things including, " ... that he doesn't need as much help as we want to give him."

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| F 689 | Continued From page 5<br><br>On 1/15/20, at 12:30 a.m. an 'SBAR [Situation, Background, Assessment, Recommendation] - Change of Condition' progress note identified the staff heard R1 yelling from his room, and responded to find him sitting on the floor with his back resting against the bed. R1 reported he was standing up to use the urinal when his left hand (affected side) slid off the bed, and caused him to lose his balance and fall. R1 denied hitting his head, and was able to move all extremities as prior. The section of the noted labeled "Assessment" identified R1's vital signs and he sustained no injuries, however, dictation read, " ... although [R1] states he thinks he will have a bruise on his left hip." Further, the final section of the note was labeled "Recommendations" and identified, "[R1] states that his left hand was not positioned correctly on the bed and that is why it slipped. Asked him if he could call for help but this seems unlikely as he is very independent. Told him he could also attempt to use urinal lying down." The note lacked any assessment of R1's condition or actions immediately prior to the fall, including his last time voiding, recent oral intake, medications consumed within the past few hours which could have contributed to the fall, or any assessment or actions to address R1's voiding habits or routines despite having fallen while attempting to use the urinal.<br><br>A subsequent progress note on 1/15/20, identified the DON had been updated on R1's fall. R1 was recorded as sleeping most of the remainder of the night, and used the urinal by sitting up on the edge of the bed instead of standing. R1 reported his left leg hurt and rated his pain as an eight out of 10 (10 being the worst). Further, an additional note, dated 1/15/20, identified FM-A had been | F 689 | | |

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updated on R1's fall, and requested an x-ray be completed since he fell onto his affected side. A corresponding North Star Mobile X-ray report dated 1/17/20, identified R1 did not sustain a fracture or acute injury as a result of the fall on 1/15/20.

R1's corresponding incident report dated 1/15/20, identified R1 was found sitting on the floor with his back to the bed and legs extended. R1 voiced he was using his left hand to prop himself up while standing at the bedside to use the urinal, when his hand slipped and caused him to lose his balance. R1 sustained no injuries as a result of the fall. The report continued, "[R1] is very independent -- does not want help --"I can do it." A section labeled "Predisposing Physiological Factors" identified R1 had an unsteady gait, history of falls, gait imbalance, and consumed several medications on a routine basis including psychotropics and anticonvulsants. Further, the report outlined a section labeled "Predisposing Situation Factors" which identified, "Responding to toileting needs." The report lacked any data or reference to the last time R1 had voided prior to his fall, or any immediate interventions taken to ensure R1 was safe and did not fall again while trying to void using the urinal.

R1's corresponding MHM Incident Review and Analysis V-3 dated 1/16/20, identified R1's fall from 1/15/20, was reviewed which identified it as, "Fall from bed." The form listed a total of four sections to be completed. The section labeled "Incident Analysis" outlined several sections to be completed including describing any causal factors of the fall, and included several written prompts including any toileting factors, time of day,and environmental factors. However, this section had

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none of that prompted data and listed, "Fall occurred during [night] shift." There was no recorded data or analysis of R1's toileting factors, or environmental factors despite these being listed as prompts within the assessment. The section provided additional spacing to write any identified contributing factors, and listed several prompts for this section including diagnoses, cognitive status, and consumed medications. This section was dictated with, "Resident was admitted 1/11/2020 with femoral neck fracture, hemiplegia from cerebral infarction affecting left side." There was no recorded mention of R1's cognitive status, other medical diagnoses, or consumed medications despite these being listed as prompts within the assessment. The assessment continued and listed a section labeled, "Follow-up/Interventions," which asked for current interventions in place which read, "See Care plan." A series of other interventions were listed which could be selected as being implemented at that time by placing a checkmark next to them; these included several examples to help reduce the risk of falls including anti-roll brakes to the wheelchair, changes to the resident' toileting plan, environmental changes, and signage being placed in the room to remind to ask for assistance. However, none of these were selected and they were all left blank, however, dictation was present underneath these which outlined, "Intervention: anti slip strips to floor in front of bed, gripper socks to be worn at all times except while bathing." Further, the assessment had various things to place a checkmark next to when completed which included completing staff education, updating the care plan, and, "Appropriate assessment/s completed." These were all selected with a visible checkmark placed next to them. The final section of the form was

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labeled "Additional Notes" which recorded R1 was attempting to use the urinal independently at his bedside when he slid off the bed. The note continued, "[R1] can be impulsive and unaware of safety limitations." The assessment concluded with the DON's signature and date.

On 1/18/20, at 12:51 a.m. an 'SBAR' progress note was recorded which identified R1 had sustained another fall. R1 had been sitting up in his wheelchair when it had tipped over. R1 was found laying on his right side, with the wheelchair on it's side next to him, and the note outlined, " ... has [history] of falls, this is the second fall this week." R1 received a 2 by (x) 2 centimeter (cm) abrasion on his forehead which was cleansed and a small dressing applied. However, the remainder of the note sections, including 'Response' and 'Recommendations' were left blank and not completed.

R1's corresponding incident report dated 1/18/20, identified R1 was found on the floor by the nursing assistant (NA) staff laying on his right side. R1 voiced he was trying to go to bed and the report writer had witnessed him playing computer games earlier, however, the report did not clarify a time frame. R1 received a "small abrasion on the [right] side of forehead, cleansed and bandage applied." A section labeled "Predisposing Environmental Factors" identified R1's failed to lock his wheelchair brakes, and was confused and had a recent change in condition. However, again, the report lacked any identified immediate interventions taken to ensure R1 did not sustain another fall from his wheelchair.

R1's corresponding MHM Incident Review and Analysis V-3 dated 1/21/20 (three days after R1

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fell), identified R1's fall from 1/18/20, was reviewed which identified it as, "Fall from chair or wheelchair." The form listed a total of four sections to be completed. The section labeled "Incident Analysis" outlined several sections to be completed including describing any causal factors of the fall, and included the same written prompts including any toileting factors, time of day,and environmental factors. However, this section had none of that prompted data and listed, "See care plan." There was no recorded data or analysis of R1's toileting factors, environmental factors, or explanation of what R1 was doing at the time of, or immediately prior to the fall, despite these being listed as prompts within the assessment. The section provided additional spacing to write any identified contributing factors, and listed several prompts for this section including diagnoses, cognitive status, and consumed medications. This section was dictated with, "Cerebral infarction affecting left side, femoral neck [fracture]." There was no recorded mention of R1's cognitive status, other medical diagnoses, or consumed medications despite these being listed as prompts within the assessment. The assessment continued and listed a section labeled "Follow-up/Interventions" which asked for current interventions in place which read, "Resident to wear gripper socks at all times except while bathing, anti tips to wheelchair." A series of other interventions were listed which could be selected as being implemented at that time by placing a checkmark next to them; these included several examples to help reduce the risk of falls including anti-roll brakes to the wheelchair, changes to the resident' toileting plan, environmental changes, and signage being placed in the room to remind to ask for assistance. However, none of these were

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selected and they were all left blank and no further dictation was present in the section of the assessment. Further, the assessment had various things to place a checkmark next to when completed which included completing staff education, updating the care plan, and, "Appropriate assessment/s completed." However, the option to select and identify the appropriate assessments had been completed was left blank and unchecked. The final section of the form was labeled "Additional Notes" which recorded R1 was attempting to get into bed independently when his wheelchair tipped over and he fell. R1 was recorded as being cognitively impaired and not remembering his physical limitations. The assessment concluded with the DON's signature and date.

On 1/18/20, a progress note was recorded which identified FM-A had called the nursing home to discuss R1's falls. R1 had sustained two falls thus far, and FM-A was recorded as wondering why R1 had fallen, and continued to fall. The staff explained R1 had anti-slip strips installed next to his bed, and reviewed R1's pain medication consumption and blood glucose levels with FM-A to see if a correlation had been present. Further, FM-A was told the facility would have the physician or provider see R1 at the next facility visit on 1/20/20. However, R1's medical record lacked evidence of a physician and/or provider visit being completed on 1/20/20.

On 1/21/20, at 2:14 p.m. a progress note identified R1 had fallen in the bathroom while trying to pull himself up on the grab bar, but his hand kept slipping down the grab bar so he "went to the ground." R1 denied hitting his head and had normal range of motion. A subsequent note,

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dated 1/21/20, identified a clarification which read, "The hand splint was on the left hand," during R1's fall.

R1's corresponding incident report dated 1/21/20, at 2:21 p.m., identified R1 fell "from the toilet" and was on the floor when the report writer responded. R1 denied hitting his head, however, did complain of left hip pain. R1 was recorded as having a hand splint in place which therapy was trialing for him and that hand "slipped on the grab bar." R1 reported his hand was slipping down the grab bar while attempting to rise from the toilet, so he lowered himself to the floor. R1 was recorded in the report as having a history of falls, being forgetful, and not being able to always realize his limitations. However, the report again lacked any information on if immediate interventions were taken to prevent similar fall recurrence.

R1's corresponding MHM Incident Review and Analysis V-3 dated 1/22/20, identified R1's fall from 1/21/20 at 2:21 p.m. was reviewed which identified R1 had been, "Found on floor." Again, the form listed a total of four sections to be completed. The section labeled "Incident Analysis" outlined several sections to be completed including describing any causal factors of the fall, and included the same written prompts including any toileting factors, time of day,and environmental factors. However, this section had none of that prompted data and listed, "Resident was attempting to take off his pants independently." There was no recorded data or analysis of R1's toileting factors, environmental factors, or explanation of what R1 was doing at the time of, or immediately prior to the fall, despite these being listed as prompts within the

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assessment. The section provided additional spacing to write any identified contributing factors and listed several prompts for this section including diagnoses, cognitive status and consumed medications. This section was dictated with "Hemiplegia from cerebral infarction affecting left side." There was no recorded mention of R1's cognitive status, other medical diagnoses or consumed medications despite these being listed as prompts within the assessment. The next section labeled "Follow-up/Interventions" which asked for current interventions in place which read, "See care plan." A series of other interventions were listed which could be selected as being implemented at that time by placing a checkmark next to them; these included several examples to help reduce the risk of falls including anti-roll brakes to the wheelchair, changes to the resident' toileting plan, environmental changes, and signage being placed in the room to remind to ask for assistance. However, none of these were selected and they were all left blank, however, dictation was present which read, "Hipsters to be worn at all times except while bathing." Further, the assessment had various things to place a checkmark next to when completed which included completing staff education, updating the care plan, and, "Appropriate assessment/s completed." These were all checked as being completed. The final section of the form was labeled "Additional Notes" which recorded R1 was attempting to remove his pants when he stood up and lost his balance causing him to fall which resulted in a laceration to his forehead. The note identified R1 was noted to have increased weakness over the previous two days, and concluded with dictation which read, " ... was sent to ER [Emergency Room] for evaluation and closure of laceration. Resident

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does not always remember his physical limitations, resident did not call for assistance with removing his pants." The assessment concluded with the DON's signature and date.

There was no evidence in R1's progress note completed on 1/21/20 at 2:14 p.m., R1 had sustained an injury to his head which was reflected in the corresponding MHM Incident Review and Analysis assessment which reviewed the fall on 1/21/20, at 2:21 p.m.

On 1/21/20, at 8:44 p.m. an 'SBAR' progress note was recorded which identified staff heard a noise in R1's room, and entered to find R1 on the floor. The note outlined, " ... found resident face down on the floor, blood on floor, and resident's pants were around his ankles." R1 was identified as having increased weakness for the past couple days and had sustained another fall, on the same date, prior in the afternoon (2:14 p.m.) due to self transferring. The note identified 911 was called and R1 was recorded as having an injury which read, " ... 2 - 3 cm [centimeter] lac [laceration] noted mid fore-head, bleeding profusely." R1 stated he was sitting in the wheelchair and trying to get his pants off when he fell. R1 was transported to the Emergency Department (ED) for his sustained injuries. A subsequent note dated 1/22/20, identified R1 returned from the ED with a bandage present on his forehead. R1 had laboratory work completed along with multiple CT scan(s) in the ED which showed no changes and added, "Hospital could find no reason for increased weakness or falls." Further, the note added, "[R1] stated they used 'surgical glue' on his forehead laceration."

R1's corresponding incident report dated 1/22/20,

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identified staff heard a noise in R1's room and responded. R1 was recorded as, "... face down on floor, blood on face and floor, residents pants were around his ankles." R1 voiced he was trying to remove his pants and fell forward from the wheelchair. The report identified staff held pressure to a wound on his mid-forehead and called 911. R1 received a laceration to the top of his scalp and was listed as, "lethargic [drowsy]." A recorded environmental factor was listed, "Failure to lock w/c [wheelchair] brakes," along with several other factors including R1 being forgetful, having an unsteady gait and a history of falls. There was no recorded evidence on the report regarding if R1's wheelchair had anti-roll brakes installed on them or not when this fall occurred, despite that intervention being identified as needed from a prior fall (1/18/20).

R1's After Visit Summary dated 1/21/20, identified R1 was seen in the ED for a fall with subsequent head laceration. A series of imaging tests were completed which included CT scan(s) and an EKG. The indication of the CT scan(s) was recorded as, "Head trauma, mod-severe," and, "Neck trauma, midline tenderness." No acute findings were identified, however, discharge instructions to care for R1's recorded diagnoses including head injury and head laceration were listed.

There were no identified MHM Incident Review and Analysis assessment(s) identified in R1's medical record which formally addressed or assessed R1's fall on 1/21/20, at 8:44 p.m. which resulted in R1 obtaining a head laceration, and requiring emergency care in the ED.

A Twin Cities Physicians progress note dated

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1/22/20, identified R1 was seen by his physician for , "2nd fall in week, med [medication] review." R1 was a 63 year old male with a past medical history significant for stroke with resulted left sided weakness, depression, and diabetes mellitus. R1 admitted to the nursing home for therapy, however, was recorded as "not been making good progress and appears to be increasingly fatigued." R1's hemiplegia and hemiparesis was evaluated which identified R1 had a history of three strokes and, "At baseline, he is able to ambulate with a cane, short distances." A section labeled "Review of Systems" identified R1 as sedated but easily arousable, and had dictation which read, "Gen: No falls, fevers, chills [complaints of] fatigue." A physical examination was completed which identified, "Bruise on forehead." An assessment and plan was listed which identified R1 consumed multiple medications which could increase his fatigue and sedation, so some would be decreased. However, the completed note lacked any additional dictation or assessment of R1's repeated falls to ensure potential trends, causative factors or subsequent nursing-provided interventions (i.e. increased supervision, toileting habits analysis) were identified and implemented to reduce R1's risk of continued falls despite having sustained four falls, including one with a head laceration, prior to the note being completed on 1/22/20.

On 1/23/20, a progress note was recorded which identified R1 was transferred back to the hospital and admitted for an elevated temperature and shortness of breath (unrelated to the fall on 1/21/20). R1 did not return to the nursing home.

When interviewed on 2/20/20, at 12:15 p.m.

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nursing assistant (NA)-A stated they recalled R1 and voiced his cognition was "not always quite there." R1 was "very determined" to do things on his own, most of the time, and staff would often find him alone in the bathroom after he self transferred himself there as "he didn't like to wait." NA-A expressed she did not recall R1 ever being placed on more supervision specific interventions, such as 30 or 15 minute checks for safety, however, felt it had been implied by some of the nurses so they tried to keep him out of his room and by the nursing station. However, NA-A added, this was not done until towards the very end of his stay at the nursing home.

When interviewed on 2/20/20, at 2:13 p.m. NA-B stated they recalled R1 as someone who "liked to transfer himself a lot." NA-B recalled R1 had fallen trying to pull his pants up on 1/21/20, when they had to "call the ambulance" to take him to the ED for a head injury. NA-B stated they often reminded R1 to use his call light, however, he often would not use it and just self transfer as he "thought he could do it on his own." NA-B stated she had thought not keeping R1's wheelchair next to his bed would maybe stop him from self transferring and remind him to use the call light, however, verified they "didn't do that with him." NA-B stated she did not recall R1 ever being placed on formal checks for safety, despite his known history of self transfers and not using the call light, and verified the NA staff were not doing them during R1's stay at the nursing home adding the nurses should have been the one's doing them if they were needed.

R1's medical record was reviewed and lacked evidence R1 had ever been comprehensively assessed for his fall risk despite having an

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identified history of falls with injury upon admission, nor was there evidence of any interventions being placed prior to R1's initial fall at the nursing home despite having this history. The record lacked evidence R1 was comprehensively assessed or reviewed after each subsequent fall to ensure causal factors were identified and appropriate interventions were determined and placed, including reviewing R1's toileting habits despite multiple falls occurring while attempting to void without physical assistance; nor did the record demonstrate R1's direct supervision needs (i.e. safety checks) were assessed or increased despite multiple falls while attempting to self transfer and being repeatedly identified as impulsive and un-accepting of help.

On 2/21/20, at 8:10 a.m. the physical therapy assistant (PTA)-A and certified occupational therapy assistant (COTA)-A were interviewed and voiced they both recalled R1's stay at the nursing home. R1 had reported "falling 60 times within the past year" to them and the main focus of his therapy was gait training. COTA-A recalled R1 as "a pretty high fall risk" and recommended assistance with all transfers as a result, however, R1 often didn't follow recommendations due to his cognition. R1 was "stubborn" and "very impulsive," and PTA-A stated his transfers "were pretty sketchy." They reviewed R1's treatment plan and voiced they had noticed a decline with R1's cognition during his stay at the nursing home which seemed to accelerate towards the end of his stay. This resulted in staff even having to use a mechanical lift to transfer him. They recalled R1 had sustained repeated falls during his admission to the nursing home which resulted in staff trying to keep a closer watch on him towards the end of his stay, however, they could not recall any formal

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safety checks or one to one supervision ever being done for R1. PTA-A and COTA-A expressed there were several interventions which could be implemented for someone who was impulsive or had cognitive impairment, including hanging signage in their room to remind them to ask for help, providing more "constant supervision," and setting up toileting schedules to better try to meet a resident' need before they self transfer. When questioned if R1 ever had signage hung in his room directing to ask for assistance, PTA-A responded, "I don't remember."

On 2/21/20, at 8:35 a.m. the DON and regional nurse consultant (RNC) were interviewed as R1's medical record was reviewed. DON explained the person who completed R1's initial fall risk evaluation (MHM Fall Review Evaluation dated 1/11/20) should have recorded if there were any environmental hazards, and completed the assessment' summary to identify their findings and subsequent actions taken to decrease R1's risk of falls. DON verified the lack of documentation in the assessment, and stated it "was not done," adding it should have been completed to demonstrate what actions were identified and taken "to keep him safe." RNC acknowledged these findings and expressed, "I agree." R1's temporary care plan was reviewed, and DON verified the lack of recorded interventions being identified upon R1's admission. DON stated there should have been interventions identified on the care plan and the lack of them was concerning, however, DON expressed she recalled several interventions had been put in place and just not documented on the temporary care plan. DON explained the facility' process when a fall happens included assessing the resident for injuries immediately after a fall,

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documenting the incident in the 'risk management' system (the completed incident reports), and placing an immediate intervention to help prevent additional falls while the IDT meets to review the fall and help determine the "root cause" of it.

DON reviewed each of R1's completed incident reports in the 'risk management' section of the record and stated they each lacked evidence of what immediate interventions were put into place to help prevent continued falls for R1. DON expressed, "I can see where you're [surveyor] going." DON explained each subsequent intervention taken for R1's falls and reviewed each completed MHM Incident Review aloud. The DON acknowledged she was aware R1 was impulsive, so they felt gripper slippers and anti-slip strips would make it safer while R1 stood to urinate after his first fall on 1/15/20, however, the DON verified the assessment piece of the review (i.e. assessing causative and contributing factors) had not been completed correctly. R1's sustained a second fall on 1/18/20, which they added anti-roll brakes to his wheelchair to help prevent it moving if he attempted to stand up, however, again, acknowledged the evaluation of causative and contributing factors was not completed correctly. On 1/21/20, R1 sustained a fall while in his bathroom after he self transferred. DON stated their thought process then turned to more prevention of injury, not preventing the falls as R1's continued to self transfer and remained impulsive. As a result, the decision was made to order and implement a set of hipsters for him, however, again acknowledged the evaluation of causative and contributing factors had not been completed correctly. DON stated there was no documented evidence demonstrating the anti-roll

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brakes or hipsters had ever been installed and/or implemented for R1 after being assessed as needed on these reviews.

The DON verified a MHM Incident Review and Analysis had not been completed for R1's fall which resulted in a head laceration and required medical care, however, she recalled reviewing the incident in the stand up meeting and determining they would provide R1 with a risk and benefit disclaimer for self transferring. DON reviewed R1's medical record and expressed there was no evidence that had ever been completed in the medical record. Further, the DON acknowledged the medical record lacked evidence of a comprehensive assessment being completed for R1's falls which included reviewing the patterns or trends of the falls; R1's toileting habits, despite several falls occurring while attempting to void; or reviewing the falls to determine if just overall increased supervision was needed (i.e. safety checks). DON and RNC explained, "We need to change our processes," and make sure better, more comprehensive assessments of falls were being completed to ensure staff are getting to "the root causes" of falls and keeping the residents safe. DON added, "More education is needed."

On 2/21/20, at 10:51 a.m. R1's nurse practitioner (NP)-A was interviewed. NP-A recalled R1 had a history of stroke with some resulted physical disability along with a history of falls, including a recent hospitalization for a fracture related to a fall prior to his admission. NP-A voiced she was aware R1 had sustained "a couple falls" at the nursing home, however, she was unaware of the circumstances surrounding the them. NP-A felt R1 was someone who would be able to voice his

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needs, but added she was unaware "if he was doing that or not." NP-A explained a process to help reduce R1's falls or prevent injury would include ongoing education to him and answering his call light quickly as he could "be impulsive" from her recall. NP-A stated implementing a system of frequent checks or reviewing R1's toileting plan or pain management program would have been appropriate interventions for him, as her role was primarily medication management. NP-A explained a good process for helping prevent falls for R1, or any resident who had repeated falls, would include a comprehensive assessment of the person and their falls to help determine "the underlying reason for the patient moving and following up." Further, NP-A stated she had been updated by the facility about R1's falls he had sustained while there, however, the nursing staff were responsible to ensure fall assessments and precautions are in place adding, "I just assume that's happening."

R3's admission MDS dated 2/5/20, identified R3 had severe cognitive impairment and required extensive assistance for transfers. Further, R3 used a wheelchair for mobility and had sustained fall(s) within the month prior to admission to the nursing home.

R3's MHM Incident Review and Analysis V-3 dated 2/8/20, identified R3 had sustained a fall from his wheelchair. The report outlined, "Resident was self transferring to bed from wheelchair, wheelchair was not locked and rolled back away from resident. Anti roll backs ordered for his wheelchair."

R3's care plan dated 2/10/20, identified R3 as a

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fall risk related to his confusion and impulsive behaviors. A goal was listed for R3 which read, "will be safe and free from falls," along with several interventions which included not leaving R3 alone in the bathroom and having anti-roll backs applied to his wheelchair.

On 2/20/20, at 12:57 p.m. R3 was seated in a wheelchair in the main dining room with several other residents watching television. The wheelchair was labeled with R3's name. R3's wheelchair lacked any anti-roll backs or other devices intended to stop the wheelchair from moving if not locked.

When interviewed on 2/20/20, at 1:23 p.m. nursing assistant (NA)-A stated she was assigned to care for R3 that day, and she was unaware if he had sustained any recent falls adding, "not that I know of." NA-A described anti-roll backs as brackets which appear to wrap around the wheel of the chair which lock if someone stands up. NA-A observed R3 seated in the wheelchair in the commons area and verified the lack of anti-roll back brakes being installed and stated she was unaware if he needed them or not, however, if someone did need them, NA-A expressed the maintenance department would have to install them.

On 2/20/20, at 1:26 p.m. the director of maintenance was interviewed. He explained he had been told R3 needed the anti-roll backs on his wheelchair, however, the facility was out of them so he placed an order for some on 2/17/20, which still had not been approved. He stated there were "two others that needed [them]" as well, however, verified there was no supply. Further, he explained it typically did not take three

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or more days to get parts approved for order, and he was unaware why there was a delay in getting these parts approved.

During interview on 2/20/20, at 2:21 p.m. NA-B stated R3 often self transfered, and "likes to do things by himself." R3 often removed his own wheelchair locks and was able to self propel around the facility on his own. Further, NA-B expressed she "was not aware of that [fall on 2/8/10], but not surprised," and stated she was not aware of what new interventions were being done to help keep R3 safe since he had fallen on 2/8/10.

R3's medical record was reviewed, and lacked evidence of any stop-gap interventions being assessed or implemented to provide adequate supervision and help prevent continued falls for R3 until the assessed anti-roll backs were supplied and installed.

On 2/20/20, at 2:35 p.m. the DON was interviewed. R3 had sustained "a couple" falls since he admitted to the nursing home, and was described as "very impulsive." R3 had fallen on 2/8/10, when his wheelchair was not locked, and he self transferred to his bed, and it had appeared the wheelchair rolled backwards after he stood up. R3 sustained no injuries from the fall. DON explained they decided to install the anti-roll back brakes on his wheelchair to help prevent continued falls when he self transfered. DON stated she was unaware the anti-roll brakes still needed to have approval before they could be ordered, and expressed she never did re-visit R3's wheelchair to ensure they had been installed, or if something else had been needed in the mean time. DON stated, "We need to come

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up with a way to make sure the interventions are carried through," adding this was important to do to help prevent falls and "make sure we keep the resident safe."

An undated Fall Prevention and Management policy was provided. This identified a purpose of identifying residents at risk for falls, implementing interventions to help prevent falls, and providing guidelines for assessing a resident post-fall. The policy directed a Fall Risk Evaluation was to be completed upon admission, annually, with a significant change in condition and as needed. A section labeled, "Managing Falls and Fall Risk," directed facility staff would identify interventions related to the resident's specific risks and cause to try to prevent falls and minimize complications from falling. A process was outlined for staff to help identify causes of a fall or someone's fall risk which included trying to identify possible, or likely, causes of the incident including referring to the specific resident's medical history, functional impairments and evaluating circumstances around a fall including the time of day, the last time the person was toileting or repositioned, last time ate, any environmental risks and whether a pattern of falls had been identified.

Certified Mail #7016 2070 0000 7235 1409

March 6, 2020

Administrator
The Estates At Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

Re: State Nursing Home Licensing Orders
Event ID: 7ROM11

Dear Administrator:

The above facility was surveyed on February 20, 2020 through February 21, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 2/20/20 to 2/21/20, surveyors of this Department's staff visited the above provider and the following correction orders are issued.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been | 2 000 | | |

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| 2 000 | Continued From page 1<br>assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>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 attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |

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| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to reduce the risk of falls for 2 of 3 residents (R1, R3) reviewed for accidents. This resulted in actual harm for R1 who fell multiple times without being assessed, and obtained a head laceration which required emergency medical care.<br><br>Findings include:<br><br>R1's Hospital Discharge Summary printed 1/13/20, identified R1 was being discharged from the hospital to the nursing home with a principle diagnosis listed as, "Fall with left hip fracture." R1's fracture had been deemed as a non-operative fracture, and R1 was sent to the nursing home with pain medication and orders for physical therapy. A section labeled, "After Discharge Orders and Instructions," was listed | 2 830 | | |

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| 2 830 | Continued From page 3<br>which identified R1 had orders for activity and weight bearing as tolerated with dictation reading, "Nursing staff to re-evaluate and modify as appropriate." Further, the summary identified R1 had been assessed as being at high risk for falls while admitted to the hospital.<br><br>R1's 5-Day Minimum Data Set (MDS) dated 2/10/20, identified R1 had intact cognition, and required extensive assistance with his activities of daily living (ADLs). Further, R1 had sustained falls within the month prior to his admission to the nursing home, however, had sustained no falls since his admission.<br><br>A telephone call was placed to R1's family member (FM)-A on 2/20/20, at 11:51 a.m. A return call was provided on 2/20/20, at 4:12 p.m. from FM-A who explained R1 had admitted to the nursing home from the hospital after he fell and sustained a left hip fracture. FM-A expressed significant concern as after R1 admitted to the nursing home, he proceeded to fall several times and, at times, sustained injuries including hitting his head where he "cracked it open" and had to be sent to the hospital, where he received treatment and a CT scan. FM-A stated she kept voicing concerns to the facility about R1 and his safety, however, the facility was "just not very responsive," so FM-A voiced she visited R1 frequently as she "didn't feel like he was safe there." R1 spent a majority of his time in his room and in his wheelchair, and FM-A expressed the facility would call her after R1 would fall and just kept voicing to her there "was nothing to worry about," and never really did update her with their new interventions or actions to help keep R1 safe until she was able to get hold of the director of nursing (DON). The DON explained different things which were being done which included | 2 830 | | |

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hipsters (cushioned briefs) and anti-roll brakes on R1's wheelchair, however, at no time had there been discussion about increasing R1's supervision (i.e. safety checks, one to one). FM-A stated the supervision of R1 was important as he had paralysis on one side of his body, and if his call light was not answered timely, he would attempt to do things on his own. FM-A explained R1 never had any type of grab bar or bed rail attached to his bed, which FM-A stated she had requested, however, was told it was considered a restraint and was not allowed. FM-A voiced she was frustrated with that response, as a grab bar or rail would have helped make sure R1 didn't fall from bed and would "help him stay stable" while he stood at the bedside to void using his urinal.

R1's initial MHM Fall Review Evaluation dated 1/11/20, identified R1 had sustained falls within the past six months prior to admission. R1's medication use was reviewed which included hypoglycemics, antihypertensives, narcotics and sedatives, and R1 was recorded as being alert and orientated to person, place and time. R1 had no sensory deficits identified and no orthostasis (sudden change in blood pressure with position change) present, however, R1 was identified as being unable to independently come to a standing position. The assessment identified two additional sections to be completed which included "Environmental Factors" and "Summary/Interventions." However, these sections were left blank.

R1's subsequent MHM 48-hour Baseline Care Plan V-2, dated 1/14/20, identified a section labeled "Fall Risk," along with options to select to identify R1's needs. The plan identified a checkmark placed next to "Focus: Fall Risk related to," and "Goal: Resident will be safe and

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free from falls," which identified the section would be applicable to R1, however, the remainder of the section, including areas to write out and checkmark subsequent interventions, were all left blank and not completed. There were no recorded fall interventions on the temporary, baseline care plan to help ensure R1 remained safe and free of falls until his comprehensive care plan (completed within 21 days after admission) would be completed. However, an electronic care plan initiated 1/14/20, identified R1 as a fall risk due to his left hip fracture, and listed out three falls which happened on 1/15/20, 1/18/20, and 1/20/20. A goal was listed which identified, "[R1] will be safe and free from falls," and listed four interventions including anti slip grips to the floor by his bed (initiated 1/15/20), anti tips to his wheelchair (initiated 1/18/20), gripper socks (initiated 1/18/20), and hipsters at all times except bathing (initiated 1/21/20). Both care plans lacked information or interventions which had been assessed or implemented upon R1's admission to the nursing home, despite being hospitalized for a fall and fracture.

R1's progress note(s) and medical record identified the following recorded entries:

On 1/11/20, a progress note identified R1 admitted to the nursing home from Mercy hospital where he had been due to a left hip fracture.

On 1/13/20, a progress note identified R1 as being alert and orientated to time, person, and situation. The note continued, "[R1] able to move about in bed and get up to sitting position on his own. He is using the urinal to void. Stand up at bedside to useit [sic] and wants to be as independent as he is able." A subsequent note on 1/13/20, identified R1 had met with members

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| 2 830 | Continued From page 6<br>of the interdisciplinary team (IDT) to review his care needs. R1 declined a copy of their initial care plan. However, the note lacked any dictation or evidence R1's fall risk had been reviewed and discussed with him, nor did the note contain any evidence of which fall interventions, if any, were in place after R1 had been admitted to the nursing home for two days.<br><br>On 1/14/20, a progress note recorded R1 as being up in his wheelchair for several hours and, "Attempting to transfer self onto toilet, but is unsteady-became upset when writer attempted to assist him." Further, R1 was recorded as appearing unhappy and complained of different things including, " ... that he doesn't need as much help as we want to give him."<br><br>On 1/15/20, at 12:30 a.m. an 'SBAR [Situation, Background, Assessment, Recommendation] - Change of Condition' progress note identified the staff heard R1 yelling from his room, and responded to find him sitting on the floor with his back resting against the bed. R1 reported he was standing up to use the urinal when his left hand (affected side) slid off the bed, and caused him to lose his balance and fall. R1 denied hitting his head, and was able to move all extremities as prior. The section of the noted labeled "Assessment" identified R1's vital signs and he sustained no injuries, however, dictation read, " ... although [R1] states he thinks he will have a bruise on his left hip." Further, the final section of the note was labeled "Recommendations" and identified, "[R1] states that his left hand was not positioned correctly on the bed and that is why it slipped. Asked him if he could call for help but this seems unlikely as he is very independent. Told him he could also attempt to use urinal lying down." The note lacked any assessment of R1's | 2 830 | | |

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| 2 830 | Continued From page 7<br>condition or actions immediately prior to the fall, including his last time voiding, recent oral intake, medications consumed within the past few hours which could have contributed to the fall, or any assessment or actions to address R1's voiding habits or routines despite having fallen while attempting to use the urinal.<br><br>A subsequent progress note on 1/15/20, identified the DON had been updated on R1's fall. R1 was recorded as sleeping most of the remainder of the night, and used the urinal by sitting up on the edge of the bed instead of standing. R1 reported his left leg hurt and rated his pain as an eight out of 10 (10 being the worst). Further, an additional note, dated 1/15/20, identified FM-A had been updated on R1's fall, and requested an x-ray be completed since he fell onto his affected side. A corresponding North Star Mobile X-ray report dated 1/17/20, identified R1 did not sustain a fracture or acute injury as a result of the fall on 1/15/20.<br><br>R1's corresponding incident report dated 1/15/20, identified R1 was found sitting on the floor with his back to the bed and legs extended. R1 voiced he was using his left hand to prop himself up while standing at the bedside to use the urinal, when his hand slipped and caused him to lose his balance. R1 sustained no injuries as a result of the fall. The report continued, "[R1] is very independent -- does not want help --"I can do it." A section labeled "Predisposing Physiological Factors" identified R1 had an unsteady gait, history of falls, gait imbalance, and consumed several medications on a routine basis including psychotropics and anticonvulsants. Further, the report outlined a section labeled "Predisposing Situation Factors" which identified, "Responding to toileting needs." The report lacked any data or | 2 830 | | |

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| 2 830 | Continued From page 8<br>reference to the last time R1 had voided prior to his fall, or any immediate interventions taken to ensure R1 was safe and did not fall again while trying to void using the urinal.<br><br>R1's corresponding MHM Incident Review and Analysis V-3 dated 1/16/20, identified R1's fall from 1/15/20, was reviewed which identified it as, "Fall from bed." The form listed a total of four sections to be completed. The section labeled "Incident Analysis" outlined several sections to be completed including describing any causal factors of the fall, and included several written prompts including any toileting factors, time of day,and environmental factors. However, this section had none of that prompted data and listed, "Fall occurred during [night] shift." There was no recorded data or analysis of R1's toileting factors, or environmental factors despite these being listed as prompts within the assessment. The section provided additional spacing to write any identified contributing factors, and listed several prompts for this section including diagnoses, cognitive status, and consumed medications. This section was dictated with, "Resident was admitted 1/11/2020 with femoral neck fracture, hemiplegia from cerebral infarction affecting left side." There was no recorded mention of R1's cognitive status, other medical diagnoses, or consumed medications despite these being listed as prompts within the assessment. The assessment continued and listed a section labeled, "Follow-up/Interventions," which asked for current interventions in place which read, "See Care plan." A series of other interventions were listed which could be selected as being implemented at that time by placing a checkmark next to them; these included several examples to help reduce the risk of falls including anti-roll brakes to the wheelchair, changes to the resident' | 2 830 | | |

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| 2 830 | Continued From page 9 | 2 830 | | |

toileting plan, environmental changes, and signage being placed in the room to remind to ask for assistance. However, none of these were selected and they were all left blank, however, dictation was present underneath these which outlined, "Intervention: anti slip strips to floor in front of bed, gripper socks to be worn at all times except while bathing." Further, the assessment had various things to place a checkmark next to when completed which included completing staff education, updating the care plan, and, "Appropriate assessment/s completed." These were all selected with a visible checkmark placed next to them. The final section of the form was labeled "Additional Notes" which recorded R1 was attempting to use the urinal independently at his bedside when he slid off the bed. The note continued, "[R1] can be impulsive and unaware of safety limitations." The assessment concluded with the DON's signature and date.

On 1/18/20, at 12:51 a.m. an 'SBAR' progress note was recorded which identified R1 had sustained another fall. R1 had been sitting up in his wheelchair when it had tipped over. R1 was found laying on his right side, with the wheelchair on it's side next to him, and the note outlined, " ... has [history] of falls, this is the second fall this week." R1 received a 2 by (x) 2 centimeter (cm) abrasion on his forehead which was cleansed and a small dressing applied. However, the remainder of the note sections, including 'Response' and 'Recommendations' were left blank and not completed.

R1's corresponding incident report dated 1/18/20, identified R1 was found on the floor by the nursing assistant (NA) staff laying on his right side. R1 voiced he was trying to go to bed and the report writer had witnessed him playing

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| 2 830 | Continued From page 10 | 2 830 | | |

computer games earlier, however, the report did not clarify a time frame. R1 received a "small abrasion on the [right] side of forehead, cleansed and bandage applied." A section labeled "Predisposing Environmental Factors" identified R1's failed to lock his wheelchair brakes, and was confused and had a recent change in condition. However, again, the report lacked any identified immediate interventions taken to ensure R1 did not sustain another fall from his wheelchair.

R1's corresponding MHM Incident Review and Analysis V-3 dated 1/21/20 (three days after R1 fell), identified R1's fall from 1/18/20, was reviewed which identified it as, "Fall from chair or wheelchair." The form listed a total of four sections to be completed. The section labeled "Incident Analysis" outlined several sections to be completed including describing any causal factors of the fall, and included the same written prompts including any toileting factors, time of day,and environmental factors. However, this section had none of that prompted data and listed, "See care plan." There was no recorded data or analysis of R1's toileting factors, environmental factors, or explanation of what R1 was doing at the time of, or immediately prior to the fall, despite these being listed as prompts within the assessment. The section provided additional spacing to write any identified contributing factors, and listed several prompts for this section including diagnoses, cognitive status, and consumed medications. This section was dictated with, "Cerebral infarction affecting left side, femoral neck [fracture]." There was no recorded mention of R1's cognitive status, other medical diagnoses, or consumed medications despite these being listed as prompts within the assessment. The assessment continued and listed a section labeled "Follow-up/Interventions" which asked for

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| 2 830 | Continued From page 11<br><br>current interventions in place which read, "Resident to wear gripper socks at all times except while bathing, anti tips to wheelchair." A series of other interventions were listed which could be selected as being implemented at that time by placing a checkmark next to them; these included several examples to help reduce the risk of falls including anti-roll brakes to the wheelchair, changes to the resident' toileting plan, environmental changes, and signage being placed in the room to remind to ask for assistance. However, none of these were selected and they were all left blank and no further dictation was present in the section of the assessment. Further, the assessment had various things to place a checkmark next to when completed which included completing staff education, updating the care plan, and, "Appropriate assessment/s completed." However, the option to select and identify the appropriate assessments had been completed was left blank and unchecked. The final section of the form was labeled "Additional Notes" which recorded R1 was attempting to get into bed independently when his wheelchair tipped over and he fell. R1 was recorded as being cognitively impaired and not remembering his physical limitations. The assessment concluded with the DON's signature and date.<br><br>On 1/18/20, a progress note was recorded which identified FM-A had called the nursing home to discuss R1's falls. R1 had sustained two falls thus far, and FM-A was recorded as wondering why R1 had fallen, and continued to fall. The staff explained R1 had anti-slip strips installed next to his bed, and reviewed R1's pain medication consumption and blood glucose levels with FM-A to see if a correlation had been present. Further, FM-A was told the facility would have the | 2 830 | | |

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physician or provider see R1 at the next facility visit on 1/20/20. However, R1's medical record lacked evidence of a physician and/or provider visit being completed on 1/20/20.

On 1/21/20, at 2:14 p.m. a progress note identified R1 had fallen in the bathroom while trying to pull himself up on the grab bar, but his hand kept slipping down the grab bar so he "went to the ground." R1 denied hitting his head and had normal range of motion. A subsequent note, dated 1/21/20, identified a clarification which read, "The hand splint was on the left hand," during R1's fall.

R1's corresponding incident report dated 1/21/20, at 2:21 p.m., identified R1 fell "from the toilet" and was on the floor when the report writer responded. R1 denied hitting his head, however, did complain of left hip pain. R1 was recorded as having a hand splint in place which therapy was trialing for him and that hand "slipped on the grab bar." R1 reported his hand was slipping down the grab bar while attempting to rise from the toilet, so he lowered himself to the floor. R1 was recorded in the report as having a history of falls, being forgetful, and not being able to always realize his limitations. However, the report again lacked any information on if immediate interventions were taken to prevent similar fall recurrence.

R1's corresponding MHM Incident Review and Analysis V-3 dated 1/22/20, identified R1's fall from 1/21/20 at 2:21 p.m. was reviewed which identified R1 had been, "Found on floor." Again, the form listed a total of four sections to be completed. The section labeled "Incident Analysis" outlined several sections to be completed including describing any causal factors

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| 2 830 | Continued From page 13<br>of the fall, and included the same written prompts including any toileting factors, time of day,and environmental factors. However, this section had none of that prompted data and listed, "Resident was attempting to take off his pants independently." There was no recorded data or analysis of R1's toileting factors, environmental factors, or explanation of what R1 was doing at the time of, or immediately prior to the fall, despite these being listed as prompts within the assessment. The section provided additional spacing to write any identified contributing factors and listed several prompts for this section including diagnoses, cognitive status and consumed medications. This section was dictated with "Hemiplegia from cerebral infarction affecting left side." There was no recorded mention of R1's cognitive status, other medical diagnoses or consumed medications despite these being listed as prompts within the assessment. The next section labeled "Follow-up/Interventions" which asked for current interventions in place which read, "See care plan." A series of other interventions were listed which could be selected as being implemented at that time by placing a checkmark next to them; these included several examples to help reduce the risk of falls including anti-roll brakes to the wheelchair, changes to the resident' toileting plan, environmental changes, and signage being placed in the room to remind to ask for assistance. However, none of these were selected and they were all left blank, however, dictation was present which read, "Hipsters to be worn at all times except while bathing." Further, the assessment had various things to place a checkmark next to when completed which included completing staff education, updating the care plan, and, "Appropriate assessment/s completed." These were all checked as being completed. The final | 2 830 | | |

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| 2 830 | Continued From page 14<br>section of the form was labeled "Additional Notes" which recorded R1 was attempting to remove his pants when he stood up and lost his balance causing him to fall which resulted in a laceration to his forehead. The note identified R1 was noted to have increased weakness over the previous two days, and concluded with dictation which read, " ... was sent to ER [Emergency Room] for evaluation and closure of laceration. Resident does not always remember his physical limitations, resident did not call for assistance with removing his pants." The assessment concluded with the DON's signature and date.<br><br>There was no evidence in R1's progress note completed on 1/21/20 at 2:14 p.m., R1 had sustained an injury to his head which was reflected in the corresponding MHM Incident Review and Analysis assessment which reviewed the fall on 1/21/20, at 2:21 p.m.<br><br>On 1/21/20, at 8:44 p.m. an 'SBAR' progress note was recorded which identified staff heard a noise in R1's room, and entered to find R1 on the floor. The note outlined, " ... found resident face down on the floor, blood on floor, and resident's pants were around his ankles." R1 was identified as having increased weakness for the past couple days and had sustained another fall, on the same date, prior in the afternoon (2:14 p.m.) due to self transferring. The note identified 911 was called and R1 was recorded as having an injury which read, " ... 2 - 3 cm [centimeter] lac [laceration] noted mid fore-head, bleeding profusely." R1 stated he was sitting in the wheelchair and trying to get his pants off when he fell. R1 was transported to the Emergency Department (ED) for his sustained injuries. A subsequent note dated 1/22/20, identified R1 returned from the ED with a bandage present on his forehead. R1 had | 2 830 | | |

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laboratory work completed along with multiple CT scan(s) in the ED which showed no changes and added, "Hospital could find no reason for increased weakness or falls." Further, the note added, "[R1] stated they used 'surgical glue' on his forehead laceration."

R1's corresponding incident report dated 1/22/20, identified staff heard a noise in R1's room and responded. R1 was recorded as, "... face down on floor, blood on face and floor, residents pants were around his ankles." R1 voiced he was trying to remove his pants and fell forward from the wheelchair. The report identified staff held pressure to a wound on his mid-forehead and called 911. R1 received a laceration to the top of his scalp and was listed as, "lethargic [drowsy]." A recorded environmental factor was listed, "Failure to lock w/c [wheelchair] brakes," along with several other factors including R1 being forgetful, having an unsteady gait and a history of falls. There was no recorded evidence on the report regarding if R1's wheelchair had anti-roll brakes installed on them or not when this fall occurred, despite that intervention being identified as needed from a prior fall (1/18/20).

R1's After Visit Summary dated 1/21/20, identified R1 was seen in the ED for a fall with subsequent head laceration. A series of imaging tests were completed which included CT scan(s) and an EKG. The indication of the CT scan(s) was recorded as, "Head trauma, mod-severe," and, "Neck trauma, midline tenderness." No acute findings were identified, however, discharge instructions to care for R1's recorded diagnoses including head injury and head laceration were listed.

There were no identified MHM Incident Review

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| 2 830 | Continued From page 16<br>and Analysis assessment(s) identified in R1's medical record which formally addressed or assessed R1's fall on 1/21/20, at 8:44 p.m. which resulted in R1 obtaining a head laceration, and requiring emergency care in the ED.<br><br>A Twin Cities Physicians progress note dated 1/22/20, identified R1 was seen by his physician for , "2nd fall in week, med [medication] review." R1 was a 63 year old male with a past medical history significant for stroke with resulted left sided weakness, depression, and diabetes mellitus. R1 admitted to the nursing home for therapy, however, was recorded as "not been making good progress and appears to be increasingly fatigued." R1's hemiplegia and hemiparesis was evaluated which identified R1 had a history of three strokes and, "At baseline, he is able to ambulate with a cane, short distances." A section labeled "Review of Systems" identified R1 as sedated but easily arousable, and had dictation which read, "Gen: No falls, fevers, chills [complaints of] fatigue." A physical examination was completed which identified, "Bruise on forehead." An assessment and plan was listed which identified R1 consumed multiple medications which could increase his fatigue and sedation, so some would be decreased. However, the completed note lacked any additional dictation or assessment of R1's repeated falls to ensure potential trends, causative factors or subsequent nursing-provided interventions (i.e. increased supervision, toileting habits analysis) were identified and implemented to reduce R1's risk of continued falls despite having sustained four falls, including one with a head laceration, prior to the note being completed on 1/22/20.<br><br>On 1/23/20, a progress note was recorded which | 2 830 | | |

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| 2 830 | Continued From page 17<br>identified R1 was transferred back to the hospital and admitted for an elevated temperature and shortness of breath (unrelated to the fall on 1/21/20). R1 did not return to the nursing home.<br><br>When interviewed on 2/20/20, at 12:15 p.m. nursing assistant (NA)-A stated they recalled R1 and voiced his cognition was "not always quite there." R1 was "very determined" to do things on his own, most of the time, and staff would often find him alone in the bathroom after he self transferred himself there as "he didn't like to wait." NA-A expressed she did not recall R1 ever being placed on more supervision specific interventions, such as 30 or 15 minute checks for safety, however, felt it had been implied by some of the nurses so they tried to keep him out of his room and by the nursing station. However, NA-A added, this was not done until towards the very end of his stay at the nursing home.<br><br>When interviewed on 2/20/20, at 2:13 p.m. NA-B stated they recalled R1 as someone who "liked to transfer himself a lot." NA-B recalled R1 had fallen trying to pull his pants up on 1/21/20, when they had to "call the ambulance" to take him to the ED for a head injury. NA-B stated they often reminded R1 to use his call light, however, he often would not use it and just self transfer as he "thought he could do it on his own." NA-B stated she had thought not keeping R1's wheelchair next to his bed would maybe stop him from self transferring and remind him to use the call light, however, verified they "didn't do that with him." NA-B stated she did not recall R1 ever being placed on formal checks for safety, despite his known history of self transfers and not using the call light, and verified the NA staff were not doing them during R1's stay at the nursing home adding the nurses should have been the one's doing | 2 830 | | |

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| 2 830 | Continued From page 18<br>them if they were needed.<br><br>R1's medical record was reviewed and lacked evidence R1 had ever been comprehensively assessed for his fall risk despite having an identified history of falls with injury upon admission, nor was there evidence of any interventions being placed prior to R1's initial fall at the nursing home despite having this history. The record lacked evidence R1 was comprehensively assessed or reviewed after each subsequent fall to ensure causal factors were identified and appropriate interventions were determined and placed, including reviewing R1's toileting habits despite multiple falls occurring while attempting to void without physical assistance; nor did the record demonstrate R1's direct supervision needs (i.e. safety checks) were assessed or increased despite multiple falls while attempting to self transfer and being repeatedly identified as impulsive and un-accepting of help.<br><br>On 2/21/20, at 8:10 a.m. the physical therapy assistant (PTA)-A and certified occupational therapy assistant (COTA)-A were interviewed and voiced they both recalled R1's stay at the nursing home. R1 had reported "falling 60 times within the past year" to them and the main focus of his therapy was gait training. COTA-A recalled R1 as "a pretty high fall risk" and recommended assistance with all transfers as a result, however, R1 often didn't follow recommendations due to his cognition. R1 was "stubborn" and "very impulsive," and PTA-A stated his transfers "were pretty sketchy." They reviewed R1's treatment plan and voiced they had noticed a decline with R1's cognition during his stay at the nursing home which seemed to accelerate towards the end of his stay. This resulted in staff even having to use a mechanical lift to transfer him. They recalled R1 | 2 830 | | |

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| 2 830 | Continued From page 19<br><br>had sustained repeated falls during his admission to the nursing home which resulted in staff trying to keep a closer watch on him towards the end of his stay, however, they could not recall any formal safety checks or one to one supervision ever being done for R1. PTA-A and COTA-A expressed there were several interventions which could be implemented for someone who was impulsive or had cognitive impairment, including hanging signage in their room to remind them to ask for help, providing more "constant supervision," and setting up toileting schedules to better try to meet a resident' need before they self transfer. When questioned if R1 ever had signage hung in his room directing to ask for assistance, PTA-A responded, "I don't remember."<br><br>On 2/21/20, at 8:35 a.m. the DON and regional nurse consultant (RNC) were interviewed as R1's medical record was reviewed. DON explained the person who completed R1's initial fall risk evaluation (MHM Fall Review Evaluation dated 1/11/20) should have recorded if there were any environmental hazards, and completed the assessment' summary to identify their findings and subsequent actions taken to decrease R1's risk of falls. DON verified the lack of documentation in the assessment, and stated it "was not done," adding it should have been completed to demonstrate what actions were identified and taken "to keep him safe." RNC acknowledged these findings and expressed, "I agree." R1's temporary care plan was reviewed, and DON verified the lack of recorded interventions being identified upon R1's admission. DON stated there should have been interventions identified on the care plan and the lack of them was concerning, however, DON expressed she recalled several interventions had been put in place and just not documented on the | 2 830 | | |

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| 2 830 | Continued From page 20 | 2 830 | | |

temporary care plan. DON explained the facility' process when a fall happens included assessing the resident for injuries immediately after a fall, documenting the incident in the 'risk management' system (the completed incident reports), and placing an immediate intervention to help prevent additional falls while the IDT meets to review the fall and help determine the "root cause" of it.

DON reviewed each of R1's completed incident reports in the 'risk management' section of the record and stated they each lacked evidence of what immediate interventions were put into place to help prevent continued falls for R1. DON expressed, "I can see where you're [surveyor] going." DON explained each subsequent intervention taken for R1's falls and reviewed each completed MHM Incident Review aloud. The DON acknowledged she was aware R1 was impulsive, so they felt gripper slippers and anti-slip strips would make it safer while R1 stood to urinate after his first fall on 1/15/20, however, the DON verified the assessment piece of the review (i.e. assessing causative and contributing factors) had not been completed correctly. R1's sustained a second fall on 1/18/20, which they added anti-roll brakes to his wheelchair to help prevent it moving if he attempted to stand up, however, again, acknowledged the evaluation of causative and contributing factors was not completed correctly. On 1/21/20, R1 sustained a fall while in his bathroom after he self transferred. DON stated their thought process then turned to more prevention of injury, not preventing the falls as R1's continued to self transfer and remained impulsive. As a result, the decision was made to order and implement a set of hipsters for him, however, again acknowledged the evaluation of causative and contributing factors had not been

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| 2 830 | Continued From page 21 | 2 830 | | |

completed correctly. DON stated there was no documented evidence demonstrating the anti-roll brakes or hipsters had ever been installed and/or implemented for R1 after being assessed as needed on these reviews.

The DON verified a MHM Incident Review and Analysis had not been completed for R1's fall which resulted in a head laceration and required medical care, however, she recalled reviewing the incident in the stand up meeting and determining they would provide R1 with a risk and benefit disclaimer for self transferring. DON reviewed R1's medical record and expressed there was no evidence that had ever been completed in the medical record. Further, the DON acknowledged the medical record lacked evidence of a comprehensive assessment being completed for R1's falls which included reviewing the patterns or trends of the falls; R1's toileting habits, despite several falls occurring while attempting to void; or reviewing the falls to determine if just overall increased supervision was needed (i.e. safety checks). DON and RNC explained, "We need to change our processes," and make sure better, more comprehensive assessments of falls were being completed to ensure staff are getting to "the root causes" of falls and keeping the residents safe. DON added, "More education is needed."

On 2/21/20, at 10:51 a.m. R1's nurse practitioner (NP)-A was interviewed. NP-A recalled R1 had a history of stroke with some resulted physical disability along with a history of falls, including a recent hospitalization for a fracture related to a fall prior to his admission. NP-A voiced she was aware R1 had sustained "a couple falls" at the nursing home, however, she was unaware of the circumstances surrounding the them. NP-A felt

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| 2 830 | Continued From page 22<br><br>R1 was someone who would be able to voice his needs, but added she was unaware "if he was doing that or not." NP-A explained a process to help reduce R1's falls or prevent injury would include ongoing education to him and answering his call light quickly as he could "be impulsive" from her recall. NP-A stated implementing a system of frequent checks or reviewing R1's toileting plan or pain management program would have been appropriate interventions for him, as her role was primarily medication management. NP-A explained a good process for helping prevent falls for R1, or any resident who had repeated falls, would include a comprehensive assessment of the person and their falls to help determine "the underlying reason for the patient moving and following up." Further, NP-A stated she had been updated by the facility about R1's falls he had sustained while there, however, the nursing staff were responsible to ensure fall assessments and precautions are in place adding, "I just assume that's happening."<br><br>R3's admission MDS dated 2/5/20, identified R3 had severe cognitive impairment and required extensive assistance for transfers. Further, R3 used a wheelchair for mobility and had sustained fall(s) within the month prior to admission to the nursing home.<br><br>R3's MHM Incident Review and Analysis V-3 dated 2/8/20, identified R3 had sustained a fall from his wheelchair. The report outlined, "Resident was self transferring to bed from wheelchair, wheelchair was not locked and rolled back away from resident. Anti roll backs ordered for his wheelchair."<br><br>R3's care plan dated 2/10/20, identified R3 as a | 2 830 | | |

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| 2 830 | Continued From page 23<br><br>fall risk related to his confusion and impulsive behaviors. A goal was listed for R3 which read, "will be safe and free from falls," along with several interventions which included not leaving R3 alone in the bathroom and having anti-roll backs applied to his wheelchair.<br><br>On 2/20/20, at 12:57 p.m. R3 was seated in a wheelchair in the main dining room with several other residents watching television. The wheelchair was labeled with R3's name. R3's wheelchair lacked any anti-roll backs or other devices intended to stop the wheelchair from moving if not locked.<br><br>When interviewed on 2/20/20, at 1:23 p.m. nursing assistant (NA)-A stated she was assigned to care for R3 that day, and she was unaware if he had sustained any recent falls adding, "not that I know of." NA-A described anti-roll backs as brackets which appear to wrap around the wheel of the chair which lock if someone stands up. NA-A observed R3 seated in the wheelchair in the commons area and verified the lack of anti-roll back brakes being installed and stated she was unaware if he needed them or not, however, if someone did need them, NA-A expressed the maintenance department would have to install them.<br><br>On 2/20/20, at 1:26 p.m. the director of maintenance was interviewed. He explained he had been told R3 needed the anti-roll backs on his wheelchair, however, the facility was out of them so he placed an order for some on 2/17/20, which still had not been approved. He stated there were "two others that needed [them]" as well, however, verified there was no supply. Further, he explained it typically did not take three or more days to get parts approved for order, and | 2 830 | | |

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| 2 830 | Continued From page 24<br>he was unaware why there was a delay in getting these parts approved.<br><br>During interview on 2/20/20, at 2:21 p.m. NA-B stated R3 often self transfered, and "likes to do things by himself." R3 often removed his own wheelchair locks and was able to self propel around the facility on his own. Further, NA-B expressed she "was not aware of that [fall on 2/8/10], but not surprised," and stated she was not aware of what new interventions were being done to help keep R3 safe since he had fallen on 2/8/10.<br><br>R3's medical record was reviewed, and lacked evidence of any stop-gap interventions being assessed or implemented to provide adequate supervision and help prevent continued falls for R3 until the assessed anti-roll backs were supplied and installed.<br><br>On 2/20/20, at 2:35 p.m. the DON was interviewed. R3 had sustained "a couple" falls since he admitted to the nursing home, and was described as "very impulsive." R3 had fallen on 2/8/10, when his wheelchair was not locked, and he self transferred to his bed, and it had appeared the wheelchair rolled backwards after he stood up. R3 sustained no injuries from the fall. DON explained they decided to install the anti-roll back brakes on his wheelchair to help prevent continued falls when he self transfered. DON stated she was unaware the anti-roll brakes still needed to have approval before they could be ordered, and expressed she never did re-visit R3's wheelchair to ensure they had been installed, or if something else had been needed in the mean time. DON stated, "We need to come up with a way to make sure the interventions are carried through," adding this was important to do | 2 830 | | |

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| 2 830 | Continued From page 25<br>to help prevent falls and "make sure we keep the resident safe."<br><br>An undated Fall Prevention and Management policy was provided. This identified a purpose of identifying residents at risk for falls, implementing interventions to help prevent falls, and providing guidelines for assessing a resident post-fall. The policy directed a Fall Risk Evaluation was to be completed upon admission, annually, with a significant change in condition and as needed. A section labeled, "Managing Falls and Fall Risk," directed facility staff would identify interventions related to the resident's specific risks and cause to try to prevent falls and minimize complications from falling. A process was outlined for staff to help identify causes of a fall or someone's fall risk which included trying to identify possible, or likely, causes of the incident including referring to the specific resident's medical history, functional impairments and evaluating circumstances around a fall including the time of day, the last time the person was toileting or repositioned, last time ate, any environmental risks and whether a pattern of falls had been identified.<br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise applicable policies and procedures pertaining to comprehensive fall assessments; then educate staff and on ensuring timely completion of such assessments; then audit to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |