STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review, the facility failed to ensure a fall with serious injury with potential neglect was reported to the State Agency (SA) for 2 of 3 residents (R3 and R2) reviewed for falls. Findings include: R3 A Vulnerable Adult Maltreatment Report submitted to the State Agency on [DATE] at 5:45 p.m., alleged caregiver neglect for an incident that had occurred on [DATE] at approximately 5:00 a.m. The report indicated R3 fell on [DATE] and was sent to the emergency department (ED) for a broken finger and again, fell on [DATE] in the morning and was sent to the ED with injuries and died the next day. Further indicated R3 had COVID and was in his room with the door shut and needed staff assistance to transfer. In review of Facility Reported Incidents (FRI), it was not evident R3's fall was reported to the State Agency. R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease. R3's fall report dated [DATE] at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell . Further indicates R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the ED for evaluation. A follow up noted dated [DATE], identified R3 was trying to get through a doorway when he went weak. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's ED After Visit Summary dated [DATE], indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger. R3's fall report dated [DATE] at 7 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have open area to feet, toes, and a large hematoma to left upper eye. R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. A follow up note on [DATE] indicated R3 was deceased due to respiratory complications. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. factors. R2 A Vulnerable Adult Maltreatment Report was submitted to the SA on [DATE] at 12:44 p.m., alleged caregiver neglect for an incident that occurred on [DATE]. The report indicated R2 was sent to the hospital after falling and busted eye open due to having only one person assist with a transfer when it should have been two staff assisting. In review of Facility Reported Incidents (FRI), it was not evident R2's fall was reported to the State Agency. R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2 diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling. R2 Fall report dated [DATE] at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a laceration to the left eye and emergency medical services (EMS) were called for transport to the emergency department (ED). A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. R2's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R2's care plan had been followed at the time of the fall. During observation and interview on [DATE] at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, things aren't going very well here. Further clarified she fell a few weeks ago, hit her head, and went to the hospital for stitches, Stated, I usually transfer with two people but there was only one [staff] here. During an interview on [DATE] at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but R2 had reported that when she fell and hit her head, there was only one person assisting her to the commode. FM-A further indicated R2 had to go to the hospital for stitches as a result of that fall. Further clarified the fall occurred on [DATE] and R2 reports that she frequently only has one person assisting her although she is supposed to have two. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:30 p.m., nursing assistant (NA)-A indicated she was assisting R2 at the time of the [DATE] fall. NA-A indicated she was an agency NA, and it was her first time working with R2. She was told R2 required only one person assist with gait belt and walker. Further indicated she was independently transferring R2 with gait belt and walker when R2 leaned forward and fell and hit her head. During an interview on [DATE] at 9:30 a.m., registered nurse (RN)-B indicated she was working at the time of R2's fall on [DATE]. Further identified on [DATE], R2 had fallen transferring to the commode and had bleeding from the left eye and was sent to the ED. Indicated NA-A alerted her to the fall and was in the room with R2 but did not know if NA-A had assisted R2 or not. RN-B assumed NA-A was waiting for help but was not sure of the details and confirmed R2 was a two person assist with walker and gait belt but thought R2 had self-transferred causing her to fall. During an interview on [DATE] at 9:20 a.m., the administrator indicated they would only report falls if the facility would be at fault or could have done something to prevent it. Regarding R2 and R3's falls with injury, the administrator indicated he considered reporting to the SA but the care plan was followed, and the facility was not at fault. During a follow-up interview on [DATE] at 2:00 p.m., the administrator reviewed the facility incident reports and acknowledged that vital pieces of the investigations were missing and that the investigations were not thorough enough to determine if the care plan was followed or that neglect did or did not occur. The facility policy titled, Reporting of Accidents and Incidents last updated [DATE], indicates the facility shall take ongoing steps to identify each resident at risk for accidents and/or falls, and adequately plan care, implement procedures to prevent accidents. In addition, residents shall receive a complete, comprehensive, accurate and reproduceable assessment of their functional capacity and the degree of accident risk to which each resident's condition places them. This assessment shall be standardized within the facility shall be carried out in an informal manner on a day-to-day basis and as needed to prevent injury and/or accidents within the facility. The facility shall ensure that all alleged violation involving, abuse, neglect, mistreatment of resident property including injuries of unknown source are reported immediately to the administrator and to other agencies in accordance with state law through established procedures. Accura HealthCare shall have evidence that all alleged violations are thoroughly investigated and shall prevention further potential abuse while the investigation is in process. Further identifies the administrator or the director of nursing shall determine if the incident/allegation meets the criteria for Reportable Incident. All incidents deemed reportable under MN stature are submitted to MDH via the on-line reporting system immediately (as soon as possible). The facility policy titled, Fall Risk and Prevention Guidelines with revision date February 23, indicates It is critical for nursing centers to address and mitigate adverse events and potential adverse events. An action plan, otherwise known as a mitigation plan, is a necessary response to adverse events and potential adverse events. For many such events, it is important to respond and start the mitigation process immediately. Housing Manager/ED must be notified immediately at the time of the adverse event. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review, the facility failed to complete an accurate and thorough investigation of falls to determine the root cause, if the care plan was followed, and if the fall was reportable to the State Agency (SA) for 3 of 3 residents (R2, R3, and R4) reviewed for falls. Finding include R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2 diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling. R2's care plan last revised on [DATE], identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, [NAME] [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist. R2's Fall report dated [DATE] at 9:16 p.m., indicated nursing assistant (NA) was transferring resident from WC (wheelchair) to bed when resident fell on to right knee. R2 sustained an abrasion on the right knee. Note dated [DATE], indicated interdisciplinary team (IDT) reviewed fall report and determined resident fell to knee while transferring to bed with NA. No injuries and the intervention was to educate staff on safety when transferring resident. No other fall information was included. R1's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R2's care plan had been followed at the time of the fall. R2's Fall report dated [DATE] at 9:13 p.m., indicated R2 was lying on her back on the floor and had hit her head. R2 stated she was reaching when she fell . Root cause indicated R2 slid out of wheelchair while trying to rearrange things. There was no further information about the fall. Further, the record did not include a thorough investigation and/or comprehensive fall analysis that would include but not limited to if R2's care plan was followed at the time of the fall. R2's Fall report dated [DATE] at 7:00 p.m., indicated R2 was found on the floor after reaching to pick trash off the floor. Nurse recommended R2 use her call light. Note section updated [DATE] identified R2 was trying to pick garbage off the floor, staff will place call light reminder signs in R2's room. R2's record did not include a thorough investigation and/or comprehensive fall analysis that would include but not limited to if R2's care plan had been followed at the time of the fall. R2's Progress Note dated [DATE] at 3:53 p.m., indicated a therapist reported that R2 had fallen in therapy. Further described knees became weak, fell back into the wheelchair, hyperextended, and slid down to the floor. The medical record did not include a Fall report. Further R2's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 Fall report dated [DATE] at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a laceration to the left eye and emergency medical services (EMS) were called for transport to the emergency department (ED). A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. Notes section dated [DATE], identified R2 was transferring without assistance. R2's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause which would have identified according to NA-A's interview on [DATE] at 3:30 the report was not accurate. During an interview on [DATE] at 3:30 p.m., NA-A indicated she was assisting R2 at the time of the [DATE] fall. NA-A indicated it was her first time working with R2. She was told R2 required only one person assist with gait belt and walker. NA-A had been independently transferring R2 with gait belt and walker when R2 leaned forward and fell and hit her head. NA-A indicated the nurse did not ask her any questions about what happened or how the fall happened. Indicated she thought a nurse would usually ask her for a detailed explanation of the fall but stated, I thought it was pretty weird that she did not ask me anything. Further denied being asked by any employee of the facility about the fall. During observation and interview on [DATE] at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, things aren't going very well here. Further clarified she fell a few weeks ago, hit her head, and went to the hospital for stitches, Stated, I usually transfer with two people but there was only one [staff] here. During an interview on [DATE] at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but R2 had reported that when she fell on [DATE] and hit her head, there was only one person assisting her to the commode. R2 had reported to FM-A staff frequently transferred her with only one. During an interview on [DATE] at 9:30 a.m., registered nurse (RN)-B indicated she was working at the time of R2's fall on [DATE]. Further identified on [DATE], R2 had fallen transferring to the commode and had bleeding from the left eye and was sent to the ED. Indicated NA-A alerted her to the fall and was in the room with R2 but did not know if NA-A had assisted R2 or not. RN-B assumed NA-A was waiting for help but was not sure of the details and confirmed R2 was a two person assist with walker and gait belt but thought R2 had self-transferred causing her to fall. R3's quarterly MDS dated [DATE], indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease. R3's fall care plan last revised on [DATE], indicated R3 had limited physical mobility and a history of falling. Interventions included requires one staff with gait belt and a walker for ambulation and transferring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's fall report dated [DATE] at 11:20 p.m., indicated R3 had tried to self-transfer to bed and missed causing a fall to the floor with no apparent injuries. The report identified possible causal factors as gait imbalance and ambulating without assist. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. R3's fall report dated [DATE] at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell . Further indicates R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the ED for evaluation. The report identified furniture, weakness, and ambulating without assist to be a potential causal factor. A follow up noted dated [DATE], identified R3 had an unwitnessed fall when he was trying to get through a doorway when he went weak with intervention as ED evaluation and increase checks upon return. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. R3's ED After Visit Summary dated [DATE], indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger. R3's fall report dated [DATE] at 10 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. The fall report indicates R3 was oriented to person only. R3 had confusion and was ambulating without assist as potential causal factors. Follow note dated [DATE], indicates R3 had an unwitnessed fall and immediate intervention was to encourage to sleep in bed. There was no further information about the fall. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. R3's fall report dated [DATE] at 7 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have open area to feet, toes, and a large hematoma to left upper eye. R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. The fall report indicated items out of reach, other with no description, gait imbalance, recent illness, weakness, ambulating without assist, improper footwear, and oxygen tubing on the floor, and overnight catheter bag were all identified as possible causal factors to the fall. A follow up note on [DATE] indicated R3 was deceased due to respiratory complications. R3's record did not include a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R3's care plan had been followed at the time of the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:30 a.m., registered nurse (RN)-B identified she was working at the time of R3's fall on [DATE]. Indicated R3 was a high fall risk, history of dementia and occasionally forgetful, recently had COVID, and had been isolated in his room with the door closed for 10 days. On [DATE], she heard him yelling and found him on the floor with gashes to his toes, heels and a hematoma to his head resulting in R3 transferring to the ED. RN-B indicated R3 was to be checked on every two hours but was not sure when he was checked on prior to his fall or when he was last assisted to the toilet. She thought he was independent but was not sure. R4's quarterly MDS dated [DATE], indicated R4 was cognitively intact, has unclear speech but makes himself understood, limitation in range of motion in all extremities and requires staff limited assist with bed mobility, transfers, eating, and toilet use. Diagnoses include Huntington's disease (disease of the nerve cells in the brain that affects a person's movements, thinking ability, and mental health), repeated falls, muscle spasms, cramp and spasm, and anxiety disorder. R4's care plan indicated staff assist of one, gait belt, and walker required for transfers and toileting. R4 does self-transfer. The fall prevention interventions identified in the fall reports were not added to the care plan from [DATE] to [DATE]. R4's medical record indicates R4 most recent falls were [DATE] at 10:24 p.m., [DATE] at 8 p.m., [DATE] at 9:11 a.m., [DATE] at 2:11 p.m., [DATE] at 10:54 a.m., [DATE] at 11:25 a.m., [DATE] at 7 p.m., [DATE] at 4:10 p.m., [DATE] at 1:54 a.m., [DATE] at 8:55 a.m., [DATE] at 8:55 a.m., [DATE] at 5 p.m., [DATE] at 3:01 p.m., [DATE] at 9:20 a.m., [DATE] at 1:45 p.m., [DATE] at 5:25 p.m., [DATE] at 7:50 a.m., [DATE] at 10:50 a.m., [DATE] at 4:35 p.m., and at [DATE] at 12:20 p.m Twenty (20) falls total from [DATE] to [DATE]. In review of R4 records it was not evident for all 20 falls a thorough investigation and/or comprehensive fall analysis for probable root cause(s) that would include but not limited to if R4's care plan had been followed at the time of the fall. During an interview on [DATE] at 11:10 a.m., registered nurse (RN)-D indicated R4 falls a lot because he is impulsive. Further indicated difficult to investigate his falls and were inquiring if there was a way not to do any more fall reports on him because he falls so frequently. During an interview on [DATE] at 9:30 a.m., RN-B indicated the nurses do not do the fall investigations or the post fall huddle. Instead, they ask what happened and document the results in the progress notes. During an interview on [DATE] at 12:15 p.m., the administrator indicated all falls in the facility get reported to him. Further identified the only investigation on the regular falls without injury would be the incident reports unless, there was an injury then he would investigate it as well. The administrator indicated he expects nursing staff to follow the facility's policies and procedures to determine if we caused any injuries or whether the care plan was followed and had everything in place. During an interview on [DATE] at 12:30 p.m., the regional nurse manager indicated the expectation of the clinical team would be to do a post fall huddle and get the information to determine the root cause of the fall and identify and implement the appropriate fall prevention 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
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on [DATE] at 2:00 p.m., the administrator reviewed the facility incident reports and acknowledged that vital pieces of the investigations were missing and that the investigations were not thorough enough to determine if the care plan was followed or that neglect did or did not occur. During an interview on [DATE] at 12:00 p.m. the medical director indicated the facility does have a high number of falls but felt the lack of consistent nursing management and staff turnover has contributed to the fall policies not being implement adequately. The facility's policy titled, Fall Risk and Prevention Guidelines directs clinical staff to: Conduct interviews of; the resident, the first responder, the person who last saw the resident, any witnesses. Make note of the resident's immediate surroundings and the position the resident/tenant was found. Determine from staff the provision of the last cares, what the cares were and when they were provided. Review the record for medications in use; psychotropic, narcotics, diuretics, anticonvulsants, cardiovascular meds etc. Review the record for any medications/doses changed in the previous 30 days. Review recent laboratory values. Review the plan of care to determine care provided was consistent with plan. The nurse reviews the information collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated. Complete Adverse Event, Report in Risk Management, Complete Post Fall Data Collection in Electronic Medical Record, Update SNF Care Plan and NAR Care Plan/HHA Care Plan, 24-hour Report Updated, Family Medical Practitioner, DNS and ED notified of incident. IDT discussion of Incident for Review. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on observation, interview and document review the facility failed to revise the care plan for 3 of 3 residents (R2) who were reviewed for falls. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2 diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling. R2's care plan last revised on 6/12/24, identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, [NAME] [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist. R2's Fall report dated 6/24/24 at 21:13 (9:13 p.m.), indicated R2 was lying on her back on the floor and had hit her head. The report lacked a new immediate intervention to prevent further falls. Root cause analysis indicated R2 slid out of wheelchair while trying to rearrange things. Although a reacher was identified as an appropriate intervention, it was not added to R2's care plan until 8/20/24 and had been in place since 6/12/24. R2's Fall report dated 6/25/24 at 19:00 (7:00 p.m.), indicated R2 was found on the floor after reaching to pick trash off the floor. Root cause was identified as trying to pick garbage off the floor with the added intervention to put a reminder to use call light sign in room however, R2's care plan was not updated to reflect the intervention until 8/20/24. R2's Fall report dated 7/2/24 at 18:25 (6:25 p.m.), indicated R2 was found on the floor in front of the wheelchair. R2 complained of left elbow pain. The fall report lacked a comprehensive assessment of the fall. Although the intervention was to put Dysem [sic] in wheelchair to prevent sliding, it was not added to the care plan until 8/20/24. R3's quarterly MDS dated [DATE], indicates R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease. R3's fall care plan last revised on 5/9/24, indicated R3 had limited physical mobility and a history of falling. Interventions included requires one staff with gait belt and a walker for ambulation and transferring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's fall report dated 7/4/24 at 11:20 p.m., indicated R3 had tried to transfer to bed and missed causing a fall to the floor with no apparent injuries. The medical record lacked updates to the care plan related to fall prevention. R3's fall report dated 7/18/24 at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell . Further indicates R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the ED for evaluation. The medical record lacked updates to the care plan related to fall prevention. R3's Progress Noted dated 7/19/24 at 10:45 a.m., identifies R3 returned from the ED following a closed reduction procedure his 5th metacarpal falange {sic}and had a temporary soft cast on and was to follow up with orthopedics. The medical record lacked updates to the care plan related to a change in activity of daily living (ADL) status. R3's fall report dated 7/21/24 at 10 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. Immediate intervention was to encourage to sleep in bed. The medical record lacked updates to the care plan related to fall prevention. During an interview on 8/20/24 at 9:30 a.m., RN-B indicated R3 was a high fall risk and had several falls trying to self-transfer. Further indicated R3 had a history of dementia and was forgetful. Identified R3 had been diagnosed with COVID-19 and was in isolation for 10 days with his door shut but did not know how often staff checked for safety or personal needs. Did not update the care plan to reflect the change of condition. R4's quarterly MDS dated [DATE], indicated R4 was cognitively intact, has unclear speech but makes himself understood, limitation in range of motion in all extremities and requires staff limited assist with bed mobility, transfers, eating, and toilet use. Diagnoses include Huntington's disease (disease of the nerve cells in the brain that affects a person's movements, thinking ability, and mental health), repeated falls, muscle spasms, cramp and spasm, and anxiety disorder. R4's Morse Fall Scale dated 6/13/24 indicated R4 was at a high risk for falling. R4's medical record indicates R4 most recent falls were 6/11/24 at 10:24 p.m., 6/12/24 at 8 p.m., 6/13/24 at 9:11 a.m., 6/16/24 at 2:11 p.m., 6/21/24 at 10:54 a.m., 6/28/24 at 11:25 a.m., 7/2/24 at 7 p.m., 7/3/24 at 4:10 p.m., 7/12/24 at 1:54 a.m., 7/15/24 at 8:55 a.m., 7/22/24 at 8:55 a.m., 7/23/24 at 5 p.m., 7/28/24 at 3:01 p.m., 8/4/24 at 9:20 a.m., 8/6/24 at 1:45 p.m., 8/6/24 at 5:25 p.m., 8/17/24 at 7:50 a.m., 8/17/24 at 10:50 a.m., 8/19/24 at 4:35 p.m., and at 8/20/24 at 12:20 p.m Twenty (20) falls total from 6/11/24 to 8/19/24. R4's care plan indicated staff assist of one, gait belt, and walker required for transfers and toileting. R4 does self-transfer. The fall prevention interventions identified in the fall reports were not added to the care plan from 6/9/24 to 8/20/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/20/24 at 9:30 a.m., RN-B indicated after a fall they sometimes put some kind of intervention in place and would be documented in the resident progress note if they did. RN-B indicated staff nurses do not update the care plans and did not know who was responsible for updating the care plan or if the care plans are updated after a fall. During an interview on 8/21/24 at 3:45 p.m., NA-B indicated fall interventions were sometimes written on a white board in the nurse's station or was communicated through oral report. NA-B explained she does not look at the resident care plans or Kardex. During an interview on 8/22/24 at 12:00 p.m., RN-C indicated fall interventions should be put on the care plan once they are determined. Further verified care plans were not updated with fall interventions and it is an area that needs to be improved. During an interview on 8/22/24 at 12:15 p.m., the administrator indicated the expectation is nursing staff follow the facilities process or procedures. The facility's policy titled, Fall Risk and Prevention Guidelines last revised February 2023, directs clinical staff to review the plan of care to determine care provided was consistent with plan. The nurse reviews the information collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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** 39998 Based on observation, interview, and document review the facility failed to compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury for 2 of 2 residents (R3 and R2) with history of falls. This resulted in actual harm for R3 when he sustained a hand fracture and lacerations to his face and foot and R2 when she sustained a laceration above the eye that required sutures as a result of a fall. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had moderately impaired cognition and required staff assistance with toileting, dressing, and transferring, R3's diagnoses included encephalopathy (brain disease that alters brain function), heart failure, renal disease, diabetes, Alzheimer's disease, Parkinson's disease, depression, and chronic obstructive pulmonary disease. R3's Care Area Assessment (CAA) dated [DATE], indicated R3 triggered for cognitive loss/dementia, self-care and mobility, and falls. R3's Fall CAA indicated R3 was at risk for falls related to recent hospitalization , diagnoses, and physical limitations. R3's Morse Fall Scale dated [DATE], indicated R3 was at a high risk for falls. R3's Physical Therapy Treatment Encounter Note dated [DATE] indicated R3 verbalized need for full time mobility assist for all weight bearing mobility; however, reduced insight and judgement limits patients understanding of fall risk. R3's fall care plan last revised on [DATE], indicated R3 had limited physical mobility and a history of falling. Interventions included: required one staff with gait belt and a walker for ambulation, and transferring. R3's fall report dated [DATE] at 11:20 p.m., indicated R3 had tried to self-transfer to bed and missed causing a fall to the floor with no apparent injuries. The report identified there were no predisposing environmental factors, gait imbalance as a predisposing physiological factor and ambulating without assist as a predisposing situation factor. R3's fall record did not include any further information about the fall. R3's medical records did not include a comprehensive fall analysis for root cause, nor interventions for the identified risk factors from the fall report such as, but not limited, self-ambulating, that would prevent falls and/or mitigate the risk of falls or falls with major injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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	R3's fall report dated [DATE] at 7:00 p.m., indicated R3 had fallen in his doorway and was complaining about pain to his head and buttocks. R3 indicated he was trying to get out the door when his legs went weak and fell . The report further indicated R3 sustained a skin tear to his right lower leg, bump to the top of scalp, and fracture to his left hand. R3 was transferred to the emergency department (ED) for evaluation. The report identified furniture, weakness, and ambulating without assist to be a potential causal factor. A follow up noted dated [DATE], identified R3 had an unwitnessed fall when he was trying to get through a doorway when he went weak with intervention as ED evaluation and increase checks upon return. R3's record did not include any further information about the fall. R3's record did not identify an assessment that determined and/or defined frequency of checks R3 required based on his risk factors, mannerisms, and behaviors. Furthermore, not evident the care plan, care sheets, and/or orders were revised to include the intervention of increase checks. Additionally, R3's records did not include a comprehensive fall analysis for root cause, nor interventions for the identified risk factors from the fall report such as, but not limited, self-ambulating and furniture that would prevent falls and/or mitigate the risk of falls or falls with major injury. R3's ED After Visit Summary dated [DATE], indicates diagnoses of history of falling, closed fracture of the fifth metacarpal (long bone of the hand), and displaced closed fracture of the little finger. R3's Progress Noted dated [DATE] at 10:45 a.m., identified R3 returned from the ED following a closed reduction procedure of his 5th metacarpal falange {sic}and had a temporary soft cast on and was to follow up with orthopedics. R3's fall report dated [DATE] at 10:00 p.m., indicated R3 was found in front of his recliner in his room. R3 had a bloody nose and yelled out in pain but was unable to say the location of the pain. The fall report indicated R3 was oriented to person only. R3 had confusion and was ambulating without assist as potential causal factors. Follow-up note dated [DATE], indicated R3 had an unwitnessed fall and immediate intervention was to encourage to sleep in bed. R3's fall record did not include any further information about the fall, nor evident R3's care plan/care sheets were revised to include the intervention. In review of R3's records identified a comprehensive fall analysis for root cause and interventions was not completed that addressed risk factors included in the fall report, even though the report identified R3 had confusion and self-transferred, the intervention for increased checks was not individualized and/or assessed to address that risk factor. Further, no evidence the intervention of increase checks was provided and was evaluated for effectiveness. R3's fall report dated [DATE] at 7:00 a.m., indicated R3 had fallen while trying to get up and dressed for the day. R3 was alert and oriented upon initial nurse assessment and then condition worsened. R3 was noted to have open area to feet, toes, and a large hematoma to left upper eye. R3 also noted to have a laceration to his face. EMS were called and R3 transferred to the ED. The fall report indicated items out of reach, other with no description, gait imbalance, recent illness, weakness, ambulating without assist, improper footwear, and oxygen tubing on the floor, and overnight catheter bag were all identified as possible causal factors to the fall. A follow up note on [DATE] indicated R3 was deceased due to respiratory complications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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	During an interview on [DATE] at 9:30 a.m., RN-B indicated R3 was a high fall risk and had several falls trying to self-transfer. Further indicated R3 had a history of dementia and was forgetful. Identified R3 had been diagnosed with COVID-19 and was in isolation for 10 days with his door shut but did not know how often staff checked for safety or personal needs. R3 had apparent injuries during two recent falls; one he broke his hand, and the last fall, his head, a couple of toes, and heel were gashed open. R2's admission MDS dated [DATE], indicated R2 had severe cognitive impairment, no behaviors, required extensive assist of staff with bed mobility, transfers, and toilet use. R2 used a walker and wheelchair for mobility and was frequently incontinent of bowel and bladder. R2's diagnoses included progressive supranuclear ophthalmoplegia (a rare brain disease that affects walking, balance, eye movements, and swallowing), dementia, anxiety disorder, depression, morbid obesity, restless leg syndrome, diabetes, and a history of falling. R2's updated Brief Interview for Mental Status dated [DATE], indicated R2 was cognitively intact. R2's CAA dated [DATE], indicated R2 triggered for cognitive loss/dementia, functional abilities (self-care and mobility), and urinary incontinence. In addition, R2 triggered for falls related to fall history and high-risk medications. The Fall CAA further indicated R2 is alert and oriented, able to make needs known, and will call for staff assist with toileting but is impulsive and may forget. R2's admission Morse Fall Scale, dated [DATE], indicated R2 was at a high risk for falls. R2's Physical Therapy Progress Report dated [DATE], indicated R2 required assist of two for safety with the second assist for wheelchair management due to tendency towards right trunk lean and decreased right lower extremity foot clearance and stride length. R2's care plan last revised on [DATE], identified R2 was at risk for falls due to limited physical mobility. Interventions included to ensure appropriate footwear, ensure reacher is within reach of resident, [NAME] [sic] (Dycem is a non-slip material) placed under wheelchair cushion to prevent it from sliding off, remind to utilize pendant to call for staff assistance, reminder signs placed in room, and to transfer with two staff assist. The undated form labeled CNA (certified nursing assistant) Individual Report Sheet indicated R2's transfer status was assist of 2 (two). R2's Fall report dated [DATE] at 9:16 p.m., indicated NA was transferring resident from WC (wheelchair) to bed when resident fell on to right knee. R2 sustained an abrasion on the right knee. Note dated [DATE], indicated interdisciplinary team (IDT) reviewed fall report and determined resident fell to knee while transferring to bed with NA. No injuries and intervention was to educate staff on safety when transferring resident. No other information about the fall was documented. R2's record did not include a comprehensive fall analysis that identified probable root cause including if the care plan was followed, if the care plan was appropriate, and/or if R2 had a change in transfer ability. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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	R2's Fall report dated [DATE] at 9:13 p.m., indicated R2 was lying on her back on the floor and had hit her head. R2 stated she was reaching when she fell . Root cause analysis indicated R2 slid out of wheelchair while trying to rearrange things. Note section dated [DATE], indicated R2 was reaching for something outside of her grasp. The intervention was to keep her reacher within reach of her so that she can utilize it. The reacher was an intervention that had already been put in place on [DATE]. R2's record did not include a comprehensive fall analysis that included but not limited to if R2's care plan was followed and/or if R2 had the ability to use the reacher. Further did not identify any other interventions that would mitigate R2 from re-current falls related to the same identified cause. R2's Fall report dated [DATE] at 7:00 p.m., indicated R2 was found on the floor after reaching to pick trash off the floor. Nurse recommended R2 use her call light. Note section updated [DATE] identified R2 was trying to pick garbage off the floor, staff will place call light reminder signs in R2's room. There was no further information about the fall. R2's record did not include a comprehensive fall analysis that included but not limited to if R2's care plan was followed and/or if R2 had the ability to use the reacher. Further did not identify any other interventions that would mitigate R2 from re-current falls related to the same identified cause. R2's Fall report dated [DATE] at 6:25 p.m., indicated R2 was found on the floor in front of the wheelchair. R2 fell while trying to throw something away. R2 complained of left elbow pain. Notes section dated [DATE] identified R2 fell trying to throw something away and her chair cushion was found on the floor. Intervention for staff to put [NAME] [sic] under wheelchair cushion to prevent it from sliding off. Although the intervention was to put Dycem [sic] in wheelchair to prevent sliding, it was not added to the care plan until [DATE]. R2's fall record did not include any further information about the fall including a comprehensive analysis that included but not limited to if R2's care plan was followed at the time of the fall. R2's Progress Note dated [DATE] at 3:53 p.m., indicated a therapist reported that R2 had fallen in therapy. Further described knees became weak, fell back into the wheelchair, hyperextended, and slid down to the floor. The medical record lacked a fall report, comprehensive assessment, root cause analysis, and intervention to prevent further falls. R2 Fall report dated [DATE] at 6:30 a.m., indicated R2 was transferring to the commode and lost balance and fell to the floor. R2 sustained a laceration to the left eye and emergency medical services (EMS) were called for transport to the ED. A follow up note by registered nurse (RN)-A indicated R2 was not using a walker or gait belt during transfer, R2's shoes on, and lights were on in her room. R2's pants were around her ankles. Notes section dated [DATE], identified R2 was transferring without assistance and the intervention was to re-educate R2 on pendant (call light usage). No other information was included and the record did not include a comprehensive analysis that would have identified R2's transfer care plan that directed 2 staff assist was not followed per interview with nursing assistant (NA)-A on [DATE] at 3:30 p.m. NA-A reported she was working with R2 at the time of the fall with injury. NA-A explained it was her first time assisting R2 and unknown NA told her that R2 transferred with one staff assist, gait belt, and walker. She assisted R2 to transfer to the commode when R2 leaned forward, and NA-A could not stop the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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	R2's After Visit Summary dated [DATE], indicated R2 was evaluated in the ED following a fall and diagnosed with a face laceration and head injury. During observation and interview on [DATE] at 3:20 p.m., R2 was seated in a wheelchair in her room. R2 appeared upset and stated, things aren't going very well here. R2 further clarified she fell a few weeks ago, hit her head, and went to the hospital for stitches, Stated, I usually transfer with two people but there was only one [staff] here. During an interview on [DATE] at 10:45 a.m., family member (FM)-A indicated R2 has always needed two people to assist with transfers but R2 had reported that when she fell and hit her head, there was only one person assisting her to the commode. FM-A further indicated R2 had to go to the hospital for stitches as a result of that fall. Further clarified the fall occurred on [DATE] and R2 reports that she frequently only has one person assisting her although she is supposed to have two. During an interview on [DATE] at 3:45 p.m., NA-B indicated R2 had always required two staff assist to transfer. Further identified they use a cheat sheet (CNA Individual Report Sheet) to learn how residents transfer but did not know how often it was updated. During interview on [DATE] at 9:30 a.m., registered nurse (RN)-B indicated she was working on [DATE] and responded to R2's fall. Indicated R2 was care planned to transfer with two staff assist at all times. Further stated that they sometimes put some kind of intervention in place and would be documented in the resident progress note if they did. During an interview on [DATE] at 12:30 p.m., the regional nurse manager indicated the expectation of the clinical team would be to do a post fall huddle and get the information to determine the root cause of the fall and identify and implement the appropriate fall prevention interventions. During an interview on [DATE] at 12:15 p.m., the administrator reviewed R3's falls and confirmed the record did not include a comprehensive analysis for any of R3's falls. Adminstartor identified increase in checks was not defined nor documented and could not determine how frequently the checks had been completed and therefor could not ascertain the effectiveness of the intervention. Adminstartor conceded that the facility was not performing in depth assessments and expected the facility's fall process and procedures be followed for all falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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	The facility's policy titled, Fall Risk and Prevention Guidelines directs clinical staff to: Conduct interviews of; the resident, the first responder, the person who last saw the resident, any witnesses. Make note of the resident's immediate surroundings and the position the resident/tenant was found. Determine from staff the provision of the last cares, what the cares were and when they were provided. Review the record for medications in use; psychotropic, narcotics, diuretics, anticonvulsants, cardiovascular meds etc. Review the record for any medications/doses changed in the previous 30 days. Review recent laboratory values. Review the plan of care to determine care provided was consistent with plan. The nurse reviews the information collected, determines the root cause, and initiates a plan based on the information. The plan of care is updated and revised with changes as indicated. Complete Adverse Event, Report in Risk Management, Complete Post Fall Data Collection in Electronic Medical Record, Update SNF Care Plan and NAR Care Plan/HHA Care Plan, 24-hour Report Updated, Family Medical Practitioner, DNS and ED notified of incident. IDT discussion of Incident for Review. Investigations should be thorough, accurate, fact based, be well documented, concise, and understandable. All falls are trended, analyzed and interventions introduced for areas of concern via monthly QAPI Meetings. Tracking of these discussions are listed within QAPI Minutes Ppt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34985 Based on interview and document review the facility failed to develop, implement, monitor, and evaluate falls quality improvement project (QIP) that was an identified problem-prone area to improve performance and ensure sustainability. This had the potential to affect all residents residing in the facility. Findings include SEE F689: Based on observation, interview, and document review the facility failed to compressively assess falls for root cause, implement appropriate interventions and follow the care plan to prevent and/or reduce the risk of falls with major injury for 2 of 2 residents (R3 and R2) with history of falls. This resulted in actual harm for R3 when he sustained a hand fracture and lacerations to his face and foot and R2 when she sustained a laceration above the eye that required sutures as a result of a fall. During the facility resident record review on 8/20/24 for resident sample selection revealed from 6/11/24 through 8/20/24, the facility had 29 fall incidents between three residents. R2 had 5 falls in which one fall resulted in a laceration that required sutures, R3 had 4 falls in which one fall resulted in a hand fracture and lacerations to face and foot, and R4 had 20 falls that did not result in major injuries. In further review of records it was not evident the facility completed comprehensive causal analysis for any of the 29 falls. During review of the facility's quality assurance activities, even though the facility identified falls as a problem prone area, it was not evident the facility developed and implemented action plans to improve. Further, it was not evident the quality assurance committee had identified causal analysis was not being completed and in certain instances the care plan was not followed and/or the care plan was not revised to include the new interventions after a fall occurred. The facility's quality assurance documentation included the following: On 8/22/24, the administrator provided Grand Meadow QAPI/QAA (quality assurance performance improvement/quality assurance activity): Minutes Power Point. The power point included a slide titled Nursing/Clinical which had a table that identified the State Quality Indicators (QI) Analysis of Trends/All Areas Below 75th Percentile from December 2023 to May 2024. The QI's listed included Falls and Falls with major injury. The table identified from December to May there were no falls with major injury. From the December 2023 to May 2024 the fall quality indicator was below 75th percentile; April was 44.4% and May was 41.2%. In the column titled Action Plan (include reasons WHY QM's [quality measures] above average +SMART goals & progress) included a summation for May which indicated quality measures improved for falls however, did not identify activities that were completed or rational on how the metric was improved. The next slide identified in May 2024 there were 10 falls and in June there were 20 falls. Trends for May included we had 10 falls this month with 2 repeat residents .The second resident has shown non-compliance however, we haven't been able to fully determine the reason for the falls. June 2024 analysis included we had 20 falls this month, 3 residents with repeat falls. One resident account for 9 of the falls. No further analysis of trending and/or action plan was included in the slide show. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's corresponding Quality Assessment and Assurance Action Plan for the falls quality measure identified no action plans for April 2024, May 2024, and June 2024. The Action plan for falls with an implementation date of 7/25/24 included the action DON [director of nursing] or another assigned person will audit fall interventions monthly to ensure greater effectiveness. The responsible team member was identified as the DON with a target date of 8/28/24. The progress and evaluation were not completed. Review of QUAPI documents did not include any evidence audits had completed after the implementation date of 7/25/24. During an interview on 8/22/24 at approximately 11:30 a.m. administrator stated the quality committee met monthly. All the departments were represented by their managers and the pharmacist and medical director also attended in person or by phone. Quality improvement projects were determined based on the State and Federal quality performance measures. Each department was responsible for collecting the information pertaining to each of the identified quality improvement projects and created the slide to share with the committee on the progress and results. The administrator stated he would only get the slide and not the records and/or audits that were used to account for the data presented to the committee. Administrator verified between April through July 2024 the only action plan created for all the quality projects identified in the slide show was for falls that was implemented on July 25th and was not complete with an entire activity plan. The administrator confirmed there were no previous action plans for falls prior to that date. The administrator explained even though the fall QIP did not identify activities the facility had implemented care plan audits that the social worker was completing however could not articulate what the social worker was auditing on the care plans. Administrator also indicated the facility had started interdisciplinary meetings in April 2024 where falls were discussed, however in review of the meeting minutes there was limited information, or no information documented other than fall next to the resident's name. During an interview on 8/22/24 at 12:00 p.m. medical director (MD) stated she was newer to the facility within the last several months and was still acclimating to her new role as medical director. MD stated an awareness of the facility's high fall incidence but was not aware the facility did not have any action plans for the fall quality improvement project. MD indicated she thought the fall policy/program was not being implemented correctly. MD has been providing medical input on potential causes for at the individual resident level.