Electronically Delivered via Email
October 6, 2020

Administrator
Belgrade Nursing Home
103 School Street, Po Box 340
Belgrade, MN 56312-0340

RE: CCN: 245418
Cycle Start Date: July 27, 2020

Dear Administrator:

On September 30, 2020, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 12, 2020

Administrator
Belgrade Nursing Home
103 School Street, Po Box 340
Belgrade, MN 56312-0340

RE: CCN: 245418
Cycle Start Date: July 27, 2020

Dear Administrator:

On July 27, 2020, a 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 27, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 27, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	C 07/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312**

(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 7/21/20-7/27/20, 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# 5418023C. Deficiency issued at F Tag # 689. The following Complants were found to be unsubstantiated: H5418018C, H5418019C, H5418020C, H5418021C, H5418022C, H5418024C, H5418025C, H5418026C, H5418027C However, a deficiency was issued at F Tag # 609 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		9/9/20

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

Electronically Signed | 08/21/2020

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F 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to report an allegation of abuse to the state agency (SA) immediately, but not later than 2 hours after an allegation of abuse was made for 1 of 3 residents (R5) reviewed for abuse. Findings include: R5's Minimum Data Set (MDS), dated 6/17/20, indicated cognitive impairment and diagnosis of traumatic brain injury (TBI).	F 609	On 7/24/2020, LPN-1 was provided counseling on the abuse reporting timeline. LPN-1 was also provided reeducated on the facilities Abuse, Neglect, and Exploitation Policy and Procedure. All staff will be reeducated on the Abuse, Neglect, and Exploitation Policy and Procedure. The New Hire orientation will be modified	

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F 609	Continued From page 2 During an interview on 7/21/20, at 2:10 p.m. LPN-1 stated she had been trained on abuse and neglect. Further, LPN-1 stated she had witnessed abuse by a staff person poking a resident in the head during a family visit but failed to report the incident. LPN-1 stated "I should have reported it last week". LPN-1 immediately went to the director of nursing's (DON) office and reported the incident. During an interview on 7/21/20, at 2:48 p.m. R5 stated she recently had an outdoor visit with family and R7. Further, R5 stated no one had ever poked her in the head and that staff have never hurt her. During an interview on 7/21/20, at 3:05 p.m. R7 stated he'd recently had outdoor visits with R5 and family members. R7 stated he felt safe in the facility. During an interview on 7/21/20, at 3:16 p.m., family (F)-2 stated she had been to visit R5 a couple times during the previous few days and had no concerns of abuse. During an interview on 7/21/20, at 4:10 p.m. F1 stated she had been to visit R5 on 7/5/20 and there had been no physical abuse by staff. During an interview on 7/22/20, at 9:30 a.m. the Administrator stated at about 2:47 p.m. on 7/21/20 the alleged perpetrator (AP) was suspended pending investigation. Further, the Administrator stated it was LPN-1 responsibility to file the report to SA within 2 hours, however, it was not completed until around 7:00 p.m. that night. Further, the Administrator stated the	F 609	to have more emphasis on the timely reporting of suspected abuse, neglect, and exploitation. The Director of Nursing or Designee will conduct 10 audits per week to ensure staff know their reporting obligations and timely reporting requirements of suspected abuse, neglect, and exploitation. Audits will continue unit 100% compliance is achieved two consecutive weeks; then random audits will be conducted. These audits will be reviewed and reported to the QAPI team to ensure continued compliance.	

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F 609	Continued From page 3 alleged incident had happened on July 5, 2020 during a family visit and was not aware of the reason why LPN-1 had not reported the incident earlier. During an interview on 7/22/20, at 9:47 a.m. the DON stated LPN-1 was responsible to file the report of alleged abuse on 7/21/20 within 2 hours of reporting it to her. However, the DON did not receive confirmation until 7:34 p.m. on 7/21/20 and therefore the report was late. DON stated LPN-1 was immediately re-educated to report within 2 hours of an allegation and planned further counseling related to abuse policy for LPN-1. The facility's Abuse policy, not dated, stated the facility would ensure all alleged violations of abuse would be reported immediately, but not later than 2 hours after the allegation was made.	F 609		
F 689 SS=D	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 document review, the facility failed to follow care plan intervention of 2 staff to assist in transfer to reduce risk of or prevent a fall for 1 of 3 residents, (R1) reviewed for accidents.	F 689	On 4/15/2020, CNA-A was counseled and provided reeducation on following the resident care plan. Fall policy was reviewed and updated.	9/9/20

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F 689	Continued From page 4 Findings include: R1's face sheet included diagnosis of low back pain, pain, and muscle weakness. R1's significant change Minimum Data Set (MDS) dated 1/27/2020, indicated R1 had moderate cognitive impairment and required extensive assistance from two staff for transfers and bed mobility, he was not able to ambulate. R1's activities of daily living (ADL) Care Area Assessment (CAA) worksheet, dated 1/22/20, identified R1 required extensive assistance with transfers. The CAA for falls indicated R1's strength and balance was moderate to poor in the upper and lower extremities. R1's care plan dated 4/13/20, indicated R1 had an ADL self-care performance deficit related to bilateral lower extremity weakness, activity intolerance, deconditioning, impaired balance and poor motivation towards independence. R1's care plan, revised on 2/17/20, indicated R1 required assist of two between bed/wheelchair/recliner/bedside commode. The care plan further indicated, resident has a history of leaning to the right. R1's progress note dated 4/14/20, reported a staff was transferring R1 from recliner to wheelchair using gait belt. Resident slipped while wearing gripper socks and slippers and was lowered to the floor by staff. Per incident report dated 4/14/20, R1 was transferred with one staff assist instead of two staff as noted was his need in the care plan. The progress note further indicated R1 stood, but was	F 689	Nursing staff education will be provided on the Fall policy. The Director of Nursing or Designee will conduct 3 CNA audits per week to ensure resident care is consistent with the care plan. Audits will continue until 100% compliance is achieved two consecutive weeks; then random audits will be conducted. These audits will be reviewed and reported to the QAPI team to ensure continued compliance.	

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F 689	Continued From page 5	F 689		

unable to step and pivot, his legs and knees became weak and was lowered to the floor.

R1's progress noted dated 4/15/20, identified R1 was lowered to the floor during transfer. Care plan stated, R1 required two assist for transfer, only one assist was used during transfer. Nursing assistant (NA-A) was standing on his right side and wheelchair was locked in place on his left. Electric recliner was raised up to standing position. Extensive assist used to help to standing position with gait belt (a safety device used to help someone move). R1 grabbed his walker. He was able to lift his feet to pivot transfer to wheelchair, his knees and legs gave out due to weakness. R1 grabbed for the side of the wheelchair and disengaged the brake. NA-A lowered him to the ground.

During interview on 7/22/20, at 12:01 p.m. director of nursing (DON), confirmed at time of fall, R1 was care planned to receive assistance from two staff for transfers. She further confirmed that R1's care plan was not followed at the time of his fall, as he received assist from one staff for the transfer. DON stated the overnight nurse printed a document each night which provided information with resident changes. This was given to the staff at the start of their shift. Furthermore, the staff had access to the care plan for each resident. Staff were also alerted of changes to resident needs when they logged into the computer, which they did at the start of their shift. DON stated she provided staff with re-education, but did not complete a re-education form as it was verbal.

During interview on 7/22/20, at 2:34 p.m. NA-A, stated she transferred R1 from his recliner to his

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F 689	Continued From page 6 wheelchair using his gait belt. NA-A stated she did not ask for help from another staff member. R1 was lowered to the floor when his legs gave out and he was not able to hold himself up. NA-A stated she called for assistance while she lowered him to the floor and again once he was on the floor. NA-A stated she checked the computer at the start of her shift for changes with R1 and didn't see any changes. The previous shift told her R1 had a good day and was doing good with his transfers so she thought she could transfer him by herself. NA-A stated she did not check his care plan before she completed the transfer. Facility fall policy, revision date 2/22/2018, did not address following care plan interventions to reduce risk of fall.	F 689		

Electronically delivered
August 12, 2020

Administrator
Belgrade Nursing Home
103 School Street, Po Box 340
Belgrade, MN 56312-0340

Re: State Nursing Home Licensing Orders
Event ID: VMUY11

Dear Administrator:

The above facility was surveyed on July 21, 2020 through July 27, 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00626	A. BUILDING: _____ B. WING _____	C 07/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312**

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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 7/21/20-7/27/20, 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. The following complaint found to be UNSUBSTANTIATED: H5418018C, H5418019C,	2 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 H5418020C, H5418021C, H5418022C, H5418024C, H5418025C, H5418026C, Hh548027C SUBSTANTIATED: H5418023C, licensing orders were issued at 083. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow care plan intervention of 2 staff to assist in transfer to reduce risk of or prevent a fall for 1 of 3 residents, (R1) reviewed for accidents.	2 830	On 4/15/2020, CNA-A was counseled and provided reeducation on following the resident care plan. Fall policy was reviewed and updated.	9/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00626	A. BUILDING: _____ B. WING _____	C 07/27/2020

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2 830	Continued From page 2 Findings include: R1's face sheet included diagnosis of low back pain, pain, and muscle weakness. R1's significant change Minimum Data Set (MDS) dated 1/27/2020, indicated R1 had moderate cognitive impairment and required extensive assistance from two staff for transfers and bed mobility, he was not able to ambulate. R1's activities of daily living (ADL) Care Area Assessment (CAA) worksheet, dated 1/22/20, identified R1 required extensive assistance with transfers. The CAA for falls indicated R1's strength and balance was moderate to poor in the upper and lower extremities. R1's care plan dated 4/13/20, indicated R1 had an ADL self-care performance deficit related to bilateral lower extremity weakness, activity intolerance, deconditioning, impaired balance and poor motivation towards independence. R1's care plan, revised on 2/17/20, indicated R1 required assist of two between bed/wheelchair/recliner/bedside commode. The care plan further indicated, resident has a history of leaning to the right. R1's progress note dated 4/14/20, reported a staff was transferring R1 from recliner to wheelchair using gait belt. Resident slipped while wearing gripper socks and slippers and was lowered to the floor by staff. Per incident report dated 4/14/20, R1 was transferred with one staff assist instead of two staff as noted was his need in the care plan. The progress note further indicated R1 stood, but was unable to step and pivot, his legs and knees	2 830	Nursing staff education will be provided on the Fall policy. The Director of Nursing or Designee will conduct random audits to ensure nursing staff are following the care plans. These audits will be reviewed and reported to the QAPI team to ensure continued compliance.	

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2 830	Continued From page 3 became weak and was lowered to the floor. R1's progress noted dated 4/15/20, identified R1 was lowered to the floor during transfer. Care plan stated, R1 required two assist for transfer, only one assist was used during transfer. Nursing assistant (NA-A) was standing on his right side and wheelchair was locked in place on his left. Electric recliner was raised up to standing position. Extensive assist used to help to standing position with gait belt (a safety device used to help someone move). R1 grabbed his walker. He was able to lift his feet to pivot transfer to wheelchair, his knees and legs gave out due to weakness. R1 grabbed for the side of the wheelchair and disengaged the brake. NA-A lowered him to the ground. During interview on 7/22/20, at 12:01 p.m. director of nursing (DON), confirmed at time of fall, R1 was care planned to receive assistance from two staff for transfers. She further confirmed that R1's care plan was not followed at the time of his fall, as he received assist from one staff for the transfer. DON stated the overnight nurse printed a document each night which provided information with resident changes. This was given to the staff at the start of their shift. Furthermore, the staff had access to the care plan for each resident. Staff were also alerted of changes to resident needs when they logged into the computer, which they did at the start of their shift. DON stated she provided staff with re-education, but did not complete a re-education form as it was verbal. During interview on 7/22/20, at 2:34 p.m. NA-A, stated she transferred R1 from his recliner to his wheelchair using his gait belt. NA-A stated she did not ask for help from another staff member.	2 830		

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2 830	Continued From page 4 R1 was lowered to the floor when his legs gave out and he was not able to hold himself up. NA-A stated she called for assistance while she lowered him to the floor and again once he was on the floor. NA-A stated she checked the computer at the start of her shift for changes with R1 and didn't see any changes. The previous shift told her R1 had a good day and was doing good with his transfers so she thought she could transfer him by herself. NA-A stated she did not check his care plan before she completed the transfer. Facility fall policy, revision date 2/22/2018, did not address following care plan interventions to reduce risk of fall. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review resident care plans. The director of nursing or designee, could review and update policies and educate staff. The DON or designee could conduct random audits to ensure following the care plan and could bring this audit information to the QAPI team to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		