STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the medical provider and resident's family representative after a resident, who was on an anticoagulant, fell , struck her head and had a laceration that bled and was hospitalized four days later with subdural hematoma, bilateral cranial bleeding and a T11 fracture ([MEDICAL CONDITION]) for 1 of 3 residents (R1) reviewed for falls. Findings include: R1 was interviewed in her room on 2/28/20, at 1:50 p.m., R1 stated on 2/3/20, she realized she was late for lunch, got up in a hurry, her right foot turned in and as she fell to the floor, she hit her head, bled from her head and hurt her back. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1's cognition was impaired, included a [DIAGNOSES REDACTED]. R1's MDS indicated R1 needed extensive of one staff, assistance with bed mobility, transfers, dressing, toileting and personal hygiene. R1's MDS indicated R1 walked with a walker and was independent with ambulation in her room and off unit. Review of R1's medical record revealed no evidence of physician and/or family notification of R1's fall on 2/3/20, and/or any evidence of a progress note written. R1 was hospitalized four days later on 2/7/20, with subdural hematoma, bilateral intracranial bleed, and T11 back fracture. Director of nursing (DON) stated on 2/28/20, at 11:05 a.m. she had not been notified of R1's fall on 2/3/20, and should have been notified. DON further stated the physician and family had not been notified of the fall with a head injury. DON stated the physician and the family should have been notified right away and an incident report and fall risk management should have been completed. DON stated R1 complained of back and rib pain on 2/7/20, and asked for an x-ray and then was sent out to the hospital and was diagnosed with [REDACTED]. ADON stated RN-C had said she had asked R1 if she wanted to go to the hospital but did not explain the risks of a fall with head injury while on an anticoagulant. R1 declined to go to the hospital after the fall. ADON stated she had not reeducated RN-C nor any other nurses other than licensed practical nurse (LPN)-B, who worked on 2/3/20, about notification to a physician for a resident who was on an anticoagulant, fell , and had a head injury. LPN-B stated on 2/28/20, at 2:00 p.m. she was called in R1's room on 2/3/20 around lunchtime, and saw R1 on the floor with moderate amount of blood on the floor and on R1's head. LPN-B stated RN-C came into the room and asked R1 if she wanted to go to the hospital and R1 told RN-C no. Nurse manger (RN-F) stated on 2/28/20, at 2:18 p.m. she was not aware of R1's fall on 2/3/20. RN-F stated she would have expected RN-C to notify her of R1's fall on 2/3/20. Regional nurse consultant (RNC) stated on 2/28/20, at 2:30 p.m. she had spoken with RN-C on 2/28/20, after the surveyors arrived, and RN-C said there was no notification to the physician or R1's family after the fall on 2/3/20, but did pass fall information along to the next shift. RN-C was unavailable for surveyor to interview. Transition Care Unit Nurse Manger, RN-J stated on 3/2/20, at 11:04 a.m. if a resident fell and had a head injury she would expect the nurse to control the bleeding, render first aide, notify the provider, DON, family, follow the provider instructions and document in a progress note. The Nurse Practitioner (NP) stated on 3/2/20, at 11:45 a.m. she would expect the nurse to call her right away whenever a resident fell and was surprised that she was not notified on 2/3/20, when R1 fell and injured her head. NP stated she would have send R1 immediately to the ER. The medical director stated on 3/2/20, at 11:51 a.m. the physician should have been notified right away after R1 fell on [DATE], especially with R1 being on an anticoagulant and with a head injury. R1's family member (FM)-B stated on 3/4/20, at 8:25 a.m. he had not been notified of R1's fall on 2/3/20, and had not known about the head injury until two days later when he visited R1. At that time FM-B only knew R1 hurt her head and was not aware R1 fell . FM-B stated the facility notified him about R1's fall four days after the fall when she was transferred to the hospital for an x-ray because of back and abdominal pain. Facility provided [MEDICATION NAME] medicine information sheet dated January 1, 2020, which indicated [MEDICATION NAME] may cause very bad and sometimes deadly bleeding and to call the doctor right away with any signs of bleeding. Policy on Notification to the Provider and/or family was requested and not provided.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess and monitor for change of condition after a resident on an anticoagulant fell with head injury/laceration and bleeding and four days later was hospitalized with subdural hematoma, bilateral cranial bleeding, pain, and a T11 back fracture resulting in an immediate jeopardy situation for 1 of 3 residents (R1) reviewed for falls. R1 sustained actual harm with subdural hematoma, bilateral cranial bleeding, and a T11 back fracture. The immediate jeopardy began on 2/3/20, when R1, who was on an anticoagulant therapy medication, fell and hit her head, the physician and family were not notified and the facility failed to assess and monitor a change in condition, identified on 2/28/20. The interim administrator, director of nursing, and regional nurse consultant were notified of the immediate jeopardy at 5:30 p.m. on 2/28/20. The immediate jeopardy was removed on 2/29/20, but noncompliance remained at the lower scope and severity level of G which indicated actual harm that is not immediate jeopardy. Findings include: R1's Details of Hospital Stay dated 2/10/20, indicated R1 presented to the emergency department (ED) 4 days after fall with pain and nausea and was on [MEDICATION NAME] (blood thinner) for [MEDICAL CONDITION] (irregular heartbeat). A head CT (scan) was obtained which revealed scattered areas of subarachnoid (fluid-filled space around brain) hemorrhage (bleeding) along the left frontoparietal and right frontal and temporal lobes. Lumbar spine CT revealed an acute obliquely oriented fracture through the T11 vertebrae as well as a chronic L1 compression fracture. Her INR (blood clotting time test) blood level was 3.6 (normal range 2.0 to 3.0) and she was administered [MED], vitamin K, and 1 unit FFP (fresh frozen plasma) for reversal. R1 was interviewed on 2/28/20, at 1:50 p.m. sitting in her recliner in her room alone, walker near her chair. R1 stated she had fallen a year ago and broke her elbow. R1 stated the same thing happened when she fell on [DATE], and broke her back and hit her head and bled. R1 stated on 2/3/20, she realized she was late for lunch, was in a hurry, and her right foot turned in and she fell to the floor and hit her head. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1's cognition was impaired, included a [DIAGNOSES REDACTED]. R1's MDS indicated R1 needed extensive assist of one staff, with bed mobility, transfers, dressing, toileting and personal hygiene. R1's MDS indicated R1 walked with a walker and was independent with ambulation in her room and off unit. R1's Care Area assessment dated [DATE], indicated R1's cognition was impaired and R1 was not steady when moved from a seated to upright position and only able to stabilize with staff assistance. Assistant Director of Nursing (ADON) stated on 2/28/20, at 12:05 p.m. the dietary manager (DM) had reported in morning report in interdisciplinary team (IDT) meeting on 2/4/20, that she had seen steri strips and dried blood in the back of R1's head when R1 was in the dining room. ADON said the nurse manager (NM) was

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) responsible to check the risk management system after a resident fell to make sure the fall was noted and the nurse manager would identify fall interventions. ADON stated she did not know if this had been completed for R1's fall on 2/3/20, as NM registered nurse (RN)-F's last day of employment had been 2/3/20, and a new NM had not yet started in her place. ADON stated RN-C should have automatically sent R1 to the emergency room for a CT scan since R1 was on an anticoagulant medication and had had a head injury with her fall on 2/3/20, and was at increased risk for bleeding. ADON stated RN-D had said she had asked R1 if she wanted to go to the hospital and R1 declined. R1 was not provided education about the risks of increased bleeding when on an anticoagulant medication and a fall. ADON stated she had not re-educated RN-C nor any other nurses other than licensed practical nurse (LPN)-A about notification to the physician after a resident, who is on an anticoagulant, falls and received a head injury. ADON confirmed no fall intervention had been put in place after R1's fall on 2/3/20. ADON verified R1's neurological (neuro's) checks and vital signs had not been completed per protocol from 2/3/20 to 2/4/20, and verified there were no other neuro checks and/or vital signs documented in R1's medical record up to the hospitalization on [DATE]. ADON confirmed the nurses should have followed protocol and followed the guidelines and completed as guided. LPN-B stated on 2/28/20, at 2:00 p.m. she was called in R1's room on 2/3/20, around lunchtime, and saw R1 on the floor with moderate amount of blood on the floor and on R1's head. LPN-B stated RN-C came into the room and asked R1 if she wanted to go to the hospital and R1 told RN-C no. LPN-B stated she would have sent R1 into the ED because of R1's age and that she had fallen. LPN-B stated she did not know if it made a difference or not of R1 being on an anticoagulant but reiterated she would have sent R1 to the hospital because of her age. ADON verified on 2/28/20, at 1:15 p.m. the facility's fall policy lacked any information about residents who are on an anticoagulant and would be at risk to bleed if they fell and hit their head. ADON stated she verbally educated nurses upon orientation and annually about residents on anticoagulants and risk of bleeding if they fell . ADON stated she did not have any written documentation to support her verbalization to the nurses. Trained medication assistant (TMA)-B stated on 2/28/20, at 2:10 p.m. she had taken R1's vitals later in the day on 2/3/20, but had not looked at R1's head wound and was unaware of whether R1 had steri strips on her head. RN-F stated on 2/28/20, at 2:18 p.m. she had not been made aware of R1's fall on 2/3/20. RN-F stated R1 had fallen about a month previously, received a bruise on her face, had not broken anything; however, did not remember what fall intervention had been put in place after the fall. RN-F stated R1 was independent with ambulation, walked with a walker to meals. RN-F stated she would have expected RN-C to have notified her of R1's fall on 2/3/20. RN-F stated she tried to re-educate staff and provide on the spot training when needed but did not always document it. Regional nurse consultant (RNC) stated on 2/28/20, at 2:30 p.m. she had spoken with RN-C and RN-C told her she had not notified the physician or R1's family after her fall on 2/3/20, but had passed the fall information along to the next shift nurse coming in. RN-C was unavailable for surveyor to interview. RNC stated R1 had asked for an x-ray on 2/7/20, because of back pain radiating to her abdomen from her fall and had been sent to the hospital on [DATE], for an x-ray of her back and ribs. R1 was observed on 3/2/20, at 10:16 a.m. in her recliner in her room with a distressed look on her face. R1 stated she had pain across her abdomen to her right side and explained she broke one of her bones in her back when she fell and also had a brain bleed. R1 stated she has had pain since the fall and stated she felt less pain when she stood versus when she sat. R1 stated she did not feel she could get out of her chair alone and had asked staff earlier for something for her pain. R1 stated she had had two falls since she was admitted and both occurred in her room. ADON stated on 3/2/20, at 10:49 a.m. IDT would change would discuss resident falls more in. ADON stated she had talked to RN-C later on 2/28/20, and reeducated her about the importance to call the physician, family, DON and a progress note, incident report and risk management needed to be completed after all falls. ADON explained she told RN-C when a resident on an anticoagulant medication and falls and hits their head they are to be sent to the ER for evaluation. Transition Care Unit NM RN-J stated on 3/2/20, at 11:04 a.m. when a resident falls and had a head injury she expected the nurse to control the bleeding, render first aide, notify the provider, DON, family and follow the provider instructions. RN-F stated neuro checks were to be started with unwitnessed fall and resident hits head, complete vitals, range of motion, access pain, and cognition changes, put an order in to monitor injury every shift and put in a progress note where everybody could find it. The Nurse Practitioner (NP) stated on 3/2/20, at 11:45 a.m. she expected the nurse to call her right away whenever a resident fell and was surprised to find out she had not been notified on 2/3/20, when R1 fell and injured her head. NP stated she would have wanted R1 immediately sent to the ED on 2/3/20, and stated R1's fall was traumatic because she hit her head on the dresser. NP explained the provider at the ED would have decided R1's plan of care and could have diagnosed earlier an intervention for the brain bleed and an intervention with the x-ray for her broken back. NP stated she thought R1's quality of life had been affected when R1 was not walking to the dining room and sequestered herself in her room to eat. The medical director (MD) stated on 3/2/20, at 11:51 a.m. the physician should have been notified right away after R1 fell on [DATE], especially because R1 was on an anticoagulant and sustained a head injury. MD noted she noticed at the quality assurance performance improvement (QAPI) meeting, falls in the facility had increased and QAPI would now look at all resident falls. NM RN-F verified on 3/2/20, at 1:49 p.m. there was no fall assessment completed for R1's fall on 2/3/20, and no incident review and analysis completed until 3/1/20, when DON completed it. RN-F stated IDT had talked about R1's fall on 2/3/20, and how R1 had stumbled in her room and now therapy would complete an evaluation. RN-F stated she had not reviewed R1's neuro's sheet completed after her fall but confirmed neuro's and vitals were missing on the 24 hour report sheet. The medical physician (MP) stated on 3/2/20, at 2:05 p.m. she nor the NP been notified regarding R1's fall on 2/3/20. MP was alarmed at the lack of notification to a medical provider when R1 fell and hit her head. LPN-A stated on 3/2/20, at 3:01 p.m. she came in to work the evening shift on 2/3/20, the day R1 had fallen in her room. RN-C reported to her R1 had hit her head on the television stand, steri-strips were applied, and neuro checks were started. LPN-A stated she had not known an incident form and risk management form had not been completed. She also was not aware the physician or the family had not been notified. LPN-A stated four days later when she worked on Friday 2/7/20, R1 complained of stomach pain in the morning and RN-J had sent R1 to the hospital as R1 wanted an x-ray for pain in her back and abdomen from her fall on Monday. LPN-A stated the hospital had called her and when LPN-A could not find anything in R1's medical record about the fall she had on 2/3/20, she had called the DON to notify her. LPN-A stated the hospital staff had told her they were transferring R1 to the Rochester hospital because of R1's brain bleed and back fracture. R1's family member (FM)-B stated on 3/4/20, at 8:25 a.m. he had not been notified of R1's fall on 2/3/20, did not know R1 hit her head until FM-B visited two days after her fall and at that time still did not know she fell . The facility had not notified him about the fall until four days later when she was transferred to the hospital for an x-ray because of back and abdominal pain. FM-B stated after hospitalization R1 now had therapy, got tired easily, needed therapy to build her strength back up and had pain. FM-B stated R1 used to go independently to the dining room with her walker and now does not go to the dining room and preferred to eat in her room. FM-B stated the hospital had told him R1 had two spots on the brain with intracranial bleeding. FM-B stated the hospital had told him the back fracture would take R1 three months to heal. The DON stated on 2/28/20, at 11:05 a.m. the IDT met daily Monday through Friday discussed resident falls, chose a fall intervention which the nurse manager updated on the resident care plan and implemented with staff. DON stated she had not been called on 2/3/20, regarding R1's fall but would have wanted to be notified. DON verified no fall incident report, fall assessment or progress note was completed after the fall. The physician or R1's family was notified, and the fall had not been put on the 24 hour report. DON stated R1 had been complaining of back and rib pain on 2/7/20, and went to the hospital with a [DIAGNOSES REDACTED]. R1's Neurological Flow Sheet revealed 7 of the 24 neuro checks and 3 of the 24 vital signs on 2/3-2/4/20, were not completed for R1. R1's medical record revealed no evidence of any vital signs and/or neuro checks completed from 2/4/20, until R1 was hosptalized on [DATE]. R1's progress note dated 2/7/20, indicated R1 had pain that wrapped around lower back and abdomen and R1 wanted an x-ay to rule out fracture from fall earlier this week. Facility provided [MEDICATION NAME] Medicine Information sheet dated January 1, 2020, indicated [MEDICATION NAME] may cause very bad and sometimes deadly bleeding and to call the doctor right away with any signs of bleeding. Policy on change of condition and/or monitoring requested and not made available. The immediate jeopardy that began on 2/28/20, was removed on 2/29/20, when the facility educated all residents/families of the risk regarding anticoagulant therapy and falls and care plans of these residents were updated to include the risk of anticoagulant therapy and falls. All licensed staff were educated immediately on fall prevention and management, IDT was reeducated on fall management, and daily audits around falls were started. Policies and procedures were reviewed and updated. Fall intervention guidelines were posted at each nursing station and updated neurological flow sheet with direction were implemented. The noncompliance remained at the lower scope and severity level which indicated actual harm that is not immediate jeopardy, Level G. R1 sustained actual harm after a fall in which R1, who was on an anticoagulant medication, fell and hit her head, was not adequately monitored and was

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) hospitalized four days after the fall with a subdural hematoma, bilateral cranial bleeding, and a T11 back fracture
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement safety recommendations from therapy post hospitalization for 1 of 1 residents (R1) reviewed for falls when staff were not aware the resident needed stand by assistance and thought resident was independent. The facility also did not implement fall interventions post fall for R1. The facility failed to investigate causal factors related to falls, comprehensively reassess, and monitor and evaluate effectiveness of interventions for 3 of 3 residents (R1, R2, R3) reviewed for falls. Findings include: R1 was interviewed on 2/28/20, at 1:50 p.m. sitting in her recliner in her room alone, walker near her chair. R1 stated she had fallen a year ago and broke her elbow. R1 stated the same thing happened when she fell on [DATE], and broke her back and hit her head and bled. R1 stated on 2/3/20, she realized she was late for lunch, was in a hurry, and her right foot turned in and she fell to the floor and hit her head. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1's cognition was impaired, included a [DIAGNOSES REDACTED]. R1's MDS indicated R1 needed extensive of one staff, with bed mobility, transfers, dressing, toileting and personal hygiene. R1's MDS indicated R1 walked with a walker and was independent with ambulation in her room and off unit. R1's Care Area assessment dated [DATE], indicated R1's cognition was impaired and R1 was not steady when moved from a seated to upright position and only able to stabilize with staff assistance. R1's Mobility/Fall Prevention care plan revised 12/4/18, indicated R1 was at risk for falls due to urinary incontinence and balance, had tripped and fallen in the past, and would like to remain free from injury should a fall occur. R1's Fall Review Evaluation dated 11/26/19, indicated R1 was at risk for falls and had a fall 4/9/18, with a fracture to arm and was independent with transfers and ambulation. Review of R1's medical record (MR) revealed no evidence of a fall incident report or risk management analysis or fall interventions identified after R1's fall on 2/3/20. Assistant Director of Nursing (ADON) stated on 2/28/20, at 12:05 p.m. the dietary manager (DM) had reported at the morning report interdisciplinary team (IDT) meeting on 2/4/20, that she had seen steri strips and dried blood on the back of R1's head when R1 was in the dining room. ADON said the nurse manager (NM) was responsible to check the risk management system after a resident fell to make sure the fall was noted and the nurse manager would identify fall interventions. The ADON stated she did not know if this had been completed for R1's fall on 2/3/20, as NM Registered Nurse (RN)-F's last day of employment had been 2/3/20, and a new NM had not yet started in her place. ADON confirmed no fall intervention had been put in place after R1's fall on 2/3/20. LPN-B stated on 2/28/20, at 2:00 p.m. she was called in R1's room on 2/3/20, around lunchtime, and saw R1 on the floor with moderate amount of blood on the floor and on R1's head. LPN-B stated RN-C came into the room and asked R1 if she wanted to go to the hospital and R1 told RN-C no. ADON verified on 2/28/20, at 1:15 p.m. the facility's fall policy lacked any information about residents who are on an anticoagulant and would be at risk to bleed if they fell and hit their head. ADON stated she verbally educated nurses upon orientation and annually about residents on anticoagulants and risk of bleeding if they fell . ADON stated she did not have any written documentation to support her verbalization to the nurses. Nursing assistant (NA)-B stated on 2/28/20, at 2:05 p.m. when she did not see R1 in the dining room for lunch on 2/3/20, she went to her room and saw R1 lying on the floor with blood on her head and floor. NA-B stated she yelled for help and LPN-B came into R1's room and then RN-C. NA-B stated at the time, R1 was independent with transfers and ambulation, walked with a walker and was not a fall risk. NM RN-F stated on 2/28/20, at 2:18 p.m. she had not been made aware of R1's fall on 2/3/20. RN-F stated R1 had fallen about a month previously, received a bruise on her face, had not broken anything; however, did not remember what fall intervention had been put in place after the fall. RN-F stated R1 was independent with ambulation, and walked with a walker. RN-F stated she would have expected RN-C to have notified her of R1's fall on 2/3/20. Regional nurse consultant (RNC) stated on 2/28/20, at 2:30 p.m. she had spoken with RN-C on 2/28/20, after the surveyors arrived and RN-C told her she had not notified the physician or R1's family after her fall on 2/3/20, but had passed the fall information along to the next shift. RN-C was unavailable for surveyor to interview. RNC stated R1 had asked for an x-ray on 2/7/20, because of back pain that radiated to her abdomen from her fall and had been sent to the hospital on [DATE], for an x-ray of her back and ribs. R1 was observed on 3/2/20, at 10:16 a.m. in her recliner in her room with a distressed look on her face. R1 stated she had pain across her abdomen to her right side and explained she broke one of her bones in her back when she fell and also had a brain bleed. R1 stated she has had pain since the fall and stated she felt less pain when she stood versus when she sat. R1 stated she did not feel she could get out of her chair alone and had asked staff earlier for something for her pain. R1 stated she had had two falls since she was admitted and both occurred in her room. The Nurse Practitioner (NP) stated on 3/2/20, at 11:45 a.m. she expected the nurse to call her right away whenever a resident fell and was surprised to find out she had not been notified on 2/3/20, when R1 fell and injured her head. NP stated she would have wanted R1 immediately sent to the ED on 2/3/20, and stated R1's fall was traumatic because she hit her head on the dresser. The medical director (MD) stated on 3/2/20, at 11:51 a.m. the physician should have been notified right away after R1 fell on [DATE], especially because R 1 was on an anticoagulant and sustained a head injury. MD noted she noticed at the quality assurance performance improvement (QAPI) meeting, falls in the facility had increased and QAPI would now look at all resident falls. NA-B stated on 3/2/20, at 11:59 am. R1 had been eating her meals in her room, had pain, and was not walking to the dining room since her fall. NA-B stated R1 was still independent in her room and only needed help from nights when helped her out of bed. TMA-A stated on 3/2/20, at 12:02 p.m. that R1 needed assistance with help out of bed and assistance with dressing otherwise R1 was independent with her transfers and ambulation. NM RN-F verified on 3/2/20, at 1:49 p.m. there was no fall assessment completed for R1's fall on 2/3/20, and no incident review and analysis completed until 3/1/20, when DON completed it. RN-F stated at the 3/2/20 IDT meeting, R1's fall was discussed and therapy would complete an evaluation. RN-F stated she had not reviewed R1's neurological sheet completed after her fall and confirmed there were missing neurological checks and vitals on the 24 hour sheet. The medical physician (MP) stated on 3/2/20, at 2:05 p.m. she nor the NP been notified regarding R1's fall on 2/3/20. MP was alarmed at the lack of notification to a medical provider when R1 fell and hit her head. The occupational therapy (OT) staff stated on 3/2/20, at 2:25 p.m. R1 had pain and still ate in her room and had not returned yet to the dining room for her meals as she could not get up from the chair in the dining room. OT stated she helped R1 with activities of daily living (ADLs) and dressing and upper body strength as she had gotten weaker in the hospital and needed staff assistance due to pain in her back now. OT stated she saw R1 walk around in her room independently more than once and reminded her she needed staff assistance with ambulation. The physical therapist (PT) stated on 3/2/20, at 2:35 p.m. he was going to show R1 a seated exercise program because of balance issues. PT stated R1 was now staff stand by assistance with all ADLs, transfers and ambulation in her room and off the unit due to her lack of safety awareness. PT stated R1 sometimes forgot to lock her wheelchair brakes, was concerned about her walker placement and observed her walk in her room without her walker. PT stated R1 gets confused a lot and since she used to be independent it was hard for her to ask for staff assistance. PT stated R1 was a fall risk and was impulsive. Pt stated he worked with her to try to get her back to her baseline. LPN-A stated on 3/2/20, at 3:01 p.m. she had come in to work the evening shift on 2/3/20, the day R1 had fallen in her room, and RN-C had reported to her R1 had hit her head on the television stand and had cracked open her head and steri-strips were applied and neurological checks were started on her. LPN-A stated she had not known an incident form and risk management had not been completed, and had not known the physician or the family had not been notified. LPN-A stated four days later when she worked on Friday 2/7/20, R1 complained of stomach pain in the morning and NM RN-J had sent R1 to the hospital as R1 wanted an x-ray for pain in her back and abdomen from her fall on Monday. LPN-A stated the hospital had called her and when LPN-A could not find anything in R1's medical record in regards to the fall on 2/3/20, she had called the DON to notify her. LPN-A stated the hospital staff had told her they transferred R1 to the Rochester hospital because of R1's brain bleed and back fracture. PT stated on 3/3/20, at 10:25 a.m. he had evaluated R1 after the hospitalization for balance, safety, transfers and a plan of care for safe retrieval of her walker and safety to get her walker in front of her. PT stated R1 would walk in her room without a walker. PT stated since the hospitalization R1 liked to eat meals in her room and stated staff should check in on R1 and remind her at least every 30 minutes to use her walker. R1 was observed on 3/3/20, at 10:38 a.m. pushed in a wheelchair (w/c) by NA-E down the hall R1 leaned to her left, and guarded her abdomen, with distressed look on her face and R1 stated she had been having abdominal pain off and on since her fall. PT stated on 3/3/20, at 10:39 a.m. that he thought R1's abdominal pain was from the [MEDICATION NAME] spine because of the back fracture from the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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** - Some	(continued... from page 3) PT stated he had told the NAs to check on R1, as she tended to get up and not use her walker. PT stated he had made a safety therapy recommendation that included R1 to be stand by assist with staff for all transfers, ambulation and all ADLs. PT stated he had not written it out the recommendation form as therapy usually did upon discharge from therapy but had told LPN-B about the therapy recommendation for R1's needed level of staff assistance and for R1's safety. NA-D stated on 3/3/20, at 10:52 a.m. night shift used to help R1 get up in the mornings, however, since hospitalization R1 needed two staff assistance to pull up her pants. NA-D stated R1 was independent in her room with transfers, ambulation and her ADLs. NA-D stated she was unaware of any therapy safety recommendation for R1 to have stand by assist for staff and verified in the therapy book there was no recommendation for R1 and no recommendation posted on the bulletin board. NA-E stated on 3/3/20, at 10:55 a.m. R1 was independent with her cares and ADLs and would help R1 if she asked for assistance. NA-E stated R1 was independent in her room with her transfers and ambulation with her walker. NA-E stated she knew of no therapy recommendation for R1's safety and needed stand by assist with staff. NA-E verified in the therapy book there was no recommendation in the book nor posted on the bulletin board and she had never been told this from anyone. PT stated on 3/3/20, at 10:59 a.m. he had not put a copy of the R1's exercise in the therapy book and had not put a therapy recommendation in the book or on the bulletin board. PT stated he had just made the therapy recommendation that R1 needed increased staff stand by assist for all ADLs which included transfers and ambulation verbally to LPN-B a while ago, and indicated he had not notified any NAs about R1's safety recommendation. PT stated he had not yet told the nurse about R1's need for exercises to be completed. PT verified there was no therapy recommendation in the therapy book for nursing staff regarding R1 and stated, I need to update this therapy book, either (OT) or me. Director of Rehab stated on 3/3/20, at 11:07 a.m. when R1 returned from the hospital, therapy completed an OT and PT evaluation for assessment of transfers how R1 walked. R1 required more assistance to get in and out of bed, wheelchair transportation to the dining room, assistance with transfer to the toilet, and stand by assist to walk. Director of Rehab stated therapy recommendations were to be put in the binder at the nursing station and therapy staff were to tell the nurse about it and notify the NM, and since NM RN-F no longer worked at the facility the expectation was therapy staff should tell NM RN-J about it or the DON. NA-B stated on 3/4/20, at 8:02 a.m. R1 had received an x-ray yesterday for pain and stated R1 remained independent in her room and outside of her room. NA-B stated R1 had walked independently earlier that morning out on unit with her walker, got her medications and then walked back into her room by herself. NA-B stated she had not escorted R1 back to her room as she had not known R1 was no longer independent with ambulation and was not aware of any therapy recommendation that R1 needed more staff assistance with stand by assist for ADLs and transfers and ambulation. NA-B stated she was not aware of R1's lack of safety awareness as assessed by therapy. NA-B verified on NA care guide R1 was independent with ambulation and transfers. NA-C stated on 3/4/20, at 8:04 a.m. she had not known R1 received an x-ray yesterday and stated R1 remained independent in her room and outside of her room. NA-C stated R1 had walked out on the unit with her walker by herself asked staff questions and then went back into her room independently. NA-C stated she had not escorted R1 back to her room as she had not known R1 was no longer independent with ambulation and was not aware of any therapy recommendation for R1's safety and needed increased staff assistance for stand by assistance with ADLs and ambulation and transfers. NA-C verified on NA care guide R1 was independent with ambulation and transfers. LPN-B stated on 3/4/20, at 8:05 a.m. she knew R1 had an x-ray yesterday but did not know the results or any changes with care. LPN-B stated R1 came out of her room independently with her walker that morning and received her medications. LPN-B stated she had not escorted R1 back to her room as she had not known R1 was no longer independent with ambulation and was not aware of any therapy recommendation for R1 needing more staff assistance with stand by assist for ambulation, transfers and ADLs in and out of her room. R1's family member (FM)-B stated on 3/4/20, at 8:25 a.m. he had not been notified of R1's fall on 2/3/20, did not know R1 hit her head until FM-B visited two days after her fall and at that time still did not know she fell . The facility had not notified him about the fall until four days later when she was transferred to the hospital for an x-ray because of back and abdominal pain. FM-B stated after hospitalization R1 now had therapy, got tired easily, needed therapy to build her strength back up and had pain. FM-B stated R1 used to go independently to the dining room with her walker and now doesn't go to the dining room and preferred to eat in her room. FM-B stated the hospital had told him R1 had two spots on the brain with intracranial bleeding. FM-B stated the hospital had told him the back fracture would take R1 three months to heal. R1's NA care guide dated 2/7/20, indicated R1 was independent with FFW (front wheeled walker). R1's care plan revised 2/4/19, indicated R1 could ambulate independently with FWW. The DON stated on 2/28/20, at 11:05 a.m. the IDT met daily Monday through Friday discussed resident falls, chose a fall intervention which the nurse manager updated on the resident care plan and implemented with staff. DON stated she had not been called on 2/3/20, regarding R1's fall but would have wanted to be notified. DON verified no fall incident report, fall assessment or progress note was completed after the fall. The physician or R1's family was notified, and the fall had not been put on the 24 hour report. DON stated R1 had been complaining of back and rib pain on 2/7/20, and went to the hospital with a [DIAGNOSES REDACTED]. Review of R1's medical record revealed no evidence of a fall incident report or risk management analysis completed before surveyors entered facility on 2/28/20. There were no fall intervention put in place after 2/3/20, when R1 fell with head injury and was hospitalized four days later for subdural hematoma, intracranial bleed, and T11 back fracture. R1's medical record also lacked evidence of a written therapy safety recommendation for R1 after returning from the hospital on [DATE]. R2's admission record indicated R2 was admitted to the facility on [DATE]. R2's [DIAGNOSES REDACTED]. R2's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R2's cognition was impaired, had declined in mobility, used walker and wheelchair, required extensive assistance and/or assist of one person with all activities of daily living. R2 had history of falls, 10-20 times at home in the last two to three months, poor balance and daily antidepressant use. R2's care plan dated 12/7/19, and revised on 2/28/20, identified R2 was at risk for falls and interventions included using pummel wheelchair cushion, teddy bear, magazine, colors book to help with activities, within nurse's eyesight, take nap after meals, yellow blanket on the back of her wheelchair to alert staff, call light within reach and proper footwear. A review of R2's Fall Incident Review and Analysis dated 12/17/19, 1/10/20, 1/25/20, 1/26/20, 1/28/20, [DATE] and [DATE], indicated she had seven falls during past three months. A review of progress notes indicated R2 had a history of [REDACTED]. During an observation on 2/28/20, at 12:10 p.m. R2 sat in a large wheel chair with a pummel and held a baby doll next to nurse's medication cart in the dining area. On 3/1/20, at 3:53 p.m. R2 sat in a large wheel chair with a pummel, leaned forward and reached out her arms, one foot was on the floor and another foot did not touch the floor. R2 attempted to get out of the chair and reached for the nearby car, staff handed her a baby doll to sit back down. On 3/2/20, at 9:29 a.m. R2 sat in a large wheel chair with a pummel and tried to get up. NA-A reminded R to scoot back to her chair and assisted her to sit back. At 9:42 a.m. R2 was by herself in the dining room with others residents. Nurse walked around to put empty trays away. R2 tried to get up and held onto another chair next to her. NA-A walked by and reminded her to wait for help. At 10:05 a.m. RN-A put a side table in front of her. She gave her magazines to read. RN-A said, I need you to be here so I can see you when R2 asked her why she needed to be there. On 3/3/20, at 10:10 a.m. R2 sat by the nurse's station in a smaller wheel chair with a pummel and had her eyes closed. At 10:42 a.m. NA-A approached R2 and assisted her to lie down to rest. During an interview on 3/02/20, at 10:39 a.m. NA-A stated residents who are a fall risk have a yellow blanket on the back of their chair. Staff keep a majority of residents in the dining room so they can watch them. NA-A stated that R2 was a fall risk, had a yellow blanket on the back of her chair and NA-A tried to keep an eye on her the best she can. At 10:49 a.m. family member (FM)-A stated that R2 was never like to sit and liked to walk. They were wondered if the facility could have her work with physical therapy again. Per family, neurology doctor recommended R2 to go back in therapy and the family would like the same thing. They voiced their concerns but was not sure if the facility implemented it. R2 loved to listen to music but there was no extra plug in her room for a radio. Family believed if staff engaged R2 and kept her busy it would tire her out and she would not attempt to get up. FM-A stated that he had been told the facility was under staffed and staff was not able to walk R2 and that is why she was in a chair all day. FM-A stated R2 walked more at home and fell less at home. At 11:14 a.m. RN-A confirmed that she did not know what the yellow blanket behind the resident's wheelchair was for. However, she knew R2 was a fall risk. At 12:28 p.m. RN-B was interviewed and said she was not sure if R2 was able to walk. However, knew that she attempted to self-transfer. RN-B indicated R2 had dementia, did not no know her limitations and had not seen staff walk with R2 since RN-B stated work with the facility two weeks ago. On 3/2/20, at 3:01 p.m. LPN-A was interviewed and stated she would wheel R2 wherever she went to keep a visual eye on her so R2 would not fall. LPN-A confirmed she tried to keep an eye on R2 but could not always. R2 got tired but they could not lie her down for nap because R2 would try to self-transfer out of bed and staff could not keep an eye on her in her room. LPN-A claimed that it was hard

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	245067	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) to keep her safe and had reported it to nurse manager the situation. On 3/3/20, at 10:15 a.m. PT stated he was asked by RN-C to put a pummel cushion in a wheelchair for R2 to prevent her sliding out of the chair. PT provided R2 a smaller wheelchair with a pummel on 3/2/20 so both feet could touch the floor. The previous chair was to large for R2 and she was not able to have both feet touch the floor. PT said he now worked with R2 for therapy three times a week for strength to stand, balance and ambulation. There was no evidence in the record of an assessment for the use of the pummel for R2 by the nursing staff or therapy. At 11:14 a.m. director of rehab was interviewed and stated the therapy department worked with R2 for four to six weeks for activities of daily living, transfers and ambulation and then was discharge from therapy when she was admitted to dementia care unit. The director of rehab stated the interdisciplinary team meets every Monday through Friday to discuss falls and implement different strategies to prevent falls. The director of rehab did not recall if R2 was discussed in the meetings. Director of rehab believed they should had been brought in sooner as an intervention for R2's safety and for her wheelchair evaluation. Director of Rehab agreed a scheduled to lay R2 down, stand up and assist to walk could help to decrease chance of more falls. During an interview on 3/3/20, at 10:48 a.m. NM RN-J stated there should be a fall assessment after each fall but could not provide the documents for all of the 14 falls R2 had. NM-F agreed the facility lacked the appropriated fall interventions for R2. The record lacked documentation of investigation related to of all R2's falls, a comprehensive analysis of the falls and monitoring of the effectiveness of the fall interventions. R3's admission record indicated R3 was admitted to the facility on [DATE]. R3's [DIAGNOSES REDACTED]. R3's admission MDS dated [DATE], indicated R3's cognition was impaired, oriented to self only and was able to follow simple direction. R3 triggered for falls related to having poor balance, history of falls prior to admission and after admission, and antidepressant medication use. He had a progressive decline in mobility due to progressing dementia and had a recent further decline following hospitalization for a fall at home. R3's care plan initiated 11/6/19, identified R3 was at risk for falls and interventions included physical therapy per medical doctor's order, dycem underneath wheelchair cushion and on top seat, keep room clean and free of clutter, keep call-light within reach, follow resident specific fall prevention plan and wedge cushion which was attached to the back of the wheelchair. A review of R3's Fall Incident Review and Analysis included incidents for four incidents; 11/11/19, 11/13/19, 11/18/19, and 1/7/20. However, a review of progress notes indicated R2 had a history of [REDACTED]. During an observation on 3/3/20, at 8:26 a.m. R3 sat in a wheelchair and watched television by himself close to nurse's station. No staff were observed around at that time. At 12:04 p.m. on 3/3/20, R3 sat in a wheelchair by himself at the common area and no staff were around. On 3/4/20, at 11:30 a.m. R3 slept while he sat in wheelchair in his room. His feet were on the ground with the foot pedals in place. He was observed in the middle of the room without his call light and or dycem was under the cushion. No grabber or reacher was found in R3's room. During an interview on 3/3/20, at 11:34 a.m. LPN-B was not aware R3 was a fall risk. She stated that he could be fine to be in his room alone and could move around when he was in a wheelchair. At 11:48 a.m. on 3/3/20, NA-B stated that R3 had not had any falls for a while and there were no specific interventions put in place as far as she knew of. She confirmed that R3 had no reacher or grabber while R3 was in his room. R3's bed always was in lowest position and when R3 was in bed, and staff kept a close eye on him all the time. NA-B said R3 fell out of his wheelchair one time when he fell asleep in the wheelchair and it happened when he was alone. NA-B said R3 did not like to lie down in bed. At 1:32 p.m. on 3/3/20, FM-F stated that R3 fell often at home and the facility knew about it. FM-F confirmed that she did not know he had fallen five times in the facility until she called and asked them. The facility did not always call and tell her that R3 fell . At 1:43 p.m. on 3/3/20, NA-C stated that R3 was a two person assist and fell while he was in transitional care unit. He leaned forward while he was in wheelchair and fell . R3 tried to get up and then he fell again on different day. In the mornings, staff assist R3 with cares and then bring him to the nursing station so nursing staff can keep an eye on him. NA-C thought that staff would laid him down in bed and let him sleep if he was tired. She confirmed that there was no grabber or reacher in his room On 3/4/20, at 1:52 p.m. TCU NM RN-J stated that she had put a wander guard on R3 after he had tried to leave the facility after admission and had fallen outside the facility; but was not sure if he still had the wander guard on. NM RN-J confirmed they had not done fall assessments after the all incidents and stated R3 had three to four other falls since admission. RN-J indicated some fall interventions included dycem, a change to the wheelchair cushion, encourage R3 to lay down in between meal and place all the items within reach and provide a reacher or grabber. RN-J confirmed that staff just gave R3 reacher recently but could not remember what day. RN-J stated staff notified the wife every time R3 fell . The record lacked documentation of investigation related to of all R3's falls, a comprehensive analysis of the falls and monitoring of the effectiveness of the fall interventions. The facility protocol Falls Prevention and Management Protocol revised date 2/2020, indicated The purpose of this protocol is to identify resident at risk for falls, implement fall prevention interventions, and provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.