

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Oakland Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 123 Baken Street Thief River Falls, MN 56701	
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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure staff transporting residents in a facility vehicle were trained on safe transport practices and had appropriate driver's license clearance for 3 of 3 (R1, R2, R3) residents reviewed for accidents. This resulted in an immediate jeopardy for R1 when he fell from his wheelchair to the floor of the van during transport after being improperly secured. Findings include: The immediate jeopardy (IJ) began on 7/2/25, at approximately 4:00 p.m., when nursing assistant (NA)-A was directed to transport R1 to the hospital, loaded him in the front passenger's seat of the van, securing only two out of the four required four-point tie downs, and no seat/lap belt. R1's wheelchair fell backwards onto the floor of the van during transport resulting in a skin tear on top of the left hand. Additionally, NA-A driver's license had not been cleared by the facility's insurance prior to this incident. The IJ was identified on 7/17/25, the administrator was notified of the IJ on 7/17/25, at 4:15 p.m. The IJ was removed on 7/2/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. R1's admission Minimal data set dated [DATE], identified moderate cognitive impairment. R1's Morse Fall Scale (a tool used to assess fall risk) completed on 6/30/25 at 1:49 p.m. identified a history of falls, used a wheelchair for mobility, and impaired and weak gait. His fall risk score was 40 (low risk 0 to 24, moderate risk 25 to 44, high risk 45 or higher), and placed him at moderate risk for falls. R1's care plan dated 6/27/25, identified he had poor decision-making abilities and impaired safety awareness. R1's progress notes from 7/2/25 through 7/4/25, identified: -On 7/2/25 at 4:47 p.m., writer was alerted by daughter-in-law the new onset of confusion and worsening slurred speech. Upon assessment, resident was pale and noted to be having hard retention of fluid in abdomen, bilateral upper and lower extremities. He talked nonsense, had delayed responses to questions, confusion, and incomprehensible speech. He was sent to emergency department (ED) via facility van as he was unable to get into daughter-in-law's vehicle. He left facility at 4:16 p.m. with necessary paperwork. -On 7/2/25 at 6:30 p.m. local hospital called and indicated he was being admitted for pneumonia. -On 7/3/25 at 12:01 p.m., received nurse report from local hospital ambulance would bring him back to facility, scans clear, laceration to left hand covered with mepilex, left elbow skin covered with steri strip. Family discussed comfort care, oxygen 3 liters (L).-On 7/3/25 at 1:56 p.m., he returned to facility via ambulance at 12:50 p.m. minimally responsive. -On 7/3/25 at 3:25 p.m., fall assessment- In facility van on 7/2/25, via in route to ED for evaluation after change in condition. R1 was assisted to van with brake locks and tie downs being applied to front and rear. During transport he tipped backwards in wheelchair and sustained a skin tear to left hand. Staff present helped him back to seated position and continued to ED for evaluation. Unknown if he hit head, sustained back of left hand skin tear. Baseline mental status: oriented to person, place and time. Displayed poor safety awareness and long, short term memory loss, and recent decline in activities of daily living (ADL) abilities. -On 7/3/25 at 3:44 p.m. he returned on comfort cares; hospitalist prescribed comfort measures. Facility incident report identified on 7/2/25 at 4:00 p.m., R1 experienced a change in condition and was determined he should be seen in the emergency department (ED) for evaluation. R1 was assisted to load in his wheelchair into the facility van with an oxygen tank by staff who secured straps front and rear of wheelchair. When accelerating after stopping at a stop sign, R1's wheelchair came loose from the tie down and tipped backwards. He was assisted back to an upright position and driver proceeded to ED. Per staff report there was a red spot on his head, no bleeding and a skin tear to left hand. CT scan showed no other injuries. He was admitted to the hospital for treatment of pneumonia. ED triage notes dated 7/2/25 at 4:10 p.m., identified R1 arrived to ED via wheelchair with family with complaints of slurred speech, confusion and a fall on the way to ED. Family was told by nursing home (NH) staff that he was having mini strokes due to his noted slurred speech and confusion that had started today but had not given a timeframe of events to family or ED staff. On the way to the hospital, NH staff told family they did not have a front strap for his wheelchair and when staff hit the brakes, he proceeded to fall backwards while in the wheelchair and hit his head. No blood thinners on chart, no injury noted to back of head. Small skin tear to top of left hand, bleeding controlled. Slurred speech and confusion started prior to his fall. He was noted to have a delayed responses and incomprehensible words on arrival which had changed from his recent admission to this facility. Stroke code called on arrival at 4:08 p.m. and sent to have CT. ED provider note date of service 7/2/25 at 9:42 p.m., identified R1's computed tomography (CT) scan (imaging using x-ray techniques to create detailed images of bones, blood vessels</p>		