STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hills Living Center	1314 Eighth Street North New Ulm, MN 56073

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 interview and document review the facility failed to implement a known safety intervention of a gait belt when ambulating a resident to prevent accident hazards for 1 of 1 residents (R1) who had a fall with major injury. This resulted in harm when R1 sustained a femur fracture. The facility corrected the deficiency prior to the survey, so the citation was issued at past non-compliance. Findings include: R1's face sheet dated 5/23/25, identified diagnoses of type 2 diabetes (condition that affects how the body uses insulin and sugar), peripheral vascular disease (narrowed arteries reduce blood flow to the arms or legs), absence of right foot, edema (swelling), and open-angle glaucoma (gradual vision loss leading to blindness). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 did not have any memory loss issues. R1 required supervision or touching assistance to walk. R1's care plan dated 4/8/21, identified R1 required use of a gait belt, walker, and assistance of one person for transfers. Walking/ambulation created on 4/9/25, identified R1 required a transfer belt for ambulating, one staff member, and a front wheeled walker. R1 was to push off arm rests to stand and reach back before sitting down. R1 required limited assistance of one person. Staff were to bring wheelchair behind R1 when walking. R1's progress note dated 5/21/25 at 6:35 p.m., identified R1 fell on 5/21/25 at 5:00p.m. R1 was noted to be lying semi on left side and semi on stomach in the middle of the floor. R1's left leg was bent under the right leg, which was straight. R1 was wearing a gait belt and had on non-slip shoes. Wheelchair was directly behind her and R1 was being walked by a nursing assistant. R1 stated she was going for a walk and removed her hand from the walker to scratch her nose and fell. R1 was unable to roll onto her back. Emergency medical team was notified and R1 was transferred to hospital for further evaluation at 5:15 p.m. R1's progress note dated 5/21/25 at 10:09 p.m., identified the hospital notified facility that R1 had a broken femur (proximal part)/hip and will have surgical intervention. R1's hospital history and physical dated 5/22/25, identified R1 had a displaced fracture of the left proximal femur/hip. R1 was a candidate for surgery and the plan was to return to facility after surgery. R1 returned to facility after surgery on 5/27/25. (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
	245490	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hills Living Center	1314 Eighth Street North New Ulm, MN 56073

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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 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Post incident response to fall dated 5/23/25, identified care plan was not followed at time of incident, and education provided to staff involved. During an interview on 6/17/25 at 2:38 p.m., nursing assistant (NA)-A stated this was her first time ambulating with R1, and NA-A was not sure how R1's balance was prior to walking her. NA-A placed the gait belt on R1, and had R1 walk with her walker while she pushed the wheelchair behind R1 in case R1 would fall backwards. NA-A stated R1 took her hand off the walker to clean her eye and fell sideways. NA-A was not able to assist R1 to the floor. NA-A was unaware that the gait belt should be held while assisting residents to walk and not just put the gait belt on while staff push the wheelchair behind residents. After the incident NA-A was educated to hold the gait belt and the wheelchair when walking a resident. During an interview on 6/18/25 at 12:19 p.m., R1 stated on 5/21/25, she was walking and let go of the walker with one hand, R1 thought it was to itch her nose, and she fell. R1 was unsure if NA-A was holding the gait belt during the incident. During an interview on 6/17/25 at 1:56 p.m., physical therapist (PT)-A stated R1 had been assist of one with front wheeled walker since 12/21 and had not been on case load since that time. PT-A explained when walking with residents who require staff assistants the expection was for staff to hold onto the gait belt at all times to prevent falls. During an interview on 6/17/25 at 2:17 p.m., NA-B stated staff are to walk residents with a gait belt and pull the wheelchair behind. The staff had continued education after R1 fell and managers are always watching staff walk residents. During an interview on 6/18/25 at 12:02 p.m., registered nurse (RN)-A stated the nurse working the floor decides an immediate intervention for a resident that falls. The nurse will review with NA's and notify family of intervention. The Interdisciplinary Team (IDT) consists of management staff and they will review the details of the fall and interventions to determine causal factors and if an intervention needs adjusted. During an interview on 6/18/25 at 12:34 a.m., director of nursing (DON) stated individual education was provided to NA-A on 5/22/25. The clinical educator, and designees, completed competencies with nursing staff on 5/29/25 and documented them on a spreadsheet. Yearly nursing assistant training competencies were completed on 6/17/25 and 6/18/25. Nursing staff competencies were completed every six months with all staff. The facility has been working on falls and fall prevention for over a year. The facility Group Team Member Education/Counseling Form undated, identified all staff members will ambulate residents correctly with a gait belt by holding on to the gait belt for the duration of the walking activity until resident is safely back on a seated surface. Staff must hold on to the gait belt with an upwards grasp throughout the entire time the resident is being walked. If a resident required a wheelchair behind while walking, staff should either pull the wheelchair while holding on to the gait belt or ask a co-worker to push the wheelchair while the resident is being walked.