Electronically delivered
June 15, 2020

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

SUBJECT: SURVEY RESULTS
CCN: 245580
Cycle Start Date: May 22, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 22, 2020, the Minnesota Department of Health completed a complaint investigation at Lakewood Care Center to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 22, 2020 survey. Lakewood Care Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your

facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

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

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 22, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Lakewood Care Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 05/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH BAUDETTE, MN 56623**

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F 000	INITIAL COMMENTS	F 000		

On 5/18/20 to 5/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.

The following complaint was found to be substantiated:

H5580006C with citations F689

The immediate jeopardy began on 4/17/20, R2 fell in her room and sustained a fractured humerus. The administrator, vice president of patient services, director of nursing, licensed social worker, activities director, registered nurse (RN)-A, RN-B, RN-C, and licensed practical nurse (LPN)-C were notified of the immediate jeopardy at 3:45 p.m. on 5/20/20. The immediate jeopardy was removed on 5/22/20 at 12:30 p.m. however, noncompliance remained at a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy.

As a result of identifying substandard quality of care, an extended survey was conducted on 5/21/20-5/22/20.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2020

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 000	Continued From page 1 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision, follow the care plan interventions and conduct reassessment of risk for falls to prevent and/or reduce the likelihood of future falls for 2 of 3 residents (R1, R2) reviewed for falls. This resulted in an immediate jeopardy for R1 who had repeated falls and fell on 5/11/20 and sustained a fracture when left unattended, and for R2 who had repeated falls and sustained a fractured humerus. The immediate jeopardy began on 4/17/20, R2 fell in her room and sustained a fractured humerus. The administrator, vice president of patient services, director of nursing, licensed social worker, activities director, registered nurse (RN)-A, RN-B, RN-C, and licensed practical nurse (LPN)-C were notified of the immediate jeopardy at 3:45 p.m. on 5/20/20. The immediate	F 689	Regarding R1 the resident was hospitalized post fall and did not return to the facility. Regarding R2 facility completed sleep study and toileting assessment for 2 weeks to determine sleep patterns and toileting needs and their effect on R2 safety. 1:1 coverage was provided for both PM and Noc shift during this time. Facility determined resident was safely monitored on the AM shift. Following the 2 week assessments it was determined that resident sleeps though out the night. Her restlessness has been related toileting needs and with bowel and bladder audit it showed she would benefit with toileting every 1.5 hours and she has not had any falls since this adjustment. The care plan and group sheets have been updated to reflect these changes. The 1:1 coverage	7/3/20

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F 689	Continued From page 2 jeopardy was removed on 5/22/20 at 12:30 p.m. however, noncompliance remained at a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R1 fell on 5/11/20, and fractured sacrum. On 5/18/20, at 4:44 p.m. licensed practical nurse (LPN)-A verified she had been working the night shift of 5/11/20, when R1 fell and fractured her sacrum. LPN-A stated R1 had been "up and down throughout the night." R1 was toileted at 12:30 a.m. and received Tylenol at that time as well. LPN-A said R1 was restless at night and did not sleep well. LPN-A added R1 had been put on 1:1 supervision a day or two prior to the 5/11/20 fall. LPN-A stated R1 had been sitting in a recliner in the common area with the footrest elevated. LPN-A indicated R1 had been sleeping when there had been another resident needing assistance. LPN-A had gone around the corner to respond to the other resident, leaving R1 unattended. Before she could return, R1 had woken up, tried to crawl out of the chair and had fallen, the chair alarm was sounding. LPN-A said 1:1 supervision was pretty hard to do with only three staff scheduled at night. During telephone interview on 5/18/2020, at 11:12 p.m. nursing assistant (NA)-A verified she had worked on 5/11/20, the night R1 fell although was on break at the time of the fall. NA-A said R1 had been up at night "constantly" and needed to be kept at staff's side. NA-A added sometimes it gets a little hard to watch residents on a 1:1 and answer call lights. NA-A said she would often put the residents requiring supervision, including R1, in a wheelchair and take them with her to answer	F 689	on PM shift could be safely discontinued but 1:1 will remain on the night shift as we follow up for effectiveness of staff training to meet residents needs. During interview with staff by surveyor it was indicated that there were 5 other residents with ongoing behaviors making them difficult to monitor and safeguard the residents during part of PM shift and night shift. A 2 week hourly assessment was put into place gathering data on these residents. 3 of residents of the 5 routinely slept thru out night. One of the residents does wander frequently at night, it is her routine. She has been evaluated by PT and she is safe to walk with a walker with supervision. Resident has had no falls since her admission date. Care plan has been reviewed and updated to sufficiently describe her needs with walker and supervision. Group sheet is accurate to her needs. The last resident has slept thru the night 3 nights out of the 2 weeks of monitoring. She has seen her ongoing behavioral health provider and has had medication changes trying to find a level that will benefit her with her hyperactivity due to her Dementia. She has not had a fall since 2/28/19. Care plan and group sheets have been reviewed and they are adequate for keeping her safe while we make these medication effectiveness assessments. All staff responsible to this F-tag and cited deficiency will be retrained to their responsibility regarding this F-tag.	

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F 689	Continued From page 3 other resident's call lights, positioning them outside the door when attending to other residents' needs. NA-A confirmed R1 had issues with sleeping and hallucinations which progressively worsened. NA-A stated for weeks prior to R1's recent hospitalization staff had difficulty supervising R1 the way she should have been. NA-A verified she was aware R1 required 72 hour, 1:1 supervision. NA-A also verified R1's foot rest on the recliner had been elevated the night she fell. NA-A indicated staff were not to elevate residents' feet when seated in a recliner if unsupervised and stated this had been implemented a couple of months prior to R1's fall. Review of R1's Fall Scene Investigation and Root Cause Analysis forms: -1/17/20, at 4:30 a.m. unwitnessed fall in room. R1 found seated on floor in front of closet, stated she was going to the bathroom, was hot and had taken off gripper socks. Interventions identified: schedule every two hour cue for toileting, preferred footwear with grippers. -2/2/20, at 10:15 p.m. unwitnessed fall in room, found on the floor asleep, extremely tired the whole shift, recent medication changes for sleep (increased Haldol [antipsychotic] from 0.5 milligrams [mg] to 1.0 mg) R1 sustained a golf ball-sized raised hematoma on her right arm after a fall from bed. Interventions identified: monitor sleep schedule, update psychiatrist. -4/7/20, at 5:05 a.m. unwitnessed fall in room. Staff noted R1 doing a crab walk in the hallway in front of room, stated she needed the toilet. Resident had intermittent confusion, hallucinations, delusions, and had medication	F 689	Training will be completed by July 3, 2020. To assure this deficiency does not reoccur audits will be completed regarding falls and regarding staff understanding/performing their responsibilities as trained above daily x 2 weeks, biweekly x 4 weeks and monthly for 2 months and ongoing thereafter. Success will be measured at 95%. From 94-80% more training will be provided individually to those having difficulty. 80% or less will indicate the need for broader staff retraining. Responsibility for this deficient practice improvement lies with the DON and the Interdisciplinary team. The results of this training and the following audits will be reported at the QA&A meeting.	

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F 689	Continued From page 4	F 689		

changes to Seroquel (antipsychotic) last week (12.5 mg to 25 mg daily). Resident is independent. Unable to determine if true fall. R1 sustained injury to left hip/pelvis with pain experienced upon ambulation and palpation. Interventions identified increase from hourly to every 30 minute safety rounds, contact psychiatrist for recommendations.

-4/10/20, at 12:45 a.m. unwitnessed fall in room. R1 found laying on floor next to bed and had sustained a goose-egg above left eye. R1 stated she was going to the bathroom and had slipped and fallen. Root cause listed R1 lost balance and fell down when attempting to toilet herself. She was independent, yet had increased delusions, hallucinations and confusion. Resident had recent medication changes. Interventions identified: increase from every 30 minutes to every 15 minute safety rounds, evaluation by PT for level of appropriate independence, and follow up with psychiatrist due to continued delusions, hallucinations and confusion.

-4/28/20, at 5:00 a.m. unwitnessed fall in room. R1 found seated on floor next to bed with walker laying in front of her and had sustained a 4 centimeter (cm) x 2.5 cm bruise to her right forearm. Found on floor with walker on top of her, stated she was going to get cookies. Increased insomnia, confusion, hallucinations and delusions. Recent medication change (Thorazine-antipsychotic). Interventions identified: OT suggestion with room arrangement, consult with psychiatrist again.

-5/9/20, at 2:45 p.m. unwitnessed fall common area. R1 found seated on floor facing the main entrance in the hall with no walker, no gripper

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socks/shoes, alarm not sounding and unable to report what happened. R1 sustained bruising to right buttocks. Resident had ongoing confusion, delusions, and hallucinations. Resident fell after ambulating self in an unsafe manner and alarm battery failed to alarm staff. Interventions identified: Treatment administration record (TAR) cue added for battery change weekly, 1:1 supervision for 72 hours.

-5/11/20, at 3:15 a.m. unwitnessed fall in common area/hallway. R1 fell when attempting to transfer from a chair, which was reclined with footrest up. R1 sustained a hematoma to the right forehead and it was later determined she had suffered a fractured sacrum. The analysis identified R1 had been left unattended in recliner with legs up, unable to use chair independently so tried to crawl out and fell. The 1:1 intervention implemented after the 5/9/20, fall was not maintained, therefore R1 fell. Interventions identified included: Continue 1:1 at all times for 72 hours after fall. R1 was seen in follow up by the psychiatrist on 5/12/20, who recommended further medication changes. Further, the analysis listed the facility notified family who indicated they would like to allow time prior to making further changes.

R1's Diagnosis Report indicated, displaced fracture of upper end of humerus. Insomnia, cognitive communication deficit, hallucinations, major depressive disorder, psychosis and history of falling.

R1's significant change Minimum Data Set (MDS) assessment dated 3/25/20, indicated R1 had intact cognition. R1 had not exhibited any physical or verbal behavioral symptoms directed

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F 689	Continued From page 6	F 689		

toward others, and no rejection of cares, or wandering. The MDS indicated R1 required extensive assistance with one person for dressing and limited assistance for personal hygiene and was independent with all other activities of daily living (ADL). R1's balance was not steady with transitions and walking and the MDS further indicated R1 had experienced falls with injuries (skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains or any fall-related injury that causes the resident to complain of pain) and one fall without injury since the previous assessment.

R1's Care Plan, revised 5/1/20, indicated R1 was at risk for falls related to history of left humerus fracture related to fall at home and poor safety awareness. R1's interventions included low bed, chair and bed alarms for safety, wander guard for safety, call light in place of reach, stand by assistance for mobility when using walker, gripper strips in front of bed, chair, and toilet and staff to cue, reorient and supervise as necessary.

Completed after 6 prior falls, R1's Morse Fall Scale (rapid and simple method of assessing a resident's likelihood of falling) dated 5/10/20, evaluated R1 at high risk for falling.

Review of Progress Notes from 3/15/20, to 5/11/20, revealed R1 experienced increasing insomnia, hallucinations, delusions and confusion, being up and down during the night shift with increased frequency, at times walking/pacing the hallways, sometimes throughout the night, or sitting in a recliner/sleeping in the hallway/alcove, eventually requiring 1:1 monitoring/supervision.

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During telephone interview on 5/18/20, at 11:36 p.m. LPN-B indicated R1 had been a challenge almost every night prior to her last fall and stated she could not sit in a wheelchair comfortably and did not want to sit back in the wheelchair. LPN-B stated R1 would maybe sleep 20 minutes at a time and staff had to hold her hand constantly. LPN-B also confirmed R1 was to have the foot of her chair down when in the chair. LPN-B verified R1 required 1:1 supervision at the time of her fall.

On 5/19/20, at 10:44 p.m. during a group interview, NA-F and NA-G verified R1 had been independent with ADL's but was at risk for falls. NA-F stated prior to a fall on 5/9/20, R1 had been on every 15 minute safety checks, however, after the fall she was on a 72 hour watch and someone was to be with her at all times.

On 5/19/20, at 12:00 p.m. DON verified R1's aforementioned fall information and confirmed R1 was to be on 1:1 supervision after the fall on 5/9/20. DON indicated R1 should not have been left unattended on 5/11/20. DON also verified the foot of R1's recliner had been elevated at the time of her fall and should not have been. DON added they had tried finding extra staff to work 1:1 with R1 when she was experiencing falls and had been able to find staff to stay with her until 10:00 p.m. one evening and midnight one night, however had not been able to find additional staff to provide ongoing 1:1 supervision.

During a follow up interview on 5/19/20, at 3:29 p.m. DON indicated after the fall on 5/11/20, R1 was sent to the ER on 5/13/20, due to agitation and complaints of pain and burning, being diagnosed with a urinary tract infection. DON indicated on 5/14/20, R1 had been doing better

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F 689	Continued From page 8	F 689		

and then on 5/15/20, R1 was sent back to the ER for increased pain, was admitted to the hospital and determined to have a sacral fracture. DON indicated LPN-A had received education regarding following the care plan for R1.

During a follow up interview on 5/20/20, at 1:21 p.m., DON indicated R1 had been on every 15 minutes safety checks prior to her fall on 5/9/20. DON stated the 15 minute safety checks were not effective, and she determined R1 required increased supervision and implemented 1:1 supervision at that time.

R2

R2's Diagnosis Report included, dementia without behavioral disturbance, urge incontinence, muscle weakness, history of fall with fracture of right pubis, fracture of skull and facial bones, and traumatic subarachnoid hemorrhage (bleeding into the space between the surface of the brain) with loss of consciousness, and history of nondisplaced fracture of left radial styloid process (wrist).

R2's annual MDS dated 5/6/20, indicated R2 had severe cognitive impairment with continuous inattention and disorganized thinking. The MDS indicated R2 required assistance with bed mobility, transfer, walking, locomotion on and off unit, dressing, toilet use and personal hygiene. The MDS also indicated R2 had experienced two or more falls with injury and one fall with major injury since the previous assessment dated 2/12/20.

R2's Falls Care Area Assessment (CAA) dated 5/12/20, indicated R2 had a history of falls with a

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F 689	Continued From page 9	F 689		

recent fall and fracture of the left humerus and currently wore a sling to left arm. R2 received assistance with all ADL's related to cognition and mobility needs. R2 ambulated with staff assistance via assistive device and had bed and chair alarms in place for safety related to dementia, impulsivity and poor safety awareness and had periods of restlessness and anxiety. R2 did not always make needs known and needed cues and assistance. R2 was on a toileting schedule and ambulated often with staff. R2 was at risk for falls related to cognition, impulsivity and mobility needs. Staff were to monitor R2 and assist with mobility and toileting needs.

R2's Care Plan indicated R2 had an ADL self-care performance deficit related to dementia without behavioral disturbance and directed staff to provide R2 contact guard assistance (CGA) for transfers with gait belt for ambulation in room and the corridor with the assist of 1-2 staff to follow with wheelchair as needed. The care plan listed R2 exhibited symptoms of anxiety/repetitive questioning, and intermittent confusion. The staff were directed to assist R2 into a recliner for comfort and when restless or unsettled. When in the recliner, the staff were directed to not elevate the feet unless R2 remained in the direct supervision of staff. The care plan further indicated R2 was high risk for falls related to confusion, gait/balance problems, and psychoactive drug use and directed staff to implement interventions, which included but were not limited to:
-At least every 15 minute checks, ambulation/transfers CGA with transfer belt on, PT/OT [physical therapy/occupational therapy] evaluation, bed alarm at shoulder level, chair alarm, wheelchair alarm, bed at sitting level at

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	245580	A. BUILDING _____ B. WING _____	C 05/22/2020

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tape marked on wall.
-Monitor while in wheelchair
-Door left open while resident in room
-If appears restless or attempts to get out of bed after all emotional and physical needs are met get up and out of her room where she can be monitored more closely

R2's Morse Fall Scale dated 5/4/20, evaluated R2 at high risk for falling.

On 5/18/2020, at 3:53 p.m. R2 was observed being propelled in a high-backed wheelchair that both rocked and reclined by the physical therapist (PT)-A into the hallway of the facility from the courtyard. PA-A left R2 positioned in her wheelchair by the nurses' office. An alarm box was attached to the back of R2's Rock 'N Go wheelchair at shoulder level, on the right side. R2 wore gripper socks on her feet. LPN-E wheeled R2 up to a table in alcove area and sat next to her. At 4:13 p.m. LPN-E wheeled R2 into her room, assisted her to don a face mask and then returned R2 to the alcove table.

Review of R2's Progress Notes (PN) from 3/1/20, to 5/21/20, indicated documentation describing R2 as restless, anxious, or unsettled, with behaviors described as being "up and down" ongoing multiple times throughout the night shift, sometimes as often as every 1-2 minutes. The progress notes identified R2 often spent time either awake or asleep in a wheelchair or recliner in the hallway between the hours of 9:00 p.m. and 7:00 a.m. and at times required 1:1 supervision/monitoring. The PN's also indicated R2 had some medication changes.

R2's PN dated 4/1/20, at 6:11 a.m. indicated R2

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does not sleep well in her bed at night. Once she wakes up to go to the bathroom, she is pretty much done laying in bed. Once she is awake, she will sit in the rock and go chair and she will doze off there. She sleeps well this way but is then on 1:1 monitoring through the remainder of the night, as she will sometimes try to stand up.

Review of R2's Fall Scene Investigation and Root Cause Analysis forms indicates:

-3/2/20, at 1:02 p.m. unwitnessed fall in room. R2 found on floor, right side of face on floor, right arm bent behind back, left arm out in front, both legs bent and in front of body. Recliner chair had the foot rest extended and the whole chair was leaning forward with foot rest on the floor and R2's bottom on the end of the chair. R2 sustained a "goose egg" to right side of forehead. Placed in chair with feet up, unable to get self out of chair independently. Interventions identified: update care plan for not putting feet up while unattended by staff.

-3/31/20, at 4:30 p.m. near miss in hallway. R2 was seated in rock and go wheelchair and attempted to stand on own. R2 was leaning while standing, started to fall forward and was caught by staff before she could fall. It was determined R2's last time toileted (1:05 p.m.) was not appropriate to R2's every 2 hour toileting schedule. Interventions identified after fall included R2 toileted and 1:1 monitoring provided.

-4/17/20, at 11:20 p.m. unwitnessed fall in room. R2's alarm was sounding and she was found on the floor next to her bed. R2 had indicated she thought it was time to get up. No injury was initially found at the time of the fall, however, R2

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was later determined to have suffered a left humerus fracture. R2 fell when getting self out of bed thinking it was time to get up. Interventions identified: increase safety rounds to every 15 minutes, PT/OT evaluate shoulder pain, door open when in room, monitored when in wheelchair.

-5/1/20, at 6:30 p.m. witnessed fall in hallway. R2's alarm sounded and she was observed to try to get up. The nurse directed R2 to sit down. R2 stood up and fell face first on the floor. Her left arm was in a sling due to previous fall. She landed face first and on her already broken left arm and sustained a scrape to the forehead and nose. R2 was attempting to get self up from chair and fell; stated she needed to go to the bathroom. It was determined R2's last time toileted (3:30 p.m.) was not appropriate to R2's every two hour toileting schedule. Interventions identified: place wheeled walker in front of R2 when in rock and go, place within close proximity for supervision when in wheelchair, reinforced education regarding necessity to follow care-plan for toileting.

During telephone interview, on 5/18/20, at 11:12 p.m. NA-A verified R2 was routinely up at night and indicated it was not uncommon she [NA-A] would be running from one door to the next and R2 would already be standing up. NA-A verified R2 broke her arm related to a fall and stated she always put R2's walker by the bed so at least she could be steadier if she got out of bed unsupervised.

During telephone interview, on 5/18/20, at 11:36 p.m. LPN-B stated they had residents out in the common areas every night. LPN-B stated R2

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was routinely up at night and indicated she was one of three residents currently up and seated in the hallway/alcove. LPN-B stated no residents required an "official" 1:1 at this time but indicated if residents were up, staff had to be on the hallway at all times and use their judgement to determine if the resident required constant supervision versus a check. LPN-B indicated the three residents currently up, including R2, required 15 minutes safety checks to visually ensure they were in bed, when not seated in the hallway due to their risk for falls. LPN-B indicated it could be difficult to provide the necessary supervision at staff break times and also indicated it was a "juggling act" when the NAs completed their rounds; the nurse supervised the other hallway. LPN-B stated if the residents who were at fall risk got up, they had to really move [to respond prior to a fall]. LPN-B stated she thought R2 fell during the night shift when she broke her arm. LPN-B indicated R2 had not initially experienced pain in the arm and then the fracture was found after a few days. LPN-B indicated she thought R2 had gotten up by herself at night and stated she thought R2 had woken up and crawled out of bed and fell before staff could respond. At this time, LPN-B had to drop the phone to attend to R2 who she stated was leaning forward in the chair. When she returned to the interview, LPN-B indicated she did not remember if there were residents in the common area the night R2 fell.

On 5/19/20, at 12:00 p.m. the DON verified R2's aforementioned fall information and confirmed R2 suffered a fall with humerus fracture on 4/17/20. DON also verified R2's care plan was not followed prior to the fall on 5/1/20, and the NA responsible had received disciplinary action. Record review lacked evidence of training

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completed for licensed and non-licensed nursing staff related to this concern.

On 5/19/20, at 10:44 a.m. NA-F and NA-G indicated R2 needed to be supervised as she tried to get up on her own at times and required assistance with transfers. NA-F indicated R2 utilized a bed alarm, floor mat/alarm as well as a chair alarm to alert staff of her movements and also required every 15 minutes safety checks. NA-F stated if R2 started moving around or was "getting antsy" she usually needed to use the bathroom or to walk. NA-F and NA-G confirmed R2 was a resident they needed to keep an eye on due to unsafe transfers. They indicated on the night shift there were two NA's and if the NA's were busy, the nurse would have to cover or they would need to bring R2 along them to keep an eye on her. NA-F further indicated R2 had been up during the previous night shift.

The Fall Prevention Policy reviewed/revised 12/17, indicated residents at risk for falls will be identified and minimized. The policy also directed all fall interventions put in place would be monitored for their continued placement and functioning by nurse staff and reported to IDT [interdisciplinary team] at QI [quality improvement] meetings.

The immediate jeopardy that began on 5/11/20, was removed on 5/22/20, when the facility reassessed R2 and implemented interventions and staffing strategies to meet R2's care needs. Upon R1's return to the facility, R1 will be re-assessed and the care plan will be reviewed and revised as appropriate and a second staff member will be added if indicated. Additionally, the facility identified a responsible charge nurse

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F 689	Continued From page 15 to complete rounding to ensure 1:1 supervision for identified residents and the staffing that was in place, as well as education plan was identified and implemented for all licensed and non-licensed nursing staff.	F 689		

Electronically delivered
June 15, 2020

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

Re: State Nursing Home Licensing Orders
Event ID: TY6D11

Dear Administrator:

The above facility was surveyed on May 18, 2020 through May 22, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00332	A. BUILDING: _____ B. WING _____	C 05/22/2020

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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 5/18/20 to 5/22/20, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

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2 000	Continued From page 1 The following complaints were found to be substantiated: H5580006C: Oders issued 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. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	2 000		

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2 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision, follow the care plan interventions and conduct reassessment of risk for falls to prevent and/or reduce the likelihood of future falls	2 830	Completed 07/03/2020	7/3/20

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2 830	Continued From page 3 for 2 of 3 residents (R1, R2) reviewed for falls. This resulted in an immediate jeopardy for R1 who had repeated falls and fell on 5/11/20 and sustained a fracture when left unattended, and for R2 who had repeated falls and sustained a fractured humerus. The immediate jeopardy began on 4/17/20, R2 fell in her room and sustained a fractured humerus. The administrator, vice president of patient services, director of nursing, licensed social worker, activities director, registered nurse (RN)-A, RN-B, RN-C, and licensed practical nurse (LPN)-C were notified of the immediate jeopardy at 3:45 p.m. on 5/20/20. The immediate jeopardy was removed on 5/22/20 at 12:30 p.m. however, noncompliance remained at a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R1 fell on 5/11/20, and fractured sacrum. On 5/18/20, at 4:44 p.m. licensed practical nurse (LPN)-A verified she had been working the night shift of 5/11/20, when R1 fell and fractured her sacrum. LPN-A stated R1 had been "up and down throughout the night." R1 was toileted at 12:30 a.m. and received Tylenol at that time as well. LPN-A said R1 was restless at night and did not sleep well. LPN-A added R1 had been put on 1:1 supervision a day or two prior to the 5/11/20 fall. LPN-A stated R1 had been sitting in a recliner in the common area with the footrest elevated. LPN-A indicated R1 had been sleeping when there had been another resident needing assistance. LPN-A had gone around the corner to respond to the other resident, leaving R1 unattended. Before she could return, R1 had	2 830		

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2 830	Continued From page 4 woken up, tried to crawl out of the chair and had fallen, the chair alarm was sounding. LPN-A said 1:1 supervision was pretty hard to do with only three staff scheduled at night. During telephone interview on 5/18/2020, at 11:12 p.m. nursing assistant (NA)-A verified she had worked on 5/11/20, the night R1 fell although was on break at the time of the fall. NA-A said R1 had been up at night "constantly" and needed to be kept at staff's side. NA-A added sometimes it gets a little hard to watch residents on a 1:1 and answer call lights. NA-A said she would often put the residents requiring supervision, including R1, in a wheelchair and take them with her to answer other resident's call lights, positioning them outside the door when attending to other residents' needs. NA-A confirmed R1 had issues with sleeping and hallucinations which progressively worsened. NA-A stated for weeks prior to R1's recent hospitalization staff had difficulty supervising R1 the way she should have been. NA-A verified she was aware R1 required 72 hour, 1:1 supervision. NA-A also verified R1's foot rest on the recliner had been elevated the night she fell. NA-A indicated staff were not to elevate residents' feet when seated in a recliner if unsupervised and stated this had been implemented a couple of months prior to R1's fall. Review of R1's Fall Scene Investigation and Root Cause Analysis forms: -1/17/20, at 4:30 a.m. unwitnessed fall in room. R1 found seated on floor in front of closet, stated she was going to the bathroom, was hot and had taken off gripper socks. Interventions identified: schedule every two hour cue for toileting, preferred footwear with grippers.	2 830		

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2 830	Continued From page 5 -2/2/20, at 10:15 p.m. unwitnessed fall in room, found on the floor asleep, extremely tired the whole shift, recent medication changes for sleep (increased Haldol [antipsychotic] from 0.5 milligrams [mg] to 1.0 mg) R1 sustained a golf ball-sized raised hematoma on her right arm after a fall from bed. Interventions identified: monitor sleep schedule, update psychiatrist. -4/7/20, at 5:05 a.m. unwitnessed fall in room. Staff noted R1 doing a crab walk in the hallway in front of room, stated she needed the toilet. Resident had intermittent confusion, hallucinations, delusions, and had medication changes to Seroquel (antipsychotic) last week (12.5 mg to 25 mg daily). Resident is independent. Unable to determine if true fall. R1 sustained injury to left hip/pelvis with pain experienced upon ambulation and palpation. Interventions identified increase from hourly to every 30 minute safety rounds, contact psychiatrist for recommendations. -4/10/20, at 12:45 a.m. unwitnessed fall in room. R1 found laying on floor next to bed and had sustained a goose-egg above left eye. R1 stated she was going to the bathroom and had slipped and fallen. Root cause listed R1 lost balance and fell down when attempting to toilet herself. She was independent, yet had increased delusions, hallucinations and confusion. Resident had recent medication changes. Interventions identified: increase from every 30 minutes to every 15 minute safety rounds, evaluation by PT for level of appropriate independence, and follow up with psychiatrist due to continued delusions, hallucinations and confusion. -4/28/20, at 5:00 a.m. unwitnessed fall in room. R1 found seated on floor next to bed with walker	2 830		

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2 830	Continued From page 6	2 830		

laying in front of her and had sustained a 4 centimeter (cm) x 2.5 cm bruise to her right forearm. Found on floor with walker on top of her, stated she was going to get cookies. Increased insomnia, confusion, hallucinations and delusions. Recent medication change (Thorazine-antipsychotic). Interventions identified: OT suggestion with room arrangement, consult with psychiatrist again.

-5/9/20, at 2:45 p.m. unwitnessed fall common area. R1 found seated on floor facing the main entrance in the hall with no walker, no gripper socks/shoes, alarm not sounding and unable to report what happened. R1 sustained bruising to right buttocks. Resident had ongoing confusion, delusions, and hallucinations. Resident fell after ambulating self in an unsafe manner and alarm battery failed to alarm staff. Interventions identified: Treatment administration record (TAR) cue added for battery change weekly, 1:1 supervision for 72 hours.

-5/11/20, at 3:15 a.m. unwitnessed fall in common area/hallway. R1 fell when attempting to transfer from a chair, which was reclined with footrest up. R1 sustained a hematoma to the right forehead and it was later determined she had suffered a fractured sacrum. The analysis identified R1 had been left unattended in recliner with legs up, unable to use chair independently so tried to crawl out and fell. The 1:1 intervention implemented after the 5/9/20, fall was not maintained, therefore R1 fell. Interventions identified included: Continue 1:1 at all times for 72 hours after fall. R1 was seen in follow up by the psychiatrist on 5/12/20, who recommended further medication changes. Further, the analysis listed the facility notified family who indicated they would like to allow time prior to making further

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2 830	Continued From page 7 changes. R1's Diagnosis Report indicated, displaced fracture of upper end of humerus. Insomnia, cognitive communication deficit, hallucinations, major depressive disorder, psychosis and history of falling. R1's significant change Minimum Data Set (MDS) assessment dated 3/25/20, indicated R1 had intact cognition. R1 had not exhibited any physical or verbal behavioral symptoms directed toward others, and no rejection of cares, or wandering. The MDS indicated R1 required extensive assistance with one person for dressing and limited assistance for personal hygiene and was independent with all other activities of daily living (ADL). R1's balance was not steady with transitions and walking and the MDS further indicated R1 had experienced falls with injuries (skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains or any fall-related injury that causes the resident to complain of pain) and one fall without injury since the previous assessment. R1's Care Plan, revised 5/1/20, indicated R1 was at risk for falls related to history of left humerus fracture related to fall at home and poor safety awareness. R1's interventions included low bed, chair and bed alarms for safety, wander guard for safety, call light in place of reach, stand by assistance for mobility when using walker, gripper strips in front of bed, chair, and toilet and staff to cue, reorient and supervise as necessary. Completed after 6 prior falls, R1's Morse Fall Scale (rapid and simple method of assessing a resident's likelihood of falling) dated 5/10/20, evaluated R1 at high risk for falling.	2 830		

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2 830	Continued From page 8 Review of Progress Notes from 3/15/20, to 5/11/20, revealed R1 experienced increasing insomnia, hallucinations, delusions and confusion, being up and down during the night shift with increased frequency, at times walking/pacing the hallways, sometimes throughout the night, or sitting in a recliner/sleeping in the hallway/alcove, eventually requiring 1:1 monitoring/supervision. During telephone interview on 5/18/20, at 11:36 p.m. LPN-B indicated R1 had been a challenge almost every night prior to her last fall and stated she could not sit in a wheelchair comfortably and did not want to sit back in the wheelchair. LPN-B stated R1 would maybe sleep 20 minutes at a time and staff had to hold her hand constantly. LPN-B also confirmed R1 was to have the foot of her chair down when in the chair. LPN-B verified R1 required 1:1 supervision at the time of her fall. On 5/19/20, at 10:44 p.m. during a group interview, NA-F and NA-G verified R1 had been independent with ADL's but was at risk for falls. NA-F stated prior to a fall on 5/9/20, R1 had been on every 15 minute safety checks, however, after the fall she was on a 72 hour watch and someone was to be with her at all times. On 5/19/20, at 12:00 p.m. DON verified R1's aforementioned fall information and confirmed R1 was to be on 1:1 supervision after the fall on 5/9/20. DON indicated R1 should not have been left unattended on 5/11/20. DON also verified the foot of R1's recliner had been elevated at the time of her fall and should not have been. DON added they had tried finding extra staff to work 1:1 with R1 when she was experiencing falls and had been able to find staff to stay with her until	2 830		

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2 830	Continued From page 9 10:00 p.m. one evening and midnight one night, however had not been able to find additional staff to provide ongoing 1:1 supervision. During a follow up interview on 5/19/20, at 3:29 p.m. DON indicated after the fall on 5/11/20, R1 was sent to the ER on 5/13/20, due to agitation and complaints of pain and burning, being diagnosed with a urinary tract infection. DON indicated on 5/14/20, R1 had been doing better and then on 5/15/20, R1 was sent back to the ER for increased pain, was admitted to the hospital and determined to have a sacral fracture. DON indicated LPN-A had received education regarding following the care plan for R1. During a follow up interview on 5/20/20, at 1:21 p.m., DON indicated R1 had been on every 15 minutes safety checks prior to her fall on 5/9/20. DON stated the 15 minute safety checks were not effective, and she determined R1 required increased supervision and implemented 1:1 supervision at that time. R2 R2's Diagnosis Report included, dementia without behavioral disturbance, urge incontinence, muscle weakness, history of fall with fracture of right pubis, fracture of skull and facial bones, and traumatic subarachnoid hemorrhage (bleeding into the space between the surface of the brain) with loss of consciousness, and history of nondisplaced fracture of left radial styloid process (wrist). R2's annual MDS dated 5/6/20, indicated R2 had severe cognitive impairment with continuous inattention and disorganized thinking. The MDS indicated R2 required assistance with bed	2 830		

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2 830	Continued From page 10	2 830		

mobility, transfer, walking, locomotion on and off unit, dressing, toilet use and personal hygiene. The MDS also indicated R2 had experienced two or more falls with injury and one fall with major injury since the previous assessment dated 2/12/20.

R2's Falls Care Area Assessment (CAA) dated 5/12/20, indicated R2 had a history of falls with a recent fall and fracture of the left humerus and currently wore a sling to left arm. R2 received assistance with all ADL's related to cognition and mobility needs. R2 ambulated with staff assistance via assistive device and had bed and chair alarms in place for safety related to dementia, impulsivity and poor safety awareness and had periods of restlessness and anxiety. R2 did not always make needs known and needed cues and assistance. R2 was on a toileting schedule and ambulated often with staff. R2 was at risk for falls related to cognition, impulsivity and mobility needs. Staff were to monitor R2 and assist with mobility and toileting needs.

R2's Care Plan indicated R2 had an ADL self-care performance deficit related to dementia without behavioral disturbance and directed staff to provide R2 contact guard assistance (CGA) for transfers with gait belt for ambulation in room and the corridor with the assist of 1-2 staff to follow with wheelchair as needed. The care plan listed R2 exhibited symptoms of anxiety/repetitive questioning, and intermittent confusion. The staff were directed to assist R2 into a recliner for comfort and when restless or unsettled. When in the recliner, the staff were directed to not elevate the feet unless R2 remained in the direct supervision of staff. The care plan further indicated R2 was high risk for falls related to confusion, gait/balance problems, and

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2 830	Continued From page 11 psychoactive drug use and directed staff to implement interventions, which included but were not limited to: -At least every 15 minute checks, ambulation/transfers CGA with transfer belt on, PT/OT [physical therapy/occupational therapy] evaluation, bed alarm at shoulder level, chair alarm, wheelchair alarm, bed at sitting level at tape marked on wall. -Monitor while in wheelchair -Door left open while resident in room -If appears restless or attempts to get out of bed after all emotional and physical needs are met get up and out of her room where she can be monitored more closely R2's Morse Fall Scale dated 5/4/20, evaluated R2 at high risk for falling. On 5/18/2020, at 3:53 p.m. R2 was observed being propelled in a high-backed wheelchair that both rocked and reclined by the physical therapist (PT)-A into the hallway of the facility from the courtyard. PA-A left R2 positioned in her wheelchair by the nurses' office. An alarm box was attached to the back of R2's Rock 'N Go wheelchair at shoulder level, on the right side. R2 wore gripper socks on her feet. LPN-E wheeled R2 up to a table in alcove area and sat next to her. At 4:13 p.m. LPN-E wheeled R2 into her room, assisted her to don a face mask and then returned R2 to the alcove table. Review of R2's Progress Notes (PN) from 3/1/20, to 5/21/20, indicated documentation describing R2 as restless, anxious, or unsettled, with behaviors described as being "up and down" ongoing multiple times throughout the night shift, sometimes as often as every 1-2 minutes. The progress notes identified R2 often spent time	2 830		

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2 830	Continued From page 12 either awake or asleep in a wheelchair or recliner in the hallway between the hours of 9:00 p.m. and 7:00 a.m. and at times required 1:1 supervision/monitoring. The PN's also indicated R2 had some medication changes. R2's PN dated 4/1/20, at 6:11 a.m. indicated R2 does not sleep well in her bed at night. Once she wakes up to go to the bathroom, she is pretty much done laying in bed. Once she is awake, she will sit in the rock and go chair and she will doze off there. She sleeps well this way but is then on 1:1 monitoring through the remainder of the night, as she will sometimes try to stand up. Review of R2's Fall Scene Investigation and Root Cause Analysis forms indicates: -3/2/20, at 1:02 p.m. unwitnessed fall in room. R2 found on floor, right side of face on floor, right arm bent behind back, left arm out in front, both legs bent and in front of body. Recliner chair had the foot rest extended and the whole chair was leaning forward with foot rest on the floor and R2's bottom on the end of the chair. R2 sustained a "goose egg" to right side of forehead. Placed in chair with feet up, unable to get self out of chair independently. Interventions identified: update care plan for not putting feet up while unattended by staff. -3/31/20, at 4:30 p.m. near miss in hallway. R2 was seated in rock and go wheelchair and attempted to stand on own. R2 was leaning while standing, started to fall forward and was caught by staff before she could fall. It was determined R2's last time toileted (1:05 p.m.) was not appropriate to R2's every 2 hour toileting schedule. Interventions identified after fall included R2 toileted and 1:1 monitoring provided.	2 830		

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2 830	Continued From page 13 -4/17/20, at 11:20 p.m. unwitnessed fall in room. R2's alarm was sounding and she was found on the floor next to her bed. R2 had indicated she thought it was time to get up. No injury was initially found at the time of the fall, however, R2 was later determined to have suffered a left humerus fracture. R2 fell when getting self out of bed thinking it was time to get up. Interventions identified: increase safety rounds to every 15 minutes, PT/OT evaluate shoulder pain, door open when in room, monitored when in wheelchair. -5/1/20, at 6:30 p.m. witnessed fall in hallway. R2's alarm sounded and she was observed to try to get up. The nurse directed R2 to sit down. R2 stood up and fell face first on the floor. Her left arm was in a sling due to previous fall. She landed face first and on her already broken left arm and sustained a scrape to the forehead and nose. R2 was attempting to get self up from chair and fell; stated she needed to go to the bathroom. It was determined R2's last time toileted (3:30 p.m.) was not appropriate to R2's every two hour toileting schedule. Interventions identified: place wheeled walker in front of R2 when in rock and go, place within close proximity for supervision when in wheelchair, reinforced education regarding necessity to follow care-plan for toileting. During telephone interview, on 5/18/20, at 11:12 p.m. NA-A verified R2 was routinely up at night and indicated it was not uncommon she [NA-A] would be running from one door to the next and R2 would already be standing up. NA-A verified R2 broke her arm related to a fall and stated she always put R2's walker by the bed so at least she could be steadier if she got out of bed	2 830		

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2 830	Continued From page 14 unsupervised. During telephone interview, on 5/18/20, at 11:36 p.m. LPN-B stated they had residents out in the common areas every night. LPN-B stated R2 was routinely up at night and indicated she was one of three residents currently up and seated in the hallway/alcove. LPN-B stated no residents required an "official" 1:1 at this time but indicated if residents were up, staff had to be on the hallway at all times and use their judgement to determine if the resident required constant supervision versus a check. LPN-B indicated the three residents currently up, including R2, required 15 minutes safety checks to visually ensure they were in bed, when not seated in the hallway due to their risk for falls. LPN-B indicated it could be difficult to provide the necessary supervision at staff break times and also indicated it was a "juggling act" when the NAs completed their rounds; the nurse supervised the other hallway. LPN-B stated if the residents who were at fall risk got up, they had to really move [to respond prior to a fall]. LPN-B stated she thought R2 fell during the night shift when she broke her arm. LPN-B indicated R2 had not initially experienced pain in the arm and then the fracture was found after a few days. LPN-B indicated she thought R2 had gotten up by herself at night and stated she thought R2 had woken up and crawled out of bed and fell before staff could respond. At this time, LPN-B had to drop the phone to attend to R2 who she stated was leaning forward in the chair. When she returned to the interview, LPN-B indicated she did not remember if there were residents in the common area the night R2 fell. On 5/19/20, at 12:00 p.m. the DON verified R2's aforementioned fall information and confirmed R2 suffered a fall with humerus fracture on 4/17/20.	2 830		

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2 830	Continued From page 15 DON also verified R2's care plan was not followed prior to the fall on 5/1/20, and the NA responsible had received disciplinary action. Record review lacked evidence of training completed for licensed and non-licensed nursing staff related to this concern. On 5/19/20, at 10:44 a.m. NA-F and NA-G indicated R2 needed to be supervised as she tried to get up on her own at times and required assistance with transfers. NA-F indicated R2 utilized a bed alarm, floor mat/alarm as well as a chair alarm to alert staff of her movements and also required every 15 minutes safety checks. NA-F stated if R2 started moving around or was "getting antsy" she usually needed to use the bathroom or to walk. NA-F and NA-G confirmed R2 was a resident they needed to keep an eye on due to unsafe transfers. They indicated on the night shift there were two NA's and if the NA's were busy, the nurse would have to cover or they would need to bring R2 along them to keep an eye on her. NA-F further indicated R2 had been up during the previous night shift. The Fall Prevention Policy reviewed/revised 12/17, indicated residents at risk for falls will be identified and minimized. The policy also directed all fall interventions put in place would be monitored for their continued placement and functioning by nurse staff and reported to IDT [interdisciplinary team] at QI [quality improvement] meetings. The immediate jeopardy that began on 5/11/20, was removed on 5/22/20, when the facility reassessed R2 and implemented interventions and staffing strategies to meet R2's care needs. Upon R1's return to the facility, R1 will be re-assessed and the care plan will be reviewed	2 830		

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LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

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2 830	Continued From page 16 and revised as appropriate and a second staff member will be added if indicated. Additionally, the facility identified a responsible charge nurse to complete rounding to ensure 1:1 supervision for identified residents and the staffing that was in place, as well as education plan was identified and implemented for all licensed and non-licensed nursing staff. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures related to the supervision of residents at high risk for falls and implementation of interventions following a fall. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 830		