STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson Memorial Hosp & Home	1290 Locust Street Dawson, MN 56232

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** Based on interview and document review the facility failed to assess and monitor injuries after a fall, provide pain relieving treatment and physician notification for 1 of 1 resident (R1) who had a fall with a hip fracture that required surgical repair. This resulted in harm when R1's pain was not comprehensively assessed for eight hours after R1 reported and displayed severe pain causing delay in pain relief and medical attention. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's face sheet dated 1/22/25, identified R1 had diagnoses that included, parkinsonism (neurodegenerative disorder that causes tremors, stiffness, and slow movement), dementia, and Picks Disease (a degenerative brain disease that affects individuals under [AGE] years old). R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was admitted to the facility on [DATE], and had moderate cognitive impairment with no noted behaviors. R1 was dependent on facility staff for eating, toileting, dressing, personal hygiene, bed mobility, transfers, and walking. R1 did not receive scheduled or as needed pain medication and did not have reports of pain during the assessment period. R1's care plan printed on 1/22/25, indicated R1 had a diagnosis of dementia and primary progressive aphasia (language disorder that affects a person's ability to communicate). R1 required two staff assist and mechanical lift for all transfers; two staff assist and walker, gait belt, and wheelchair behind for walking and staff may have to steer the walker. The fall care plan identified R1 is a high risk for falls due to balance problems, poor communication/comprehension, and unaware of safety needs. R1's progress notes titled Late Entry dated 1/15/25 at 5:50 p.m., indicated R1 was found on the floor lying on his back; three staff transferred resident to his wheelchair, brought him to the side of the bed to stand and assisted R1 to bed. The note indicated R1 denied pain but was noted to have a red area on right lower back. R1's record did not address any further monitoring and assessment for injuries as a result of the fall until 1/16/25 at 8:43 a.m. almost 14 hours after the fall occurred. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson Memorial Hosp & Home	1290 Locust Street Dawson, MN 56232

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	R1's progress notes dated 1/16/25 at 8:43 a.m., indicated the oncoming day shift nursing assistant (NA) was notified by the night shift NA that R1's right leg was hurting. When the NA tried to put his sock on, he jumped and indicated he had pain. R1 was assessed and on-call provider notified and ordered x-rays. R1's progress notes on 1/16/25 at 4:39 p.m., identified R1 was admitted to the hospital due to finding of acute nondisplaced fracture of the proximal femur involving femoral neck and intertrochanteric regions (right hip fracture) and was scheduled for surgery on 1/17/25. R1's emergency department (ED) Provider Note dated 1/16/25, identified R1 was being seen for concerns of right hip pain after an unwitnessed fall out of bed the evening prior. The note further identified R1 was diagnosed with a closed right hip fracture with surgical repair scheduled for 1/17/25. R1's medication administration record (MAR) was reviewed between 1/15/25 through 1/16/25. The MAR identified no additional pain medication was given after his scheduled dose of Tylenol at 5:00 p.m. prior to the fall in which documentation identified R1 did not have any pain. The MAR identified R1 received his regular scheduled dose of Tylenol on 1/16/25, at approximately 8:00 a.m. in which documentation identified pain rating of 5 with no further pain assessment completed. During an interview on 1/21/25 at 2:25 p.m., licensed practical nurse (LPN)-A indicated she worked the evening and night shift on 1/15/25, it was a very busy night. LPN-A was notified by nursing assistant (NA)-A at approximately 7:10 p.m., that R1 had fallen, was agitated, and scooting around on the floor. LPN-A identified she assessed R1, and noted a little bit of redness on the right hip but thought it could have been a rash and did not note any symptoms of pain. NA-A assisted R1 to stand up and put him back to bed. LPN-A was notified on 1/16/25 at approximately 5:00 a.m. that R1 was having pain but did not check on him nor did she give R1 anything for pain. LPN-A stated, I didn't do anything, however she did report to the oncoming shift nurse that R1 had some pain but did not tell them that R1 had fallen the night before, stating, I completely forgot. During an interview on 1/22/25 at 9:35 a.m., NA-B indicated on 1/15/25 she started her shift at 10:30 p.m., typically the on-coming NA's would get report from the prior shift. NA-B explained she did not get report from NA-A, so NA-B had no awareness R1 had fallen earlier that evening. When NA-B did her first check shortly after 10:30 p.m., R1 seemed ok. At 12:30 a.m. while attempting to change R1's incontinent pad, R1 was having pain, he was screaming telling her he was in pain and had facial grimaces, however NA-B indicated an unawareness of where R1's pain was originating from. NA-B stopped what she was doing, then called for NA-A to assist with the repositioning to complete incontinent care. NA-A came to help, however, having a second person did not help alleviate R1's pain; R1 continued to yell out in pain and had facial grimaces. NA-A still had not disclosed to NA-B that R1 had a fall. Immediately after they had finished personal cares, NA-B notified LPN-A by text message that R1 was having pain and requested pain medication. NA-B stated, LPN-A told her No to the pain medication and was not aware if LPN-A had checked on R1 after that. NA-B indicated at approximately 4:30 a.m., R1 was restless and continued to have pain. NA-B again requested NA-A to assist with cares. NA-B stated R1 was making faces like he was in pain again, so she again reported to LPN-A that he was having pain and was told by LPN-A she would pass it on [to the dayshift] in the morning. NA-B indicated R1 was usually smiley and did not have signs that he was pain, so it was a definite change for him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson Memorial Hosp & Home	1290 Locust Street Dawson, MN 56232

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	During an interview on 1/22/25 at 12:10 p.m., LPN-B identified she worked the morning shift on 1/16/25 and received morning shift to shift report that R1 did not sleep well the night before. LPN-B further identified later that morning she was notified that R1 was having some pain and that he had pain during the over night shift. LPN-B stated this was the first I heard of his [R1] pain LPN-B assessed R1 and could tell he was in pain, notified the provider, told the NA's not to move him. LPN-B indicated the medical record lacked any of reports of R1's pain, R1's falls the evening prior, or the required paperwork, notifications, and follow up after a resident fall. During an interview on 1/22/25 at 12:20 p.m., the director of nursing (DON) identified that although NA-A and LPN-A were aware and responded to R1's fall on 1/15/25, they did not complete the assessment, notifications, and follow up after the fall. Further identified the facility was made aware of R1's fall by his family who witnessed the fall on the security camera in his room. DON indicated the facility immediately notified the physician when they became aware and completed a thorough investigation. Additionally, the facility provided coaching to staff involved and provided education to all staff on chain of command, documentation, vulnerable adults policy and reporting; shift report process; fall management, documentation, and follow-up. The following facility's corrective actions dated 1/16/25 were verified as implemented prior to the survey: -Assessed and notified provider of R1's change in condition. -The facility completed a thorough investigation that identified the facility falls and notifications policies were not followed. Further identified R1's severe pain was not assessed, monitored or treated. -Provided coaching and corrective action to LPN-A, NA-A, and NA-B -Provided education to all staff on chain of command, documentation, vulnerable adults policy and reporting; shift report process; fall management, documentation, and follow-up. Review of the facility policy Pain Management last revised 7/2023, indicated a pain assessment would be completed for all residents when there is a change of condition, or onset of new unrelieved or persistent pain or when staff assessment shows any indicators of pain, including: non-verbal sounds, vocal complaints, facial expressions, protective body movements or postures. Review of the facility's undated Fall Check List and Monitoring Sheet indicated the following steps: Obtain full set of vitals and document Perform full assessment of elder and document Initiate neuros for suspected head injury or any unwitnessed fall Notify DON of every fall immediately day or night. Notify family/veteran group/hospice (if applicable) and document in PCC on fall report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson Memorial Hosp & Home	1290 Locust Street Dawson, MN 56232

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	The DON or registered nurse (RN) on-call only need be notified if there is injury or have concerns Review of the facility policy Notification of Changes in Resident's Condition last revised 11/2019, indicated it is the policy of the facility to inform resident, physician, family/legal representative of an abrupt change in resident condition. The procedure is as follows: Licensed nursing staff will: Assess any changes noted through direct observations Obtain and a complete set of vital signs at the onset of the change and/or at four-hour intervals and /or more often as appropriate/ordered. Obtain any other data necessary for a complete assessment and/or per policy specific to the type of change and/or as ordered by the physician. Notify the resident of the change and assessment findings. Notify the physician of the change and after hours the physician on-call of the change base on the On-Call Physician Policy. If a mess is left continue follow-up every ½ to 4 hours depending on the significance of the change Notify the resident's legal representative and/or designated person of the changes and follow up done by facility and/or physician. Document all assessment data, observations, and notification of resident, family, and physician. Address the change on a temporary care plan for follow through by the next shifts. Follow up should continue as indicated in the policy specific to the change or as order by the physician. The resident, physician, and family should be updated about the resident's status. Update the care plan as needed.