STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aitkin Health Services	301 Minnesota Avenue South Aitkin, MN 56431

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790 Based on interview and document review, the facility failed to supervise, implement, and assess fall interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm when R1 fell and sustained a laceration to the middle of her forehead which required an emergency department (ED) visit and sutures. Findings include: R1's Face Sheet dated 4/29/24, indicated R1 had arthritis in both hips, spinal stenosis (abnormal narrowing of the spinal canal), and mild cognitive impairment. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had mild impaired cognition, had two or more falls without injury and one fall with minor injury, and needed extensive assistance with transfers, toileting and bed mobility. R1's Fall Risk assessment dated [DATE] indicated R1 had three or more falls in the last 90 days, was confined to her chair, needed assistance with elimination, and not steady on her feet without assistance. R1's score was 20 (a score of 10 or higher put the resident at risk for falls). R1's care plan dated 10/2/24, identified R1 was at risk for falls due to cognitive impairment. An intervention directed staff would not leave R1 in her wheelchair in her room alone. R1 would stay in a common area if she did not want to sit in her recliner after meals or activities. Additional interventions identified encouraging R1 to wear glasses, wear good footwear, and to use a reacher when grabbing items out of reach. R1's Emergency Department (ED) Provider Encounter note dated 11/18/24, indicated R1 had a large laceration in the middle of her forehead that needed 15 sutures to close. On 11/19/24 at 12:51 a.m., a progress note written by registered nurse (RN)-A indicated on 11/18/24 at around 6:14 p.m., R1 was found in her room on the floor in front of her closet, yelling for help. R1's wheelchair was behind her. R1 was bleeding from her forehead, she was assessed and sent to the ED. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility communication book was located on each unit (Garden Terrace and Town Square) and in the administration office. The front of the book indicated staff were to review the book at the start of the shift, and staff were to sign after reading the new information. The Garden Terrace communication book had eleven updates from 11/4/24 to 12/11/24, with three staff signatures total. The Garden Terrace communication book lacked updates pertaining to R1 and her fall on 11/18/24. The Town Square communication book had eleven updates from 11/4/24 to 12/11/24, with two staff signatures on several pages. The Town Square communication book lacked updates pertaining to R1 and her fall on 11/18/24. The administration office communication book had ten updates from 11/4/24 to 12/11/24 with three staff signatures on one page. An update to the administration office communication book dated 11/19/24 indicated R1 could not be left alone in her room in her wheelchair. There were no other changes to R1's fall risk interventions in the administration office communication book. On 12/11/24 at 12:19 p.m., nursing assistant (NA)-A stated she was an agency staff member on 11/18/24. After dinner, she went into R1's room and asked if she wanted to go to bed and R1 declined. She left R1 in her wheelchair in her room alone. She was not aware R1 was not supposed to be left alone in her room while she was in her wheelchair until after she fell the evening of 11/18/24. She has been directed to look in the communication book for any changes in interventions for residents, but she could not recall the last time she looked in the communication book. She had access to document in R1's electronic medical record (EMR), but was not given access to review R1's care plan and interventions. On 12/12/24 at 10:54 a.m., RN-B stated the facility did not have a good way to communicate with agency staff. The facility had relied on word of mouth, but this was not working. The facility had a communication book for any changes in interventions or other updates on residents. Staff were to read and sign when they come into work. RN-B stated she was not sure who was responsible for ensuring the communication book had been read by staff, and she was not sure why the communication book was not being signed by staff. There was a hole in the process that had not been fixed. On 12/12/24 at 11:01 a.m., RN-A stated on 11/18/24 at around 6:14 p.m., she was getting report from another staff member when she heard someone yelling. She went into R1's room and saw R1 on the floor in front of her closet. R1's wheelchair was behind her, and she was bleeding from her head. R1 had been left alone in her room in her wheelchair, and shouldn't have been. She assessed R1 and sent her into the ED due to R1's forehead laceration. On 12/12/24 at 11:19 a.m., the director of nursing (DON) stated agency staff had access to document in the resident's EMRs, but were not able to review resident care plans or interventions. The EMR had a care stream section that showed activity of daily living (ADL) needs, but it would have been a hit or miss if fall interventions were in the care stream for staff to see. Staff should look in the communication book for any interventions or changes to resident care. The nurse managers were responsible for making sure staff were looking at the communication books and signing them. She was not sure why staff were not looking at the communication book. On 12/12/24 at 11:57 a.m., physician's assistant (PA)-A stated she was aware R1 had a fall, but was not aware staff were not following the care plan. It was possible if the care plan had been followed, R1 would not have fallen. R1 had been was declining prior to the fall, but after the fall on 11/18/24, R1 had a more rapid decline, and was more confused and agitated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility Fall Prevention and Management policy dated 2/15/24, directed there will be interventions implemented to minimize future falls.