STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER: Mayo Clinic Health System - Lake City		STREET ADDRESS, CITY, STATE, ZIP CODE: 500 West Grant Street Lake City, MN 55041	

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** 38685 Based on interviews and document reviews, the facility did not assess or analyze trends in falls to determine causal factors or root causes and implemented individualized interventions aimed at preventing or reducing the risk of falls with major injuries for one of three residents (R1) who experienced falls. This resulted in actual harm when R1 suffered two thoracic spinal fractures and hospitalization after he was left unsupervised on the commode and fell . Findings include: R1's After Visit Summary (AVS) dated 2/1/25 to 2/20/25, identified R1 had a newly diagnosed stroke with left sided hemianopsia (loss of vision in half of visual field) hemiparesis (weakness on one side of body), left sided neglect, and right gaze deviation (condition where the right eye deviates to one side and there's difficulty looking to the opposite side). Further identified R1 had safety considerations due to R1's cognition identified he had poor safety awareness, poor attention/concentration and poor judgement. R1's Fall Risk assessment dated [DATE], identified a score of 8 indicating R1 was at moderate risk of falls. R1's AVS dated 2/27/25 to 3/7/25, identified R1's admitting diagnosis was sepsis due to cholecystitis (gall bladder inflammation), presumed prostate cancer with bone metastasis (occurs when cancer cells from a primary tumor elsewhere in the body spread to and establish secondary tumors within the bones), and stercoral colitis (an inflammatory condition of the colon caused by prolonged constipation and fecal impaction). Further identified R1 had safety considerations due to R1's cognition identified he was impulsive, had poor judgement, and poor safety awareness. R1's fall care plan revised 3/13/25, R1 was at risk for falls due to impulsivity related to stroke, cognitive impairment, dependence on staff for transfers and all cares. was reviewed and identified R1 was impulsive, had cognitive impairment and required extensive assist with activities of daily living (ADL's). Interventions dated 3/6/25, included: -R1 needed prompt response to all requests for assist -Anticipate and meet needs. (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Be sure call light was in reach -Encourage use for assistance as needed, needed prompt response to all requests for assist -physical therapy (PT) to evaluate and treat as ordered. Care plan was revised on 3/7/25 directed to make sure R1 was centered in bed and ensure bed is in lowest position when cares not being performed. R1's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 3/7/25, identified the reason for therapy was the recommended level of skilled therapy services required due to age, complicated medical history, concomitant cognitive deficits, impairment to multiple areas of the body, impairments to multiple systems, interaction of conditions, multiple diagnoses, need for multiple therapies and patient with dementia requiring repetition of structured task to facilitate new learning. R1's progress note dated 3/8/25, identified R1 was found on the floor in front of his wheelchair at 12:45 p.m., had removed grippy socks and slid out of the wheelchair. When asked what he was doing he replied, my socks aren't very good. R1 had been needing more assist since readmission with confusion. R1 had been sitting in wheelchair but declined to eat lunch. R1 had been more restless since admission wanting staff or someone with him all the time. R1 was last toileted at 12:20 p.m. At 12:40 p.m. nurse offered R1 lunch and R1 declined. Root cause was R1 slid from his wheelchair, new intervention identified blue grippy in wheelchair, R1 not to be left unattended in room when in wheelchair and dining room for meals if family is not present. R1's Fall Incident report dated 3/8/25 at 12:45 p.m., included the aforementioned description of the fall. The incident report also included: Immediate action taken was vital signs were performed, range of motion (ROM) performed with no concerns. Neuros initiated due to an unwitnessed fall. R1 oriented to person with impaired memory. R1's corresponding Fall Scene Investigation Report (FSI) dated 3/8/25, was requested and not received. In review of R1's fall record dated 3/8/25, there was no indication the care plan had been revised with the interventions identified in the progress note. Although the report identified the intervention that directed staff not to leave R1 alone in his room in his wheelchair, the record did not include and assessment that would identify if R1 could be left alone in his room sitting on other surfaces such as commode/toilet or other type of chair. Further, the record did not identify an assessment that determined R1's overall level of supervision to prevent/negate falls related to R1's impulsivity as identified on hospital AVS dated 2/27/25. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment and diagnoses of stroke with left sided hemiplegia, cognitive impairment and long-term use of anticoagulants. R1 had behavioral symptoms not directed at others occurring 1-3 days, impairment in ROM to upper and lower side of body, was extensive assist of two staff with bed mobility, toileting and transfers and was frequently incontinent of bowel and bladder. In addition, R1 had one fall with no injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Care Area Assessment (CAA) dated 3/13/25, identified R1 had fall risk factors due to being newly diagnosed with a stroke, anticoagulation use, assistance needed for all cares. R1 had a fall when he slid out of his wheelchair (3/8/25) due to two cushions being in place. Cushion was removed and a slip resistant material placed in wheelchair. R1 was not to be up in wheelchair in his room alone. Internal risk factors included diagnoses of stroke with hemiplegia, incontinence, loss of arm or leg movement, cognitive impairment and agitation behavior. R1's Fall Incident report dated 3/13/25 at 6:05 a.m., indicated R1 had an unwitnessed fall and when nursing assistant (NA) entered room R1 was found on the floor; R1's legs were in bed, and he was lying on his back. R1 stated he was trying to get in wheelchair. Immediate action taken was ROM was within normal limits (WNL) for R1. Vital Signs (VS) and neuros started per policy. R1 stated his back hurt when he landed on floor but now it's his pride that hurts. No injuries noted. R1 returned to bed with assist of 2 and lift. Aides changed brief and did ADL's. Mental status identified R1 was cognitively impaired and oriented to person. Predisposing physiological factors that were identified was confused, incontinent, impaired memory and impaired safety judgement. R1's corresponding FSI included the following additional information: R1 was last seen at 4:30 a.m., when staff were taking tube feeding off and flushing his G-tube. Section 5 of the form identifying, last time toileted, was left blank. Interventions included offer fluids when restless, must be supervised and mats next to the bed. R1's progress note dated 3/13/25 at 8:03 a.m., identified R1 had a fall trying to get from his bed to his wheelchair. R1 stated he wasn't hurt and had no injury; he was just trying to get up. Activity level identified R1 had minimal activity and was restless. New intervention to place fall mats on each side of his bed. R1's Occupational Therapy (OT) notes dated 3/13/25, identified spoke with nursing who reported R1 had a fall close to 6:00 a.m., trying to get out of bed. Discussed with nursing strategies to reduce restlessness such as scheduled times to offer him ice chips due to frequently feeling thirsty, typically had not wanted to spend a lot of time outside of his bed. R1's care plan interventions dated 3/13/25, included blue floor mats to be placed on both sides of bed every time R1 was in bed, offer fluids when restless, fluids or ice chips on last rounds, oral care to be done first, scheduled assist with ice chips/free water protocol with staff only in between meals, and wear appropriate footwear; grippy socks or shoes with transfers. Review of R1's fall record dated 3/13/25, identified although the facility determined the predisposing physiological causal factors included incontinence, R1's record did not include an assessment and/or individualized interventions that would prevent or mitigate the risk for falls that would be related to incontinence. R1's Fall Risk assessment dated [DATE], identified a score of 8 indicating R1 was at moderate risk of falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 3/16/25 at 9:30 a.m., identified aide walked past R1's room and noted him to be lying on the floor, nurse was alerted. Note indicated prior to the fall, R1 was lying in his bed slightly positioned on his left side with head of bed elevated 45 degrees. All four mats were on the floor two on each side of the bed. R1's call light was in his hand and on. R1 was transferred back to bed with the Hoyer lift and ensured R1 was positioned more in the center of the bed with the head of the bed not elevated more than 45 degrees. R1's Fall Incident Report dated 3/16/25 at 9:30 a.m., included the aforementioned fall description. Additional information included: R1 had been asking for drinks of water all morning, does not like ice chips, educated on reason why, R1 was upset about not being able to drink water. R1's FSI report dated 3/16/25 was requested and not received. R1's fall record dated 3/16/25 did not include a comprehensive analysis that identified causal factors/root cause nor identify individualized interventions that prevent and/or negate risk for re-current falls. R1's OT notes dated 3/26/25, identified R1's precautions were decreased vision to left side, left sided hemiplegia and decreased coordination, feeding tube-pureed diet with no liquids, biliary drain, safety/cognition/impulsivity, fall risk and history of 2 assist with Hoyer. R1's cognition was assessed for discharge, results identified a cognitive performance test (CPT) was completed with a score of 4.1 identifying moderate cognitive deficits, requiring 24-hour supervision, up to 1:1 cognitive assist with ADL's and assist with ADL's. All tasks were modified for left visual cut and vision deficits. During a phone interview on 4/3/25 at 2:13 p.m., Occupational Therapist (OT)-A stated R1's cognition was assessed and he required 24-hour supervision and 1:1 with ADL's which therapy educated the aides on. Therapy never saw R1 try to self-transfer, we know he had tried to get out of bed in the past, we did try to come up with a plan to reduce his restlessness. OT-A further stated R1 was impulsive when it came to toileting and drinking. Therapy educated the nurses on R1's impulsiveness quite a bit. OT-A was unable to articulate when a resident who had cognitive deficits with impulsivity and required assistance would be assessed for the level of supervision during toileting tasks. During an interview on 4/3/25 at 11:28 a.m., physical therapist (PT)-A indicated the last day she assessed R1 was on 3/27/25, where R1 had improved since his last hospitalization on [DATE]. PT-A stated R1's balance was better, required supervision and stand by assist with adl's. R1 could ambulate up to 100 feet with minimal assist and a two wheeled walker. R1 was very willing to work in therapy, however, could not tolerate sitting long because it hurt him, so he spent a lot of time in bed. R1's cognition was poor, and he was very impulsive. Therapy performed several cognitive tests with results that identified significant impairment indicating a level of dementia. PT-A stated she did not assess R1 to see if he required supervision with toileting and could not find anything in the therapy notes that indicated R1 was ever assessed for supervision with toileting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Fall Incident report dated 3/29/25 at 9:25 a.m., indicated R1 had an unwitnessed fall in his room. R1 was found on the floor in between commode and foot of bed lying on his back. R1 complained of level 4 out of 10 low back pain, prn (as needed) Tylenol administered. NA had informed nurse they had placed R1 on the commode as requested. R1 explained he was on the commode and thought he could walk back to bed. R1 stated, I knew I shouldn't have, and I should have tucked and rolled. Immediate Action Taken: writer assessed R1 for physical injury, R1 transferred to bed using a Hoyer. Predisposing factors were gait imbalance, confused, weakness, impaired safety judgement, self-transfer and ambulating without assist. Staff statement identified co-worker, and myself went to toilet R1 on the commode using a gait belt. We sat him down gave him his call light and told him to turn on his call light when he was done. She was checking on other residents when his call light go on. When she went to his room, she saw him lying on the floor. R1's corresponding FSI report dated 3/29/25, was requested and not received. R1's progress notes dated 3/29/25, included the aforementioned fall description. At 4:20 p.m. R1's family wanted R1 sent to the emergency department (ED). R1 was reporting pain 10 out of 10 in his low back. On-call provider gave order to transfer R1 to ED. R1 was transferred to the ED at 4:30 p.m. R1's progress note dated 3/30/25 at 11:37 a.m., identified R1 was admitted to the hospital for fracture in T11 and T12. R1 was discharged from facility because no bed hold was signed. R1's physician visits on 3/10/25, 3/17/25, 3/24/25 and 3/26/25 did not address R1's falls. During a phone interview on 4/3/25 at 2:29 p.m., family member (FM)-A stated R1 fell on [DATE], because staff left him on the commode by himself. Nursing staff should not have done that because R1 was very impulsive and did not always remember to ask for help. FM-A stated R1 ended up in the hospital from that fall and suffered two fractures in his spine- T11 and T12. The injuries had really set [R1] back and will be transferring to another facility from the hospital today (4/3/25). During an interview on 4/3/25 at 1:21 p.m., nursing assistant (NA)-A stated on 3/29/25 around 9:00 a.m., R1 had put his call light on and had asked to go to the bathroom. NA-A was not familiar with R1's care and was not aware he had previous falls, so she checked R1's care plan before transferring him. NA-A and another staff member used a gait belt and two wheeled walker and walked R1 from his bed approximately 13 feet to his commode. NA-A placed R1's walker in front of him and tied his call light to it. NA-A instructed R1 to push his button when he was done. NA-A explained she then left the room to answer a call light a couple of rooms away. NA-A noticed call light was on then heard a thud, when she got to R1's room, she found R 1 lying on the floor partially on his right side and back. R1 had made it three steps from the commode. NA-A stayed with R1 and radioed for help. R1 had reported pain and pointed to his middle back. After the nurse assessed him, R1 was transferred back to bed using a hoyer. NA-A did not remember R1 being on the Falling Star Program and would have seen the star on R1's door. (continued on next page)

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	245218	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/3/25 at 10:07 a.m., nurse manager (NM)-A stated with a fall, the floor nurse would assess the resident and provide any needed care. Floor nurse would then fill out a fall huddle form, make an incident report, and put in a fall progress note. After each fall nursing staff should try to determine the root cause of the fall and update the care plan with an appropriate intervention. NM-A stated R1's incident reports for the falls on 3/8/25, 3/13/25 and 3/18/25 did not identify if R1's basic needs were met. For example, the incident reports did not identify if R1 had been incontinent at the time of the fall and the last time he was toileted. Because of the lack of information it was not possible to appropriately root cause each fall. NM-A stated she did not see root cause for R1's 3/16/25 fall and did not see that R1's care plan was updated with any new interventions. The root cause of R1's fall on 3/29/25 was due to staff leaving R1 unattended on his commode where he fell and was hospitalized with two thoracic fractures. During an interview on 4/3/25 at 11:01 a.m., director of nursing (DON) verified R1 had 4 falls since 3/8/25 to 3/29/25. DON explained the facility used a fall huddle form that the floor nurse was supposed to fill out at the time of the fall to help determine a root cause of the resident's fall. During morning meeting interdisciplinary team (IDT) discuss the resident falls to ensure prevention interventions are put in place. DON reviewed R1's falls and verified the nurse did not fill out a fall huddle form for 3/8/25, 3/16/25, and 3/29/25. The fall investigations did not always identify or include in the analysis if R1's needs were met such as toileting, pain and thirst. R1's fall on 3/16/25 did not include a comprehensive analysis due to the lack of investigation. Further the care plan had not been updated to include any new fall prevention interventions. DON stated R1 was left on the commode on 3/29/25 unsupervised when he fell and was sent to the hospital that resulted in two thoracic fractures. DON was unaware of how long R1 was left on the commode and verified his cognition was impaired, was impulsive and required extensive assist with toileting. DON further stated we usually have therapy assess a resident for safety with supervision of ADL's if they are dependent on staff for care and have impaired cognition. Facility Policy entitled, Fall Risk, Post Fall Investigation, Follow Up and Care, effective dates of 7/2021, 10/21 and 12/23, identified purpose-to define Nursing's role in the management of patients at risk for falls and post fall investigation, follow up and care. 2. Universal fall precautions are used for all patients based on individual patient needs. Interventions should be selected based on individual patient needs. Document interventions in the medical record. Falls risk and interventions should be noted on the plan of care. POST FALL INVESTI AT ON, FOLLOW UP AND CARE-1. Evaluate patient's pain range of motion and level of consciousness or change in cognitive level before moving or helping patient to a safer position/chair/bed. Document Post Fall Huddle completed. Document Care Plan reviewed and revised as indicated. Document and complete UDA's that were triggered if applicable. 3. Any changes in interventions will be noted, on the resident's Care Plan and Kardex. The IDT (interdisciplinary team) will meet each weekday to review fall(s) and determine if further investigation of incident is needed; and assign who will assist with assessing further intervention(s). Risk Management Reports and statistics of the falls that have occurred to be maintained and reported to the QAPI committee for interpretation of patterns and quality improvement interventions. Nursing staff actions-information gathering .assess for basic needs-hunger, pain, toileting .bowel and bladder training programs in place and effective .review care plan to ensure fall prevention strategies are included .increase patient observation .Mandatory high-risk interventions, but not limited to: o Place a yellow wristband on wheelchair, walker, o Place Falling Star symbol on doorframe outside patient's room. and o Ensure that the falling star is removed upon discharge from falling star program.