Electronically delivered
November 24, 2020

Administrator
St Marks Living
400 - 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: November 2, 2020

Dear Administrator:

On November 2, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 9, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 9, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 9, 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:

• 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 $11,160; 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 December 9, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Marks Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 9, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 May 2, 2021 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/2/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H#5369100C, with a deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H#5369099C H#5369101C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/3/20

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

Electronically Signed | 12/03/2020

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to adequately assess and implement new fall prevention interventions to prevent falls for 1 of 3 residents (R1) reviewed for falls in the facility. In addition, the facility failed to communicate fall interventions that were developed for implementation by nursing staff for R1. R1 sustained actual harm when she was found on the floor and sustained a hip fracture resulting from the fall. Findings include: R1's Diagnosis Report dated 1/2/20, indicated R1 had muscle weakness, reduced mobility and history of falling. R1's admission Minimum Date Set (MDS) assessment dated 9/7/20, indicated R1 scored 14 on the Brief Interview for Mental Status assessment, indicating R1 did not have cognitive deficient. The MDS further indicated R1 required extensive assistance with all activities of daily living, including ambulation. R1's care plan included a fall focus initiated 9/1/20, and last revised date on 10/11/20, indicating R1 had an actual fall due to poor balance, poor vision, and unsteady gait. During an interview on 11/2/20, at 12:50 p.m. nursing assistant (NA)-A stated in the event of a fall, nursing staff complete an incident report and	F 689	1. Corrective Action R1 was transferred to hospital on 10/14/20. R1 expired at hospital. 2. Corrective Action (As applies to all residents) Facility process updated for Nursing Leadership. Nursing Leadership staff were educated on updated process at leadership meeting on 12/3/20. Current falls up to date. Nurse leadership reviewing risk management daily including updating interventions, ensuring proper notification, staff communication completed and updating care plan during each IDT meeting. 3. Date of completion: 12/3/20 4. Recurrence will be prevented by: ED or designee to manage risk management spreadsheet. As this	

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F 689	Continued From page 2 it goes to administration. The interdisciplinary team (IDT) will review the fall and create new fall prevention interventions. NA-A further stated, the new fall prevention interventions can be found in the nursing assistant Kardex. Lastly, NA-A stated the Kardex includes interventions from the care plan and what needs to be done to keep the resident from falling. During an interview on 11/2/20, at 12:55 p.m. registered nurse (RN)-A stated after a fall, an incident report must be completed immediately in their Point Click Care (PCC) electronic medical record, in the Risk Management section. RN-A stated once the incident report is completed, it is saved and reviewed by administration and the IDT. The IDT creates new fall prevention interventions which are documented in the care plan. RN-A stated, "Whenever new fall prevention interventions are created in the care plan, they pop up upon logging into PCC. This is how I know a new fall prevention intervention was created." Review of R1's falls indicated R1 experienced five falls from 9/2/20 to 10/14/20 including: On 9/2/20, at 6:54 a.m. R1 was found on the floor in her room with an abrasion noted to the right forehead. An Incident/Root Cause Analysis was completed and interventions included the resident was added to falling star program, fall mat placed at bedside, low bed placed in room, resident reoriented to room call light and safety measures. Although fall prevention interventions were documented in the Incident/Root Cause Analysis report form, the interventions were not entered into the care plan so licensed and unlicensed staff could view the interventions. Additionally, licensed staff would not be automatically notified	F 689	includes auditing items completed after each fall. Audits will be completed weekly for 1 month, and then monthly per 3 months. Staff Developer or other designee to audit facility's "5 minute meetings" to ensure staff compliance. "5 Minute Meetings" is facility's documentation used to communicate information to all nursing staff. Audits will be completed weekly for 1 month, and then monthly for 3 months. 5. Correction will be monitored by DON or designee and QAPI Committee.	

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F 689	Continued From page 3	F 689		

of the new interventions and non-licensed do not have access to the Risk Management folder.

On 9/2/20, at 4:18 p.m. no details of the fall event were documented however, R1 sustained a hematoma to left forehead. The Incident/Root Cause Analysis was completed and interventions documented resident is on one-to-one visual observation by placing at the nurse's station and in a Broda Chair. Although fall prevention interventions were documented in the Incident/Root Cause Analysis report form, the interventions were not entered in the care plan so licensed and unlicensed staff could view the interventions. Additionally, licensed staff would not be automatically notified of the new interventions and non-licensed do not have access to the Risk Management folder.

On 9/9/20, at 6:30 a.m. R1 was observed on the floor beside bed in her room with no injuries documented. The Incident/Root Cause Analysis was not fully completed. Neither the physician nor family were notified of the fall. There are no fall prevention interventions noted in the Incident/Root Cause Analysis report.

On 9/10/20, at 2:07 p.m. an Incident/Root Cause Analysis report was initiated but not completed. The details of the incident only documented the resident had no self-attempts to transfers and denied having any pain when asked. No other documentation was filled in on the Incident/Root Cause Analysis report.

A progress note dated 10/14/20, at 1:38 p.m. indicated R1 was found on the floor with a small laceration to the right hand. The progress note indicated the fall was reported to hospice, and no

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F 689	Continued From page 4	F 689		

other documentation was provided. An Incident/Root Cause Analysis report on the fall was not found.

A hospital emergency department admission noted dated 10/14/20, at 8:38 p.m. indicated R1 sustained a left hip fracture from a 10/14/20, 1:38 p.m. fall that would require orthopedic surgical intervention. Due to R1's advance age and comorbidities, the orthopedic surgeon and anesthesia indicated it would be safer for R1 to have surgery at a tertiary surgical center so they transferred R1. R1 did not return to the nursing home facility.

During an interview on 11/2/20, at 1:45 p.m. the director of nursing (DON) stated after each fall an Incident/Root Cause Analysis is completed and the IDT reviews each fall. She stated the IDT creates new fall prevention interventions and the DON documents the new fall prevention intervention(s) in the care plan. The DON verified fall prevention interventions had not been entered timely due to her current workload and management staffing issues. The DON stated, "There just isn't enough time to get all the work done by one person." The DON further explained that due to time-constraints, the facility administrator had created a 5-Minute Meeting document to keep staff up to date on fall prevention interventions. The DON stated that staff are mandated to read the report before each shift, and were expected to initial that they have read the report.

During an interview on 11/2/20, at approximately 2:15 p.m. the DON stated, "Since care planning was identified as a quality improvement issue, the facility administrator created a fall analysis and

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F 689	Continued From page 5	F 689		

follow through Excel spreadsheet. It was completed by 10/27/20, and included the name of the resident and the completion date when the care plan was updated with new fall prevention interventions." Following this interview, it was observed that two residents had been included on the Excel spreadsheet by 10/27/20, and check marks in the completion column indicated these residents had updated fall prevention care plans.

However during document review on 11/2/20, when the 5-Minute Meeting documents dated 7/7/20, 7/27/20, 8/10/20, 9/15/20, 9/16/20, and 10/16/20 were reviewed. It was discovered from the six reports, nineteen designated staff were documented on each report who are mandated to read and initial the report. Staff had only initialed completion of reading the document 15 of the 114 opportunities.

The facility's policy Assessing Falls and Their Causes last revised 10/2020, directed staff to notify the physician and family after each fall. In addition, the policy indicated a detailed incident report must be completed and submitted to the DON no later than twenty-four hours after a fall, and indicated appropriate fall prevention interventions were to be documented in the resident's chart to prevent future falls.

The facility's policy Falls, Clinical Protocol last revised 9/2020, directed staff to document risk factors for falling and to develop pertinent fall prevention interventions. In addition, the protocol indicated staff were to monitor and document an individual's response to interventions to reduce future falls, to address whether the individual continues to fall, and to ensure staff would re-evaluate and consider other interventions.

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F 689	Continued From page 6 The facility's policy Care Plans, Comprehensive Person-Centered revised 12/2006, directed the IDT to develop and implement a person-centered care plan based on the comprehensive assessment. In addition the care plan was to reflect objective and measurable outcomes, and was to be updated by the IDT whenever there is a significant change or an outcome which is not being met.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 24, 2020

Administrator
St Marks Living
400 - 15th Avenue Southwest
Austin, MN 55912

Re: State Nursing Home Licensing Orders
Event ID: Y9XH11

Dear Administrator:

The above facility was surveyed on November 2, 2020 through November 2, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/2/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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	00394	A. BUILDING: _____ B. WING _____	C 11/02/2020

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H#5369100C with a licensing order issued at 4658.0520 Subp.1 The following complaints were found to be unsubstantiated: H#5369099C and H#5369101C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to adequately assess and implement new fall prevention interventions to prevent falls for 1 of 3 residents (R1) reviewed for falls in the facility. In addition, the facility failed to communicate fall interventions that were developed for implementation by nursing staff for	2 830	1. Corrective Action R1 was transferred to hospital on 10/14/20. R1 expired at hospital.	12/3/20

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2 830	Continued From page 2 R1. R1 sustained actual harm when she was found on the floor and sustained a hip fracture resulting from the fall. Findings include: R1's Diagnosis Report dated 1/2/20, indicated R1 had muscle weakness, reduced mobility and history of falling. R1's admission Minimum Date Set (MDS) assessment dated 9/7/20, indicated R1 scored 14 on the Brief Interview for Mental Status assessment, indicating R1 did not have cognitive deficient. The MDS further indicated R1 required extensive assistance with all activities of daily living, including ambulation. R1's care plan included a fall focus initiated 9/1/20, and last revised date on 10/11/20, indicating R1 had an actual fall due to poor balance, poor vision, and unsteady gait. During an interview on 11/2/20, at 12:50 p.m. nursing assistant (NA)-A stated in the event of a fall, nursing staff complete an incident report and it goes to administration. The interdisciplinary team (IDT) will review the fall and create new fall prevention interventions. NA-A further stated, the new fall prevention interventions can be found in the nursing assistant Kardex. Lastly, NA-A stated the Kardex includes interventions from the care plan and what needs to be done to keep the resident from falling. During an interview on 11/2/20, at 12:55 p.m. registered nurse (RN)-A stated after a fall, an incident report must be completed immediately in their Point Click Care (PCC) electronic medical record, in the Risk Management section. RN-A	2 830	2. Corrective Action (As applies to all residents) Facility process updated. Current falls up to date. Nurse leadership reviewing risk management daily including updating interventions, ensuring proper notification, staff communication completed and updating care plan during each IDT meeting. 3. Date of completion: 12/3/20 4. Recurrence will be prevented by: ED or designee to manage risk management spreadsheet. As this includes auditing items completed after each fall. Audits will be completed weekly for 1 month, and then monthly per 3 months. Staff Developer or other designee to audit facility's "5 minute meetings" to ensure staff compliance. "5 Minute Meetings" is facility's documentation used to communicate information to all nursing staff. Audits will be completed weekly for 1 month, and then monthly for 3 months. 5. Correction will be monitored by DON or designee and QAPI Committee.	

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2 830	Continued From page 3 stated once the incident report is completed, it is saved and reviewed by administration and the IDT. The IDT creates new fall prevention interventions which are documented in the care plan. RN-A stated, "Whenever new fall prevention interventions are created in the care plan, they pop up upon logging into PCC. This is how I know a new fall prevention intervention was created." Review of R1's falls indicated R1 experienced five falls from 9/2/20 to 10/14/20 including: On 9/2/20, at 6:54 a.m. R1 was found on the floor in her room with an abrasion noted to the right forehead. An Incident/Root Cause Analysis was completed and interventions included the resident was added to falling star program, fall mat placed at bedside, low bed placed in room, resident reoriented to room call light and safety measures. Although fall prevention interventions were documented in the Incident/Root Cause Analysis report form, the interventions were not entered into the care plan so licensed and unlicensed staff could view the interventions. Additionally, licensed staff would not be automatically notified of the new interventions and non-licensed do not have access to the Risk Management folder. On 9/2/20, at 4:18 p.m. no details of the fall event were documented however, R1 sustained a hematoma to left forehead. The Incident/Root Cause Analysis was completed and interventions documented resident is on one-to-one visual observation by placing at the nurse's station and in a Broda Chair. Although fall prevention interventions were documented in the Incident/Root Cause Analysis report form, the interventions were not entered in the care plan so licensed and unlicensed staff could view the interventions. Additionally, licensed staff would	2 830		

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2 830	Continued From page 4	2 830		

not be automatically notified of the new interventions and non-licensed do not have access to the Risk Management folder.

On 9/9/20, at 6:30 a.m. R1 was observed on the floor beside bed in her room with no injuries documented. The Incident/Root Cause Analysis was not fully completed. Neither the physician nor family were notified of the fall. There are no fall prevention interventions noted in the Incident/Root Cause Analysis report.

On 9/10/20, at 2:07 p.m. an Incident/Root Cause Analysis report was initiated but not completed. The details of the incident only documented the resident had no self-attempts to transfers and denied having any pain when asked. No other documentation was filled in on the Incident/Root Cause Analysis report.

A progress note dated 10/14/20, at 1:38 p.m. indicated R1 was found on the floor with a small laceration to the right hand. The progress note indicated the fall was reported to hospice, and no other documentation was provided. An Incident/Root Cause Analysis report on the fall was not found.

A hospital emergency department admission noted dated 10/14/20, at 8:38 p.m. indicated R1 sustained a left hip fracture from a 10/14/20, 1:38 p.m. fall that would require orthopedic surgical intervention. Due to R1's advance age and comorbidities, the orthopedic surgeon and anesthesia indicated it would be safer for R1 to have surgery at a tertiary surgical center so they transferred R1. R1 did not return to the nursing home facility.

During an interview on 11/2/20, at 1:45 p.m. the

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2 830	Continued From page 5 director of nursing (DON) stated after each fall an Incident/Root Cause Analysis is completed and the IDT reviews each fall. She stated the IDT creates new fall prevention interventions and the DON documents the new fall prevention intervention(s) in the care plan. The DON verified fall prevention interventions had not been entered timely due to her current workload and management staffing issues. The DON stated, "There just isn't enough time to get all the work done by one person." The DON further explained that due to time-constraints, the facility administrator had created a 5-Minute Meeting document to keep staff up to date on fall prevention interventions. The DON stated that staff are mandated to read the report before each shift, and were expected to initial that they have read the report. During an interview on 11/2/20, at approximately 2:15 p.m. the DON stated, "Since care planning was identified as a quality improvement issue, the facility administrator created a fall analysis and follow through Excel spreadsheet. It was completed by 10/27/20, and included the name of the resident and the completion date when the care plan was updated with new fall prevention interventions." Following this interview, it was observed that two residents had been included on the Excel spreadsheet by 10/27/20, and check marks in the completion column indicated these residents had updated fall prevention care plans. However during document review on 11/2/20, when the 5-Minute Meeting documents dated 7/7/20, 7/27/20, 8/10/20, 9/15/20, 9/16/20, and 10/16/20 were reviewed. It was discovered from the six reports, nineteen designated staff were documented on each report who are mandated to read and initial the report. Staff had only initialed	2 830		

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2 830	Continued From page 6 completion of reading the document 15 of the 114 opportunities. The facility's policy Assessing Falls and Their Causes last revised 10/2020, directed staff to notify the physician and family after each fall. In addition, the policy indicated a detailed incident report must be completed and submitted to the DON no later than twenty-four hours after a fall, and indicated appropriate fall prevention interventions were to be documented in the resident's chart to prevent future falls. The facility's policy Falls, Clinical Protocol last revised 9/2020, directed staff to document risk factors for falling and to develop pertinent fall prevention interventions. In addition, the protocol indicated staff were to monitor and document an individual's response to interventions to reduce future falls, to address whether the individual continues to fall, and to ensure staff would re-evaluate and consider other interventions. The facility's policy Care Plans, Comprehensive Person-Centered revised 12/2006, directed the IDT to develop and implement a person-centered care plan based on the comprehensive assessment. In addition the care plan was to reflect objective and measurable outcomes, and was to be updated by the IDT whenever there is a significant change or an outcome which is not being met. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement interventions following resident falls. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented;	2 830		

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2 830	Continued From page 7 to better ensure implementation of fall interventions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		