STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. Building B. Wing	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review, the facility failed to complete comprehensive fall assessments with root cause analysis, identify patterns of falls, and failed to consistently implement immediate individualized appropriate interventions to prevent additional falls for 3 of 25 residents (R8, R5, R4), who were at high risk for falls. This deficient practice resulted in an immediate jeopardy (IJ) when R8 sustained a fractured neck and ultimate death, R5 who sustained degloving of the hand and a facial laceration requiring emergency room visit, and R4 who sustained a fall with a pelvic fracture. In addition to the resident(s) in immediate jeopardy, the facility failed to comprehensively assess each fall for R6 and failed to provide prevention interventions to decrease future falls resulting in the potential for harm to R6. The IJ began on [DATE], when R8 had not been comprehensively assessed and individualized apropriate interventions were implemented. The interim administrator and interim director of nursing (IDON), were notified of the IJ on [DATE], at 5:19 p.m. The IJ was removed on [DATE], at 4:20 p.m. but noncompliance remained at the lower scope and severity level 2 at an E which indicates a pattern and no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings included: R8's, hospital, After Visit Summary (AVS) dated [DATE], identified R8 was hospitalized from [DATE], until [DATE], for increased falls with orthostatic hypotension, new medications to start are midodrine (medication to help with low blood pressure that can cause severe dizziness or fainting), and was not able to walk due to hypotension. R8's admission record, identified R8 was admitted on [DATE], with diagnoses that included history of falling, Parkinson's disease, Lewy bodies dementia, restless leg syndrome, abnormalities of gait and mobility, and long term use of anticoagulants. R8's Fall Risk Evaluation, dated [DATE], identified R8 was a moderate risk for falls, and indicated interventions of rubber soled shoes for walking and utilize a toileting plan. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R8's admission, minimum data set (MDS), dated [DATE], identified moderate cognitive impairment, exhibited delusions and other behaviors for ,d+[DATE] days that significantly interfered with his care and activities. R8 required extensive assistance with activities of daily living (ADL)'s and used a wheelchair for mobility. R8 was occasionally incontinent of bowel and bladder. Further identified R8 had a fall 1 month prior to admit, 1 fall without injury and 1 fall with major injury. R8's, Physical Therapy (PT) Treatment Encounter Note, dated [DATE], identified that R8 reported weakness upon standing for short periods of time. R8's blood pressure was taken in a seated position with a reading of , d+[DATE], upon standing his blood pressure reading was ,d+[DATE], after 3 minutes of standing blood pressure rechecked with a reading of ,d+[DATE]. (Normal blood pressure reading is ,d+[DATE]). R8's medical record between [DATE] to [DATE], identified R8 had sustained three falls. Dates of the falls were [DATE], which resulted a lumbar spinal fracture, [DATE], and [DATE]. After each fall event, R8's record lacked a comprehensive assessment for causal factors, identification of probable root cause, and immediate appropriate interventions to prevent and/or mitigate risk of recurrent falls. In addition, it was not evident the care plan and/or interventions were evaluated for effectiveness, nor evident the care plan was reviewed or revised after the fall. Following R8's fall on [DATE], there was no indication R8 had been assessed for injuries nor evidence the physician was notified. R8's fall on [DATE], resulted in death according to his death certifcate. R8's Fall Report, dated [DATE], at 6:30 a.m. identified R8 had an unwitnessed fall in the bathroom and was found to be incontinent, immediate action taken was R8 was reoriented to the call light usage and hourly safety checks were started. R8's incident report identified the aforementioned information. Despite R8 being found in the bathroom and incontinent, it was not evident R8's toileting plan was assessed or revised. R8's Physician Progress note, dated [DATE], identified that prior to admit that R8 had been hospitalized for recurrent falls and had hematuria (blood in the urine) following a transurethral resection of bladder tumor. R8 had several episodes of bilateral limb shaking and decreased level of consciousness and was found to have significant positive orthostatic hypotension. Additionally, describes that R8 had a fall overnight with some back pain this morning that is congruent with findings of sacral and S4 fractures seen back in early March. R8 had reported he needed to use the restroom, could not find his call button, he attempted to get up on his own, and fell from standing height landing on hips without injury. Physician orders were updated to include staff to complete hourly safety checks, due to high risk for falls and history (of falls). R8's fall care plan, dated [DATE], identified R8 was at high risk for falls related to confusion, deconditioning, and hypotension. Corresponding interventions included the following: anticipate and meet R8's needs, be sure the call light is within reach and encourage to use it for assist as needed, waist high compression stockings on in AM and off at HS (bedtime), and hourly checks for safety. R8's progress noted dated [DATE], at 9:50 p.m. identified that R8 had increased confusion and staff had to do a 1:1 with R8 since 9:00 p.m. because R8 was caught self-transferring and ambulating in his room three times after supper and had complained of chest pain, increased respirations, shaking and acting non-sensible at times. At 10:30 p.m. R8 was sent to the emergency department (ED) for a change in condition. R8 returned to facility at 3:50 a.m. R8's AVS included an order for CT Pelvis Lumbar Spine on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R8's physician progress note dated [DATE], indicated that R8 had an emergency room visit over the weekend related to increased confusion after a fall, imaging was negative for an intracranial bleed, there was a new L1 (lumbar region of the spine) compression fracture and some interval healing at S4 (sacral region of the spine). R8's Sinemet (antiparkinsonian drug) was decreased with thoughts that this could be causing R8's orthostatic hypotension. R8's care plan was not revised to address the new lumbar fracture. R8's progress note dated [DATE], at 11:59 p.m. identified that shortly before supper R8 had been fidgety and busy, was self-transferring, pulling his call light out of the wall and trying to fix things. R8 was also noted to be dragging his furniture around the room, could not explain to staff why he needed to move these things stating it just needed to be done, was also found walking while holding onto his curtain. R8 was found on the floor in his room seated on his bottom. R8's record did not include any other additional information pertaining to the fall, nor evident the physician was notified. R8's rogress note dated [DATE], identified that at 8:45 a.m. R8 was found by a nurse on the floor in his bathroom. R8 was bleeding from a laceration to his left forehead and had a small laceration under his right eye, R8 complained of back pain and was unable to answer questions per his baseline, staff stayed with R8 until emergency services arrived for transport by ambulance to the ED. R8's Minnesota Document of Death was reviewed, and indicated that R8 died at the hospital on [DATE], at 5:42 p.m., causes for death indicated, complications of Lewy Body Dementia and blunt force injury to the head and spine from a fall. Date of injury was [DATE], at 8:50 a.m. Injury occurred from a fall at standing height. During an interview on [DATE], at 1:25 p.m. with the clinical manager (CM) and interim director of nursing (IDON) present, CM verified that R8 had 3 falls during his stay from [DATE], to [DATE], with no root cause analysis, and no prevention interventions were put in place. CM was not aware of the second fall that occurred until it was brought to her attention by the surveyor. CM further verified R8 was not assessed for injury, no comprehensive assessment was completed and failed to root cause or place prevention interventions for future falls. CM was aware that R8's last fall had resulted in a neck fracture and had passed away. R5's admission record, identified R5 had diagnoses of psychophysical visual disturbances (visual disturbance in which a person with partial or severe blindness experiences visual hallucinations), polymyositis (inflammatory disease that causes muscle pain and stiffness), osteoarthritis, macular degeneration (eye condition that distorts or causes loss of central vision), glaucoma (eye diseases that can cause vision loss and blindness), and insomnia. R5's significant change, MDS, dated [DATE], identified R8 had significant cognitive impairment, exhibited delusions, did not walk, and required extensive assistance of ,d+[DATE] staff with ADL's and used a wheelchair for mobility. R5 was occasionally incontinent of bowel and bladder and had 1 fall with injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R5's fall care plan dated [DATE], identified R5 was at risk for falls characterized by history of falls/injury, with multiple risk factors related to diagnoses of hypertension, history of fractures, glaucoma, medication use, required assist with ADL's and the use of an assistive device. Interventions were to: anticipate and meet R5's needs, be sure the call light is within reach, transfer and change positions slowly, wear proper and non-slip footwear, reinforce need to call for assistance, have commonly used articles within easy reach and check R5 frequently to ensure safety. R5's care plan did not identify additional and/or revisions to fall interventions after [DATE]. R5's fall record was reviewed between [DATE], to [DATE]. R5's record identified R5 had falls on [DATE], and [DATE], in which both caused injury. R5's record lacked a comprehensive assessment for causal factors/root cause, was not evident immediate interventions were developed or implemented. R5's Fall Report dated [DATE], at 7:40 a.m. identified R5 was being transferred with an EZ-stand (a type of mechanical lift to assist a patient to and from one area to another) with the help of a nursing assistant (NA) to get to the bathroom. NA stated when she lifted R5 up, R5 lifted her feet up causing her to fall to her knees on the EZ-stand foot plate. This fall resulted in a skin tear to her right lower leg. R5's record did not include a comprehensive transfer assessment before or after the fall to ensure safety during transfers with a standing mechanical lift. R5's physician note dated [DATE], identified that R5 has had ongoing decline since her COVID diagnosis in [DATE], there was noted functional decline prior to this but has since increased. R5 has gone from the use of an EZ-stand for transfers to a Hoyer lift (full body lift). R5's Incident Audit Report, dated [DATE], identified that R5 was found at 3:30 p.m. on the floor lying against the tray table with the power lift chair tipped on top of her, pressure dressing applied to right wrist and 911 was called R5 was transported to the ER. Injury was a skin tear to the back of the right hand and unable to determine the laceration to the face. R5's [DATE] treatment administration record (TAR) identified an order for hourly checks while in the recliner from [DATE], to [DATE]. On [DATE], the order was changed to hourly checks for safety. The record did not identify why the order was changed or identify when the recliner was removed. R5's progress note dated [DATE], identified that the fall from [DATE], at 3:30 p.m. identified R5 sustained a degloving (happens when a large piece of skin and the layer of soft tissue right under it partially or completely ripped from your body) injury to her right hand and an injury to the right side of her face and scalp. Root cause of fall was R5 did not use her call light for assistance and improper use of the lift chair. The intervention that was identified was to remove the recliner and use only the Broda chair, care plan updated. R5's care plan was not updated per the progress note and according to the June TAR documentation, R5 used the recliner on [DATE], [DATE], and [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on [DATE], at 3:09 p.m., R5 was seated in her Broda chair in her room. A large L-shaped reddened scar was observed on the top of R5's right hand. R5 stated, Oh, I think it got squashed in something, then they had to wrap it. R5 put her right hand out in front of her and stated, maybe they should rewrap it. R5 indicated she had not had any falls, I have been pretty lucky. R5 stated she did not have pain, but had a problem with her eyes, I am going blind, it's been really hard to deal with and has been going on for a couple of years now, there is nothing they can do about it. During interview on [DATE], at 11:59 a.m. with CM and IDON present. CM verified that R5 had 2 falls that were not appropriately root caused, prevention interventions were inappropriate and not updated to the care plan. CM stated R5 had impaired cognition and sounded like the first fall R5 did not have the leg strap used for the EZ-stand transfer and that may have contributed to the fall. CM indicated R5 was not reassessed by therapy to determine if the leg strap should be used after the fall. R5 was eventually changed to a Hoyer lift for transfers, and thought the date was maybe [DATE]. In regard to R5's second fall on [DATE], CM indicated R5 may have had access to the remote in her recliner which may have caused her last fall and was not sure if the recliner had been removed from R5's room as it was not updated on the care plan. R4's admission record, identified R4 was admitted on [DATE], with diagnoses of history of falling and right femur fracture, dementia with Lewy bodies, bilateral hearing loss, extrapyramidal and movement disorder (involuntary or uncontrollable movements such as tremors or muscle contractions caused by side effects from certain medications), and abnormal involuntary movements. R4's significant change, MDS, dated [DATE], identified R4 had moderate cognitive impairment, and required extensive assistance of one staff with ADL's and used a walker and wheelchair for mobility. R4 was frequently incontinent of bowel and bladder and had 2 or more falls with no injury. Review of R4's, fall risk assessments, identified they were done on the follow dates, [DATE], [DATE], and [DATE], identified R4 was at risk for falls and the clinical suggestions were to utilize a toileting plan. R4's care plan, dated [DATE], identified R4 was at high risk for falls characterized by history pf falls/injury, multiple risk factors that include history of fractures, glaucoma, medication use, required assist with ADL's and use of an assistive device. Interventions were to: anticipate and meet R4's needs, be sure the call light is within reach, transfer and change positions slowly, wear proper and non-slip footwear, reinforce need to call for assistance, have commonly used articles within easy reach and check R4 frequently to ensure safety. Review of R4's TAR's from [DATE], to [DATE], identified hourly safety checks. Review of R4's care plan identified no new interventions added since [DATE], which was PT/OT consult if needed. R4's record reviewed from [DATE], to [DATE], identified R4 had five falls. Every fall lacked a comprehensive assessment to determine identification of root cause/causal factors for implementation of appropriate immediate interventions to prevent falls and/or mitigate the risk. The last fall on [DATE], resulted in a right pubic fracture, five day hospitalization and a decline in her ADL's with significant pain requiring narcotic medication to keep pain under control. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R4's progress note dated [DATE], identified at 7:00 p.m. R4 was found lying on her left side facing the bedroom door with her head towards the bathroom, R4 stated she was trying to get into her wheelchair, lost her balance and fell , intervention was reminder to use her call light. R4's progress note dated [DATE], identified at 3:30 a.m. R4 was found lying on the floor just in front of her door entry, R4 was assessed, brought to the bathroom and assisted back to bed. R4's Fall Follow Up Notation dated [DATE], (follow up fall from [DATE]) identified a root cause of not asking for assistance. R4's Falls Initial Notation dated [DATE], R4 was found on the floor in her room at 10:15 p.m., no root cause identified, prevention intervention was to place her wheelchair next to her bed (intervention was not identified in the care plan). R4's progress note dated [DATE], at 8:00 p.m. identified that R8 fell attempting to get out of her wheelchair. R4's progress note dated [DATE], identified a follow-up for a fall on [DATE], root cause identified as not using her call light for assist. R4's care conference note dated [DATE], identified R4 to have moderate cognitive impairment with noted delusions. R4 liked to be up at 6:00 a.m. and in bed by 10:00 p.m. R4's progress note dated [DATE], identified R4 experienced a bit of dizziness after breakfast and was assisted to lay down in bed. R4's progress note dated [DATE], identified that at 1:30 p.m. R4 was found flat on her back leaning towards the left side of the door. R4 had ,d+[DATE] pain in her head, left hip, lower back and spine. R4 was oriented to self only. At 2:00 p.m. paramedics arrived to transport to the hospital. At 10:55 p.m. the hospital notified the facility that R4 had a pelvic fracture. R4's Incident Audit Report dated [DATE], identified that R4 tripped when she was trying to go to her bed from her wheelchair, (does not identify what R4 tripped over), prevention intervention was to maintain a clear pathway in her room. R4's progress note dated [DATE], identified R4 returned from the hospital on a stretcher at 3:45 p.m. with a pain rating of ,d+[DATE] with movement. R4's care conference note dated [DATE], identified that R4 is now a Hoyer lift for transfers, takes dilaudid for her pain, and on occasion will experience delusions and hallucinations. Will start PT and OT. During an observation on [DATE], at 4:10 p.m. R4 was noted to be lying on her back in bed, covered with a light quilt with her eyes closed. Bed is in low position and had grip tape strips on the floor in front of the bed. R4's soft touch call light was noted to be lying at the bottom of the bed on R4's left hand side out of her reach. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on [DATE], at 3:18 p.m. R4 was noted to be lying in a low bed with the head of the bed slightly elevated. R4 stated she had pain fromy falling; her elbows both ached, her heels both ached, and this all started when her hips started hurting. R4 indicated her hips hurt from the fall, she hurt her pelvis, and her pain was managed pretty well. During an interview on [DATE], at 10:40 a.m. licensed practical nurse (LPN)-A stated the reason for R4's falls was mostly because she self-transferred, she liked to try and get herself into bed, and they try to keep her involved in activities. Her cognition has declined, especially her short-term memory, sometimes she will put her call light on and forget why she put it on. She does not utilize her call light very often since her memory had declined. During an interview on [DATE], at 10:44 a.m. nursing assistant (NA)-A stated R4 was more confused than she used to be. NA-A explained R4 would fall because she self-transferred especially if she has to go to the bathroom or when she tries to get to her bed. For interventions we try and get her in her bed, offer toileting every 2 hours. NA-A indicated an unawareness if scheduled safety checks were in place, stated she would have been notified by a nurse if there was safety checks. As far as R4's cognition goes I would say she is more confused. During an interview on [DATE], at 3:26 p.m. NA-B stated he has worked at the facility for 2 months, was assigned to work as a float (not assigned a specific group of residents) and would assist with R4 as needed. NA-B stated R4 had at least one fall and thought her fall interventions were to make sure her floor was not slippery, keep the bed in low position and do every 15 minute checks. NA-B indicated this was done for all residents who had falls (15-minute checks could not be verified as completed in R4's record). During an interview on [DATE], at 3:27 p.m. registered nurse (RN)-A verified he was the nurse for R4 for the evening shift today and was the nurse working on [DATE], when R4 last fell . RN-A stated R4 was a high fall risk, her fall intervention was every one hour checks which nurses and NA's were responsible for. RN-A was unable to figure out how to access R4's care plan in order to verify the fall interventions in the electronic health record (EHR). RN-A stated R4 was confused and thought staff had to keep reminding R4 to use her call light. During an interview on [DATE], at 3:36 p.m. NA-C stated this was his second day working the floor and was scheduled to work the floor that R4 resided on for the evening shift. NA-C was not aware if R4 ever had any falls and was not able to articulate any of R4's fall interventions. NA-C was able to state R4 was currently upgraded from a Hoyer lift to an EZ-stand for transfers, NA-C thought that R4 maybe had a broken hip. During an interview on [DATE] at 11:37 a.m. CM verified R4 had falls on [DATE], [DATE], [DATE], [DATE], and [DATE]. CM stated R4's fall on [DATE], resulted in a right pubic fracture resulting in hospitalization for 4 days, the falls were not appropriately root caused and interventions were not put in place, or updated to the care plan. IDON verified R4's care plan interventions had not been updated since [DATE], and stated, we will be having some education on making sure the nurses are more knowledgeable on how to update a care plan. R6's admission record, identified R6 had diagnoses of history of falling, repeated falls, dementia with behavioral disturbance, hydrocephalus, ataxic gait, syncope and collapse, mixed receptive-expressive language disorder, and collapsed vertebra in lumbar region. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R6's significant change MDS, dated [DATE], identified moderate cognitive impairment, required supervision with eating, limited assist of 1 with bed mobility, walking and locomotion, required extensive assist of 1 with transfers, dressing, toileting and hygiene. Balance during transitions and walking identified that R6 is not steady but able to stabilize without human assistance with the following: moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfer, used a walker for mobility. R6 was frequently incontinent of bowel and bladder and has had 2 or more falls without injury. R6's discharge assessment, dated [DATE], identified R6 had 2 or more falls without injury and had a planned discharge to another nursing home. R6's care plan for [DATE], to [DATE], with accurate revision dates was requested and not received by the facility after multiple requests. The care plan that was provided identified interventions with a revision date of [DATE], after the resident had been discharged . The care plan identified R6 was at high risk for falls related to gait/balance problems due to a history of falls prior to admission, hypertension, history of TIA's, syncope, insomnia, diabetes, dementia, depression, weakness, and ataxic gait, in addition R6 had a history of falls with a lumbar fracture, will frequently self-transfer without walker and frequently does not use call light or ask for assist. Interventions dated [DATE] included anticipate and meet needs, assist to keep clutter off the floor in the bathroom, be sure call light is in use and remind R6 to use it, ensure to wear gripper socks when in bed, ensure shoes are within, reach grip strips in front of recliner and on the floor next to bed Intervention that included a discernable implementation date included the following: -Dycem in recliner (start date [DATE]) -Hourly safety checks (start date [DATE]) -half-hour checks (start date [DATE]) -Toilet plan identified to check and change for incontinence every 2 hours, offer to go to the bathroom (start [DATE]) R6's physician visit dated [DATE], was reviewed and indicated that R6 had fallen at least 7 times in 2021, and again on [DATE]. Review of R6's fall risk assessments indicated R6 was at risk for falls and were completed on the following dates, [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The clinical suggestions were to utilize, personal/pressure sensor alarms and nonskid footwear for use with ambulation. Review of R6's medical record identified, R6 had seven falls between [DATE], to [DATE]. All falls were unwitnessed and in her room. All falls lacked a comprehensive assessment, lacked identification of accurate root cause/causal factors, was not evident immediate interventions were implemented, and the care plan was not revised. R6 did not sustain any significant injuries. R6's fall record documentation included the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-[DATE], at 5:56 a.m. R6 was found on her right side on the floor in her room, bump noted to the back of her head and R6 refused to go to the ER, did not have shoes on and stated she was trying to get into the recliner. Root cause was R6 failed to have gripper socks on and failed to use her call light, and no new intervention was provided. -[DATE], at 8:00 p.m. R6 was found on the floor in her bathroom, had told staff she was feeling ill and had an emesis. Root cause identified as R6 failed to use her call light, no intervention provided. -[DATE], at 4:37 p.m. R6 was found on the floor between her bed and recliner. Root cause identified as R6 failed to use her call light, no intervention provided. -[DATE], at 9:00 p.m. R6 was found lying in the middle of her floor, complained of level ,d+[DATE] pain to her right upper arm. R6 was walking from her bathroocm to her closet carrying long pajamas. Root cause identified as R6 failed to use her call light, no intervention provided. -[DATE], at 10:45 p.m. R6 was found on the floor in front of her recliner, R6 stated she slid out of her chair, does not identify if Dycem was used per her care plan. R6 was noted to be incontinent at the time. Root cause identified as R6 failed to use her call light, no intervention provided. -[DATE], at 8:30 p.m. R6 found sitting on the floor of her room in between the closet and her recliner with her back against the wall, stated she was trying to grab something out of the closet. R6 was noted to be oriented to person and situation only per her baseline. Root cause identified as R6 did not ask for assist and was trying to get something out of the closet, no new prevention intervention was identified. -[DATE], at 5:47 p.m. R6 could be heard from the hallway calling for help, was found in her room on the doorway of the bathroom floor, R6 complained of pain in her right upper arm. Root cause identified as R6 failed to use her call light, no intervention provided. During interview on [DATE], at 11:06, a.m. with CM and IDON present. CM indicated after a resident would have a fall, the floor nurse would immediately assess the resident for injury, when safe the resident would be transferred with a Hoyer lift to either the chair or the bed. The floor nurse would be responsible for the documentation in the record, which would include assessment, identification of root cause, and the new intervention. The care plan would then be updated to reflect the new intervention. All department heads meet every morning Monday through Friday to discuss incidents in risk management, this would include falls. CM further stated we don't really discuss the root cause of falls, there is not a section in risk management for that, we never really discuss that. The floor nurse is responsible for that. During an interview on [DATE], at 1:51 p.m. with the CM and IDON present, CM verified that R6 had 7 falls during her stay from [DATE], to [DATE], with no root cause analysis, and no prevention interventions that were put into place. CM further verified this by looking at the dates on R6's care plan with no new interventions noted. CM stated that R6 had a planned discharge to another nursing home that happened on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. Building B. Wing	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The immediate jeopardy that began on [DATE] was removed on [DATE], at 4:20 p.m. when the facility educated their staff on the policy and procedures related to the fall process, R4 and R5's falls were comprehensively assess and care plans were reviewed and revised with appropriate interventions. In addition residents were identified that were at high risk for falls and assessments were completed with necessary care plan revisions. Noncompliance remained at the lower scope and severity level 2, an E-scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Facility Policy, Fall Prevention and Reduction, reviewed ,d+[DATE], indicated, Individual fall precautions and interventions will be developed for all residents who admit to a facility. All falls will be reviewed, and preventative measures will be taken to decrease falls whenever possible to prevent injury. Interventions will be identified related to the residents' specific risks and causes in order to reduce falling and to try to minimize complications from falling. All residents are assessed for fall risk. All falls will be analyzed to determine the root cause of the fall. Procedure for Resident Fall: 1. A licensed nurse will evaluate resident's pain, range of motion and level on consciousness or change in cognition level before moving or assisting resident to a safer position. 2. Keep resident comfortable and avoid moving if there is suspected fracture. 3. A resident on the floor should not be lifted from the floor. Mechanical lift equipment is to be used to lift a resident to a chair or a bed. 4. Vital signs will be completed after all fall events; if possible, complete orthostatic blood pressure comparison. 5. If resident is diabetic, blood glucose levels should be determined. 6. Perform a skin and wound check. 7. If on anticoagulant and head strike suspected, or falls unwitnessed, note last INR reading and current dose. 8. If fall is unwitnessed or resident hits head, neurological checks will be initiated. 9. Complete post fall huddle with staff working on the unit where the resident fell . 10. Seek immediate medical care if needed: notify provider and seek orders or call 911 if the situation demands the need. 11. Notify the provider immediately for all resident falls. 12. Notify the administrator and DN immediately if the resident has a change in condition after a fall or resident hit their head. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	13. Notify the administrator and the DON by office phone and leave message if no injury from the fall, no head strike. 14. Notify the administrator and the DON immediately if the resident requires transport to the hospital within 72 hours of a fall. Includes evenings, nights and weekends. 15. Contact the resident representative on same shift for all resident falls. 16. Document the fall in risk management using appropriate fall progress note. 17. Determine the root cause as to why the resident fell and implement intervention specific to the cause of the fall. 18. Start immediate intervention to attempt to prevent further falls. (See fall intervention list.) 19. Update the care plan and the Kardex with the fall intervention. 20. Hall nurse to complete the fall risk assessment after the fall to identify