STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essentia Health Homestead	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	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** Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm to R1 when she fell out of bed and sustained a femur (the longest, heaviest, and strongest bone in the human body, located in the upper leg) fracture. Findings include: R1's Resident Face Sheet indicated she was admitted to the facility 3/28/23. Diagnoses included Parkinson's disease, dementia, anxiety and repeated falls. R1's comprehensive Minimum data set (MDS) dated [DATE], identified severely impaired cognition. The MDS indicated R1 was dependent on staff for bed mobility and transfers. R1's John Hopkins Fall Risk Assessment Tool dated 4/30/26, indicated a low risk for falls. R1 care plan dated 5/12/26, identified a risk for falls related to diagnosis of Parkinson's disease, dementia, hallucinations, impaired mobility, weakness and decreased safety awareness. The care plan identified: Fall on 3/28/23. Interventions included: call light and personal items in reach when in room. The care plan further identified an alteration in physical mobility and activities of daily living and indicated she required the use of a mechanical lift for transfers Fall on 8/10/23. Interventions included: low bed with non-slip mat next to bed. Fall on 4/22/26. Fall description indicated R1 rolled out of bed, onto the floor and sustained a femur fracture. Fall interventions included: 30-minute safety checks. Facility Safety Event dated 4/22/26, indicated on 4/22/26, at 7:00 a.m., R1 had a fall from her bed. R1's bed had been raised to working height so staff (nursing assistant (NA-A)) could get R1 ready for the day. NA-A left the room to get assistance from another staff member and when they returned, R1 was observed on the floor. R1's Resident Progress Notes indicated the following: 4/22/26, Writer was called to [R1's] room at 7:00 a.m. Upon entering room, R1 was on the floor on her right side next to the bed. R1 appeared to have rolled out of bed. No visible injury to torso, hips, head or face. 4/22/26, At 7:15 p.m., R1 was crying in bed and stated she hurt. Administered pain medication and R1 fell asleep. 4/23/26 at 8:45 a.m., While providing morning cares, R1 complained of pain with movement of right hip. R1 said ouch, ouch when attempting to reposition. Facial grimacing and guarding noted. R1 was taken to radiology for imaging. 4/23/26, 10:07 a.m., Computed Tomography (CT) scanˆ(a diagnostic imaging procedure thatˆuses a combination of X-rays and computer technologyˆto produce images of the inside of the body) returned negative for fracture. 4/24/26, 9:31 a.m., R1 was crying and leaning in her chair in the morning, and stated, I hurt. 4/24/26, 12:54 p.m., Bruise noted to R1's inner right leg, above the knee to the abdomen. Bruise measured 6.6 centimeters (cm) x 5.4 cm. No swelling in bruised area but upper thigh was swollen. Tenderness on palpitation of area. 4/25/26, 1:25 p.m., Writer was called to [R1's] room to assess her right leg. Inner thigh had a large blue/purple bruise covering most of the area. Right thigh appeared swollen and larger than the left. R1 reported pain with movement of knee. 4/25/26, 2:25 p.m., X-ray of R1's right thigh and knee performed. 4/25/26, 3:30 p.m., X-ray indicated displaced (broken bone ends have shifted out of their normal, anatomical alignment)ˆfracture extending from the lower femoral shaft to the metaphysis (section of bone located between the rounded end of the bone and the long, straight shaft). During interview on 5/18/26 at 12:51 p.m., NA-A stated on the morning of 4/22/26, staff had been getting residents up for the day. NA-A stated she (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	got R1 ready and placed the mechanical lift sling underneath her. NA-A left R1's room to get another staff to assist and forgot to put R1's bed back down. R1's bed was about three feet from the floor. NA-A stated for a few days following the fall, R1 had seemed her normal self, then started having pain. NA-A stated following the fall she met with the administrator and the director of nursing (DON) and received education related to following the plan of care and had to complete a packet of training as well as online training. During interview on 5/18/26 at approximately 1:30 p.m., registered nurse (RN)-A stated prior to R1's fall she had not been able to bear weight and had contractures (a permanent or semi-permanent tightening of muscles, tendons, skin, or other soft tissues that cause joints to become stiff and restrict normal movement). RN-A said after R1 fell; she had a CT scan of her pelvis. RN-A said the fracture had not been identified during the CT scan. RN-A stated since the fall, R1had to remain in bed because she was unable to use the mechanical lift due to the fracture. During interview on 5/18/26 at 1:42 p.m., the DON stated NA-A lifted R1's bed to perform cares. When NA-A stepped out to get help, R1 fell out of bed. The DON stated staff received education related to following the care plan. Audits were implemented related to awareness of the care plan, following the care plan and following safety interventions. During interview on 5/18/26 at 2:08 p.m., the medical director (MD) stated R1 had fallen and had a CT performed which showed no fracture. MD said R1 displayed high anxiety and difficulty communicating. A few days after the fall, R1 had increased pain and x-rays showed a fracture. The MD stated the fracture was a result of R1's fall from bed. Facility policy Care Planning - Care Conferences dated 9/15/25, indicated direct care staff are expected to follow the care plan as written to provide consistent, safe, resident centered care. Following the care plan supports the residents' highest practicable level of physical, mental and psychosocial well-being. The Past Noncompliance began on 4/22/26 when NA-A left R1 unattended with her bed raised to working height resulting in R1 falling from the bed and sustaining a femur fracture. The deficient practice was corrected by 4/23/26, 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, safety interventions and care plan awareness.^ The education was verified through interview and document review.