DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2019

Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number H5514019C

Dear Administrator:

On May 13, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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,

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

Electronically delivered
May 3, 2019

Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

RE: Project Number H5514019C

Dear Administrator:

On April 18, 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 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 May 28, 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:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 July 18, 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 October 18, 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,

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CENTER	**1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071**

(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 4/17/19 and 4/18/19 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#5514019C with a deficiency issued at F686. 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		5/13/19

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

Electronically Signed | 05/13/2019

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F 689	Continued From page 1 Based on observation, interview and record review, the facility failed to ensure the plan of care was followed for 1 of 3 (R1) residents reviewed for falls. The findings include: The facility's Incident Review and Analysis report dated 1/30/19 at 3:04 p.m., indicated R1 had been found on the floor, laying face down in front of her wheel chair, with a moderate amount of blood pooling near her forehead. The report indicated R1 had complained of back pain and a headache. Review of the incident indicated R1 had been sitting in her room in a reclined wheel chair with foot pedals on the wheelchair just prior to the fall. The report indicated R1 had not been laid down following lunch in accordance with the care plan, and indicated staff had been re-educated to follow the resident's care plan, and staff had been given a warning notice. The report indicated a vulnerable adult report had been filed because the fall had resulted in an ER visit and required sutures to the facial laceration, and a CT (computed tomography) scan. The Incident Review and Analysis report indicated at the conclusion of the investigation it had been determined R1's care plan had not been implemented, R1 had not been laid down in bed following lunch, and the foot pedals had not been removed after transport as indicated on the care plan. During observation on 4/18/19 at 8:31 a.m., R1 had just returned to her room from breakfast. R1's eyes were closed, her wheelchair was left in an upright position when the aide left the resident's room. R1's head was hanging down	F 689	R1's care plan was reviewed for fall interventions and R1's care sheet was updated to reflect those interventions All residents have the potential to be affected and will be reviewed for fall interventions, if applicable. NA-1 has been provided re-education regarding the importance of following each resident's plan of care. Mandatory Care Plan inservice held 5/8/19 reviewed resident plan of care development and implementation. Random care plan audits will be reviewed to ensure staff are following resident plan of care. DON or designee to conduct weekly audits for 4 weeks, then monthly for 2 months to ensure resident plan of care is being followed. Audit results will be reviewed by QA&A Committee for further recommendations.	

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F 689	Continued From page 2	F 689		

and forward even though a neck pillow was around her neck. R1 was not laid down in bed.

During observation on 4/18/19 at 9:22 a.m., R1 continued to be sitting up in the chair in her room. The chair was reclined approximately 10 degrees only. R1 had not been laid down and her head was noted to be tilted forward toward her chest.

During observation on 4/18/19 at 10:11 a.m., R1 continued to be up in her chair in her room, R1 remained asleep with her head hanging down and her chin almost resting on her chest. The wheelchair remained reclined at 10 degrees.

During observations on 4/17/19 at 9:23 a.m., and 10:36 a.m., R1 was found sitting in her room in a reclining wheelchair with her eyes closed. The chair was upright and leaned only slightly back, causing her head to hang forward.

R1's diagnosis sheet dated 4/18/19 included the following diagnoses: Alzheimer's disease, peripheral vascular disease, major depressive disorder, restless leg syndrome, dysphasia, and overactive bladder.

R1's annual Minimum Data Set (MDS) assessment dated 12/14/19, indicated R1 had severe cognitive impairment, and mild depression symptoms. R1 was extensive assist of one to complete all activities of daily living (ADLs). R1 was frequently incontinent of bladder and occasionally incontinent of bowel. Further, the MDS indicated R1 had not yet experienced any falls. However, the associated Care Area Assessment (CAA) for falls dated 12/18/19, revealed R1 was at risk for falls.

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F 689	Continued From page 3 R1's care plan (revised post fall and dated 1/31/19) included: The resident is risk of falls related to unawareness of safety needs, confusion, hallucinations, age, impaired mobility, diagnosis of dementia and psychoactive drug use. Interventions included: Anticipate and meet the resident's needs, auto lock brakes on wheel chair, call light in reach and encourage resident to use it for assistance as needed, bed in low position, fall mat next to bed, Dysem (a type of non-slip pad) to wheel chair, falls assessments per routine and as needed, fall out of wheel chair 1/30/19 with blow to head and emergency department visit. Intervention staff reeducation and warning notice, grab bars to aide in mobility, gripper sox in bed, proper fitting shoes during the day, have resident lay down in bed after breakfast and lunch for 1 hour- See occupational therapy directions. A physical therapy communication noted dated 7/26/17 indicated: - now using reclining back wheelchair and is placed only at slight recline to align head and shoulders over hips. - if up sleeping and hanging head or leaning forward, she should be placed in bed. -position in bed for postural rest/stretch for 1 hour in morning and 1 hour in afternoon. An interdisciplinary Progress Note (PN) dated 1/31/19 at 9:10 p.m., indicated during the fall from 1/30/19, R1 had sustained a left forearm skin tear, and abrasions to the left knuckles. An interdisciplinary PN dated 2/1/19 at 11:37 p.m., indicated bruising was noted to R1's	F 689		

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F 689	Continued From page 4	F 689		

bilateral knees. The skin tear on the left forearm was closed with steri-strips, stitches on head were intact and healing.

During an interview on 4/17/19 at 12:47 p.m., the administrator stated following the 1/30/19 incident, when the facility could not specifically identify the aide who had returned the resident to her room on the day of the fall, all staff working in the area had been re-educated. In addition, the administrator stated the two primary aides responsible for R1 at that time, had been given warning notices for not following R1's care plan.

During an interview on 4/18/19 at 10:13 a.m., the primary nursing assistant (NA)-1, confirmed she was aware the care plan indicated to lay R1 down in the morning and in the afternoon. NA-1 stated she'd made an independent decision not to follow the care plan, and had not spoken with the charge nurse. NA-1 also confirmed R1's wheelchair was reclined to only 10-15 degrees, causing the resident's head to hang forward.

During an observation and interview with the administrator on 4/18/19 at 10:20 a.m., the administrator confirmed the resident was up in her chair, sleeping, head hanging to her chest, and verified staff were not following the care plan. The administrator stated it was her expectation staff would follow the care plan.

The facility's undated Care Planning policy included: The interdisciplinary team, in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan. The care plan interventions are derived from a

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F 689	Continued From page 5 thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her care plan. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The facility's 7/18 policy Falls Prevention and Management, included to manage falls and falls risk: Facility staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.	F 689		

Electronically delivered
May 3, 2019

Administrator
Mala Strana Care & Rehabilitation Center
1001 Columbus Avenue North
New Prague, MN 56071

Re: State Nursing Home Licensing Orders - Project Number H5514019C

Dear Administrator:

The above facility was surveyed on April 17, 2019 through April 18, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5514019C. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	00811	A. BUILDING: _____ B. WING _____	C 04/18/2019

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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 4/17 and 4/18/19, an abbreviated survey was conducted to determine compliance of state licensure during a complaint survey. The following complaint was found to be substantiated: H#5514019C with a licensing order issued at MN Rule 4658.0520 Subd 1. The facility is enrolled in ePOC and therefore a	2 000		

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2 000	Continued From page 1 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		

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2 000	Continued From page 2	2 000		
	On 4/17 and 4/18/19, a surveyor of this Department's staff visited the above provider and the the facility was found NOT IN COMPLIANCE. A complaint investigation was conducted to investigate H#5514019C. As a result the following correction orders are issued. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm.			
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	2 830		5/13/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00811	A. BUILDING: _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CEN	1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071

(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
2 830	Continued From page 3 resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the plan of care was followed for 1 of 3 (R1) residents reviewed for falls. The findings include: The facility's Incident Review and Analysis report dated 1/30/19 at 3:04 p.m., indicated R1 had been found on the floor, laying face down in front of her wheel chair, with a moderate amount of blood pooling near her forehead. The report indicated R1 had complained of back pain and a headache. Review of the incident indicated R1 had been sitting in her room in a reclined wheel chair with foot pedals on the wheelchair just prior to the fall. The report indicated R1 had not been laid down following lunch in accordance with the care plan, and indicated staff had been re-educated to follow the resident's care plan, and staff had been given a warning notice. The report indicated a vulnerable adult report had been filed because the fall had resulted in an ER visit and required sutures to the facial laceration, and a CT (computed tomography) scan. The Incident Review and Analysis report indicated at the conclusion of the investigation it had been determined R1's care plan had not been implemented, R1 had not been laid down in bed following lunch, and the foot pedals had not been removed after transport as indicated on the care plan.	2 830	Corrected.	

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2 830	Continued From page 4 During observation on 4/18/19 at 8:31 a.m., R1 had just returned to her room from breakfast. R1's eyes were closed, her wheelchair was left in an upright position when the aide left the resident's room. R1's head was hanging down and forward even though a neck pillow was around her neck. R1 was not laid down in bed. During observation on 4/18/19 at 9:22 a.m., R1 continued to be sitting up in the chair in her room. The chair was reclined approximately 10 degrees only. R1 had not been laid down and her head was noted to be tilted forward toward her chest. During observation on 4/18/19 at 10:11 a.m., R1 continued to be up in her chair in her room, R1 remained asleep with her head hanging down and her chin almost resting on her chest. The wheelchair remained reclined at 10 degrees. During observations on 4/17/19 at 9:23 a.m., and 10:36 a.m., R1 was found sitting in her room in a reclining wheelchair with her eyes closed. The chair was upright and leaned only slightly back, causing her head to hang forward. R1's diagnosis sheet dated 4/18/19 included the following diagnoses: Alzheimer's disease, peripheral vascular disease, major depressive disorder, restless leg syndrome, dysphasia, and overactive bladder. R1's annual Minimum Data Set (MDS) assessment dated 12/14/19, indicated R1 had severe cognitive impairment, and mild depression symptoms. R1 was extensive assist of one to complete all activities of daily living (ADLs). R1 was frequently incontinent of bladder	2 830		

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2 830	Continued From page 5 and occasionally incontinent of bowel. Further, the MDS indicated R1 had not yet experienced any falls. However, the associated Care Area Assessment (CAA) for falls dated 12/18/19, revealed R1 was at risk for falls. R1's care plan (revised post fall and dated 1/31/19) included: The resident is risk of falls related to unawareness of safety needs, confusion, hallucinations, age, impaired mobility, diagnosis of dementia and psychoactive drug use. Interventions included: Anticipate and meet the resident's needs, auto lock brakes on wheel chair, call light in reach and encourage resident to use it for assistance as needed, bed in low position, fall mat next to bed, Dysem (a type of non-slip pad) to wheel chair, falls assessments per routine and as needed, fall out of wheel chair 1/30/19 with blow to head and emergency department visit. Intervention staff reeducation and warning notice, grab bars to aide in mobility, gripper sox in bed, proper fitting shoes during the day, have resident lay down in bed after breakfast and lunch for 1 hour- See occupational therapy directions. A physical therapy communication noted dated 7/26/17 indicated: - now using reclining back wheelchair and is placed only at slight recline to align head and shoulders over hips. - if up sleeping and hanging head or leaning forward, she should be placed in bed. -position in bed for postural rest/stretch for 1 hour in morning and 1 hour in afternoon. An interdisciplinary Progress Note (PN) dated 1/31/19 at 9:10 p.m., indicated during the fall from 1/30/19, R1 had sustained a left forearm	2 830		

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2 830	Continued From page 6 skin tear, and abrasions to the left knuckles. An interdisciplinary PN dated 2/1/19 at 11:37 p.m., indicated bruising was noted to R1's bilateral knees. The skin tear on the left forearm was closed with steri-strips, stitches on head were intact and healing. During an interview on 4/17/19 at 12:47 p.m., the administrator stated following the 1/30/19 incident, when the facility could not specifically identify the aide who had returned the resident to her room on the day of the fall, all staff working in the area had been re-educated. In addition, the administrator stated the two primary aides responsible for R1 at that time, had been given warning notices for not following R1's care plan. During an interview on 4/18/19 at 10:13 a.m., the primary nursing assistant (NA)-1, confirmed she was aware the care plan indicated to lay R1 down in the morning and in the afternoon. NA-1 stated she'd made an independent decision not to follow the care plan, and had not spoken with the charge nurse. NA-1 also confirmed R1's wheelchair was reclined to only 10-15 degrees, causing the resident's head to hang forward. During an observation and interview with the administrator on 4/18/19 at 10:20 a.m., the administrator confirmed the resident was up in her chair, sleeping, head hanging to her chest, and verified staff were not following the care plan. The administrator stated it was her expectation staff would follow the care plan. The facility's undated Care Planning policy included: The interdisciplinary team, in conjunction with the resident and the resident	2 830		

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2 830	Continued From page 7 representative, will develop and implement a comprehensive individualized care plan. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her care plan. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The facility's 7/18 policy Falls Prevention and Management, included to manage falls and falls risk: Facility staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		