STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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 - Minimal harm or potential for 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** 43080 Based on observation, interview and document review, the facility failed to comprehensively assess when a new fall risk was identified and failed to safely implement and maintain resident equipment for 1 of 3 residents (R1) who utilized an air mattress that was not maintained at the recommended pressure. Additionally, the facility failed to assess and immediately implement new interventions for 1 of 3 residents (R2) who had falls related to self-transfers. Findings include: R1: R1's significant change Minimum Data Set (MDS), dated [DATE], identified R1 was severely cognitively impaired and received total physical assist for most cares; however, extensive assist was provided for bed mobility. R1 was free of falls in the past quarter. Diagnoses included traumatic brain injury (TBI), sleep disorder, and muscle spasms. An Order Summary Report identified an order was entered on 6/5/23 for an air mattress to R1's bed. Staff were directed every shift to ensure proper function, inflation, and tie downs. A [comprehensive] Fall Review Evaluation form, locked 5/16/24, identified no history of falls in the past three months; however, R1 was at risk due to the following: medications administered, cognitive impairments, total bowel and bladder incontinence, wheelchair dependence with disorientation, and hands-on assistance to move from place to place. The Summary/Interventions section indicated R1 required dependence on a wheelchair for mobility as she was unable to walk. She was limited to only making slight changes to her extremities and required assistance with mobility. The evaluation lacked a fall analysis and information related to air mattress use, muscle spasms, chronic pain, or seizure activity, nor did it address any potential associated risks related to these. On 7/18/24, R1's weight was 145.8 pounds. (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 - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan identified an intervention for skin integrity that included a pressure redistribution mattress and for mobility she required two staff for bed mobility. The interventions were free of an assessed pressure setting identification or any additional mattress instructions. In addition, with a revision date of 3/17/22, R1 was a fall risk related to defined medication usage, impaired cognition and mobility, along with history of seizures. The goal was for her to be safe and free from falls. Interventions directed placement of foam side boards to her wheelchair for proper body alignment. Staff were directed to monitor and document on safety, review information on past falls and attempt to determine cause(s), record possible root causes of falls, and alter or remove any if possible. A Risk Management Found on Floor incident report, dated 7/20/24 at 10:40 p.m., indicated R1 was observed on the floor wrapped up in her bedding. She displayed intermitted confusion and she stated she tried to get up. R1 moaned and reported back, hip, and neck pain at a 10 when transferred to bed. She appeared still and refused to move when a skin assessment was attempted. An order was received for emergency department evaluation. Predisposing Environmental Factors identified Other and Bed Position. Predisposing Situation Factors identified Rolled out of bed. The form lacked intervention and/or any investigatory information. R1's progress notes identified the following: -7/21/24 at 0:18 a.m.: the ambulance arrived at 12:10 a.m. and R1 was transported at 12:35 a.m. A copy of the incident report was placed in the director of nursing (DON)'s box. -7/21/24 at 6:11 a.m.: hospital staff updated the facility R1 was assessed to have a C2 (cervical) fracture and was being transferred to another hospital. -From 7/21/24 through 7/24/24, the progress notes lacked identification a 7/21/24 fall analysis and/or any interventions to mitigate a reoccurrence. R1's hospital information identified the following: -7/22/24, a neurosurgical consultation note identified R1 was seen at an outside hospital where imaging revealed a C2 fracture with possible widening of the disc space. Fortunately, MRI [was] without disc injury, ligament injury or significant edema. There is a minimal fracture line at C2 - difficult to determine acuity. -An MRI cervical spine final report identified an oblique fracture at the anterior-inferior corner of the C2 vertebral body without significant displacement. There was no overlying prevertebral soft tissue swelling or evidence of ligamentous injury or malalignment. There was minimal T2 hyperintense signal along the fracture. Given the minimal associated marrow T2 hyperintensity, as well as the lack of prevertebral soft tissue swelling, this fracture is age indeterminate and could be hyperacute or subacute to chronic in nature. -R1's hospital documentation lacked evidence of suspected head/cranial injury. A progress note, dated 7/23/24 at 4:10 p.m., identified R1 returned to the facility at 1:30 p.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident Review and Analysis form, dated 7/23/24 at 2:49 p.m., identified R1's 7/20/24 fall where R1 reported she potentially laid too close to the edge of the air mattress and pressed her call light after she fell . Her mattress was assessed and functioned properly with the right weight. She was potentially too close to the edge of the bed, causing her to slip out. An intervention section directed to See Care Plan. Other interventions were identified as a foot cradle and a perimeter air mattress overlay. The form indicated that during the investigation, therapy reported R1 was unable to turn her body at all but was able to move her arms. She was not incontinent at the time of the fall and was checked on 40 minutes prior where she was left laying supine with no pillows used to offload her body and gripper socks on. R1's care plan history identified fall risk interventions were created on 7/23/24 (three days later) to include a foot cradle and a perimeter air mattress overlay. Resident group sheets were reviewed. R1 was identified as a fall risk, and she was to utilize nonskid footwear and to provide safety if a seizure occurred. Under bed mobility, staff were directed to ensure her air mattress functioned properly every shift. The group sheet lacked information related to R1's observed right sided leaning, perimeter overlay, bed cradle, mattress pump setting, bed height, and/or head elevation. An Order Listing Report, printed 7/25/24, identified all orders entered for R1 since 7/20/24. On 7/21/24, an order to send R1 to the ED for post-fall evaluation was entered. The orders lacked a fall batch order entry. When interviewed on 7/24/24, at 10:27 a.m., R1 lacked signs and/or symptoms of distress. Her forehead/face was free of bruising or signs of injury. A neck collar was in place while she laid on an inflated air mattress that housed a head and foot sectioned perimeter overlay. A foot cradle was in place without concerns. She was centered within the bed with her head slightly elevated (approximately 20-30 degrees). She was questioned on her observed neck collar use. She explained she fell from bed a couple of weeks ago when she attempted to get out of bed as it was morning. R1 confirmed this was her first fall and she was able to move in bed. However, R1 was unable to move her lower extremities when cued by the surveyor, but she brought her arms to her forehead when asked to do so. She denied any staff concerns or fears while staff rolled her in bed. R1 identified she rolled off the bed, yelled for help, and staff came right away. She acknowledged this was the first time she attempted to get out of bed herself. R1 identified she went to the hospital after the fall to get checked out and she denied any injuries were found. R1 denied concerns with her air mattress. On 7/24/24, at 10:46 a.m., immediately after R1's interview, her air mattress pump was examined. The pump identified it was a Custom Medical Solutions - Matrix ALAL Mattress System. The mattress pump identified the pump was on and lacked any lit warning identifications. The alternating cycle mode was set to every 15 minutes and the setting was set to 6. The Soft to Firm setting scale identified a setting of 6 was for a person who weighed an estimated 245 pounds. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24, at 2:27 p.m., R1's family member (FM)-A was interviewed via telephone. He stated he visited with R1 most evenings; however, missed the evening of her fall. He was concerned on how someone who was immobile for almost 40 months could flop themselves out of bed. FM-A informed him she remembered being on the floor, but she did not remember any overall details. He explained there were instances about three to four months ago when she pushed herself in her wheelchair with her left leg, and so maybe she pushed on the wall with her left leg enough to slide out of bed. Sometimes she sits too straight and may have slid a little also. He adjusted her in bed at times due to this. FM-A identified R1's head was often elevated at a 45-degree angle. He stated R1 thought she could stand and walk. She is bullheaded. FM-A stated when R2's MRI/CT scan results came back, R1 had a C2 fracture; however, no one could figure out if this was new or old as there was no swelling of the ligaments and no indication it was an acute fracture. FM-A identified R1's air mattress was never to be static; it was always to be rotating. He often checks this as he had found this on static in the past. FM-A was unaware of what the other pump settings should be. During an interview on 7/24/24, at 3:40 p.m., TMA-B stated resident care plans identified their fall risk. She did not consider R1 a fall risk prior to the fall despite episodes where she witnessed R1 leaning while in bed. When this occurred, staff just helped reposition her. TMA-B explained R1 preferred to lay on her back, with her head elevated so she could watch TV, along with the bed frame as close to the floor as it went to ensure overall safety. She indicated this was the position she left R1 in around 7:00 p.m. the evening relevant to her fall. TMA-B was unaware of R1's mattress pump settings and explained the monitoring on the TAR indicated she was to check the bed and make sure it was on and inflated: maintenance or management adjusted the beds as she was not allowed to touch any of the settings. TMA-B was unaware of any new or updated interventions to mitigate R1's fall risk. She was unaware if R1 had bumpers on her bed even though she previously worked with R1 this day. R2: R2's Face Sheet identified R2 admitted on [DATE], from the hospital, after he sustained multiple fractures of his right sided ribs. Additional diagnoses present on admission were history of a fall, muscle weakness, unsteadiness on his feet, aphasia, fracture of right femur, malnutrition, and history of TBI. R2's Admission/Initial Data Collection form, dated 7/9/24, identified memory impairments, both short and long, assistance needed for mobility and toileting, ROM impairments on both upper and lower extremities right sides. In addition, R2 was frequently incontinent of bowel and bladder, had broken ribs and femur, and experienced falls in the past month and again in the past six months. R2's 48 Hour Care Plan, dated 7/10/24, identified he was at risk for falls. No etiologies were identified. The goal was for him to remain safe and free from falls. Staff were directed to follow therapy instructions for mobility and to monitor and document on safety, review information on past falls and attempt to determine cause(s), record possible root causes of falls, and alter or remove any if possible. Staff were then to educate resident, family, caregivers, and the IDT (interdisciplinary team) on any findings. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident group sheets were reviewed. R2's was identified a fall risk. There was no additional information under the safety heading. Toileting directions were provided for every two to three hours. A Leisure Act. - Rehab. - Restorative section identified he was to be offered to get up around 4:00 a.m. and 6:00 a.m., toilet, provide a cup of coffee, turn the news on, and offer to lay back down when coffee was finished. The group sheet lacked information related to his self-transfers, the use of a night light, or ensuring a Reacher was near him. R2's medical record identified the following entries and identified information: -7/10/24 progress note at 2:56 p.m.: R1 required one-on-one supervision with staff due to his high fall risk. The note lacked any additional details. -7/10/24 progress note at 10:53 p.m.: R1 attempted self-transfers and was restless. -7/11/24 progress note at 9:34 p.m.: R1 was observed standing next to his wheelchair. -7/12/24 provider progress note: R2 was assessed. The note lacked information related to the self-transfers. The plan of care was to be continued and there were no concerns from R2 or staff at that time. -7/15/24 Task behavioral documentation at 5:59 a.m.: one self-transfer attempt. Despite reassurance being provided, the behavior was unchanged. -7/15/24 progress note at 10:25 a.m.: after a three-day bowel and bladder screen, R2 was incontinent of bowel and bladder and required assistance with toileting. A plan was initiated for him to be assisted with his toileting needs every two to three hours and as needed. -7/15/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite reassurance being provided, the behavior was unchanged. -7/15/24 progress note at 2:33 p.m.: R2 liked to self-transfer and wandered. -7/15/24 progress note at 3:01 p.m.: R2 was found seated on the floor [at 6:00 a.m.]. No injuries were assessed. R2's only response was 'look at all of this' as he pointed at the room. -7/15/24, an occupational therapy (OT) progress note at 3:01 p.m., identified OT approached R2 and found him on the floor. The note did not identify at what time R2 was found. No injuries were observed. -7/15/24 order listing report identified fall batch orders to complete a post fall progress note every shift for 72 hours with directions to Make sure to include any [signs/symptoms (s/s)] of injury and effectiveness of new fall interventions. The second order identified interventions for medication review request and call light reminder sign. There orders were discontinued 7/16/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Risk Management Found on Floor incident report, dated 7/15/24 at 6:00 a.m., identified R2 was found seated on the floor. He was unable to identify what happened and he was injury free. He was returned to bed and checked on frequently afterwards. Immediate actions identified staff placed a sign in his room to call for assistance and he was frequently checked on throughout the day. Lighting concerns were identified, along with R2's confusion, history of falls, and not always able to realize his limitations in which R2 ambulated/transferred without assist. R2's medical provider was updated at 2:59 p.m., the DON at 3:00 p.m., and FM-B at 3:24 p.m. An admission [comprehensive] Fall Review Evaluation form, dated 7/15/24 at 9:50 a.m., identified R2's history of multiple falls in the past month and past six months with risk factors related to psychotropic medication, memory impairments, impaired mobility, occasionally incontinent of bowel and bladder, and exhibited agitated, or wandering, behaviors in the past seven days. Environmental factors provided an option for Lighting [as identified on the Risk Management 7/15/24 form]; however, this was blank. A summary identified R2 had potential risk for falls related to decreased mobility and listed medication and he was disoriented and required two staff for transfers. Fall interventions directed to see the care plan and staff would continue to monitor and update the plan of care as needed. The evaluation was free of information related to the 7/15/24, 6:00 a.m. fall. An Incident Review and Analysis form, dated 7/15/24 at 10:20 a.m. and signed as complete on 7/18/24, identified the information from R2's 7/15/24 Found on Floor incident report. The form analysis indicated R2 was brought to the activity room after the incident. Contributing factors included inability to always realize his limitations, history of falls, lacked remembrance to use the call light, expressive aphasia, and the lack of room light. The form directed one to the care plan for interventions and indicated RN-C spoke to FM-B and was informed R2 enjoyed picking things up from the ground, such as sticks in the yard. In addition, he liked things tidy. The call do not fall sign was removed as R2 was severely cognitively impaired and he was provided with a grabber/Reacher. An admission MDS driven Behavioral Symptoms CAA (Care Area Assessment), dated 7/16/24, identified R2 displayed three occurrences of self-transferring within a seven day look back period. The behaviors would be care planned to slow or minimize declines and risks. The CAA was free of information related to self-transfer mitigation. An admission MDS driven Falls CAA, dated 7/16/24, identified R2's fall history with injury and that he fell on ce since admission. R2 displayed balance problems during surface transitions and transfers in which staff ensured his footwear prevented slipping, his room was set up to accommodate his needs, and his personal items were within his reach. The fall risk would be care planned to avoid complications and minimize risks. The CAA was free of information related to R2 footwear or room accommodation specifics. In addition, the CAA lacked details related to his 7/15/24 fall, his self-transfers, or any overall comprehensively assessed fall risk details and determined resident specific fall interventions. R2's subsequent medical record identified the following entries and identified information: -7/16/24 provider note identified R2 had 2 falls last night and 1 this morning. R2 continued to be forgetful and impulsive with self-transfers. A fall matt next to his bed was recommended. -7/16/24 progress note at 6:52 a.m.: Fall Charting - vitals and neuros within R2's norm. No falls tonight on this shift. The note lacked effectiveness of interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/16/24 progress notes at 10:35 a.m.: R2 was seated on his bedroom floor [at 6:25 a.m.]. No injuries assessed. R2 unable to provide fall details. He was checked on frequently afterwards. -7/16/24 order listing report identified the fall batch orders were initiated with direction to monitor the effectiveness of a medication review request and call light reminder sign. A Risk Management Found on Floor incident report, dated 7/16/24 at 6:25 a.m., identified R2 was found seated on the floor without injury. He was unable to identify what happened. He was returned to bed and checked on frequently. An immediate intervention was a fall mat. Poor Lighting was identified, along with R2's incontinence, gait imbalance, and cognitive impairments. The medical provider was updated at 11:59 a. m., the DON at 12:01 p.m., and FM-B at 11:59 a.m. An Incident Review and Analysis form dated 7/16/24 at 4:08 p.m., and signed as completed on 7/18/24, identified the information from the 7/16/24 Found on Floor incident report. R2 was found incontinent, and the room was dark. He was cleaned up and new cloths donned. Current interventions directed one to the care plan. RN-C spoke with FM-B as the falls occurred at approximately the same time on two consecutive days. Based on FM-B's statements of R2's routines, interventions were implemented; however, the poor lighting concern and the fall matt from the incident report on 7/16/24 was not addressed. R2's subsequent medical record identified the following entries and identified information: -7/18/24 progress note at 5:44 a.m.: R2 remained a fall follow up. He continued to self-transfer. The note lacked effectiveness of interventions. -7/18/24 physical therapy (PT) progress note identified R2 continued to require two staff due to his fall risk and impulsive movements. -[7/19/24 progress notes lacked documentation R2 fell at 5:00 a.m.] -7/19/24 order listing report identified an order to cleanse above the right elbow skin tear, apply skin prep, and cover with non-adherent dressing. Change every three days. -7/19/24 order listing report identified fall batch orders to complete a post fall progress note every shift for 72 hours with monitoring the effectiveness of a fall mat and night light interventions. -7/19/24 provider note identified R2 was assessed for pain, fall, and blood pressure follow-up. He continued to have multiple falls, was impulsive, and had a fall matt in place. He was reminded to use the call light and was agreeable; however, he was forgetful. Blood pressure would continue to be monitored. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Risk Management Found on Floor incident report, dated 7/19/24 at 5:00 a.m., identified R2 was found on the floor in which he was not on the fall mat. He and his bed were wet with urine. He was without socks and his bed was in the lowest position. He was unable to identify what happened and sustained a right elbow skin tear. He was changed into a new brief and gown, and socks were placed. An immediate intervention was a a toileting plan. The form lacked specific toileting plan detailed adjustments to the 7/15/24 and 7/16/24 initiated toileting plans. Lighting, Noise, and Poor Lighting concerns were identified. The report lacked evidence FM-B was notified. An Incident Review and Analysis form dated 7/22/24 (three days after the fall), at 2:57 p.m., identified the information from the 7/19/24 Found on Floor incident report; however, did not identify R2 was found off the fall mat or there were lighting issues identified. Current interventions directed one to the care plan. Other intervention identified a toileting plan. The form lacked specific toileting plan detailed adjustments to the 7/15/24 and 7/16/24 initiated toileting plans. R2's fall risk care plan identified he was at risk related to history of falls with injuries. He was to remain safe and free of falls. The following information was identified: -On 7/18/24 [two days after a fall], a grabber or Reacher intervention was initiated. -On 7/18/24 [two days after a fall], a 4:00 a.m. to 6:00 a.m. plan to offer R2 the opportunity to get out of bed, use the bathroom, have a cup of coffee, place channel 9 news on, and after done offer him to lay down for a nap was entered on the care plan. -On 7/19/24, auto-lock brakes to the wheelchair were entered on the care plan. R2's chart lacked additional information on the brakes. R2's subsequent medical record identified the following entries and identified information: -7/19/24 progress note at 11:00 p.m.: R2 remained on fall follow up. Continued to attempt self-transfers but was easily redirectable. Confused per baseline. The note lacked effectiveness of interventions. -7/20/24 Task behavioral documentation at 1:59 p.m.: five attempts at self-transfers. Despite redirection the behavior was unchanged. -7/20/24 progress note at 3:06 a.m.: R2 was found seated on his bedroom floor [at 12:30 a.m.]. He was unable to state what happened. He was free of injury and toileted with his call light left within reach. Gripper socks were applied, and he was redirected to call for help instead of self-transferring. The incident report was placed in the DON's box. -7/20/24 order listing report lacked evidence fall batch orders were initiated related to R2's 7/20/24 fall. A Risk Management Found on Floor incident report, dated 7/20/24 at 12:30 a.m., identified R2 was found seated on the floor by the bathroom and was without injury. He was unable to identify what happened. R2 was toileted. Other and Poor Lighting were identified as concerns and he continued with previously identified risk factors. The report identified RN-C was notified at 3:04 a.m., but lacked evidence FM-B was notified, and/or the provider. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident Review and Analysis form, dated 7/20/24 at 1:51 p.m. and signed as completed on 7/23/24, identified the information from the 7/20/24 Found on Floor incident report. Contributing factors identified the room was dark when he was found. Current interventions directed one to the care plan. An implemented intervention was a night light to his room. R2's provider was updated; however, the Responsible Party incident review designation box was unchecked. R2's subsequent medical record identified the following entries and identified information: -7/20/24 progress note at 9:39 p.m.: R2 remained a fall follow up. He continued to demonstrate weakness and self-transfers. He was redirected successfully. The note lacked effectiveness of interventions. -7/21/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite a change in location the behavior was unchanged. -7/22/24 PT progress note identified R2 was found self-transferring to the toilet upon therapy approach. The note lacked identification nursing was updated. -7/22/24 OT progress note identified R2 stood alone in the bathroom upon approach. The note lacked identification nursing was updated. -7/23/24 provider note identified R2 was assessed; however, the note lacked information related to his 7/20/24 fall, his continued fall risk, and self-transfers, or involved discussion related to fall interventions. -7/23/24 Task behavioral documentation at 1:59 p.m.: one self-transfer attempt. Despite redirection the behavior was unchanged. -From 7/10/24 to 7/24/24, neither OT or PT progress notes identify R2 fell on [DATE], 7/19/24, or 7/20/24 and/or any involvement with nursing staff related to fall analysis and intervention discussions. R2's fall risk care plan identified he was at risk related to history of falls with injuries. He was to remain safe and free of falls. The following information was identified: -On 7/22/24 [two days after a fall], toilet R2 every two to three hours was entered on the care plan. -On 7/23/24, [three days after a fall], night light to room was entered on the care plan. R2's July 2024 TAR was reviewed. This identified 19 shift opportunities which directed staff to monitor injury and the effectiveness of designated fall interventions associated with orders initiated on 7/15/24, 7/16/24, and 7/19/24. The TAR lacked directions related to R2's 7/20/24 fall. All 19 opportunities were signed off by staff as completed. In relation, progress notes from 7/15/24 through 7/24/24, identified six progress notes for fall follow-up. Out of these six, none evaluated the effectiveness of the fall interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Rush City LLC	650 Bremer Avenue South Rush City, MN 55069

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an initial tour on 7/24/24, at 10:18 a.m., R2 was not observed in his room. A red colored mat was on the floor. In addition, a soft-touched call light rested on the bed and the standard mattress was at an average bed height. Immediately after, TMA-A confirmed this was a fall mat. When interviewed on 7/24/24, at 1:35 p.m., R2's room was free of the previously noted red fall mat and there were two signs within his room to remind him to put his call light on for help before getting out of his wheelchair and a sign on the bathroom door to please use call light for assistance. The bed height was at a standard height. Communication was more drawn out due to his expressive aphasia; however, with communication techniques, the interview progressed. He was good and agreed it was July. When asked where he was, he responded I am not really sure. He confirmed falls since admission and these falls were from bed. When asked the reason for the falls, he stated, I know the reason .was trying to go to the bathroom. He denied injury from the falls. He was able to find his call light when cued and his Reacher when asked if he was able to use it. He acknowledged episodes where he had a hard time controlling his bladder and bowels and he felt staff toileted him to his liking. He denied concerns with his stay. During an interview on 7/24/24, at 1:51 p.m., trained medication aide (TMA)-A stated resident fall risk was identified on the group sheets and within their charting system. He lacked the group sheets on him at that time. TMA-A thought fall interventions were identified on the group sheets but was not 100 percent sure. He did not feel R1 was a fall risk, and her recent fall surprised him. He stated R1 preferred to be in bed, on her back, and was not up for long periods of time. TMA-A explained R1 was able to move herself a little bit when in bed and she preferred her head elevated. R1 was overall dependent on staff but she helped feed herself at times. TMA-A indicated R1 utilized an air mattress and denied any noted concerns with it. He denied the facility educated him on air mattress expectations and/or what the manufacturer guidelines for use were. TMA-A denied he adjusted the pump settings as It is there for a reason. He was unsure what R1's pump settings were expected to be set at. When he worked with her, he just checked to ensure the mattress was on and inflated. He was unable to identify when the perimeter overlay was placed. -TMA-A stated he continued to monitor R2 constantly, somewhere where he needs to be in sight as he tries to jump out of his wheelchair. He identified R2 was much better when he was in bed and less likely to self-transfer. Fall interventions utilized on R2 were the obvious ones such as gait belt, making sure he had a steady rail in the bathroom, etc. He did not feel R2 had any specialized fall risk interventions. However, he explained basically every two to three hours they toileted him and attempted to keep him involved in as many activities he could for distraction purposes. Despite this, R2 continued to self-transfer and required his interception. The self-transfers varied per shift and depended on what R2 was doing at those moments. He denied nurses and/or management spoke to him about his insight into R2 and his fall risk for potential assist with intervention development and/or adjustments. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 7/24/24 at 2:58 p.m., registered nurse (RN)-A stated the nurse managers performed the fall risk assessments but explained all the residents were at risk for falls - some were just higher risk than others. After a resident fell , she was expected to enter an incident report into PointClickCare (PCC) which management then reviewed and who then developed intervention(s). RN-A explained if she were to initiate an intervention, this would be documented with her fall note. She expected all fall interventions to be entered in the care plan or on the group sheets. RN-A identified that on 7/20/24, she observed R1 on the floor wrapped up in her bedding. R1 informed RN-A that she attempted to get up. R1's call light was unplugged from the wall and her bed was high despite R1's need for a low bed. RN-A clarified R1's bed was expected to be at standard height but she was higher. She was unsure of R1's head elevation status as she was more concerned with getting R1 off the floor, but R1 preferred the head of her bed elevated about 30 to 45 degrees. The air mattress was inflated, and she did not feel she remembered any notable concerns. RN-A explained the NAs checked the air mattresses every shift to ensure they functioned properly and thus she did not personally check to ensure functionality: if staff did not approach her with any concerns, she initialed it off on the treatment administration record (TAR) that it was checked. R1's mattress setting(s) were unknown to her and she guessed the setting should be maybe around 350. RN-A denied knowledge of previous R1 falls but within the past few months she had assisted R1 to reposition as she was closer to the edge of the bed with her head elevated, in which R1 had a tendency of doing when her head was elevated. RN-A explained the intervention put into place after R1's fall was her transfer to the hospital. She did not investigate any potential causes of the fall, or her concern related to the bed height. During the same interview, RN-A identified R2 required a low bed, a soft-touched call light, a fall mat, frequent checks, and gripper socks due to his self-transfers. RN-A explained R2 just get up when he felt the need but did not understand his weakness. She often had to tell R2 to use his call light. RN-A explained one-night R2 fell despite there already being a fall mat in