P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 3, 2019

Administrator
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072

RE: Project Number H5454011C and H5454012C

Dear Administrator:

On May 29, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments 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. In addition, at the time of the May 29, 2019 abbreviated standard survey the Minnesota Department of Health, completed an investigation of complaint number H5454011C and H5454012C which were substantiated.

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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is July 8, 2019.

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.

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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 August 29, 2019 (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 November 29, 2019 (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.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	245454	A. BUILDING ______ B. WING ______	C 05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	**109 COURT AVENUE SOUTH SANDSTONE, MN 55072**

(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 5/28/19, and 5/29/18, an unannounced abbreviated survey was completed at your facility to conduct a complaint investigation. Sandstone Health Care Center was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were substantiated: H5454011C H5454012C 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=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:	F 689		6/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/11/2019

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 689	Continued From page 1 Based on observation, interview, and document review, the facility failed to ensure interventions were implemented to prevent falls and/or injury for 1 of 3 residents (R2) reviewed for accidents. Findings include: R2's annual Minimum Data Set (MDS) dated 4/15/19, identified R2 had diagnoses which included depression, adult failure to thrive, repeated falls and was severely cognitively impaired. The MDS indicated R2 required extensive assistance of staff for bed mobility, transfers, and ambulation. The MDS identified R2 was not steady with moving from a seated to standing position, walking, turning around facing opposite direction while walking, moving on and off the toilet, surface to surface transfers and needed staff assistance to stabilize. The MDS further identified R2 utilized a wheelchair, and had no falls from prior assessment. R2's Falls Data Collection Assessment dated 4/15/19, indicated R2 was a high risk for falls. R2's care plan revised 4/18/19, revealed R2 was at risk for falls related to deconditioning, incontinence, psycho active drug use, history of falls resulting in left femur fracture, and pain. The care plan indicated R2 required staff assistance with ambulation and transfers. The care plan listed various interventions which included EZ-glide (one way glide) in wheelchair for proper positioning, and to follow fall protocol. R2's Group E Nursing Care Sheets undated, indicated R2 needed staff assistance of one to transfer, and ambulated with a walker. The care sheets further indicated R2 was a fall risk, and	F 689	Upon discovery, LPN-A, HH-A, NA-A and NA-B were re-educated on R2's plan of care. R2 care plan and care sheets were reviewed and revised. Review of residents at risk for falls identified, care plans and care sheets were updated/revised. All Nursing staff will be educated by DNS/Designee on Managing Falls/Fall Risk Policy and Procedure and process of updating care plan and care sheets. DNS/Designee will audit R2 and 2 additional residents at risk for falls weekly X4 weeks, monthly X 2 months. Audit results will be reported to the QAPI committee for review and further recommendations if indicated. Completion date: 6/14/2019	

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F 689	Continued From page 2	F 689		

listed several interventions under safety which included: EZ glide in wheel chair.

R2's Un-witnessed Fall Report dated 4/28/19, indicated R2 had a unwitnessed fall where staff found R2 next to the bed sitting on the floor, knees to chest, trash can touching her right upper back, her head touching the tray table drawer, bed in front of her and wheel chair to her left. R2 was assisted back into bed and no injures sustained.

R2's Post Fall Investigation dated 4/28/19, indicated R2 fell near the bed and lost her balance self transferring. The report indicated R2 had current interventions in place which included Ez glide placed in wheel chair, anti-rollbacks on wheelchair, call light within reach, call don't fall sign in room, appropriate foot wear, and risk verses benefits explained. The report concluded a new intervention was put in place after R2's fall which included staff were to ensure R2's wheelchair was next to bed with wheels locked, and to educate importance of using call light for staff assistance with transfers.

On 5/28/19 at 1:47 p.m. R2 was observed laying in bed on her back. R2's wheelchair was at the end of her bed by the foot board, facing her bed, and the right wheel was partially pushed up against R2's bed. The brakes were not locked. R2's wheelchair did not have an EZ glide on the seat of the wheelchair, and her wheelchair was not next to her bed with the brakes locked as indicated on her care plan and post fall investigation.

- at 2:01 p.m. R2 was laying in bed while nursing assistant (NA)-A and hospice nurse (HN)-A

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F 689	Continued From page 3	F 689		

assisted R2 in changing her incontinent brief. NA-A and HN-A put a clean pair of pants on R2 and proceeded to boost her up in bed. NA-A covered R2 with a blanket and put the head of her bed in the up position. NA-A placed call light next to R2 and NA-A and HN-A left the room. R2's black wheel chair was at the end of bed by the foot board and had a black cushion on the seat of her wheelchair. NA-A and HN-A did not place R2's wheel chair next to her bed with the brakes locked, and R2 did not have a EZ glide on the seat of her wheel chair.

- at 4:28 p.m. R2 was laying in bed on her back, call light with in reach, and R2 was sleeping. R2's wheelchair was at the end of bed by the foot board. As directed by her care plan R2's wheel chair did not have a EZ glide on the seat of her wheelchair, and her wheelchair was not next to her bed with the brakes locked as indicated on her post fall investigation.

On 5/29/19, at 8:08 a.m. NA-B assisted R2 to sit up on the edge of her bed, and assisted her to pivot transfer into her wheelchair to go to the bathroom. NA-B assisted R2 to pivot transfer onto the toilet, and NA-B proceeded to assist R2 to get dressed for the day. NA-B provided cares, and assisted R2 to pivot transfer back into her wheelchair, and brought her back out to her room. NA-B continued to comb R2's hair, gave R2 her glasses, and asked her what she would like to eat. R2 refused breakfast, and stated she did not feel good. NA-B reported R2's concerns to the nurse. Licensed practical nurse (LPN)-A entered the room at 8:33 a.m. R2 told LPN-A that she did not feel good, and did not want to eat. LPN-A offered R2 other choices of food and R2 declined. LPN-A told R2 he had some medication

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F 689	Continued From page 4 that might help, R2 agreed, LPN-A left the room and proceeded to get R2 her medication while NA-B collected the garbage and dirty linen and left the room. NA-B did not place an EZ glide on the seat of R2's wheelchair per the care plan. - at 8:42 a.m. R2 was seated in her wheelchair in her room when LPN-A entered the room, gave R2 her medication, and LPN-A left the room. LPN-A did not place a EZ glide on the seat of R2's wheelchair per the care plan. - at 9:16 a.m. R2 was laying in bed on her back. R2's wheelchair was at the end of bed by the foot board, and had a black cushion on the seat of her wheelchair. R2's wheelchair did not have a EZ glide on the seat of the wheelchair, and her wheelchair was not next to her bed with the brakes locked as indicated on her post fall investigation. On 5/28/19 at 1:47 p.m. HN-A confirmed R2 needed assistance with activities of daily living (ADLs), transfers, and ambulation. HN-A stated R2 had some falls in the past due to self transferring at times. On 5/29/19 at 10:05 a.m. NA-B indicated staff look at their care sheet to see how to care for the residents. NA-B confirmed R2 was a fall risk, and needed staff assistance with ambulation and transfers. NA-B confirmed R2 was to have a EZ-glide on the seat of her wheelchair and confirmed she did not put R2's wheelchair next to her bed, and lock the brakes on it to prevent R2 form falling. NA-B stated she did not know R2 was suppose to have the wheelchair next to her bed with the brakes locked, and verified it was not on her resident care sheets, and not in the	F 689		

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F 689	Continued From page 5 communication book where they would usually find the information. On 5/29/19 at 9:00 a.m. LPN-A confirmed R2 was a fall risk and needed staff assistance with ADL's, transfers and ambulation. LPN-A indicated R2 will transfer herself at times and has fallen in the past. LPN-A indicated staff will look at the care plan or will use their care sheet to find out how to take care of the residents. LPN-A confirmed R2 was to have a EZ- glide on the seat of her wheel chair and he was not aware that she was to have the wheel chair next to her bed with the brakes locked. LPN-A confirmed this was not on R2's care plan and indicated these things should be in place to prevent R2 from falling. On 5/29/19 at 10:21 a.m. registered nurse (RN)-A confirmed R2 was at risk for falls, and stated staff should be following the care plan. RN-A verified R2's care plan and care sheet were not updated to reflect having the wheelchair next to the bed with the brakes locked. RN-A stated staff were not aware of needing to have the wheelchair next to the bed when it was implemented because R2's care plan was not updated. RN-A stated the MDS coordinator was the one who normally updated the care plan and care sheets for the NAs. RN-A stated she would expect staff to make sure they have the interventions in place and they are being followed. On 5/29/19 at 10:41 a.m. the administrator and director of nursing (DON) confirmed R2 was a fall risk and needed staff assistance with ADLs, transfers, and ambulation. The adminstrator stated R2 would self transfer at times, and she would expect staff to follow the care plan. The adminstrator confirmed the care plan and NA	F 689		

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F 689	Continued From page 6 care sheets were not updated to reflect R2's wheelchair to be at her bedside with the brakes locked. The administrator stated staff were not aware of this, and said the MDS coordinator updated the care plans, and the NA care sheets. The administrator stated she was not sure what happened. The facility policy Falls and Fall Risk Managing revised on 12/07, directed based on previous evaluations and current data, the staff will identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2019

Administrator
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072

Re: State Nursing Home Licensing Orders - Complaint Number H5454011C and H5454012C

Dear Administrator:

A complaint investigation was completed on May 29, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161   Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	00452	A. BUILDING: ______ B. WING ______	C 05/29/2019

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2 000	Initial Comments	2 000		

*****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 5/28/19, and 5/29/19, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure.

The following complaints were found to be

Minnesota Department of Health

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SANDSTONE HEALTH CARE CENTER	**109 COURT AVENUE SOUTH SANDSTONE, MN 55072**

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2 000	Continued From page 1 substantiated: H5454011C H5454012C 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 observation, interview, and document review, the facility failed to ensure interventions were implemented to prevent falls and/or injury for 1 of 3 residents (R2) reviewed for accidents. Findings include: R2's annual Minimum Data Set (MDS) dated	2 830	Upon discovery, LPN-A, HH-A, NA-A and NA-B were re-educated on R2's plan of care. R2 care plan and care sheets were reviewed and revised. Review of residents at risk for falls	6/11/19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00452	A. BUILDING: ____ B. WING ____	C 05/29/2019

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2 830	Continued From page 2 4/15/19, identified R2 had diagnoses which included depression, adult failure to thrive, repeated falls and was severely cognitively impaired. The MDS indicated R2 required extensive assistance of staff for bed mobility, transfers, and ambulation. The MDS identified R2 was not steady with moving from a seated to standing position, walking, turning around facing opposite direction while walking, moving on and off the toilet, surface to surface transfers and needed staff assistance to stabilize. The MDS further identified R2 utilized a wheelchair, and had no falls from prior assessment. R2's Falls Data Collection Assessment dated 4/15/19, indicated R2 was a high risk for falls. R2's care plan revised 4/18/19, revealed R2 was at risk for falls related to deconditioning, incontinence, psycho active drug use, history of falls resulting in left femur fracture, and pain. The care plan indicated R2 required staff assistance with ambulation and transfers. The care plan listed various interventions which included EZ-glide (one way glide) in wheelchair for proper positioning, and to follow fall protocol. R2's Group E Nursing Care Sheets undated, indicated R2 needed staff assistance of one to transfer, and ambulated with a walker. The care sheets further indicated R2 was a fall risk, and listed several interventions under safety which included: EZ glide in wheel chair. R2's Un-witnessed Fall Report dated 4/28/19, indicated R2 had a unwitnessed fall where staff found R2 next to the bed sitting on the floor, knees to chest, trash can touching her right upper back, her head touching the tray table drawer, bed in front of her and wheel chair to her left. R2	2 830	identified, care plans and care sheets were updated/revised. All Nursing staff will be educated by DNS/Designee on Managing Falls/Fall Risk Policy and Procedure and process of updating care plan and care sheets. DNS/Designee will audit R2 and 2 additional residents at risk for falls weekly X4 weeks, monthly X 2 months. Audit results will be reported to the QAPI committee for review and further recommendations if indicated. Completion date: 6/14/2019	

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2 830	Continued From page 3 was assisted back into bed and no injures sustained. R2's Post Fall Investigation dated 4/28/19, indicated R2 fell near the bed and lost her balance self transferring. The report indicated R2 had current interventions in place which included Ez glide placed in wheel chair, anti-rollbacks on wheelchair, call light within reach, call don't fall sign in room, appropriate foot wear, and risk verses benefits explained. The report concluded a new intervention was put in place after R2's fall which included staff were to ensure R2's wheelchair was next to bed with wheels locked, and to educate importance of using call light for staff assistance with transfers. On 5/28/19 at 1:47 p.m. R2 was observed laying in bed on her back. R2's wheelchair was at the end of her bed by the foot board, facing her bed, and the right wheel was partially pushed up against R2's bed. The brakes were not locked. R2's wheelchair did not have an EZ glide on the seat of the wheelchair, and her wheelchair was not next to her bed with the brakes locked as indicated on her care plan and post fall investigation. - at 2:01 p.m. R2 was laying in bed while nursing assistant (NA)-A and hospice nurse (HN)-A assisted R2 in changing her incontinent brief. NA-A and HN-A put a clean pair of pants on R2 and proceeded to boost her up in bed. NA-A covered R2 with a blanket and put the head of her bed in the up position. NA-A placed call light next to R2 and NA-A and HN-A left the room. R2's black wheel chair was at the end of bed by the foot board and had a black cushion on the seat of her wheelchair. NA-A and HN-A did not place R2's wheel chair next to her bed with the	2 830		

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2 830	Continued From page 4	2 830		

brakes locked, and R2 did not have a EZ glide on the seat of her wheel chair.

- at 4:28 p.m. R2 was laying in bed on her back, call light with in reach, and R2 was sleeping. R2's wheelchair was at the end of bed by the foot board. As directed by her care plan R2's wheel chair did not have a EZ glide on the seat of her wheelchair, and her wheelchair was not next to her bed with the brakes locked as indicated on her post fall investigation.

On 5/29/19, at 8:08 a.m. NA-B assisted R2 to sit up on the edge of her bed, and assisted her to pivot transfer into her wheelchair to go to the bathroom. NA-B assisted R2 to pivot transfer onto the toilet, and NA-B proceeded to assist R2 to get dressed for the day. NA-B provided cares, and assisted R2 to pivot transfer back into her wheelchair, and brought her back out to her room. NA-B continued to comb R2's hair, gave R2 her glasses, and asked her what she would like to eat. R2 refused breakfast, and stated she did not feel good. NA-B reported R2's concerns to the nurse. Licensed practical nurse (LPN)-A entered the room at 8:33 a.m. R2 told LPN-A that she did not feel good, and did not want to eat. LPN-A offered R2 other choices of food and R2 declined. LPN-A told R2 he had some medication that might help, R2 agreed, LPN-A left the room and proceeded to get R2 her medication while NA-B collected the garbage and dirty linen and left the room. NA-B did not place an EZ glide on the seat of R2's wheelchair per the care plan.

- at 8:42 a.m. R2 was seated in her wheelchair in her room when LPN-A entered the room, gave R2 her medication, and LPN-A left the room. LPN-A did not place a EZ glide on the seat of R2's wheelchair per the care plan.

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2 830	Continued From page 5 - at 9:16 a.m. R2 was laying in bed on her back. R2's wheelchair was at the end of bed by the foot board, and had a black cushion on the seat of her wheelchair. R2's wheelchair did not have a EZ glide on the seat of the wheelchair, and her wheelchair was not next to her bed with the brakes locked as indicated on her post fall investigation. On 5/28/19 at 1:47 p.m. HN-A confirmed R2 needed assistance with activities of daily living (ADLs), transfers, and ambulation. HN-A stated R2 had some falls in the past due to self transferring at times. On 5/29/19 at 10:05 a.m. NA-B indicated staff look at their care sheet to see how to care for the residents. NA-B confirmed R2 was a fall risk, and needed staff assistance with ambulation and transfers. NA-B confirmed R2 was to have a EZ-glide on the seat of her wheelchair and confirmed she did not put R2's wheelchair next to her bed, and lock the brakes on it to prevent R2 form falling. NA-B stated she did not know R2 was suppose to have the wheelchair next to her bed with the brakes locked, and verified it was not on her resident care sheets, and not in the communication book where they would usually find the information. On 5/29/19 at 9:00 a.m. LPN-A confirmed R2 was a fall risk and needed staff assistance with ADL's, transfers and ambulation. LPN-A indicated R2 will transfer herself at times and has fallen in the past. LPN-A indicated staff will look at the care plan or will use their care sheet to find out how to take care of the residents. LPN-A confirmed R2 was to have a EZ- glide on the seat of her wheel chair and he was not aware that she was to have	2 830		

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2 830	Continued From page 6 the wheel chair next to her bed with the brakes locked. LPN-A confirmed this was not on R2's care plan and indicated these things should be in place to prevent R2 from falling. On 5/29/19 at 10:21 a.m. registered nurse (RN)-A confirmed R2 was at risk for falls, and stated staff should be following the care plan. RN-A verified R2's care plan and care sheet were not updated to reflect having the wheelchair next to the bed with the brakes locked. RN-A stated staff were not aware of needing to have the wheelchair next to the bed when it was implemented because R2's care plan was not updated. RN-A stated the MDS coordinator was the one who normally updated the care plan and care sheets for the NAs. RN-A stated she would expect staff to make sure they have the interventions in place and they are being followed. On 5/29/19 at 10:41 a.m. the administrator and director of nursing (DON) confirmed R2 was a fall risk and needed staff assistance with ADLs, transfers, and ambulation. The adminstrator stated R2 would self transfer at times, and she would expect staff to follow the care plan. The adminstrator confirmed the care plan and NA care sheets were not updated to reflect R2's wheelchair to be at her bedside with the brakes locked. The administrator stated staff were not aware of this, and said the MDS coordinator updated the care plans, and the NA care sheets. The administrator stated she was not sure what happened. The facility policy Falls and Fall Risk Managing revised on 12/07, directed based on previous evaluations and current data, the staff will identify interventions related to the residents specific risks and causes to try to prevent the resident	2 830		

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2 830	Continued From page 7 from falling and to try to minimize complications from falling. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for falls for residents at risk to assure they are receiving the necessary treatment/services. 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		