DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2024

Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, MN 56479

RE: CCN: 245420
Cycle Start Date: July 17, 2024

Dear Administrator:

On July 17, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

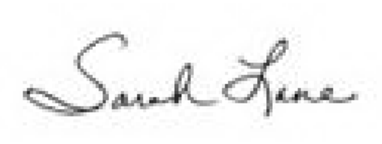
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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July 31, 2024

Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, MN 56479

Re: Event ID: BP5R11

Dear Administrator:

The above facility survey was completed on July 17, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245420	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD HEALTH SYSTEM	401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/16/24 through 7/17/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H54205429C (MN000104636) with a deficiency cited at F684 at Harm, Past Non-Compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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

Electronically Signed

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 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate supervision to prevent wandering to unsafe places and falls for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm to R1 when she fell and sustained a fracture to the right leg. The facility implemented corrective action so the deficient practice was issued at past non-compliance. Findings include: R1's annual Minimum Data Set (MDS), dated 6/24/24, identified R1 required supervision with eating, oral hygiene, toileting, and shower/bathing, partial to moderate assistance personal hygiene, roll left to right, sit to lying, lying to sitting, and toilet transfers. Substantial to maximum assistance to transfer from chair to bed and sit to stand machine. R1 was frequently incontinent of bladder and always continent of bowel. R1's diagnoses included non-traumatic brain dysfunction, arthritis, osteoporosis, Alzheimer's, and dementia. R1's medications include diuretics (increased urine output). R1's Fall risk assessment dated 6/24/24, identified intermittent confusion, incontinent, balance problem with standing and walking and required the use of assistive devices (i.e. cane wheelchair, walker, furniture). R1 was at risk for falls. R1's elopement evaluation dated 6/24/24, identified R1 wandered and identified at risk for elopement.	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 2 R1's bowel and bladder assessment dated 6/24/24, no falls in past three months, intermittent confusion, ambulatory and incontinent. R1 had balance problems while standing and while walking and required use of assistive devices (i.e. cane, wheelchair, walker, furniture). R1's care plan dated 6/24/24, directed staff to anticipate unmet needs, cue, reorient, and supervise as needed. R1 was at high risk for falls, unaware of safety needs, gait/balance problems, incontinence, and the potential to fall down and hurt herself. Staff were directed to follow urinary toileting schedule every two hours and monitor/provide reminders/assistance to turn/reposition at least every two hours, or more often as needed or requested due to potential for pressure ulcer development. R1's care plan lacked evidence of a revision following implementation of hourly safety checks on 7/4/24, though hourly checks were added to the NA tasks sheet at that time. A facility reported incident (FRI) report submitted to the State Agency (SA) on 7/4/24, at 10:40 p.m.. The report identified R1 fell at 9:35 p.m., R1 was found on the floor beside the bed lying on right side. R1 was unable to state what happened. R1 had a small amount of emesis. R1's electronic medical record identified the following: - Task of: MONITOR - Complete Hourly Safety Check every shift related to fall risk. Staff to ensure R1 had gripper always socks on. R1's hourly safety checks documentation for 7/4/24, revealed staff signed off the safety checks were completed at 2:41 p.m., 3:53 p.m., 4:41 p.m.,	F 684		

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F 684	Continued From page 3 5:00 p.m., 6:00 p.m. 7:00 p.m. Staff did not document the safety check was completed at 8:00 p.m. or 9:00 p.m. and then at 10:47 p.m. documented R1 "not available". R1's safety checks were documented to acknowledge R1 was located on 7/4/24, at 2:41 p.m., 3:53 p.m., 4:41 p.m., 5:00 p.m., 6:00 p.m. 7:00 p.m. and documented R1 was not available at 10:47 p.m. Staff did not document R1 was located after 7:00 p.m. until 10:47 p.m. (3 hours and 47 minutes). Task of: B & B (bowel and bladder): Bladder elimination - Toilet every two hours, while awake, during AM (morning) and PM (evening). First, third, and last rounds during the night. Toilet after dinner each day. R1's bladder elimination documentation on 7/4/24, revealed staff signed off at 1:00 p.m. continent, 3:41 p.m. continent, 5:00 p.m. incontinent, 9:35 p.m. incontinent. Staff did not document bladder elimination after 5:00 p.m. until 9:35 p.m. (4 hours and 35 minutes). At 10:47 p.m. staff documented R1 was not available. R1's progress notes dated from 6/25/24, to 7/5/24 were reviewed and identified the following: -6/25/24, at 6:54 a.m. staff were unable to complete brief interview for mental status (BIMS), memory problem identified and severely impaired decision making. -6/30/24, at 11:08 p.m. R1 self-transferred in room, attempted to put herself to bed, and had an unwitnessed fall. No injuries identified. -7/1/24, at 2:45 a.m. R1 was found sitting on floor next to bed at 1:10 a.m. R1 stated she was getting in her chair. Second fall within 12 hours.	F 684		

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F 684	Continued From page 4 R1 was assessed, assisted into her chair, and brought to nurse's desk. -7/1/24, at 7:01 a.m. post fall evaluation indicated fall was not witnessed, occurred in R1's room, and reason for fall was not evident. Contributing factors note: R1's bedtime routine was disrupted as R1 had company. -7/4/24, at 9:40 p.m. orders obtained to send R1 to emergency room (ER) for evaluation and treatment following fall. -7/4/24, at 9:48 p.m. Post fall evaluation: R1's fall on 7/4/24, at 9:11 p.m. was found on the floor was not facility sleep study room at 9:10 p.m., complained of right leg pain, and had an emesis. R1's fall was unwitnessed and appeared she attempted to get into a bed that was very elevated and resulted in a fall. R1 sustained an injury of the right medial leg with pain. Physical findings noted R1 had a sensory impairment of her sight and displayed right leg pain. R1 was sent to ER and evaluated. -7/4/24, at 10:56 p.m. communication with provider: staff completed the 9:00 p.m. safety check and located R1 on the floor beside the bed in sleep study room. R1 laid on her right side and complained of right leg pain. -7/5/24, at 1:26 p.m. updated R1's daughter, vulnerable adult was filed with the state agency. R1 was transferred to another local hospital for surgery then would return to facility. -7/8/24, at 2:28 p.m. R1 returned to facility via wheelchair. R1 experienced signs of short-term memory loss, was disoriented, confused, and	F 684		

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F 684	Continued From page 5	F 684		

required cues. R1 had dressing on right hip, poor balance, impairment of lower extremity on one side, and an indwelling catheter.

R1's Emergency Department (ED) triage notes dated 7/4/24, at 10:41 p.m. identified brought to ED after R1 encountered an unwitnessed fall and was found in sleep study on the ground on her right side. R1 had a lot of pain will wince and say "ouch" with range of motion (ROM) to her lower right extremity.

R1's hospital history and physical dated 7/4/24, at 10:53 p.m. was found wandering into the sleep lab in another part of the care center and found down on the ground. R1 refused to move right leg at all. R1 had swelling/deformity noted in right femur which was location of prior fracture in the past. R1 had dementia at baseline but seemed to be more confused than usual. R1's physical examination showed deformity/edema noted in lateral upper leg. R1's x-ray showed distal femur fracture that was displaced just past rod from prior surgery.

R1's discharge summary from hospital dated 7/8/24, at 11:05 a.m. identified R1 had a comminuted periprosthetic supracondylar femur fracture right leg and received surgical repair ORIF (open reduction and internal fixation) of right femur fracture with bone grafting. R1 was discharged back to skilled nursing facility at 1:18 p.m. on 7/8/24, and all transfers non-weight bearing on the right leg/foot. Right knee immobilizer was expected to be worn full-time until follow up in two weeks with orthopedics for x-rays and staple removal.

A facility five-day report submitted to the SA on

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F 684	Continued From page 6 7/8/24, at 1:12 p.m., identified R1's care plan was not followed regarding toileting and rounding. R1 was care planned to have been toileted every two hours, last toileted at 4:00 p.m. due again at 6:00 p.m. and not completed. R1 was brought to the dining room at 5:30 p.m. where R1 was last seen finishing her dinner at 6:15 p.m. At 8:30 p.m. staff were unable to locate R1, initiated a missing person alert and found R1 at 9:10 p.m. R1 was unable to explain what happened due to dementia/memory problems. R1's x-rays showed a right femur distal femur fracture and was surgically repaired. Both staff involved were immediately removed from the schedule and disciplinary actions were completed for R1's care not followed. Staff were new, acknowledged, and understood expectations moving forward. Audits were put into place for close monitoring of care and care plans. R1 would be assessed upon return from hospital for a wander guard or memory care placement due to new recent wandering behavior. R1's primary physician visit dated 7/11/24, identified R1 had a history of recurrent falls, cognitive impairment, remote right superior and inferior pubic ramus fractures, intertrochanteric fracture of the right hip post-surgical repair on 1/9/23, via right hip internal fixation of intertrochanteric fracture using cephalomedullary nail. R1 was admitted to facility on 1/25/23, unable to care for herself at home and had falls due to confusion and attempts to transfer without assistance. R1's cognitive decline continued at a slow pace. R1 was admitted to hospital on 7/4/24, after she sustained a fall and suffered a comminuted right femur fracture. R1's surgical procedure included an open reduction internal fixation of the right periprosthetic femur fracture	F 684		

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F 684	Continued From page 7 with bone grafting. R1's significant change MDS dated 7/12/24, identified R1 was dependent on staff for bed to chair transfers and had an indwelling catheter. R1's elopement evaluation dated 7/12/24, identified R1 wandered, wandering behavior was a pattern, goal directed (i.e. specific destination in mind, going home etc.) and likely to have affected the safety or well-being of self/others. R1 was identified at risk for elopement. R1's physician orders dated 7/14/24, identified a wander guard every shift for elopement risk and ensure the device was working. R1's Kardex dated 7/16/24, identified Fall Prevention: after meals, ask resident if she wants to sit on the couch and watch TV (television) or place her near the TV in her wheelchair so she was able to see people as they came in and out of the facility. R1 required monitoring/reminders/assistance to turn/reposition at least every two hours, more often as needed or requested. R1 was non-weight bearing to right leg. R1 used wander guard for elopement prevention. R1 was dependent of two staff and the total mechanical lift. HS (evening) routine: go to bed between 8:00 p.m. and 9:00 p.m. R1 had wander guard for elopement precaution. During continuous observations on 7/17/24, from 9:00 a.m. through 10:00 a.m.: -9:00 a.m. R1 sat was observed sitting in her wheelchair in the dining room at a table by herself. R1 drank coffee and looked around. R1 appeared to have eaten approximately 50 percent	F 684		

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F 684	Continued From page 8 of her breakfast, had gripper socks on both feet, feet were placed on footrests, and right leg elevated. R1's wander guard was observed to be hung on lower back side of wheelchair and lift sheet remained underneath R1. -9:03 a.m. an unidentified staff asked R1 if she was done eating, pushed her down to hallway one where R1 lived, and left her in the wheelchair where staffed continuous walked by to check on R1. -9:09 a.m. physical therapy assistant (PTA) approached R1 and asked if she was ready for physical therapy this morning. R1 stated "yes". PTA pushed R1 in wheelchair down the hallway and into her room. PTA completed R1's physical therapy at 9:25 a.m. then asked if R1 wanted to stay in her room or go out and watch the birds. Registered nurse (RN)-B located outside R1's room in hallway stated out loud that R1 needed to be outside her room in either hallway or out by the birds, and not left in her room. PTA stated, "well that answers my question" and pushed R1 down the hallway to the central lounge area by the birds. -9:35 a.m. R1 sat in wheelchair in commons/lounge area in front of the birds. -9:50 a.m. R1 sat in wheelchair awake in commons/lounge area in front of the birds. Numerous staff walked by. R1's feet both remained on the footrests and no attempt to get up out of wheelchair. -9:59 a.m. R1 remained in wheelchair in commons/lounge area in front of the birds. NA-D walked up to R1 and sat down next to her in a	F 684		

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	245420	A. BUILDING _____ B. WING _____	C 07/17/2024

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LAKEWOOD HEALTH SYSTEM	401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479

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F 684	Continued From page 9 chair. NA-D asked R1 if she wanted to remain sitting up or lay down, R1 stated lay down. NA-D pushed R1 down hallway to outside of her room, while NA-D located a lift machine. NA-D pushed lift machine into R1's room then R1 in wheelchair. NA-D placed call light on to signal staff for assistance with transfer from wheelchair to bed. NA-E entered R1's room and together they transferred R1 from wheelchair to bed with total lift machine. NA-D and NA-E checked R1's incontinent product, positioned her onto her back with pillow under both legs from knees to ankles so that heels were off bed mattress, then placed bed in lowest position. R1 had on right leg immobilizer during entire observation. NA-E placed call light within reach, moved bedside table next to the bed, and wheel chair on other side of room unreachable by R1. During a telephone interview on 7/17/24, at 1:30 a.m. licensed practical nurse (LPN)-A stated on 7/4/24, the last time she saw R1 was in the dining room at 6:15 p.m. LPN-A stated according to R1's care plan R1 was to be taken to the commons area after meals to be distracted by TV and other people but that night the intervention never happened. LPN-A stated R1 spent a lot of time in her wheelchair, attempted to self-transfer, and forgot she was unable to walk by herself. On 7/4/24, at 8:30 p.m. LPN-A noticed R1's roommate was in bed but R1 was not in her room. R1 was usually in bed by that time and a search was initiated. At 9:10 p.m. LPN-A noticed the sleep study room light was on and entered that room. R1 was sitting on the floor next to the bed with her right leg placed under the left leg. LPN-A placed a pillow behind R1, touched the right leg, tried to move R1's right leg but felt it was not in the correct position. LPN-A indicated	F 684		

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F 684	Continued From page 10	F 684		

registered nurse (RN)-A assisted with lifting R1 off the floor with a full mechanical lift and into her wheelchair. LPN-A stated the assessment of the right leg identified the leg was swollen, very painful, as R1 moaned, and when moved R1 yelled out ohhhhh, winced, and grimaced. R1's provider was notified and R1 was sent to ER via ambulance. R1 was diagnosed with a fracture of the right femur and had surgery to repair it. R1 was on a toileting plan, but was not sure when the last time she was taken to the bathroom. R1 was incontinent of urine and had a small emesis at the time of the fall. R1 told LPN-A she had been hollering out for a long time and knew someone would eventually come. R1 was supposed to have been on hourly safety checks, and the care plan was not followed; otherwise R1 would have not of been found half-way across the building. LPN-A stated had received education on monitoring, repositioning, hourly rounding, toileting and following the care plan on 7/8/24, right after incident.

During a telephone interview on 7/17/24, at 10:16 a.m. registered nurse (RN)-A stated R1 was at high risk for falls and was to be toileted every two hours and have hourly safety checks. Staff were expected to document the hourly checks and when R1 was toileted accurately. R1's cognition and memory were poor, R1 had fallen two weeks prior and was then placed on hourly checks. R1 frequently tooled herself around the facility and often tried to stand up by herself. It was after 9:30 p.m. when RN-A was made aware R1 fell. Staff placed R1 in a full total lift and lifted her off the floor of the sleep study room. RN-A stated it was obvious R1 favored her right leg and once her pants were removed they observed two swollen areas on the right thigh. RN-A stated both NA's

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F 684	Continued From page 11 involved were educated the evening incident happened and audits were started right after incident. RN-A stated all nurses were expected to have completed audits every shift on NA's to assure the care plans were being followed and education provided. RN-A stated those audits continued to be completed on every shift. RN-A also stated at any given time would check the NA's documentation in the resident's electronic medical record and at a glance would have known if cares and checks been completed and/or if they were behind in their cares and checks. RN-A stated she had sent out an email to all nursing staff regarding R1's fall regarding fall interventions and following the care plan right after R1 had fallen. During a telephone interview on 7/17/24, at 1:19 p.m. patient care attendant (PCA) verified she worked on wing one with a nursing assistant (NA)-A on 7/4/24. R1 was on hourly checks and both staff (PCA and NA-A) checked on her and worked as a team. Last time PCA toileted R1 on 7/4/24, was at 4:00 p.m. and after that the NA-A told her she had placed R1 in bed. PCA stated looked at the documentation on R1 and it looked like NA-A signed off she had checked on her every hour so figured R1 was taken care of. PCA was in the dining room assisting another resident when she saw R1 leave the room at about 6:00 p.m., and figured she headed down to her room. PCA found out later R1 was missing and had fallen and possibly injured herself. PCA stated they received education the following day after incident on 7/9/24, prior to start of next shift regarding falls, hourly, checks, transfers, and toileting. During an interview on 7/17/24, at 2:00 p.m. NA-A	F 684		

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F 684	Continued From page 12 stated R1 was on hourly safety checks and was to be toileted every two hours on 7/4/24. R1 was toileted was at 4:00 p.m. that day. NA-A stated from 2:00 p.m. to 4:00 p.m. R1 visited in café with her family. NA-A informed PCA she planned her break from 5:00 p.m. to 5:30 p.m. NA-A stated once she returned from her break at 5:30 p.m., she checked with PCA in the dining room, and saw R1 sat at a table in dining room. PCA stayed in dining room and assisted residents, and NA-A returned back to wing one, and answered call lights. NA-A was really busy answering resident call lights and then ended up in resident's rooms. NA-A verified hourly checks and every two-hour toileting on R1 were not completed as they were too busy. Call lights were crazy busy and NA-A asked PCA to complete the checks on R1. At 9:00 p.m. NA-A looked for R1 to get her ready for bed but was unable to find her. NA-A and PCA were expected to have completed the hourly checks on R1 and document in the electronic medical record. The building was searched and R1 was found by a staff nurse in the sleep study room. R1 had fallen and was sent over to ER. NA-A felt she may have been able to prevent that fall if the hourly checks would have been completed as care planned. NA-A stated she had received education the night R1 had fallen on 7/8/24, on documentation, falls, toileting, and hourly rounding. During an interview on 7/17/24, at 4:00 p.m. social worker designee (SWD) completed R1's elopement assessment on 6/24/24. SWD documented R1 did wander and scored one point on the assessment. SWD also verified a score of one or higher the resident would have been considered a risk. SWD stated her thought process was when R1 was taken out of her room	F 684		

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F 684	Continued From page 13 and wandered back into her room she considered that would be wandering. SWD stated mostly likely was an error and that question should have been answered no instead on 6/24/24. SWD stated R1 was re-assessed on 7/12/24, for her risk of elopement and identified at risk and a wander guard was placed. During an interview on 7/17/24, at 4:30 p.m. director of nursing (DON) stated on 6/13/24, at 7:35 a.m. R1 had a drop in blood pressure and fell and that's they initiated hourly safety checks as an intervention. Nursing staff were expected to follow the care plan in entirety for each resident and there were no exceptions. If it was not charted then the task was not completed. DON stated falsification of documentation was not allowed and would not be tolerated. DON indicated education was provided to the staff directly involved in incident; NA-A the evening of the incident, PCA the next day prior to shift worked, and additional education was provided to NA's while audits were completed by the staff nurse every shift initiated approximately one week ago. DON stated audits continued so that all staff were monitored for frequent checks and residents toileted according to their care plan. DON stated her expectation for staff would be the care plan followed in it's entirety and was made very clear in during audits. DON stated rounded with NA's and they were very clear on scope of practice and expectations. DON hourly rounding was not included on the care plan but was on the tasks list to be completed by NA's to help keep R1 safe and staff were aware of that. During interview, the DON identified the following was observed on video: R1 ventured down a total of three hallways to get to the education room (previously known as the sleep study room), two and ½ hallways (a	F 684		

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F 684	Continued From page 14 total of up to approximately 400 feet total). At 6:45 p.m. R1 ventured up the hallway and wheeled herself out of the main area where she sat by the bird cage. At 6:49 p.m. R1 was down just past her office (almost 2 hallways from main area) and that was the last R1 was seen on the video. DON stated R1 was in the education room approximately two hours before she was found and unsure when she fell. Staff headed down the hallway past her office at 9:04 p.m. and found R1 on the floor with right leg bent and tucked underneath the left thigh. DON indicated when the staff nurse moved R1's leg to straighten them out she said ouch ouch, noted swelling on the right upper leg, and then held her legs straight during the transfer with a total mechanical lift. R1 was then transferred to ED via ambulance and had surgery on her right hip. Review of staff education documents and shift audits identified the facility implemented corrective action and was determined to be in compliance before survey entrance. The facility policy Resident Assessment for Bowel and Bladder Retraining or Management dated 9/6/23, identified purpose was to ensure residents were maintaining the highest level of continence. The facility policy Fall/Injury Risk dated 1/17/24, revealed purpose of policy was to identify resident's risk for falling and risk from a fall, and develop an individualized plan of care to reduce falls and injury. Staff were responsible to initiate the appropriate interventions related to safety and fall prevention. Residents who have fallen will be appropriately managed. All staff member were responsible for implementing the intent and directives contained within this policy and for	F 684		

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F 684	Continued From page 15 creating a safe environment of care. Resident maybe placed on fall precautions. The facility policy Nursing Documentation dated 3/20/24, identified all nursing documentation must be completed both accurately and timely in order to enhance patient care. All nursing documentation was expected to be completed within the shift care was completed unless otherwise designated. Documentation should have displayed handling of the data and should influence the plan of care. The facility policy Hourly Rounding dated 5/15/24, identified it was the responsibility of each department director/manager to establish a method of hourly rounding practice within their department to reduce resident safety/risk issues, enable nursing staff to be proactive in their resident care, and evaluate resident for a change in condition. Staff would be expected to meet the resident personal needs such as bathroom assistance, personal hygiene, reposition to provide comfort, and respond to any resident concerns.	F 684		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/16/24 through 7/17/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The complaint H54205429C (MN000104636) was	2 000		

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

Electronically Signed

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2 000	Continued From page 1 reviewed with no licensing order issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		