STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Care Center	600 Main Avenue South Baudette, MN 56623

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on observation, interview and document review the facility failed to identify the use of restraints for 1 of 3 residents (R3) reviewed when the facility used multiple personal alarms and video cameras that restricted R3's movement and failed to attempt alternate interventions to prevent falls. Findings include: R3's Admission Record indicated he readmitted to the facility 10/23/24, with diagnosis that included history of traumatic brain injury, cerebrovascular disease, depression, and insomnia. R3's significant change Minimum Data Set (MDS) identified moderately impaired cognition. The MDS indicated R3 required partial to moderate assistance for tilting and supervision/touching assistance for transfers and ambulation. R3's care plan dated 10/23/24, identified a self-care deficit related to traumatic brain injury, loss of fingers and thumb and Cerebral vascular accident. The care plan directed staff to provide contact guard assistance for toilet use, transfers and ambulation and indicated He moved very fast and became angry when staff stopped or interrupted. The care plan directed staff to stay by his right side and explain why they were assisting him. The care plan indicated R3 was at high risk for falls and indicated he required an alarm in bed, recliner chair and dining room chair due to inability to comprehend safe choices and ask for assistance. R3 facility progress notes indicated on 10/23/24 occupational therapy completed a room safety evaluation prior to his return and added chime alarms to the bed, recliner, and dining room chair that he sat in. R3 facility progress notes indicated on 10/23/24, R3 admitted back to the facility. R3 had left sided weakness and deficit to his left eye. R3 ambulated with walker and gait belt and required contact guard assistance with transfers and ambulation. Has alarms to his bed, recliner and dining room chair for safety related to cognition and did not always use his walker. R3 facility progress notes indicated on 10/30/24, R3 had a brief episode of yelling and swearing at staff. R3 at times got up and started walking without waiting for help. Reinforced that when alarm goes off it was to let staff know he may need some help. R3 seemed to startle easily. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Restraint/Entrapment assessment dated [DATE], identified bed and chair alarms and indicated family wanted the alarms due to recent stroke that caused left side deficit and impaired vision to his left eye. The assessment indicated R3 was unable to make safe decision and required assistance with ambulation. The assessment indicated the alarms were not a restraint. The assessment did not address R3 reaction to the alarms and did not identify alternate interventions attempted prior to initiating the alarms. R3 facility progress notes indicated on 11/9/24, R3 has stood up the chair alarm went off. R3 sat back down but stated when staff approached, I want to turn this damn thing off, pointing to the alarm. This happened three times. R3 facility progress notes indicated on 11/16/24, R3 was incontinent in the dining room and moved around on the alarm on the chair. Staff offered assistance and R3 was swinging his alarms and throwing his walker around. R3 yelled, those alarms were pissing him off and he was not going to put up with it. R3 facility progress notes indicated on 11/16/24, R3 continued to have behaviors regarding alarms. R3 got very angry that they continue to make noise and yelled at staff that they need to throw the damn things in the garbage. Stated they were too loud. During observation on 11/20/24 at 9:18 a.m. R3 was seated at a table in the dining room. R3 removed a pressure pad alarm from underneath him and set it on the table, then placed it on the floor. Staff responded to the alarm and placed it underneath him. During observation at 9:49 a.m., R3 was viewed on a camera that was placed on a table in the hallway. R3 was lying in bed with the television remote control in his hand and kept looking toward the hallway. At 10:00 a.m. R3 sat up on the side of the bed and looked around. The alarm could be heard sounding and R3 laid back down on the bed. During interview on 11/20/24 at 11:43 a.m., nursing assistant (NA)-A stated the camera was used to monitor R3. NA-A stated R3 was unsteady and needed supervision and staff were unable to provide one to one supervision so the solution was to place a camera in his room. NA-A stated R3 also had alarms in his room that would sound if he got up. NA-A said usually when staff were busy, they place the camera in their pocket and a light would go on to signal if R3 got up. NA-A stated R3 had a pressure pad alarm under him in bed and the chair and if he got up it would make a god awful noise. NA-A said R3 did not like the alarms and said she was pretty sure he knew the camera was in his room and said he was always watching the camera. Regarding the alarms, NA-A stated R3 got aggressive when the alarms sounded and said they were loud and noisy. At 11:53 a.m., NA-B stated R3 had a stroke a few months prior and had weakens on one side. NA-B stated R3 could walk but needed a gait belt and had trouble gripping his walker. NA-B stated R3 had the video monitor and alarms because he would get up quickly and could fall. NA-B stated R3 did not like the alarms and said things like, shoot me in the f***ing head, the noise. At 12:05 p.m., the therapy manager (TM) stated therapy had recommended alarms and said she may have recommended the alarm in the dining room. The TM stated R3 had a history of a traumatic brain injury and a stroke and said he was impulsive and would stand up without anyone knowing. The TM stated therapy did not have a formal assessment for use of alarms. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:21 p.m., registered nurse (RN)-A stated R3 did not understand to ask for help and had poor left side vision so they decided to place alarms to give staff a heads up when he was ambulating. RN-A stated staff did not attempt other interventions prior to the alarms and said the family wanted the alarms for safety. RN-A stated R3 hated the alarms and did not understand the beeping and how to shut it up. RN-A said R3 would hear the alarm and sit back down or took off. At 1:05 p.m., R3 stated the alarms were annoying and said he was unable to turn it off. R3 said if it were up to me, I would throw it away. At 1:13 p.m., Family member (FM)-A stated he was aware of the alarms and said the facility was worried R3 would fall. Regarding the camera, FM-A stated he did not remember the camera and said they must have wanted to keep an eye on him. FM-A said he was not aware R3 had been getting upset about the alarms and said having some privacy is something he respected and said he would like to see something that kept R3 safe but did not upset him. FM-A further stated he had not requested the alarms and said the facility felt like they needed them. At approximately 2:00 p.m., the director of nursing (DON) and social worker (SW)-A were interviewed. SW-A stated the alarms were initiated after R3 had a stroke. SW-A stated R3 needed someone with him as he was unstable, jerky and ran into things. SW-A stated they felt alarms were the only way staff would know if R3 got up. The DON stated before initiating alarms they looked at whether a resident was physically able to get out of bed and if cognitively they knew where they were going. The DON stated from there they went on recommendations from therapy. SW-A stated they did not have a safety option for R3 and said it was either a one to one or he had to have an alarm. Facility policy Restraints, dated 8/2024, indicated residents had a right to be free from any physical of chemical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. The policy identified a restraint as any manual method of physical for mechanical device attached or adjacent to the resident body that restricted freedom of movement or normal access to one's body.