Electronically delivered
May 1, 2019

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: Project Number H5401020C

Dear Administrator:

On April 16, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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(ies) and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 5, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 5, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 5, 2019.

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. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by July 5, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Central Health Care will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 5, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. 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 plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

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
Phone: 651-201-3784
Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff, 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 October 16, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	C 04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	**444 NORTH CORDOVA LE CENTER, MN 56057**

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F 000	INITIAL COMMENTS On 4/15/19 and 4/16/19 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# 5401020C. Deficiency issued at F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

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F 000	Continued From page 2 On 4/17/19 and 4/18/19, an abbrevieted survey ws completed at your faciity by the Minnesota Department of Health to conduct a complaint investigation. Mala Strana Rehabilitation Center as found not to be in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care facilities. The following complaint was found to be substantiated: H5514019C. Deficiency issued at F Tag 689	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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to thoroughly assess 1 of 3 residents (R1) reviewed for falls, for safe use of resident equipment, including independent use of an electronic lift chair. The facility's failure to assess for risk factors, and implement safety interventions, resulted in harm for R1 who fell out of an electric lift chair after independently using the electronic control device to put the chair in the high lift position, resulting in a fractured hip. The findings include: A hospital admission history and physical (H&P)	F 689	This plan of correction constitutes our written allegation of compliance for the deficiency cited. Submission of this plan of correction is not an admission that the deficiency existed or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. F689 – Free of Accidents Hazards/Supervision/Devices – CFR9s): 483.25(d) (1) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and	5/10/19

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F 689	Continued From page 3 dated 3/15/19, with orders for resident discharge to the nursing home 3/18/19, indicated R1 had been living at home with her daughter caring for her. The H&P indicated R1 had been on hospice and due to increasing assistance needs her family could no longer care for her at home. In addition, the H&P included: "Safety/cognition: She is impulsive at times attempting to get out of bed herself, using pressure bed alarm. She had delirium and hallucinations, usually in late afternoon/evening. Pain: has on/off chest pain. Chronic shoulder and left knee pain." R1's undated face sheet indicated an admission date of 3/18/19, and diagnoses including: heart failure, chronic kidney disease, anxiety disorder, pressure ulcers- sacral region and left heel stage 2, and a history of falling. A facility Event Report dated 3/19/19 at 9:21 p.m., indicated R1 had been sitting in the reclining lift chair in her room, prior to a fall. The description of the event indicated the resident had been found on the floor next to her lift chair, laying on her back. The resident complained of a significant amount of inner left hip/pelvic area pain but was unable to rate it. She had denied hitting her head, but staff didn't feel she was a reliable reported. Further, the notes included: "it appears that she was attempting to get up and out of her lift chair on her own. Resident is unaware of her ambulation limitations which caused the fall. Daughter called and she came to the facility and decided that she wanted the ambulance called to transport her to the ER (emergency room) for evaluation..." The Evaluation Notes included: ..."It is noted that resident had been checked/toileted at 7:00 p.m. Resident was seated in reclining lift chair	F 689	(2) Each resident receives adequate supervision and assistance devices to prevent accidents. It is the policy of Central Health Care to provide a living environment that remains as free of accident hazards as is possible and to ensure each resident receives adequate supervision and assistance devices to prevent potential accidents. Central Health Care updated the facility fall policies and procedures to specifically address assessing risk factors and implement safety interventions to proactively prevent potential accidents from occurring. The Director of Nursing reviewed the fall risk assessment on 03/20/2019 to ensure appropriate interventions were updated on R1's care plan. The Director of Nursing also conducted a facility wide care plan review of all current residents to ensure appropriate interventions were in place to prevent accidents as is possible. The Director of Nursing provided training to the nursing team related to appropriate pre-admission screening procedure that focuses on identifying potential risk factors and interventions needed in the initial 24-hour care plan 05/03/2019. The Director of Nursing created a new preadmission medical screening process/tool that is to be used by nursing to identify potential risk factors and establish safety interventions to prevent potential accidents from occurring prior to admission. The Director of Nursing also created a Reclining Lift Chair Risk Assessment that determines if the resident is safe to operate a lift recliner or	

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F 689	Continued From page 4 watching TV. Staff verbally report that resident had been checked on twice for safety making sure her call light was within reach and the lift controller for recliner was tucked away in pocket of chair. The RN (registered nurse) entered residents room about 8 p.m. to administer HS (hour of sleep) medications and observed resident on the floor next to her lift chair, laying on her back. The lift chair was fully elevated. C/O (complained of) significant amount of inner left hip/pelvic area pain. Resident was unable to rate it. She denied hitting her head. It appears she was attempting to get up and out of her lift chair on her own. Resident is unaware of her ambulation limitations which caused the fall." Further, the Event Report described the reclining lift chair as, a fake leather type material with some slipperiness to it and indicated R1 had also been seated on a a 1 inch foam egg crate cushion that the daughter had placed on the seat of the chair to relieve pressure to R1's coccyx. Although the physician's H&P dated 3/15/18, indicated a history of falls, impulsivity and delirium, R1's baseline care plan signed 3/18/19, failed to identify the resident's risk for falls, and did not include interventions to prevent falls. A fall risk assessment completed on 3/20/19 indicated R1 had a risk for falls due to dementia, confusion, and not realizing her own limitations. The assessment further indicated R1 had been admitted on 3/18/19, had fallen the next day and had fractured her left hip. Interventions were identified to include a low bed and mats on the floor, and indicated R1 could no longer be out of bed. R1s admission Minimum Data Set (MDS)	F 689	not. Nursing staff have been trained on 05/03/2019. The Administrator and Director of Nursing created a risk review form that is utilized by the Interdisciplinary Team in morning meeting to review current resident change of condition, falls, and incidents. This tool assists with identifying current residents that potentially need changes to their care plan to address interventions to prevent accidents for occurring. When a resident has been identified as needing interventions or changes in current interventions, the identified resident will undergo a care plan review by IDT, the Director of Nursing or designee. If a resident's interventions have been updated or changed, that information is disseminated to the appropriate team members by the Director of Nursing or designee via verbal and/or written communication. The Interdisciplinary Team was educated on the new form/tool on 04/18/2019. The Director of Nursing or designee will audit and track falls/incidents, Preadmission Screenings, and Recliner Lift Chair Risk Assessments weekly x 2 then monthly thereafter. This data will be presented by the Director of Nursing or designee at the quarterly QAPI committee meeting. Compliance Date: 04/19/2019	

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F 689	Continued From page 5	F 689		

assessment dated 3/25/19, indicated R1 had severe cognitive impairment and required extensive assist of 1-2 staff to meet her care needs. The MDS also indicated R1 had a Foley catheter and was incontinent of bowel, was dependent for eating, had pain rated as intensity of 8/10, a risk for falls, and had fallen one time since admission resulting in a major injury.

The corresponding care area assessment (CAA) dated 3/25/19 indicated R1 had urinary incontinence with an indwelling Foley catheter due to a hip fracture and pressure ulcers. The CAA also indicated R1 was unable to independently get out of bed, and required repositioning with staff assist every 3-4 hours per family request because repositioning increased her pain. The CAA indicated R1 had fallen at the facility 3/19/19 and had fractured her left femur, which was not repaired due to late stages of congestive heart failure. The CAA indicated R1 was currently on hospice and was actively dying, received scheduled and as needed dilaudid for pain control, was bedridden and was repositioned every 3-4 hours.

A nurse practitioner visit note dated 4/1/19, indicated R1 had been admitted to the facility on 3/18/19 and notes from an emergency department note indicated R1 had been found on the floor at facility on 3/19/19. The notes indicated R1 had complained of pain and a subsequent x-ray showed a left hip fracture. Further, the note indicated R1's family had opted not to treat the fracture, but to focus on comfort. Nursing staff reported she had been resting in bed since her return from the emergency department. "Pain: yes due to fracture. Ambulation: bed bound."

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F 689	Continued From page 6 During an interview with licensed practical nurse (LPN)-A on 4/16/19 at 10:49 a.m., LPN-A stated the director of nursing (DON) was unavailable for interview because she had worked an overnight shift the previous night. LPN-A stated she had not been aware of R1's history of falls at home, and further verified an immediate plan of care had not been developed when the resident was admitted to indicate R1's risk of falls. On 4/16/19 at 11:55 a.m., the administrator stated during interview the DON had been working on fall prevention interventions. The administrator stated he and the DON were both new to the facility in the past 4 months. He further confirmed with R1's history of falls identified on the H&P, he would have expected immediate interventions for fall prevention to have been addressed on a plan for care stating, "we have some work to do, and need some time, but we have made progress." The facility's policies and procedures for falls and fall prevention were requested. The policies only identified what to do when a fall had already occurred. The facility did not provide any policies or procedures for assessment of newly admitted residents for risk of falls, or protocols to develop immediate interventions for residents with severe cognitive impairment and a history of falls previous to the admission.	F 689		

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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 4/15 and 4/16/19, a survey was conducted to investigate complaint #H5401020C. The complaint was substantiated and a correction order was issued at MN Rule 4658.0520 Subd. 1. Please indicate in your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to thoroughly assess 1 of 3 residents (R1) reviewed for falls, for safe use of resident equipment, including independent use of an electronic lift chair. The facility's failure to assess for risk factors, and implement safety interventions, resulted in harm for R1 who fell out of an electric lift chair after independently using the electronic control device to put the chair in the high lift position, resulting in a fractured hip. The findings include: A hospital admission history and physical (H&P) dated 3/15/19, with orders for resident discharge to the nursing home 3/18/19, indicated R1 had been living at home with her daughter caring for her. The H&P indicated R1 had been on hospice and due to increasing assistance needs her family could no longer care for her at home. In	2 830	This plan of correction constitutes our written allegation of compliance for the deficiency cited. Submission of this plan of correction is not an admission that the deficiency existed or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. F689 – Free of Accidents Hazards/Supervision/Devices – CFR9s): 483.25(d) (1) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. It is the policy of Central Health Care to provide a living environment that remains as free of accident hazards as is possible	5/10/19

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	00800	A. BUILDING: _____ B. WING _____	C 04/16/2019

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2 830	Continued From page 2	2 830		

addition, the H&P included: "Safety/cognition: She is impulsive at times attempting to get out of bed herself, using pressure bed alarm. She had delirium and hallucinations, usually in late afternoon/evening. Pain: has on/off chest pain. Chronic shoulder and left knee pain."

R1's undated face sheet indicated an admission date of 3/18/19, and diagnoses including: heart failure, chronic kidney disease, anxiety disorder, pressure ulcers- sacral region and left heel stage 2, and a history of falling.

A facility Event Report dated 3/19/19 at 9:21 p.m., indicated R1 had been sitting in the reclining lift chair in her room, prior to a fall. The description of the event indicated the resident had been found on the floor next to her lift chair, laying on her back. The resident complained of a significant amount of inner left hip/pelvic area pain but was unable to rate it. She had denied hitting her head, but staff didn't feel she was a reliable reported. Further, the notes included: "it appears that she was attempting to get up and out of her lift chair on her own. Resident is unaware of her ambulation limitations which caused the fall. Daughter called and she came to the facility and decided that she wanted the ambulance called to transport her to the ER (emergency room) for evaluation..." The Evaluation Notes included: ..."It is noted that resident had been checked/toileted at 7:00 p.m. Resident was seated in reclining lift chair watching TV. Staff verbally report that resident had been checked on twice for safety making sure her call light was within reach and the lift controller for recliner was tucked away in pocket of chair. The RN (registered nurse) entered residents room about 8 p.m. to administer HS (hour of sleep) medications and observed

and to ensure each resident receives adequate supervision and assistance devices to prevent potential accidents.
Central Health Care updated the facility fall policies and procedures to specifically address assessing risk factors and implement safety interventions to proactively prevent potential accidents from occurring.
The Director of Nursing reviewed the fall risk assessment on 03/20/2019 to ensure appropriate interventions were updated on R1's care plan. The Director of Nursing also conducted a facility wide care plan review of all current residents to ensure appropriate interventions were in place to prevent accidents as is possible.
The Director of Nursing provided training to the nursing team related to appropriate pre-admission screening procedure that focuses on identifying potential risk factors and interventions needed in the initial 24-hour care plan 05/03/2019. The Director of Nursing created a new preadmission medical screening process/tool that is to be used by nursing to identify potential risk factors and establish safety interventions to prevent potential accidents from occurring prior to admission. The Director of Nursing also created a Reclining Lift Chair Risk Assessment that determines if the resident is safe to operate a lift recliner or not. Nursing staff have been trained on 05/03/2019.
The Administrator and Director of Nursing created a risk review form that is utilized by the Interdisciplinary Team in morning meeting to review current resident change of condition, falls, and incidents. This tool

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2 830	Continued From page 3 resident on the floor next to her lift chair, laying on her back. The lift chair was fully elevated. C/O (complained of) significant amount of inner left hip/pelvic area pain. Resident was unable to rate it. She denied hitting her head. It appears she was attempting to get up and out of her lift chair on her own. Resident is unaware of her ambulation limitations which caused the fall." Further, the Event Report described the reclining lift chair as, a fake leather type material with some slipperiness to it and indicated R1 had also been seated on a a 1 inch foam egg crate cushion that the daughter had placed on the seat of the chair to relieve pressure to R1's coccyx. Although the physician's H&P dated 3/15/18, indicated a history of falls, impulsivity and delirium, R1's baseline care plan signed 3/18/19, failed to identify the resident's risk for falls, and did not include interventions to prevent falls. A fall risk assessment completed on 3/20/19 indicated R1 had a risk for falls due to dementia, confusion, and not realizing her own limitations. The assessment further indicated R1 had been admitted on 3/18/19, had fallen the next day and had fractured her left hip. Interventions were identified to include a low bed and mats on the floor, and indicated R1 could no longer be out of bed. R1s admission Minimum Data Set (MDS) assessment dated 3/25/19, indicated R1 had severe cognitive impairment and required extensive assist of 1-2 staff to meet her care needs. The MDS also indicated R1 had a Foley catheter and was incontinent of bowel, was dependent for eating, had pain rated as intensity of 8/10, a risk for falls, and had fallen one time since admission resulting in a major injury.	2 830	assists with identifying current residents that potentially need changes to their care plan to address interventions to prevent accidents for occurring. When a resident has been identified as needing interventions or changes in current interventions, the identified resident will undergo a care plan review by IDT, the Director of Nursing or designee. If a resident’s interventions have been updated or changed, that information is disseminated to the appropriate team members by the Director of Nursing or designee via verbal and/or written communication. The Interdisciplinary Team was educated on the new form/tool on 04/18/2019. The Director of Nursing or designee will audit and track falls/incidents, Preadmission Screenings, and Recliner Lift Chair Risk Assessments weekly x 2 then monthly thereafter. This data will be presented by the Director of Nursing or designee at the quarterly QAPI committee meeting. Compliance Date: 04/19/2019	

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2 830	Continued From page 4 The corresponding care area assessment (CAA) dated 3/25/19 indicated R1 had urinary incontinence with an indwelling Foley catheter due to a hip fracture and pressure ulcers. The CAA also indicated R1 was unable to independently get out of bed, and required repositioning with staff assist every 3-4 hours per family request because repositioning increased her pain. The CAA indicated R1 had fallen at the facility 3/19/19 and had fractured her left femur, which was not repaired due to late stages of congestive heart failure. The CAA indicated R1 was currently on hospice and was actively dying, received scheduled and as needed dilaudid for pain control, was bedridden and was repositioned every 3-4 hours. A nurse practitioner visit note dated 4/1/19, indicated R1 had been admitted to the facility on 3/18/19 and notes from an emergency department note indicated R1 had been found on the floor at facility on 3/19/19. The notes indicated R1 had complained of pain and a subsequent x-ray showed a left hip fracture. Further, the note indicated R1's family had opted not to treat the fracture, but to focus on comfort. Nursing staff reported she had been resting in bed since her return from the emergency department. "Pain: yes due to fracture. Ambulation: bed bound." During an interview with licensed practical nurse (LPN)-A on 4/16/19 at 10:49 a.m., LPN-A stated the director of nursing (DON) was unavailable for interview because she had worked an overnight shift the previous night. LPN-A stated she had not been aware of R1's history of falls at home, and further verified an immediate plan of care had not been developed when the resident was admitted to indicate R1's risk of falls.	2 830		

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2 830	Continued From page 5 On 4/16/19 at 11:55 a.m., the administrator stated during interview the DON had been working on fall prevention interventions. The administrator stated he and the DON were both new to the facility in the past 4 months. He further confirmed with R1's history of falls identified on the H&P, he would have expected immediate interventions for fall prevention to have been addressed on a plan for care stating, "we have some work to do, and need some time, but we have made progress." The facility's policies and procedures for falls and fall prevention were requested. The policies only identified what to do when a fall had already occurred. The facility did not provide any policies or procedures for assessment of newly admitted residents for risk of falls, or protocols to develop immediate interventions for residents with severe cognitive impairment and a history of falls previous to the admission. Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for falls in order to prevent falls from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		