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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Health System	401 Prairie Avenue Northeast Staples, MN 56479

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to ensure adequate supervision to prevent wandering to unsafe places and falls for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm to R1 when she fell and sustained a fracture to the right leg. The facility implemented corrective action so the deficient practice was issued at past non-compliance. Findings include: R1's annual Minimum Data Set (MDS), dated [DATE], identified R1 required supervision with eating, oral hygiene, toileting, and shower/bathing, partial to moderate assistance personal hygiene, roll left to right, sit to lying, lying to sitting, and toilet transfers. Substantial to maximum assistance to transfer from chair to bed and sit to stand machine. R1 was frequently incontinent of bladder and always continent of bowel. R1's diagnoses included non-traumatic brain dysfunction, arthritis, osteoporosis, Alzheimer's, and dementia. R1's medications include diuretics (increased urine output). R1's Fall risk assessment dated [DATE], identified intermittent confusion, incontinent, balance problem with standing and walking and required the use of assistive devices (i.e. cane wheelchair, walker, furniture). R1 was at risk for falls. R1's elopement evaluation dated 6/24/24, identified R1 wandered and identified at risk for elopement. R1's bowel and bladder assessment dated [DATE], no falls in past three months, intermittent confusion, ambulatory and incontinent. R1 had balance problems while standing and while walking and required use of assistive devices (i.e. cane, wheelchair, walker, furniture). R1's care plan dated 6/24/24, directed staff to anticipate unmet needs, cue, reorient, and supervise as needed. R1 was at high risk for falls, unaware of safety needs, gait/balance problems, incontinence, and the potential to fall down and hurt herself. Staff were directed to follow urinary toileting schedule every two hours and monitor/provide reminders/assistance to turn/reposition at least every two hours, or more often as needed or requested due to potential for pressure ulcer development. R1's care plan lacked evidence of a revision following implementation of hourly safety checks on 7/4/24, though hourly checks were added to the NA tasks sheet at that time. (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

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

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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 0684

Level of Harm - Actual harm

Residents Affected - Few

A facility reported incident (FRI) report submitted to the State Agency (SA) on 7/4/24, at 10:40 p.m The report identified R1 fell at 9:35 p.m., R1 was found on the floor beside the bed lying on right side. R1 was unable to state what happened. R1 had a small amount of emesis.

R1's electronic medical record identified the following:

- Task of: MONITOR - Complete Hourly Safety Check every shift related to fall risk. Staff to ensure R1 had gripper always socks on. R1's hourly safety checks documentation for 7/4/24, revealed staff signed off the safety checks were completed at 2:41 p.m., 3:53 p.m., 4:41 p.m., 5:00 p.m., 6:00 p.m. 7:00 p.m. Staff did not document the safety check was completed at 8:00 p.m. or 9:00 p.m. and then at 10:47 p.m. documented R1 not available. R1's safety checks were documented to acknowledge R1 was located on 7/4/24, at 2:41 p.m., 3:53 p.m., 4:41 p.m., 5:00 p.m., 6:00 p.m. 7:00 p.m. and documented R1 was not available at 10:47 p.m. Staff did not document R1 was located after 7:00 p.m. until 10:47 p.m. (3 hours and 47 minutes).

Task of: B & B (bowel and bladder): Bladder elimination - Toilet every two hours, while awake, during AM (morning) and PM (evening). First, third, and last rounds during the night. Toilet after dinner each day. R1's bladder elimination documentation on 7/4/24, revealed staff signed off at 1:00 p.m. continent, 3:41 p.m. continent, 5:00 p.m. incontinent, 9:35 p.m. incontinent. Staff did not document bladder elimination after 5:00 p.m. until 9:35 p.m. (4 hours and 35 minutes). At 10:47 p.m. staff documented R1 was not available.

R1's progress notes dated from 6/25/24, to 7/5/24 were reviewed and identified the following:

-6/25/24, at 6:54 a.m. staff were unable to complete brief interview for mental status (BIMS), memory problem identified and severely impaired decision making.

-6/30/24, at 11:08 p.m. R1 self-transferred in room, attempted to put herself to bed, and had an unwitnessed fall. No injuries identified.

-7/1/24, at 2:45 a.m. R1 was found sitting on floor next to bed at 1:10 a.m. R1 stated she was getting in her chair. Second fall within 12 hours. R1 was assessed, assisted into her chair, and brought to nurse's desk.

-7/1/24, at 7:01 a.m. post fall evaluation indicated fall was not witnessed, occurred in R1's room, and reason for fall was not evident. Contributing factors note: R1's bedtime routine was disrupted as R1 had company.

-7/4/24, at 9:40 p.m. orders obtained to send R1 to emergency room (ER) for evaluation and treatment following fall.

-7/4/24, at 9:48 p.m. Post fall evaluation: R1's fall on 7/4/24, at 9:11 p.m. was found on the floor was not facility sleep study room at 9:10 p.m., complained of right leg pain, and had an emesis. R1's fall was unwitnessed and appeared she attempted to get into a bed that was very elevated and resulted in a fall. R1 sustained an injury of the right medial leg with pain. Physical findings noted R1 had a sensory impairment of her sight and displayed right leg pain. R1 was sent to ER and evaluated.

(continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-7/4/24, at 10:56 p.m. communication with provider: staff completed the 9:00 p.m. safety check and located R1 on the floor beside the bed in sleep study room. R1 laid on her right side and complained of right leg pain. -7/5/24, at 1:26 p.m. updated R1's daughter, vulnerable adult was filed with the state agency. R1 was transferred to another local hospital for surgery then would return to facility. -7/8/24, at 2:28 p.m. R1 returned to facility via wheelchair. R1 experienced signs of short-term memory loss, was disoriented, confused, and required cues. R1 had dressing on right hip, poor balance, impairment of lower extremity on one side, and an indwelling catheter. R1's Emergency Department (ED) triage notes dated 7/4/24, at 10:41 p.m. identified brought to ED after R1 encountered an unwitnessed fall and was found in sleep study on the ground on her right side. R1 had a lot of pain will wince and say ouch with range of motion (ROM) to her lower right extremity. R1's hospital history and physical dated 7/4/24, at 10:53 p.m. was found wandering into the sleep lab in another part of the care center and found down on the ground. R1 refused to move right leg at all. R1 had swelling/deformity noted in right femur which was location of prior fracture in the past. R1 had dementia at baseline but seemed to be more confused than usual. R1's physical examination showed deformity/edema noted in lateral upper leg. R1's x-ray showed distal femur fracture that was displaced just past rod from prior surgery. R1's discharge summary from hospital dated 7/8/24, at 11:05 a.m. identified R1 had a comminuted periprosthetic supracondylar femur fracture right leg and received surgical repair ORIF (open reduction and internal fixation) of right femur fracture with bone grafting. R1 was discharged back to skilled nursing facility at 1:18 p.m. on 7/8/24, and all transfers non-weight bearing on the right leg/foot. Right knee immobilizer was expected to be worn full-time until follow up in two weeks with orthopedics for x-rays and staple removal. A facility five-day report submitted to the SA on 7/8/24, at 1:12 p.m., identified R1's care plan was not followed regarding toileting and rounding. R1 was care planned to have been toileted every two hours, last toileted at 4:00 p.m. due again at 6:00 p.m. and not completed. R1 was brought to the dining room at 5:30 p. m. where R1 was last seen finishing her dinner at 6:15 p.m. At 8:30 p.m. staff were unable to locate R1, initiated a missing person alert and found R1 at 9:10 p.m. R1 was unable to explain what happened due to dementia/memory problems. R1's x-rays showed a right femur distal femur fracture and was surgically repaired. Both staff involved were immediately removed from the schedule and disciplinary actions were completed for R1's care not followed. Staff were new, acknowledged, and understood expectations moving forward. Audits were put into place for close monitoring of care and care plans. R1 would be assessed upon return from hospital for a wander guard or memory care placement due to new recent wandering behavior. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Lakewood Health System		STREET ADDRESS, CITY, STATE, ZIP CODE: 401 Prairie Avenue Northeast Staples, MN 56479	

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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 0684 Level of Harm - Actual harm Residents Affected - Few	R1's primary physician visit dated 7/11/24, identified R1 had a history of recurrent falls, cognitive impairment, remote right superior and inferior pubic ramus fractures, intertrochanteric fracture of the right hip post-surgical repair on 1/9/23, via right hip internal fixation of intertrochanteric fracture using cephalomedullary nail. R1 was admitted to facility on 1/25/23, unable to care for herself at home and had falls due to confusion and attempts to transfer without assistance. R1's cognitive decline continued at a slow pace. R1 was admitted to hospital on 7/4/24, after she sustained a fall and suffered a comminuted right femur fracture. R1's surgical procedure included an open reduction internal fixation of the right periprosthetic femur fracture with bone grafting. R1's significant change MDS dated [DATE], identified R1 was dependent on staff for bed to chair transfers and had an indwelling catheter. R1's elopement evaluation dated 7/12/24, identified R1 wandered, wandering behavior was a pattern, goal directed (i.e. specific destination in mind, going home etc.) and likely to have affected the safety or well-being of self/others. R1 was identified at risk for elopement. R1's physician orders dated 7/14/24, identified a wander guard every shift for elopement risk and ensure the device was working. R1's Kardex dated 7/16/24, identified Fall Prevention: after meals, ask resident if she wants to sit on the couch and watch TV (television) or place her near the TV in her wheelchair so she was able to see people as they came in and out of the facility. R1 required monitoring/reminders/assistance to turn/reposition at least every two hours, more often as needed or requested. R1 was non-weight bearing to right leg. R1 used wander guard for elopement prevention. R1 was dependent of two staff and the total mechanical lift. HS (evening) routine: go to bed between 8:00 p.m. and 9:00 p.m. R1 had wander guard for elopement precaution. During continuous observations on 7/17/24, from 9:00 a.m. through 10:00 a.m.: -9:00 a.m. R1 sat was observed sitting in her wheelchair in the dining room at a table by herself. R1 drank coffee and looked around. R1 appeared to have eaten approximately 50 percent of her breakfast, had gripper socks on both feet, feet were placed on footrests, and right leg elevated. R1's wander guard was observed to be hung on lower back side of wheelchair and lift sheet remained underneath R1. -9:03 a.m. an unidentified staff asked R1 if she was done eating, pushed her down to hallway one where R1 lived, and left her in the wheelchair where staffed continuous walked by to check on R1. -9:09 a.m. physical therapy assistant (PTA) approached R1 and asked if she was ready for physical therapy this morning. R1 stated yes. PTA pushed R1 in wheelchair down the hallway and into her room. PTA completed R1's physical therapy at 9:25 a.m. then asked if R1 wanted to stay in her room or go out and watch the birds. Registered nurse (RN)-B located outside R1's room in hallway stated out loud that R1 needed to be outside her room in either hallway or out by the birds, and not left in her room. PTA stated, well that answers my question and pushed R1 down the hallway to the central lounge area by the birds. -9:35 a.m. R1 sat in wheelchair in commons/lounge area in front of the birds. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-9:50 a.m. R1 sat in wheelchair awake in commons/lounge area in front of the birds. Numerous staff walked by. R1's feet both remained on the footrests and no attempt to get up out of wheelchair. -9:59 a.m. R1 remained in wheelchair in commons/lounge area in front of the birds. NA-D walked up to R1 and sat down next to her in a chair. NA-D asked R1 if she wanted to remain sitting up or lay down, R1 stated lay down. NA-D pushed R1 down hallway to outside of her room, while NA-D located a lift machine. NA-D pushed lift machine into R1's room then R1 in wheelchair. NA-D placed call light on to signal staff for assistance with transfer from wheelchair to bed. NA-E entered R1's room and together they transferred R1 from wheelchair to bed with total lift machine. NA-D and NA-E checked R1's incontinent product, positioned her onto her back with pillow under both legs from knees to ankles so that heels were off bed mattress, then placed bed in lowest position. R1 had on right leg immobilizer during entire observation. NA-E placed call light within reach, moved bedside table next to the bed, and wheel chair on other side of room unreachable by R1. During a telephone interview on 7/17/24, at 1:30 a.m. licensed practical nurse (LPN)-A stated on 7/4/24, the last time she saw R1 was in the dining room at 6:15 p.m. LPN-A stated according to R1's care plan R1 was to be taken to the commons area after meals to be distracted by TV and other people but that night the intervention never happened. LPN-A stated R1 spent a lot of time in her wheelchair, attempted to self-transfer, and forgot she was unable to walk by herself. On 7/4/24, at 8:30 p.m. LPN-A noticed R1's roommate was in bed but R1 was not in her room. R1 was usually in bed by that time and a search was initiated. At 9:10 p.m. LPN-A noticed the sleep study room light was on and entered that room. R1 was sitting on the floor next to the bed with her right leg placed under the left leg. LPN-A placed a pillow behind R1, touched the right leg, tried to move R1's right leg but felt it was not in the correct position. LPN-A indicated registered nurse (RN)-A assisted with lifting R1 off the floor with a full mechanical lift and into her wheelchair. LPN-A stated the assessment of the right leg identified the leg was swollen, very painful, as R1 moaned, and when moved R1 yelled out ohhhhh, winced, and grimaced. R1's provider was notified and R1 was sent to ER via ambulance. R1 was diagnosed with a fracture of the right femur and had surgery to repair it. R1 was on a toileting plan, but was not sure when the last time she was taken to the bathroom. R1 was incontinent of urine and had a small emesis at the time of the fall. R1 told LPN-A she had been hollering out for a long time and knew someone would eventually come. R1 was supposed to have been on hourly safety checks, and the care plan was not followed; otherwise R1 would have not of been found half-way across the building. LPN-A stated had received education on monitoring, repositioning, hourly rounding, toileting and following the care plan on 7/8/24, right after incident. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/17/24, at 10:16 a.m. registered nurse (RN)-A stated R1 was at high risk for falls and was to be toileted every two hours and have hourly safety checks. Staff were expected to document the hourly checks and when R1 was toileted accurately. R1's cognition and memory were poor, R1 had fallen two weeks prior and was then placed on hourly checks. R1 frequently tooled herself around the facility and often tried to stand up by herself. It was after 9:30 p.m. when RN-A was made aware R1 fell . Staff placed R1 in a full total lift and lifted her off the floor of the sleep study room. RN-A stated it was obvious R1 favored her right leg and once her pants were removed they observed two swollen areas on the right thigh. RN-A stated both NA's involved were educated the evening incident happened and audits were started right after incident. RN-A stated all nurses were expected to have completed audits every shift on NA's to assure the care plans were being followed and education provided. RN-A stated those audits continued to be completed on every shift. RN-A also stated at any given time would check the NA's documentation in the resident's electronic medical record and at a glance would have known if cares and checks been completed and/or if they were behind in their cares and checks. RN-A stated she had sent out an email to all nursing staff regarding R1's fall regarding fall interventions and following the care plan right after R1 had fallen. During a telephone interview on 7/17/24, at 1:19 p.m. patient care attendant (PCA) verified she worked on wing one with a nursing assistant (NA)-A on 7/4/24. R1 was on hourly checks and both staff (PCA and NA-A) checked on her and worked as a team. Last time PCA toileted R1 on 7/4/24, was at 4:00 p.m. and after that the NA-A told her she had placed R1 in bed. PCA stated looked at the documentation on R1 and it looked like NA-A signed off she had checked on her every hour so figured R1 was taken care of. PCA was in the dining room assisting another resident when she saw R1 leave the room at about 6:00 p.m., and figured she headed down to her room. PCA found out later R1 was missing and had fallen and possibly injured herself. PCA stated they received education the following day after incident on 7/9/24, prior to start of next shift regarding falls, hourly, checks, transfers, and toileting. During an interview on 7/17/24, at 2:00 p.m. NA-A stated R1 was on hourly safety checks and was to be toileted every two hours on 7/4/24. R1 was toileted was at 4:00 p.m. that day. NA-A stated from 2:00 p.m. to 4:00 p.m. R1 visited in cafe with her family. NA-A informed PCA she planned her break from 5:00 p.m. to 5:30 p.m. NA-A stated once she returned from her break at 5:30 p.m., she checked with PCA in the dining room, and saw R1 sat at a table in dining room. PCA stayed in dining room and assisted residents, and NA-A returned back to wing one, and answered call lights. NA-A was really busy answering resident call lights and then ended up in resident's rooms. NA-A verified hourly checks and every two-hour toileting on R1 were not completed as they were too busy. Call lights were crazy busy and NA-A asked PCA to complete the checks on R1. At 9:00 p.m. NA-A looked for R1 to get her ready for bed but was unable to find her. NA-A and PCA were expected to have completed the hourly checks on R1 and document in the electronic medical record. The building was searched and R1 was found by a staff nurse in the sleep study room. R1 had fallen and was sent over to ER. NA-A felt she may have been able to prevent that fall if the hourly checks would have been completed as care planned. NA-A stated she had received education the night R1 had fallen on 7/8/24, on documentation, falls, toileting, and hourly rounding. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 7/17/24, at 4:00 p.m. social worker designee (SWD) completed R1's elopement assessment on 6/24/24. SWD documented R1 did wander and scored one point on the assessment. SWD also verified a score of one or higher the resident would have been considered a risk. SWD stated her thought process was when R1 was taken out of her room and wandered back into her room she considered that would be wandering. SWD stated mostly likely was an error and that question should have been answered no instead on 6/24/24. SWD stated R1 was re-assessed on 7/12/24, for her risk of elopement and identified at risk and a wander guard was placed.

During an interview on 7/17/24, at 4:30 p.m. director of nursing (DON) stated on 6/13/24, at 7:35 a.m. R1 had a drop in blood pressure and fell and that's they initiated hourly safety checks as an intervention. Nursing staff were expected to follow the care plan in entirety for each resident and there were no exceptions. If it was not charted then the task was not completed. DON stated falsification of documentation was not allowed and would not be tolerated. DON indicated education was provided to the staff directly involved in incident; NA-A the evening of the incident, PCA the next day prior to shift worked, and additional education was provided to NA's while audits were completed by the staff nurse every shift initiated approximately one week ago. DON stated audits continued so that all staff were monitored for frequent checks and residents toileted according to their care plan. DON stated her expectation for staff would be the care plan followed in it's entirety and was made very clear in during audits. DON stated rounded with NA's and they were very clear on scope of practice and expectations. DON hourly rounding was not included on the care plan but was on the tasks list to be completed by NA's to help keep R1 safe and staff were aware of that. During interview, the DON identified the following was observed on video: R1 ventured down a total of three hallways to get to the education room (previously known as the sleep study room), two and 1/2 hallways (a total of up to approximately 400 feet total). At 6:45 p.m. R1 ventured up the hallway and wheeled herself out of the main area where she sat by the bird cage. At 6:49 p.m. R1 was down just past her office (almost 2 hallways from main area) and that was the last R1 was seen on the video. DON stated R1 was in the education room approximately two hours before she was found and unsure when she fell . Staff headed down the hallway past her office at 9:04 p.m. and found R1 on the floor with right leg bent and tucked underneath the left thigh. DON indicated when the staff nurse moved R1's leg to straighten them out she said ouch ouch, noted swelling on the right upper leg, and then held her legs straight during the transfer with a total mechanical lift. R1 was then transferred to ED via ambulance and had surgery on her right hip.

Review of staff education documents and shift audits identified the facility implemented corrective action and was determined to be in compliance before survey entrance.

The facility policy Resident Assessment for Bowel and Bladder Retraining or Management dated 9/6/23, identified purpose was to ensure residents were maintaining the highest level of continence.

The facility policy Fall/Injury Risk dated 1/17/24, revealed purpose of policy was to identify resident's risk for falling and risk from a fall, and develop an individualized plan of care to reduce falls and injury. Staff were responsible to initiate the appropriate interventions related to safety and fall prevention. Residents who have fallen will be appropriately managed. All staff member were responsible for implementing the intent and directives contained within this policy and for creating a safe environment of care. Resident maybe placed on fall precautions.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	The facility policy Nursing Documentation dated 3/20/24, identified all nursing documentation must be completed both accurately and timely in order to enhance patient care. All nursing documentation was expected to be completed within the shift care was completed unless otherwise designated. Documentation should have displayed handling of the data and should influence the plan of care. The facility policy Hourly Rounding dated 5/15/24, identified it was the responsibility of each department director/manager to establish a method of hourly rounding practice within their department to reduce resident safety/risk issues, enable nursing staff to be proactive in their resident care, and evaluate resident for a change in condition. Staff would be expected to meet the resident personal needs such as bathroom assistance, personal hygiene, reposition to provide comfort, and respond to any resident concerns.