

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/31/2026
NAME OF PROVIDER OR SUPPLIER  Essentia Health Homestead		STREET ADDRESS, CITY, STATE, ZIP CODE  115 10th Avenue Northeast Deer River, MN 56636	
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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and document review the facility failed to ensure care planned interventions were implemented to reduce the risk for falls for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm to R1 who fell from her wheelchair and sustained a fracture, head injury and lacerations to her hand. Findings include:R1's Continuity of Care Document created 4/1/26, indicated she admitted to the facility 1/5/22. R1's diagnosis included aphasia (communication disorder- may affect written and spoken language as well as ability to understand), dysphagia (difficulty swallowing) muscle weakness and dependence on enabling machines and devices for transfers.R1's John Hopkins Fall Risk Assessment Tool dated 1/5/26, indicated a high risk for falls.R1's quarterly Minimum Data Set, dated [DATE], identified severe cognitive impairment and indicated she required substantial/maximal assistance for transfers. The MDS indicated R1 was dependent on staff for transport in a manual wheelchair.R1's care plan dated 3/23/26, identified a problem related to wheelchair transport safety and positioning. The care plan directed staff to ensure R1 was fully positioned and supported in wheelchair prior to transport, verify footrests were in place prior to transport and monitor for leaning, sliding or unsafe positioning. The care plan identified a risk for falls related to diagnosis of traumatic brain injury, aphasia and impaired mobility. Care planned approach dated 9/13/22, directed staff to ensure wheelchair pedals were on at all times.A facility Event Report dated 3/21/26, indicated R1 sustained a fall out of her wheelchair at 7:30 p.m. in her room. No suspected head injury was identified. The report indicated R1 was able to communicate but refused to make a statement. R1's fall was witnessed by staff. The report indicated R1 was being pushed in the wheelchair after her shower, leaned forward in the chair and fell out of it.R1's Progress Notes identified the following:3/22/26 at 1:35 a.m., Writer received call from the emergency department (ED) stating they would be admitting R1 for a thoracic fracture.3/22/26 at 8:26 a.m., Xray result indicated highly suspicious for T12 (12th thoracic vertebra at the base of the mid-back) fracture. 3/22/26 at 9:19 a.m., R1 had an abrasion to her forehead and a bruise to her left knee. R1 also had two lacerations on her right hand. 3/22/26 at 10:22 a.m., R1 had two different areas that she lacerated on her right hand, fourth finger base and sutures intact upon removal of splint. R1's entire hand was black and blue and swollen. R1 had two sutures on the outside and nine on the inside. R1 had pain in the hand.3/22/26 at 3:21 p.m., late entry note for 3/21/26. At 7:30 p.m., after shower, nursing assistant (NA) was wheeling R1 to her room. While going through the doorway, R1 leaned forward and fell out of her wheelchair. Upon assessment, R1 had a laceration on her right hand, a lump on her head and a bruise on her left knee. R1 was transferred to the ED. 3/23/26, ED physician Visit Note; R1 arrived from the facility following a fall out of her wheelchair resulting in abrasions and injury to her forehead, left knee and right hand. According to camera footage, R1 fell out of the wheelchair when she was being transported to her room in the wheelchair. The wheelchair hit the door frame stopping the chair with R1 then falling out of the chair. Assessment indicated a head injury with concussion, left upper mid head abrasion and contusion, T12 fracture and right hand laceration that required repair with sutures.During observation on 3/31/26 at 11:27 a.m., R1 was seated at a table in the dining (continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>room. R1 had a bandage on her right hand. Foot pedals were observed on R1's wheelchair. During interview on 3/31/26 at 2:14 p.m., NA-A stated R1 had received a shower and when she transported R1 from the shower room to her room, she had not put the foot pedals on the wheelchair. NA-A stated when she wheeled R1 into her room she hit the doorframe with the right side of the wheelchair. NA-A said R1 had begun to lean forward in the chair and fell onto the floor. NA-A stated she was aware she should have had the foot pedals on the wheelchair but had not put them on since she was only transporting R1 from the shower to her room. NA-A stated, following the incident, she received education related to following the care plan and was required to demonstrate transfers and transports more than once. During interview on 3/31/26 at 2:26 p.m., the director of nursing (DON) stated the care plan had not been followed when R1 had fallen. The DON stated after the incident, education had been completed with NA- A and ongoing audits had been implemented to ensure safe transport and to ensure staff were following the plan of care. Facility policy Activities of Daily Living Standards of Care dated 9/10/25, indicated a plan of care was developed for each resident based on assessment, preferences, choices and standards of care. All staff will be responsible for knowing and following the individual plan of care for each resident. The Past Noncompliance began on 3/21/26 when NA-A was assisting R1 in her wheelchair from the shower room to R1's room without use of foot pedals. R1's wheelchair hit the door frame of R1's room. This caused R1 to fall from her wheelchair which resulted in R1 sustaining a fracture, head injury and lacerations to her hand. The deficient practice was corrected by 3/22/26, after the facility provided education to NA staff related to following the plan of care and developed and implemented audits to ensure care plan compliance and safe wheelchair transfers and transport. The education was verified through interview and document review.</p>		