STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Manor	410 South McKinley Street Warren, MN 56762

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to update the care plan and implement care plan interventions for 1 of 3 residents (R1) reviewed for care plan updates and implementation.Findings include:R1's admission Minimal Data Set (MDS) dated [DATE], identified severely impaired cognition without behaviors. R1 required partial to moderate assistance for sit to stand, substantial/maximal assistance with toileting hygiene, lying to sitting on bedside, all transfers, unable to walk, and used a manual wheelchair for mobility. R1's diagnoses included fractures, anemia, non-Alzheimer's dementia, and anxiety. R1 used a bed alarm daily.R1's Fall Risk assessment dated [DATE] at 8:32 a.m., identified a score of 12 and indicated high risk for falls. R1 was disoriented, had one to two falls in past three months, was chair bond, and continent. Clinical suggestions: rubber-soled shoes or nonskid slippers worn for ambulation, utilizing toileting program and personal/pressure sensor alarms.Recliner Use and Potential Physical Restraint Determination completed on 5/18/26, identified purpose of recliner use was behavioral management and fall prevention. R1 made aware of these and agreed to sit in common area for safety monitoring. Care Plan Compliance: recliner use is included in care plan, goal of use is clearly defined (comfort, positioning, etcetera), and care plan updated with changes in condition. Recliner supports clinical goal: positioning/comfort. R1's Falls care plan dated 5/26/26, identified: Silent bed alarm. Date initiated: 5/14/26.Place call light within reach and remind R1 to use it for assistance for safety. Date initiated: 5/14/26.Fall mat to side of bed and bed at lowest position. Date initiated: 5/18/26.Assist to the recliner in the common area as needed (PRN) for comfort, correct positioning and evaluation of bilateral edema to alleviate edema. Date initiated 5/18/26.Anticipate needs due to self-transfers. Date revised: 6/17/26.R1's care plan failed to include the following information: tab alarm as an intervention for falls, direction to keep R1 out of her room as an intervention for falls and recliner in commons area as an intervention for behavior management.During an interview on 6/23/26 at 12:31 p.m., NA-D stated R1 had dementia, self-transferred, and was a high risk for falls. R1 was a stand pivot with assist of two at first then changed to assist of one, and staff were not to be walking her, no weight was to be placed on her right leg/foot due to the fracture. NA-D stated staff were expected to follow the care plan and/or Kardex located on the computer: keep a close eye on her, prevent her from being left in her room alone, and use bed and chair alarms to let staff know she was trying to self-transfer. NA-D stated she had caught R1 many times in her wheelchair after she had self-transferred, R1 had forgotten about her fractured hip.During an interview on 6/23/26 at 1:30 p.m., NA-B stated R1 was a high risk for falls and staff used a bed alarm, chair alarm, and parked her in the commons area to keep a close watch on her. R1 was not to be left in her room alone. NA-B stated there were times when R1 self-transferred in her room while she worked and unable to remember if she attached the chair alarm to R1's clothing 6/11/26. NA-B stated on 5/27/26, she was working, applied the chair alarm to R1's clothing and later heard over the walkie R1 had self-transferred herself in the commons area and fell.During an interview on 6/24/26 at 2:00 a.m., RN-A stated R1 was confused, oriented to self only, and high risk for falls. R1 had a total of three or four falls since admission while she tried to self-transfer. RN-A (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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	stated R1's interventions in place to help prevent falls: stand pivot with assist of two staff to keep her safe due to TTWB (toe-touch weight bearing), decreased cognition, and impulsiveness. R1's additional interventions included bed alarm, chair alarm, and fall mat on both sides on the floor by the bed.During an interview on 6/24/26 at 2:20 p.m., RN-C stated R1 was impulsive, poor memory, needed constant reminders to not self-transfer, and lacked safety awareness. R1's interventions included in her care plan: appropriate footwear, fall mat, TTWB, call light, and assist with sitting in recliner in commons area. RN-C stated the chair tabs alarm was not included on the care plan and should have been so the alarm was placed by staff to help prevent falls. Staff would be expected to follow the care plan.During an interview on 6/24/26 at 2:55 p.m., LPN-A stated on 5/18/26, R1 had an unwitnessed fall in her room by the bathroom, and the chair alarm was not connected. LPN-A stated the chair alarm was usually clipped to R1's back, she may have removed it herself but was unsure if she could have reached it or remembered it was there. LPN-A stated the NA was asked and she indicated she had placed the chair tabs alarm on R1. LPN-A stated on 6/11/26, around 6:50 p.m., she had seen R1 before she went on break in her wheelchair with her legs elevated and wedge positioned between her legs. LPN-A went on break and came back at 7:23 p.m. and saw R1 wheeling herself down the hallway with no wedge between her legs, with her feet on the footrests in down position, knees bent. LPN-A stated she was quite surprised when R1 informed her she had taken herself to the bathroom and removed the wedge from between her legs. LPN-A stated R1's chair tabs alarm was not attached to R1's clothing and clipped on the back of the wheelchair instead. LPN-A asked NA about the tab alarm and she admitted she had forgotten to attach it to the resident.During an interview on 6/24/26 at 4:30 p.m., LPN-B stated R1 attempted to self-transfer many times and lacked safety awareness. LPN-B stated there was a time when she observed R1 had self-transferred and pushed the wheelchair while she walked behind it independently from the dining room. Additionally, R1 was known to self-transfer out of bed on the night shift, taking herself to the bathroom, and staff were aware of the need to keep eyes on her to help prevent a fall. R1 started to fall right after admission to the facility, she was not to be left in her room alone so staff could have kept a closer watch on her. LPN-B stated R1's care plan did not include a chair tabs alarm or direction keep resident out of her room to prevent falls. Staff were expected to follow R1's care plan otherwise she would have been placed at risk for a fall or injury to the hip.During an interview on 6/25/26 at 2:00 p.m., director of nursing (DON) stated she expected staff to follow R1's care plan. DON stated staff had constantly reminded R1 she had a fractured leg/hip, had surgery, and restrictions on weight she could have placed on the right foot. DON stated once the chair tabs alarm was in place it should have been added to the care plan, within one hour, so staff would know how to provide care for R1. A tab alarm was used to alert staff when R1 was attempting to transfer herself out of the wheelchair. DON stated the chair tabs alarm should have been placed on her back, out of reach, and the string needed to be shortened. R1 was unable to self-transfer safely, did not know what to do or comprehend what the restrictions were. DON stated contributing factors that led to R1's fall were confusion, infection, anemia, unsteady balance, and possibly pain.Facility policy Care Planning/Interdisciplinary Team dated 6/9/26, identified development of an individualized comprehensive care plan shall be completed for each resident. The interdisciplinary team must review and update the care plan: when there has been a significant change in the resident's condition, the desired outcome is not met, the resident has been readmitted to the facility from a hospital stay and at least quarterly in conjunction with the required quarterly MDS assessment. The care plan serves as the resident's individualized plan of care and provides direction for safe and appropriate care delivery. All staff are required to review, understand, and follow each resident's current care plan at all times. Failure to follow a resident's care plan may result in corrective action, up to and including immediate removal from duty for the remainder of the shift, re-education, competency testing, disciplinary action, termination of employment, and/or the filing of a Vulnerable Adult (VA) report when warranted such as if a resident experienced injury, harm, or potential harm, and an investigation completed. Any instance in which a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident's care plan is not followed must be reported immediately to the charge nurse or supervisor for assessment, follow-up, and documentation.

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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 Note: The nursing home is disputing this citation.	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 record review the facility failed to provide care and supervision consistent with resident's needs, orders, and care plan to eliminate the risk of an accident during cares for 1 of 3 residents (R1) reviewed for falls. R1 needed increased monitoring for safety due to four previous falls at the facility, strict posterior hip precautions, and was unable to ambulate with nursing staff due to non-weight bearing status of right leg. This resulted in actual harm to R1 when RN-A was aware of the ambulation status, assisted R1 to the bathroom with walker and heard a popping sound during ambulation. This resulted in swelling of R1's right leg and complaints of increased pain. R1 was sent to the hospital for evaluation and required a closed reduction of the right hip related to dislocation. The facility had implemented actions to prevent recurrence prior to the survey on 6/23/26, therefore, the citation was issued at past non-compliance. Findings include:R1's admission Minimal Data Set (MDS) dated [DATE], identified severely impaired cognition without behaviors. R1 required supervision or touching assistance with personal hygiene, partial to moderate assistance for sit to stand, substantial/maximal assistance with toileting hygiene, upper and lower body dressing, lying to sitting on bedside, all transfers, was dependent on staff for shower/bathing, was unable to walk, and used a manual wheelchair for mobility. R1 was occasionally incontinent of bowl and bladder. R1's diagnoses included fractures, non-Alzheimer's dementia, and anxiety. R1 had a surgical wound. R1 used a bed alarm daily.Operative note dated 5/10/26, written by orthopedic surgeon medical doctor (MD)-A identified:Pre-operative diagnoses: right hip pain, right proximal femoral periprosthetic femur fracture (fracture occurring around or near a hip prosthesis) involving the subtrochanteric region (area of the femur that lies just below the junction of the femoral neck and shaft) and diaphysis (the shaft or central part of long bone). Displaced (broken pieces of bone are not aligned properly). Closed (break in bone that does not pierce the skin). Status post right hip replacement. Ground level fall.This patient was going to be admitted to hospital with a 30-pound weight/bearing limit for about 8 weeks; will have posterior hip precautions for the same amount of time.Hospital occupational therapy (OT) treatment note dated 5/13/26 at 2:51 p.m., identified precautions: bed/chair alarm, fall risk, right lower extremity posterior hip (back of the hip) precautions, troch off precautions (no abduction-movement of leg away from the midline of the body), and 30-pound flat foot (able to rest entire foot on the ground while standing). Do not bend past 90 degrees or lift your knee higher than your hip. Do not cross your legs at the knees or ankles. When getting out of bed keep shoulders, knees, and hips in straight line to avoid twisting. R1 required moderate cues to comply with her hip precautions.R1's right hip and pelvis X-ray dated 5/11/26 at 9:52 p.m., identified reason for exam: post op (operative). Findings: osteopenia (lower-than-normal bone density), right hip arthroplasty (joint replacement surgery). Left hip degenerative change. Postoperative changes over the right hip. Impression: right hip arthroplasty without complications.R1's total hip replacement discharge instructions dated 5/14/26, identified:30 pounds weight bearing for the next 8 weeks with posterior hip precautions.When to contact your healthcare provider: if hip pain gets worse, if incision became red, swollen, warm to touch, had increased drainage, or foul-smelling odor, and if you happen to fall and have pain.Weight bearing status: partial- right 30-pound weight bearing.Assistive device: walker /one person.Cognition: Forgetful, poor judgement, poor safety awareness, poor attention/concentration.Pain level: last filed on 5/14/26 at 7:43 a.m., right hip pain 8 out of 10.R1's care plan dated 5/26/26, identified:Bed Alarm. Silent bed alarm due to history of falls while attempting to leave her bed. R1 agreed to the alarm and being safe. Date initiated: 5/14/26.Staff were instructed to place bed alarm on. Date initiated: 5/14/26R1 had cognitive loss/dementia with memory impairment which varied throughout the day. Date initiated: 5/26/26.Staff were directed to use yes or no questions to determine R1's needs, and task segmentation (break tasks into one step at a time) to support short-term memory deficits. Cue, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	reorient, and supervise as needed. Date initiated: 5/26/26.R1 was extensive assistance with activities of daily living (ADLS) due to decreased mobility related to right hip surgery, and fluctuating cognition. Date initiated: 5/14/26.R1 was unable to ambulate with nursing staff due to her non-weight bearing status of her right leg. Date initiated 5/14/26.Bed mobility: R1 required partial assistance of one staff for turning and repositioning in bed. Date initiated: 5/14/26.Staff were instructed to encourage R1 to use bell to call for assistance.R1 required substantial assistance of two staff for toileting and to move between surfaces. Date initiated: 5/14/26. Date revised 5/26/26,Substantial assistance of one staff. Date revised 5/26/26R1 was at risk for fall due to recent right hip surgery and non-weight bearing with right hip. Date initiated 5/14/26.Silent bed alarm. Date initiated: 5/14/26.Place call light within reach and remind R1 to use it for assistance for safety. Date initiated: 5/14/26.Non-weight bearing on her right leg. Date initiated: 5/14/26. End date 5/18/26.Toe touch bearing at this time with the right leg. Date revised 5/18/26Fall mat added to side of bed and bed at lowest position. Date initiated: 5/18/26.Assist to the recliner in the common area as needed (PRN) for comfort, correct positioning and evaluation of bilateral edema to alleviate edema. Date initiated 5/18/26.Pain related to fracture and post-surgery of the right hip. Date initiated 5/14/26.Reposition R1, pillow support, and/or ice to right hip. Date initiated: 5/14/26.Use pain scale 0 to 10 due to intermittent confusion. Date initiated 5/20/26.R1's Fall Risk assessment dated [DATE] at 8:32 a.m., identified a score of 12 and indicated high risk for falls. R1 was disoriented, had one to two falls in past three months, was chair bound, and continent. Clinical suggestions: rubber-soled shoes or nonskid slippers worn for ambulation, utilizing toileting program and personal/pressure sensor alarms. R1's St. Louis University Mental Status (SLUMS) examination (examination used to detect mild cognition impairment and dementia) dated 5/18/26, identified a score of 14 out of 30 (score of 1 to 20 points indicates dementia).R1's progress notes dated from 5/14/26 through 6/19/26, identified:5/14/26 at 2:10 p.m., [AGE] year-old female admitted from hospital accompanied by husband. Admitting diagnosis was periprosthetic fracture around the internal prosthetic joint (break in the bone that occurs around or very close to an internal prosthetic joint), subsequent encounter. Other diagnoses included anxiety disorder, dementia, irritable bowel syndrome, and anemia. Has some short-term memory impairment with periods of confusion and needs cueing. Has pain in right hip radiating down right leg at 3 out of 10, relieved by pain medications, repositioning, pillow support, or ice. Transfers with assist of two, non-weight bearing on right leg so does not ambulate currently. High risk for falls due to non-weight bearing status of right hip and hip pain.5/14/26 at 10:16 p.m., R1 had been restless and self-transferred from bed several times. Brought out to nurse's station for closer observation.5/16/26 at 11:35 a.m., R1 was witnessed walking down hallway after activities today. Writer was notified and assisted R1 back into wheelchair. Reminded R1 of her fracture, which she did not remember, but did note soreness to right leg, rated pain at 5 out of 10. Chair alarm did not alert as it was not clipped on properly: staff re-educated on proper use. Currently in commons area with chair alarm attached, waiting for lunch.5/17/26 at 1:04 a.m., R1 was found on the floor on her knees by her bed with walker in front of her. She stated she was trying to point to something, I don't know. Ativan (antianxiety medication) was given two hours before fall for restlessness. Earlier, she was assisted to bed for lower extremity elevation for non-pitting edema (fluid swelling that does not leave indentation when pressure is applied to the skin) and color change to RLE (right lower extremity). She was a poor historian. Denied pain and no injuries noted at this time. Provider on call notified and ordered urinalysis to rule out urinary tract infection (UTI).5/18/26 at 9:01 a.m., R1 was significantly more confused later in the day and had poor safety awareness and despite multiple reminders during the day of her weight bearing status on her right leg, she had several episodes of getting up and ambulating independently: sometimes without assistive device, walker or pushing her wheelchair. Her weight bearing status was toe touch.5/18/26 at 10:29 p.m., Late entry. Writer was called to R1's room by NA (nursing assistant) and found resident with head in entry way of the bathroom and feet towards the bed. She denied pain and no BLE (bilateral lower extremity) abnormalities noted. She was (continued on next page)

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She landed on her back per staff member observing from a distance. She denied pain and/or discomfort at this time. Notified provider. Chair alarm went off as she fell to the floor. Cord to chair alarm shortened as intervention to alert staff if she attempted to self-transfer.6/3/26 at 5:03 p.m., Care conference identified she participated in skilled therapy: PT/OT (physical therapy/occupational therapy), where she ambulated with front wheeled walker 40 feet with two staff assistance.6/4/26 at 5:51 a.m., R1 was assisted to the restroom this morning. She ambulated with walker and maintained TTWB. A popping sound was heard to the right hip area when she took a step, and she reported some discomfort. Wheelchair was used to assist her back to bed. Right lower extremity swelling was noted. Ice pack applied to site. Numbness and tingling denied, and no discoloration noted.6/4/26 at 5:52 a.m., Writer was walking down the hallway and heard R1 yelling out for help. Writer entered her room and found her with feet on the floor mat and in the process of standing up. [NAME] was beside the bed; wheelchair was on the other side of the room. Due to her standing and not wanting to wait to use bathroom, unable to redirect, writer grabbed the walker. She used the restroom, then was assisted into the wheelchair, brought back to bed and complained of right hip discomfort. She had been having increased pain for a few days6/4/26 at 8:45 a.m., R1 sat in wheelchair leaning to the left to take weight off her right hip. She reported her right hip was very sore but unable to rate her pain. She was assisted to the toilet in her room, able to follow directions of TTWB but was grimacing in pain with every movement. Her right leg had doubled in size of her left and was warm to the touch from toe to knee. She stated her right hip and thigh really hurt. No discoloration noted. Saw provider yesterday who prescribed antibiotics for cellulitis (bacterial skin infection that causes redness, swelling, pain and warmth in the affected skin layers) of the right leg. Called clinic and spoke to his nurse. Asked if an x-ray was warranted.6/4/26 at 6:09 a.m., Received call back from clinic nurse and provider wanted her to be seen at local emergency department (ED). Her right leg remained very swollen and painful. It appeared to be internally rotated, and she was unable to straighten her leg. She was transferred from bed to wheelchair with Hoyer lift and brought over to the ED at 9:25 a.m.6/4/26 at 12:06 p.m., Spoke to registered nurse (RN) at ED. Update received: Her hip prosthesis was dislocated, no fracture to femur. She was being transferred to another hospital for further evaluation and probable surgical intervention.6/6/26 at 12:36 p.m., Called hospital for an update. R1 underwent anesthesia yesterday and they popped her hip back into place. She was a pivot transfer (mobility technique used to move a person limited mobility from one sitting surface to another) with a 30-pound weight-bearing restriction.Email titled Potential Issue with Therapy Notes /RN, dated 6/4/26 at 5:48 p.m., identified:5/28/26, Resident fell the prior night- pain in RLE 5-6/10 with walking. Walked 100-125 feet.5/29/26, Communication from nursing staff reported the patient is no longer allowed in her room by herself due to self-transferring and non-compliance with TTWB, four falls this week.6/1/26, Ambulation with FWW, TTWB to RLE 150 feet. Did she have one step where she did not comply with the TTWB but did not have pain. 6/2/26, Ambulated 175 feet with FWW TTWB. Verbal cues to maintain WB. Reports mild pain.6/3/26, Documented resident was having more pain in right hip and thigh today. Trying to go to the MD. Able to walk only about 15 feet due to pain. Pain reported 10/10 when walking.PT evaluation and plan of treatment dated 5/14/26, R1's baseline ambulation contact guard assistance (CTG) (physical contact to maintain balance and prevent falls, but the patient performs 100% of the physical effort), when allowed to bear weight, of (continued on next page)

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Transfers: moderate assist ([NAME]) of one with stand pivot transfer using FWW.R1's PT progress reports from 5/28/26 through 6/8/26, identified:5/28/26 at 3:07 p.m., R1 fell again last night and had pain in RLE 5 to 6 out of 10 while walking. Placed alarm back on her after therapy and left in dining room for bingo and coffee.6/1/26, at 3:23 p.m., R1 ambulated with FWW, TTWB to the RLE 100 feet with CGA. R1 had one step where she did not comply with TTWB, did not have any pain to mild pain but with cues did follow through.6/8/26, at 3:41 p.m., PT completed a thorough chart review and completed evaluation: R1 must always have abductor pad in place in bed and wheelchair, wearing right knee immobilizer, avoid hip abduction and monitor. Total hip arthroplasty posterior precautions and troch precautions per hospital notes. In the midafternoon, spouse, asked PT to come in room as abductor pad was not on right and her feet were not on the pedals. PT turned the abductor pad around to make it narrower, and this allowed her feet on the pedals but kept her LE's abducted and updated rehab manager.OT evaluation and plan of treatment dated 5/15/26 at 9:19 a.m., identified referred to therapy as new admission to facility. R1 fell on 5/2/26 and resulted in an open reduction and internal fixation (ORIF), then fell again on 5/9/26, and had surgery for periprosthetic (a broken bone around the components of the total hip replacement) and was TTWB. R1 was limited by cognition. R1 rated her RLE pain at 8 out of 10. Evaluation Summary identified physical/cognitive/psychosocial performance: R1 presented with impairments in balance, dexterity, gross motor coordination, mobility, sensation, strength, attention, follow through, planning, problem solving, self-modification and self-monitoring resulting in limitations and/or participation restrictions in the areas of general tasks and demand, mobility and self-care.R1's OT treatment encounters from 5/28/26 through 6/3/26, identified:5/28/26 at 2:51 p.m., R1 reported increase in right hip pain during ambulation.6/3/26 at 3:30 p.m., R1 required total assistance to raise lower extremity to doff shoes. R1 reported increase in right hip pain incision and had seen MD this afternoon with possible infection.R1's primary provider, medical doctor (MD)-A, progress notes dated 6/2/26, identified R1 had been stable, main issue continued to be her confusion/dementia which resulted in her trying to walk without assistance and had ended in multiple falls. R1 fell four times in the last two months. One of the falls resulted in a refracture of the femur fracture that required ORIF. R1's physical exam identified: slowed behavior, thought process was delusional, impaired cognition and judgement, tenderness and signs of injury present, motor weakness and abnormal gait present.R1's ED notes dated 6/4/26 at 9:34 a.m., [AGE] year-old female presented to emergency room with dementia from LTC (long term care) with complaints of right hip pain. R1 was recovering from a right total hip arthroplasty (RTHA) and seen at clinic yesterday and started on oral antibiotics for incisional infection/cellulitis. Staff stated they heard a pop when moving R1 this morning, noted significant swelling today, worsening redness, and intolerant to any movement to right hip due to pain. Pain was reported per nursing as significantly worse than previously noted. R1's physical exam identified: right lateral incision revealed swelling, tenderness, redness, and pain. No open area or drainage noted. Cellulitis surrounding incision noted. R1 was discharged at 12:25 p.m. and transferred to another hospital via emergency medical services (EMS).R1's CT of right hip dated 6/4/26 at 11:18 a.m., confirmed dislocated right hip prothesis. Femoral ball completely, superiorly dislocated (femoral head migrated upward) from the acetabular cup (prosthetic socket component used in a total hip replacement/arthroplasty). A large indistinct fluid collection ventral (front) from the proximal femur (upper thigh bone) likely from the prior evacuated (previous opening) hip joint space into the proximal thigh musculature (nearby thigh muscles) and maybe hematoma or abscess. (continued on next page)

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	245550	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Manor	410 South McKinley Street Warren, MN 56762

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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 Note: The nursing home is disputing this citation.	Cellulitis laterally.R1's hospital admission history and physical dated 6/4/26 at 5:14 p.m., identified presented with increased pain right hip with fever and redness over wound. R1 had been doing well until yesterday. Pain noted in the right hip, with some redness and swelling. Right thigh is larger than the left. R1 cannot lift the right leg off the bed which she was able to previously. R1 had slight fever yesterday and worsened hip pain today. Hemoglobin 6.8 (normal range 11.2 -15.5 grams/deciliters (gr/dL) and computed tomography (CT) scan (imaging procedure that used specialized x-ray equipment and computers to create detailed cross-sectional images of bones, organs, and soft tissues) results: dislocated right hip prosthesis and large fluid collection ventral side extending inferior from the field of view maybe hematoma or abscess. Cellulitis laterally.Facility incident report filed with State Agency (SA) on 6/4/26 at 12:10 p.m., identified on 6/4/26 at 5:51 a.m., R1 was assisted to bathroom, ambulated with walker, maintained toe touch weight bearing (TTWB) and popping noise was heard to right hip area when R1 took a step. R1 reported some discomfort. Swelling noted to right lower extremity. R1 sat in wheelchair while she ate breakfast, leaned to the left to take weight off right hip and reported right hip was very sore. R1 was assisted to bathroom after breakfast, able to follow directions of toe touch weight bearing on right leg but was grimacing in pain with every movement. R1's right leg had doubled in size of left leg and warm to the touch from toe to knee. R1 sat on toilet, leaned to the left and unable to put weight on her right hip. Provider contacted and informed nurse of the above and asked if an x-ray was warranted. Allegation detail: unexplained injury. Described Injury: dislocated hip and received treatment at hospital.Facility 5-day report submitted on 6/10/26 at 10:55 a.m., identified on 6/4/26 RN-A heard R1 hollering for help. Bed alarm sounded. RN-A stated the walker was closer than the wheelchair and she felt that she could maintain the TTWB status to get her to the bathroom. RN-A was aware of the ambulation status and heard a popping but noted nothing out of the ordinary after R1 returned to bed via wheelchair. R1 was sent to emergency room (ER) to be evaluated, transferred to another hospital on 6/4/26 and returned to facility on 6/5/26. Elements of the care plan were not followed: care plan identified R1 was unable to ambulate with nursing staff due to non-weight bearing status of right leg. Staff assisted R1 to the restroom with the walker maintaining TTWB. The physician order was for 30 pounds weight bearing but therapy utilized toe touch only. The allegation was verified: in combination with increased pain, multiple falls, non-compliance, inability to recall transfer status. There was a hematoma in the capsule postoperatively that may have contributed to the dislocation. Severely low hemoglobin.During an interview on 6/23/26 at 1:07 p.m., with MD-A and the administrator, MD-A verified he had saw R1 on 6/3/26. At that time the right hip was not the issue. R1 dislocated her hip three times while in the facility. MD-A felt the dislocations were related to the initial total hip replacement not being performed correctly. R1 had dementia, never followed instruction, tried to get up by herself, which made it difficult to avoid her self-transferring. MD-A stated the first time R1 dislocated her hip she was sent to the hospital where the hip was placed back in. R1 then dislocated hip again two days later, was sent to the hospital where it was placed it back in. MD-A stated he had not seen any abnormal positioning or concerns of dislocation of R1's leg on 6/3/26. MD-A stated he would have expected staff to follow the recommendations and the care plan on how to transfer R1, TTWB only and no ambulation. When staff heard the popping noises, during the transfer, it would have identified when the dislocation occurred with the right hip and would be extremely painful. MD-A stated R1's hip was repaired improperly. For the most common reasons and with normal activity the hip can pop out with force. MD-A stated a hematoma would not cause R1's hip to dislocate; however, the hematoma would have been caused by the falls she had. MD-A stated R1's hip was dislocated from walking to the bathroom and/or normal activity, but it was not normal for her joint replacement, and not something she was supposed to do without assistance due to her dementia. MD-A indicated R1 basically did things she should not have done due to her dementia.During an interview on 6/23/26 at 12:31 p.m., NA-D stated R1 had dementia, self-transferred, and was a high risk for falls. R1 was a stand pivot with assist of two at first then changed to assist of one, and staff were not to be walking (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	her, no weight was to be placed on her right leg/foot due to the fracture. NA-D stated staff were expected to follow the care plan and/or Kardex located on the computer: keep a close eye on her, prevent her from being left in her room alone, and used bed and chair alarms to let staff know she was trying to self-transfer. NA-D stated she had caught R1 many times in her wheelchair after she had self-transferred, R1 had forgotten about her fractured hip. NA-D stated on 6/4/26 around 6:45 a.m., R1 had to go to the bathroom, NA-D stood her up with a transfer belt to pivot, R1 dragged her right leg, crying and stated it hurt. NA-D stated she informed the staff nurse.During an interview on 6/23/26 at 1:30 p.m., NA-B stated R1 was a high risk for falls and staff used a bed alarm, chair alarm, and had her sit in the commons area to keep a close watch on her. R1 was not to be left alone in her room. NA-B stated there were times when R1 self-transferred in her room. During an interview on 6/23/26 at 2:11 p.m., RN-D stated R1 had dementia, lacked cognition, with impaired balance due to TTWB. R1 was to be transferred with stand pivot with two staff and provided reminders to just touch your toe, to avoid injury or damage to her right hip. RN-D stated on 6/4/26, during breakfast R1 sat in her chair eating, leaned towards her left side like she did not want pressure on her right buttock. RN-D stated in morning report she was made aware R1's hip had made popping noises when she was transferred earlier. R1's right hip appeared swollen, almost like it was half size bigger than the left hip. R1 stated her hip hurt but was unable to identify what type and how much pain she had. RN-D stated R1 had grimaced when transferred to the toilet after breakfast around 8:45 a.m. R1 was sent to ER with a diagnosis of right dislocated hip, then transferred to another hospital, a closed reduction was completed and R1 sent back to facility.During an interview on 6/24/26 at 10:05 a.m., orthopedic surgeon MD-B stated he had completed three of four hip surgeries R1 had. After R1's initial hip repair, R1 had fallen due to dementia, broke her hip a second time due to the quality of the bone was poor. MD-B stated during R1's falls the femoral stem on the implant rotated 30 to 40 degrees, which normally would have been at 10 to 15 degrees. The hip prosthesis continued to dislocate and had to be removed. MD-B stated R1's stem was placed in an anteversion position, rotated towards the front of the body and was not faulty. MD-B stated R1's implant was placed properly, at the correct angle and the angle changed because the bone had not grown to secure it and moved substantially when falling. It was the fall(s) on the hip, especially after surgery that created the problem opposed to the surgical process. This category (age group and decreased cognition) of patients had restrictions on ambulation, and the inability to follow those restrictions made them more vulnerable. The restrictions of 30# weight bearing, avoiding internal rotation of the leg was important to follow to protect the top of the bone and muscles that supported the area where the prosthesis was attached. MD-B stated during the falls and/or not following those restrictions pulled on the part just repaired, and the stem won't heal properly. MD-B stated if there was too much weight placed on the hip/leg the stem will not heal. Most likely it moved after the first fall after admission, due to being new, less healed, and not solid. MD-B stated it takes 6 weeks to 2 months for the implant to cement in and if you continue to have trauma, keep bleeding, kept moving, it will not heal and will continue to dislocate.During an interview on 6/24/26 at 2:00 a.m., RN-A stated R1 was confused, oriented to self only, and high risk for falls. R1 had a total of three or four falls since admission while she tried to self-transfer. RN-A stated R1's interventions in place to help prevent falls included: stand pivot with assist of two staff to keep her safe due to TTWB, decreased cognition, and impulsiveness. RN-A stated on 6/4/26, she was aware R1 required assistance from two staff for transfers, was only to ambulate with therapy, and RN-A should have used the wheelchair to transfer her to the bathroom that day. R1's wheelchair was not close to the bed, R1 already stood up independently, was unable to wait to go to the bathroom, and at that moment RN-A did what she had to do. R1's additional interventions included: bed alarm, chair alarm, and fall mat on both sides on the floor by the bed. RN-A stated on 6/4/26 just before 6:00 a.m., R1 had slight hip pain that day, it did not get worse when she ambulated, she was able to ambulate with RN-A, she followed cues, and was able to maintain TTWB. RN-A stated she watched R1, so that she did not place a lot of weight on her right foot and would hop as she (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	ambulated. RN-A stated she heard a popping noise that came from R1's right hip with every step while she ambulated to the bathroom. RN-A stated she should not have ambulated R1 due to difficulty maintaining TTWB, therapy placed ambulation on hold. RN-A stated she did not think the ambulation affected her hip at all and if she had to do it all over again, she hoped the wheelchair would be closer to the bed so she could complete a pivot transfer instead. RN-A stated she had a walkie on her and could have called another staff member for assistance. RN-A stated staff would be expected to follow the resident care plan to provide most accurate and best care for resident safety. RN-A stated she was unaware of what caused R1's displacement of the hip, she had many falls and self-transfers at the facility and increased pain that could have increased the possibly of displacement. The provider had seen R1 earlier that day prior to the incident. RN-A stated she had received education on 6/5/26, regarding R1's current mobility status and how she should have been transferred.During an interview on 6/24/26 at 2:20 p.m., RN-C stated R1 was confused and seemed to get worse in the evening. R1 was impulsive, had poor memory, needed constant reminders to not self-transfer, and lacked safety awareness. R1's care planned interventions included: appropriate footwear, fall mat, non-weight bearing that was changed to TTWB by therapy, call light, and assist with sitting in recliner in commons area. Staff would be expected to follow the care plan which meant R1 should have ambulated with therapy only due to weight restrictions, TTWB, and pivot transfer only. RN-C stated staff should not ambulated R1, they are not trained therapists, were unable to know if R1 maintained the TTWB restriction and placed her at risk of becoming unsteady, falling, and injuring the right hip.During an interview on 6/24/26 at 2:43 p.m., licensed practical nurse (LPN)-C stated R1 was confused, forgetful, impulsive, and had poor safety awareness. On 5/17/26, R1 was found kneeling on the floor by the side of her bed. LPN-C stated she was unable to recall hearing the alarm go off, was unsure if the bed alarm was used, and the NA could have turned it off, but was unsure. LPN-C stated it would be important for the bed alarm to be used to alert staff R1 had gotten herself up and prevented a fall. LPN-C stated a fall would have placed R1 at risk for hip displacement and/or a hematoma.During an interview on 6/24/26 at 2:55 p.m., LPN-A stated on 5/18/26, R1 had an unwitnessed fall in her room by the bathroom, and the chair alarm was not connected. LPN-A stated the chair alarm was usually clipped to R1's back, R1 may have removed it herself, usure if she could have reached it or remembered it was there. LPN-A stated the NA was asked and indicated she had placed the chair tabs alarm on R1. LPN-A stated that R1's falls could possibly be related to the displacement of her hip, unsteadiness of the hip, and extended the healing process due to trauma.During an interview on 6/24/26 at 4:30 p.m., LPN-B stated R1 was pleasantly confused when she was first admitted and the confusion worsened quickly. R1 attempted to self-transfer many times and lacked safety awareness. LPN-B stated she observed R1 self-transfer and push her wheelchair while she walked behind it independently from the dining room. LPN-B stated she intervened, reminded that R1 assistance for transfers was needed, and R1 stated her right hip was sore. Additionally, R1 was known to self-transfer out of bed on the night shift, taking herself to the bathroom, and staff were aware of the need to keep eyes on her to help prevent a fall.During an