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	08/02/2022

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 - Actual harm Residents Affected - Few	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 appropriately assess and implement known interventions to prevent repeated falls for 2 of 2 residents (R1 and R2), who were at high risk for falls. This failure resulted in actual harm for R1 who had an unwitnessed fall and received two rib fractures. Findings include: R1 R1's admission record, indicated R1 had diagnoses of history of falls, dementia, muscle weakness and other specified cognitive deficit. R1's 5/25/22, Significant Change, Minimum Data Set (MDS) indicated R1 had severe cognitive impairment, inattention and disorganized thinking that would not fluctuate, required extensive assistance of 1 staff with Activities of Daily Living (ADL)'s and used a walker and wheelchair for mobility. R1 was frequently incontinent of bowel and bladder. R1's 7/5/22, physician visit (MD)-A) progress note identified R1 was outside enjoying the sunshine that day. She was brought back to her room and was in good spirits but quite confused. She denied any pain and had as needed pain medicine available but had not used it all month. The MD reported she had no falls and required ambulation with supervision. She was to use a wheelchair for long distances and required mechanical assist with transfers. There was no indication MD-A was aware of R1's multiple falls or identified interventions to assist in preventing further falls. R1's 7/24/22 at 9:15 p.m., Post Fall Huddle form identified a post fall huddle was not called. R1 had attempted to get to her wheelchair which was not close to her bed and was agitated earlier in the evening and had reportedly wanted to drive her car. R1's 7/24/22, progress note identified at 9:15 p.m., R1 was found on the floor by her door with her head facing upward. The back of her head was noted to be swollen. She appeared confused, had moderate pain, and was last toileted at 7:30 p.m. R1 reportedly fell when she self-transferred into the wheelchair. R1 was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's current, undated care plan identified on 11/1/19, R1 required assistance with ADL completion and mobility secondary to dementia and weakness. R1 required assist of 1 staff for transfers, hygiene, and dressing. R1 was to be toileted every two hours and was on a toileting program. R1 was at risk for falls related to her confusion, deconditioning, gait/balance problems, incontinence, diagnosis of retinal edema (swelling of the retina which may cause blindness), dementia, history of falls, right ankle pain, muscle weakness and high blood pressure. R1 was to have grippy socks on when in bed and staff were to ensure R1 had well-lit, low glare lighting and provide frequent checks. Staff were not to leave her alone in her room unless she was in her bed or recliner. They were also to encourage her to remain in common areas. A Dycem (specialized cushion to prevent accidental forward sliding) was to be placed in her wheelchair and grip strips were to be placed on the floor in front of her bed. On 7/20/22, staff were to add wheelchair pedals only when staff would need to push R1 long distances, or she would need to leave the facility. R1 was known to have a history of tripping on them during attempted self-transfer. Staff were also to ensure they placed her wheelchair in locked position close to bed when in bed beginning 7/25/22. There was no indication why the facility had identified the need for increased supervision after her numerous falls, nor if they identified R1 may need to be toileted more often than her 2 hr toileting program. During an observation on 8/1/22, at 11:48 a.m. R1 was seated in the hallway in her wheelchair holding onto a baby doll, her foot pedals were on the wheelchair and R1's feet were placed on top of the wheelchair pedals. At 4:53 p.m. R1 was observed to be in the hallway, seated in her wheelchair with her feet resting on her wheelchair pedals, holding onto a baby doll. There was no indication R1 had her foot pedals removed, so it would not create increased risk if she self-transferred. R1's 7/25/22, Fall Report identified R1 had a fall on 7/24/22. That was noted to be R1's first fall in 30 days, 4th fall in 6 months, 8th fall in 1 year and 15th fall since her admission on 8/20/19. R1 was found on the floor, lying on her back in her room at 9:15 p.m R1 denied pain at that time. When she was returned to bed, the attending nurse noted that she had swelling to the back of her head. The nurse called 911 immediately. R1 was sent to the hospital. The facility noted R1 had been in bed when they believe she got up and attempted to get to her wheelchair by herself. R1 was noted to be unable to say what she was going to do after getting in her wheelchair. She was last toileted at 7:30 p.m. The root cause of fall was determined to be restlessness and agitation likely from impaired cognition and emotional lability (tendency to shift rapidly and dramatically between different emotional states). Contributing factors identified were severe cognitive impairment, received medications such as Sertraline (antidepressant) and Oxycodone (narcotic pain reliever). Contributing diagnoses were noted to be a history of falling, dementia, muscle weakness and major depressive disorder. The new fall intervention identified at that time was staff were to place R1's wheelchair in locked position close to bed while in bed. There was no indication the facility had identified the potential need for increased supervision for R1 or had identified why R1 continued to fall. R1's, 7/25/22, Falls Follow-up Notation identified the new fall intervention was to place wheelchair in a locked position close to bed. There was no indication the post fall notation identified the need for increased supervision. R1's Treatment Administration Record (TAR) for July 2022, indicated 30-minute safety checks were discontinued on 7/22/22, at 1:30 p.m. There was no indication why those checks were discontinued or how that determination was made. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/22, at 12:00 p.m. licensed practical nurse (LPN)-B stated R1's fall preventions were to have her bed in low, offer toileting every 2 hours, have her call light in reach, provide freqeunt rounds and give her her baby doll. LPN-B stated R1 liked to sit by the nurse's desk. I have never heard that she had any behaviors. I have not known [R1] to have any recent falls LPN-B was unaware R1 had any fractures. R1's current, undated Kardex, identified R1 preferred to get up at 7:00 a.m. and go to bed at 9:00 p.m Staff were to toilet her every two hours and document crying or weeping episodes. R1 preferred to have a baby doll for comfort. Staff were to ensure her wheelchair was in locked position next to her bed when she was in bed. Wheelchair foot pedals were to be used only for pushing [R1] for long distances or out of facility due to history of tripping on them during attempted self-transfer. There was no mention R1 should have increased supervision at times when behaviors of self-transferring were more likely to occur or that R1 may require more frequent toileting. R1's 7/25/22. at 5:30 a.m., progress note identified R1 returned from the emergency room . R1 arrived via ambulance, was alert and crying she was hurting .oxycodone [narcotic pain medication for severe pain] given for pain. During an interview on 8/1/22, at 11:49 a.m. with registered nurse (RN)-B, she verified she was R1's nurse for the day (8/1/22). When asked if R1 had any recent falls, RN-B stated that R1 has not had any recent falls and does not know of any resident that has had a recent fall with a fracture. RN-B stated R1's fall interventions were to make sure her bed was in a low position while R1 was in it, and to assist her with all transfers and have her call light within reach. RN-B further stated that R1 can talk but gets very confused, we try and keep her out by us to keep an eye on her. I don't think she ever self-transfers. R1's 7/25/22 at 12:50 p.m., Falls Follow-up Notation identified the interdisciplinary team (IDT) met, and R1's fall was reviewed. Physical Therapy (PT) was noted to have not worked with R1 for a long time. Staff were to obtain an order for PT to evaluate and treat and place anti-roll back breaks on wheelchair. There was no indication the facility identified the need for increased supervision or ensure interventions were appropriate. R1's progress note dated 7/28/22, identified the fall committee reviewed the fall on 7/24/22. A root cause was identified, and interventions were deemed appropriate. There was no mention the facility had identified the need for increased supervision to prevent R1's numerous falls to prevent further injury. During an interview on 8/1/22, at 1:46 p.m., nursing assistant (NA)-E verified she was familiar with R1. She stated that R1 will have behaviors like crying, she sometimes thinks no one likes her and gets very tearful and wanders. Staff were to give her a baby doll as it gave her comfort. R1 was mostly incontinent. When she's having a 'good day', she is able to tell us when she needs to go to the bathroom . otherwise we are supposed to offer toileting every 2 hours. Staff were to transfer her with 1 assist and a walker. NA-E stated recently staff had been trying to walk her. I don't think she was able to before. NA-E was not aware of any residents who had had a recent fall with a fracture, and stated, I would know if someone had a fall with a fracture, because my nurse would tell me. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/22, at 2:00 p.m., NA-D stated she was the aide responsible to care for R1. With R1's memory, she does not remember much. Sometimes she can be upset and screaming . sometimes calm and sleepy. NA-D stated R1 was a fall risk so she was not to be left alone in her room. I heard today that last week she had a fall but I didn't get any details. I don't think she got any injuries. I know her routine. When she lays down in bed, it must be in the low position. If she keeps getting up, that means she wet herself. She does not use her call light. When she's awake, we keep her in the hallway so we can keep a close eye on her. During an interview on 8/1/22, at 3:02 p.m. with the clinical manager (CM) and interim director of nursing (IDON) identified the root cause of R1's fall was she self-transferred from her bed to her wheelchair. She was last toileted at 7:30 p.m., Staff were to keep her wheelchair locked at bedside. IDON verified LPN-C was working the evening of the fall and failed to do the post fall huddle per policy and procedure. When LPN-C called her to report the fall, he should have done a post fall huddle. The IDON and CM were unaware, staff that were currently working had no information about R1's recent fall with a fracture or any new interventions related to her fall. During an interview on 8/1/22 at 4:46 p.m., LPN-C verified he worked the evening shift when R1 fell on [DATE], at 9:15 p.m He stated R1 was found outside her room into the hallway on her left side. He felt R1 may have gotten herself out of bed and walked across her room to get her wheelchair. He stated he had not identified any new or revised interventions. LPN-C agreed he failed to follow the facility's policy and did not do a post-fall huddle. When asked how R1 was acting prior to the fall, LPN-C stated during suppertime on 7/24/22 R1 was troubled at one point. She was saying, I have no one . I have no family . He tried to comfort her. R3 had come to the nurse's station and stated to R1, I have been taking care of you for years. You are my daughter. LPN-C was unable to tell if this upset R1 as she was already upset. He stated he had to deal with R3 so he was unsure what staff took R1 to bed. He believed it to be around 7:00 or 7:30 p.m., as that was the time R1 usually went to bed. During an observation on 8/2/22, at 9:25 a.m., R1 was seated near the front desk in her wheelchair with her feet resting on her wheelchair pedals holding onto her baby doll. There was no indication staff identified R1 was not to have pedals on her wheelchair as identified. During an interview on 8/2/22, at 10:34 a.m. NA-F verified she was scheduled to provide care for R1. R1 was assisted in her wheelchair from her bed at around 7:00 a.m. that morning. NA-F stated when she got R1 up at that time, her brief was wet. R1 was to be offered toileting every two hours. NA-F had been unable to toilet R1 since she got up that morning, stating she had not had a chance to do that because she had been very busy down the hall with getting residents, assisting them to get up and answer call lights. It is just me down this hallway today. NA-F was unable to articulate what fall prevention interventions were in place for R1 and was not aware R1 had any recent falls or any fractures. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/2/22 at 10:41 a.m., LPN-A stated she had worked at the facility for about 4 years. LPN-A stated R1 had poor cognition, was oriented to herself only and needed 1 assist for transfers. RN-A stated R1 will cry if she doesn't have her baby doll. R1 was different during the evening hours. She was known to cry saying, Mamma! R1 could get up on her own and self-propelled in her wheelchair. 9 times out of 10 we have her foot pedals on, and then she can't self-propel in her wheelchair. She was unaware of R1's rib fractures. LPN-A then asked the clinical manager (CM)-A why the intervention to have her wheelchair locked at bedside was in place and was told it was due to R1 self-transferring. LPN-A stated she did not think it would be safe for R1 to self-transfer from her bed to her wheelchair. LPN-A was unsure why R1's 30-minute checks were taken away on 7/22/22. LPN-A stated, There is usually something in the risk management communication page about a residents fall. She verified there was nothing there. During a phone interview on 8/2/22, at 11:02 a.m., NA-C stated he was working the evening of 7/24/22. R1 was in a rampage that night. She was looking her for her car keys. We tried to give her a baby doll for distraction, but it only lasted a few minutes. R1 was upset when he came to work that day. NA-C reported the day shift had told staff she had a tough day. NA-C stated they did not do a fall huddle after R1 fell . During an interview on 8/2/22, at 11:11 a.m. trained medication aide, (TMA)-A stated she was scheduled to R1's wing the evening of 7/24/22. TMA-A stated she has known R1 for years used to work with her prior to her becoming a resident. TMA-A stated R1's cognition is poor, occasionally R1 would have a fleeting moment when she remembered who TMA-A was. When she first got there that day, R1 was saying she wanted to go home. Staff tried redirection and 1:1 supervision when able. Staff also gave her some pudding to eat, and after supper she was little better. TMA-A stated I was the one that found her when she fell . I was in the little nurse's station down that hallway. I was doing some of my charting when I heard her hollering and found her on the floor in the hallway outside of her room. LPN-C assessed and performed vitals on R1. Then we got her up with a total mechanical lift and placed her back into bed. At that time, staff observed the bump on the back of her head. When TMA-A first found her, she was her lying on her left side in the middle of the hallway and her wheelchair was behind her facing towards her room. TMA-A recalled NA-A put R1 to bed and advised TMA-A he put her wheelchair across her room by the window when he put her into her bed. Earlier, R1 was upset because R3 agitated her. Usually when we put R1 to bed she stays in bed and sleeps. Right before emergency services (EMS) arrived, R1 she told TMA-A she had to go potty. TMA-A then took her to the bathroom. TMA-A stated she was not aware R1 ended up with 2 fractured ribs from the fall and stated, This is something we should be told. During an interview on 8/2/22, at 10:34 a.m. NA-F stated she was able to get R1 toileted at 11:00 a.m. and then again at 2:00 p.m., stated she will be working a double shift. NA-F further stated, I know she is care planned to be offered to be toileted every 2 hours I was very busy today and I didn't have time to do that, but I know that is what she is care planned for. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/2/22, at 12:49 p.m. IDON verified R1's fall on 7/24/22, was not thoroughly investigated to determine a root cause of her fall. IDON verified that she had only interviewed LPN-C and he had stated the fall was unwitnessed. The IDON stated she had not proceeded with any further investigation. The IDON stated LPN-C did not follow the facility fall policy and do a post fall huddle to determine the root cause. The IDON verified no one interviewed all the staff that worked that evening to determine an actual root cause of R1's fall, if interventions were implemented, or if increased supervision should have occurred when R1 had known behaviors. The IDON agreed a potential root cause may have been R1 needing to go to the bathroom and staff failing to anticipate her needs. The IDON stated moving forward, the facility needed to ensure 1 staff was designated to oversee the fall investigation and stated the current process was not working. IDON agreed R1's care plan intervention to keep foot pedals off was not being followed. She agreed staff should anticipate R1's needs, follow the care plan interventions, and provide increased supervision when R1 showed behaviors known to cause her to potentially self-transfer. Interview and video footage review on 8/2/22 at 6:12 p.m., of R1's 7/24/22, fall with the interim administrator, IDON and maintenance staff, it was determined R1 was brought to her room at 7:19 p.m. At 8:45 p.m. an unidentified aide was seen wheeling R1 who was dressed in a facility gown, out of her room and into the hallway. She was then seen wheeling R1 back to her room shortly after at 8:46 p.m. At 8:47 p.m., the unidentified aide was seen leaving the room. At 9:03 p.m. R1 walked independently out of her room pushing her wheelchair. R1 appeared to have tried to turn her wheelchair around in her doorway, lost her balance, and fell backwards onto the floor in the hallway, hitting the back of her head on the floor. R1 then turned to her left side while she was lying on the floor and placed her hands under the left side of her head. NA-A was the first on the scene and placed a pillow under her head. LPN-C was seen bringing equipment to do R1's vital signs. The IDON stated the intervention to keep R1's wheelchair in a locked position by her bed may not be appropriate after watching the video footage. The IDON verified she was not aware that R1 could get up on her own and walk. R2 R2's 7/22/22, Client Coordination Note Report (hospice note) identified the hospice nurse got to R2's room at 4:30 p.m. and found R2 on the floor screaming. 2 facility staff came and used a Hoyer lift to get R2 into the bed. No fracture was identified at that time. R2 could get up and move around in her wheelchair. The hospice nurse asked facility staff to give R2 some Morphine (narcotic pain medicine) and lorazepam (used for anxiety and muscle relaxation). The facility nurse stated R2 had no current orders for that. Verbal orders were obtained for the Morphine and lorazepam which were given to the facility nurse so they could update it in their system. The facility nurse gave R2 the morphine and lorazepam but R2 proceeded to spit it out. A new hospital bed with an air mattress and a fall floor mat was ordered. R2 was brought to the dining room for dinner and ate 100% of her dinner. R2's admission record, indicated R2 had diagnoses of dementia with behavioral disturbance, anxiety disorder, low back pain, unspecified hearing loss, mixed incontinence, and macular degeneration (eye disease leading to blindness), disorientation, abnormalities of gait (walking) and mobility and muscle weakness. R2's Significant Change, Minimum Data Set (MDS), dated [DATE], indicated R2 had severe cognitive impairment, inattention that came and went, hallucinations, and delusions. R2 required extensive assistance of 1 staff with ADL's and used a wheelchair for mobility. R2 was frequently incontinent of bowel and bladder. R2 had 1 fall with no injury noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's 7/19/22, Fall Risk Assessment identified R2 was at risk for falls and the clinical suggestions were to utilize a toileting program. R2's 7/22/22, Fall Risk Assessment identified R2 was at risk for falls and clinical suggestions were to now utilize a toileting plan with addition of non-skid slippers worn for ambulation. Review of R2's Treatment Administration Record (TAR) for July 2022, indicated 30-minute safety checks that were discontinued on 7/22/22. R2's 7/22/22 at 1:46 p.m., progress note identified the IDT met and agreed 30-minute checks could be removed due to the intervention of adding anti-roll back breaks have been added to the wheelchair. R2's current, undated care plan identified R2 had an ADL self-care performance deficit related to impaired balance, limited mobility, Intervention to offer toileting every 2 hours. R2 had a history of falls due to dementia, incontinence, anxiety disorder, history of a stroke, macular degeneration, and abnormal gait. Staff were to encourage R2 to be in public places when restless or agitated, wear gripper socks while in bed, keep bed in lowest position, offer to use toilet or offer ambulation when she became agitated, ensure her environment was free of clutter, and apply anti-roll breaks to wheelchair. 30-minute checks due to high risk of falls were initiated on 4/12/20 but discontinued on 7/22/22. Staff were to ensure a fall mat was beside her bed, initiated on 7/23/22. R2's current, undated Kardex, identified R2 preferred to get up at 8:00 a.m. and go to bed at 8:00 p.m Staff were to offer toileting every hour or when R2 became agitated. A hi/low bed was ordered and had arrived from hospice. Staff were to keep the bed in the lowest position, ensure she wore gripper socks when in bed, and ensure her fall mat was at her bedside. During an observation on 8/1/22, at 1:35 pm, R2 was lying on her back in her bed. A blue fall mat was located under her bed and not beside her bed as care planned. R2 was covered with a blanket but was noted to have red shoes on and not wearing gripper socks. A pillow was placed on the left side of R2's back where the soft touch call light was also located, out of R2's reach. Her walker and wheelchair were not within R2's reach. During an interview on 8/1/22, at 1:42 p.m. NA-E stated that most of the time R2 would become really irritated. If she tries to self-transfer, that means she has to go to the bathroom. She had some falls, but it was usually on the evening shift. R2 had liked to wander around. I think she is supposed to be checked every hour, but I am not sure if the evening staff know that or not. When NA-E would put her to bed or lay her down for a nap, she would place a pillow on her left side for positioning and then put her soft touch call light on top of that pillow. NA-E recalled R2 had a mat to put next to her bed on the floor but thought that was to be done only during the evening shift, Not for our shift though. R2's 7/25/22, progress note identified the IDT team met and falls were reviewed since 5/1/22. The care plan was determined to be updated and appropriate. There was no indication the facility audited interventions to determine if staff were carrying out the interventions to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 8/1/22, at 1:48 p.m. R2 was still noted to be sleeping in her bed, the fall mat was now next to her bed and not underneath it. Clinical consultant (CC)-A and CC-B were noted to be in the hallway outside the room, a tray table with printed documents was noted to sitting on top along with an electronic device. CC-B verified she just put the mat down next to R2's bed. CC-B stated it is supposed to be there it is on her care plan. CC-A stated they were now performing the fall audits. During an interview on 8/1/22, at 2:06 p.m. NA-D stated that R2 was not known to lay down. She liked to wander around from room to room and staff walked her with a walker. She will just get up and start walking so we have to keep an eye on her. She is a high fall risk, but no recent falls that I know of. When we lay her down at night she will stay in the bed unless she has to go to the bathroom. During an interview on 8/1/22, at 2:46 p.m. CM-A was present and IDON identified no fall huddle was completed after the fall R2 had on 7/22/22, so the IDON could not determine a root cause. LPN-C was the nurse responsible to do it. The IDON stated she had re-educated LPN-C. The IDON verified she did not go back and interview staff that were working the evening of the fall to try and determine a root cause. The IDON recalled she did not identify any new interventions or review previously implemented interventions to determine if staff were implementing them or if they needed to be revised, because she was unaware what the root cause was. When IDON was notified that none of the staff that were working today were aware that R2 had a recent fall, the IDON stated, It may be because there was no new intervention put in her care plan, and it wouldn't have showed up on the communication board. IDON was informed that R2's care plan was not being followed during observations of her fall mat not being placed next to the bed and the appropriate footwear applied. The IDON agreed staff should follow the care plans and oversight was needed to ensure investigations, analysis of interventions, and auditing were critical to preventing further falls. Additional interview on 8/2/22, at 11:58 a.m. IDON stated regarding R2's fall, she identified her fall occurred at approximately 4:30 p.m The IDON was not sure what time R2 was assisted to bed for her nap but guessed around 2:00 p.m R2 was last offered toileting at 11:58 a.m She was unsure if she was incontinent at the time of her fall as that was not noted by staff in the incident report. that was not identified. She now determined the root cause of R2's fall identified R2's call light was on. R2 may have had to go to the bathroom. R2 wanted to get up she had been in bed for 3 hours after she was done with her nap. She stated she had added an intervention to wake R2 daily at 3:00 p.m Review of the July 2022, Fall Prevention and Reduction policy identified individual fall precautions and interventions were to be developed for all residents who were admitted to the facility. All falls were to be reviewed, and preventative measures taken to decrease falls whenever possible to prevent injury. Interventions were to be identified related to the residents' specific risks and causes to reduce falling and to try to minimize complications from falling. All residents were to be assessed for fall risk. All falls were to be analyzed to determine the root cause of the fall. Procedure for staff to follow after a fall occurred were: 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2022

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.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 DON immediately if the resident has a change in condition after a fall or resident hit their head. 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 the new or changing risk factors for resident fall. 21. Hall nurses begin documentation for Falls Follow up Notation a minimum of once per shift for 72 hours. Complete VS ROM, neurological checks (if required). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	22. Nurse Manager for designee is responsible to ensure the completion of the Risk Management for a fall. Procedure for Fall Risk Assessment included in the policy was for staff to: 1. Completed a fall risk assessment upon admission, prior to annual MDS, quarterly (reviewed), significant change and following a resident fall. 2. Implement appropriate interventions/precautions. All member of the interdisciplinary team will participate and contribute to the plan of care with resident specifics fall reduction efforts. 3. Notify the resident representative and medical provider as appropriate.