STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	05/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Immediate jeopardy **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 observation, interview, and document review, the facility failed to provide adequate supervision, follow the care plan interventions and conduct reassessment of risk for falls to prevent and/or reduce the likelihood of future falls for 2 of 3 residents (R1, R2) reviewed for falls. This resulted in an immediate jeopardy for R1 who had repeated falls and fell on [DATE] and sustained a fracture when left unattended, and for R2 who had repeated falls and sustained a fractured humerus. The immediate jeopardy began on 4/17/20, R2 fell in her room and sustained a fractured humerus. The administrator, vice president of patient services, director of nursing, licensed social worker, activities director, registered nurse (RN)-A, RN-B, RN-C, and licensed practical nurse (LPN)-C were notified of the immediate jeopardy at 3:45 p.m. on 5/20/20. The immediate jeopardy was removed on 5/22/20 at 12:30 p.m. however, noncompliance remained at a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R1 fell on [DATE], and fractured sacrum. On 5/18/20, at 4:44 p.m. licensed practical nurse (LPN)-A verified she had been working the night shift of 5/11/20, when R1 fell and fractured her sacrum. LPN-A stated R1 had been up and down throughout the night. R1 was toileted at 12:30 a.m. and received Tylenol at that time as well. LPN-A said R1 was restless at night and did not sleep well. LPN-A added R1 had been put on 1:1 supervision a day or two prior to the 5/11/20 fall. LPN-A stated R1 had been sitting in a recliner in the common area with the footrest elevated. LPN-A indicated R1 had been sleeping when there had been another resident needing assistance. LPN-A had gone around the corner to respond to the other resident, leaving R1 unattended. Before she could return, R1 had woken up, tried to crawl out of the chair and had fallen, the chair alarm was sounding. LPN-A said 1:1 supervision was pretty hard to do with only three staff scheduled at night. During telephone interview on 5/18/2020, at 11:12 p.m. nursing assistant (NA)-A verified she had worked on 5/11/20, the night R1 fell although was on break at the time of the fall. NA-A said R1 had been up at night constantly and needed to be kept at staff's side. NA-A added sometimes it gets a little hard to watch residents on a 1:1 and answer call lights. NA-A said she would often put the residents requiring supervision, including R1, in a wheelchair and take them with her to answer other resident's call lights, positioning them outside the door when attending to other residents' needs. NA-A confirmed R1 had issues with sleeping and hallucinations which progressively worsened. NA-A stated for weeks prior to R1's recent hospitalization staff had difficulty supervising R1 the way she should have been. NA-A verified she was aware R1 required 72 hour, 1:1 supervision. NA-A also verified R1's foot rest on the recliner had been elevated the night she fell . NA-A indicated staff were not to elevate residents' feet when seated in a recliner if unsupervised and stated this had been implemented a couple of months prior to R1's fall. Review of R1's Fall Scene Investigation and Root Cause Analysis forms: -1/17/20, at 4:30 a.m. unwitnessed fall in room. R1 found seated on floor in front of closet, stated she was going to the bathroom, was hot and had taken off gripper socks. Interventions identified: schedule every two hour cue for toileting, preferred footwear with grippers. -2/2/20, at 10:15 p.m. unwitnessed fall in room, found on the floor asleep, extremely tired the whole shift, recent medication changes for sleep (increased [MEDICATION NAME] (antipsychotic) from 0.5 milligrams (mg) to 1.0 mg) R1 sustained a golf ball-sized raised hematoma on her right arm after a fall from bed. Interventions identified: monitor sleep schedule, update psychiatrist. -4/7/20, at 5:05 a.m. unwitnessed fall in room. Staff noted R1 doing a crab walk in the hallway in front of room, stated she needed the toilet. Resident had intermittent confusion, hallucinations, delusions, and had medication changes to [MEDICATION NAME] (antipsychotic) last week (12.5 mg to 25 mg daily). Resident is independent. Unable to determine if true fall. R1 sustained injury to left hip/pelvis with pain experienced upon ambulation and palpation. Interventions identified increase from hourly to every 30 minute safety rounds, contact psychiatrist for recommendations. -4/10/20, at 12:45 a.m. unwitnessed fall in room. R1 found laying on floor next to bed and had sustained a goose-egg above left eye. R1 stated she was going to the bathroom and had slipped and fallen. Root cause listed R1 lost balance and fell down when attempting to toilet herself. She was independent, yet had increased delusions, hallucinations and confusion. Resident had recent medication changes. Interventions identified: increase from every 30 minutes to every 15 minute safety rounds, evaluation by PT for level of appropriate independence, and follow up with psychiatrist due to continued delusions, hallucinations and confusion. -4/28/20, at 5:00 a.m. unwitnessed fall in room. R1 found seated on floor next to bed with walker laying in front of her and had sustained a 4 centimeter (cm) x 2.5 cm bruise to her right forearm. Found on floor with walker on top of her, stated she was going to get cookies. Increased [MEDICAL CONDITION], confusion, hallucinations and delusions. Recent medication change ([MEDICATION NAME]-antipsychotic). Interventions identified: OT suggestion with room arrangement, consult with psychiatrist again. -5/9/20, at 2:45 p.m. unwitnessed fall common area. R1 found seated on floor facing the main entrance in the hall with no walker, no gripper socks/shoes, alarm not sounding and unable to report what happened. R1 sustained bruising to right buttocks. Resident had ongoing confusion, delusions, and hallucinations. Resident fell after ambulating self in an unsafe manner and alarm battery failed to alarm staff. Interventions identified: Treatment administration record (TAR) cue added for battery change weekly, 1:1 supervision for 72 hours. -5/11/20, at 3:15 a.m. unwitnessed fall in common area/hallway. R1 fell when attempting to transfer from a chair, which was reclined with footrest up. R1 sustained a hematoma to the right forehead and it was later determined she had suffered a fractured sacrum. The analysis identified R1 had been left unattended in recliner with legs up, unable to use chair independently so tried to crawl out and fell . The 1:1 intervention implemented after the 5/9/20, fall was not maintained, therefore R1 fell . Interventions identified included: Continue 1:1 at all times for 72 hours after fall. R1 was seen in follow up by the psychiatrist on 5/12/20, who recommended further medication changes. Further, the analysis listed the facility notified family who indicated they would like to allow time prior to making further changes. R1's [DIAGNOSES REDACTED]. [MEDICAL CONDITION], cognitive communication deficit, hallucinations, major [MEDICAL CONDITIONS] and history of falling. R1's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had intact cognition. R1 had not exhibited any physical or verbal behavioral symptoms directed toward others, and no rejection of cares, or wandering. The MDS indicated R1 required extensive assistance with one person for dressing and limited assistance for personal hygiene and was independent with all other activities of daily living (ADL). R1's balance was not steady with transitions and walking and the MDS further indicated R1 had experienced falls with injuries (skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains or any fall-related injury that causes the resident to complain of pain) and one fall without injury since the previous assessment. R1's Care Plan, revised 5/1/20, indicated R1 was at risk for falls related to history of left humerus fracture related to fall at home and poor safety awareness. R1's interventions included low bed, chair and bed alarms for safety, wander guard for safety, call light in place of reach, stand by assistance for mobility when using walker, gripper strips in front of bed, chair, and toilet and staff to cue, reorient and supervise as necessary. Completed after 6 prior falls, R1's Morse Fall Scale (rapid and simple

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) method of assessing a resident's likelihood of falling) dated 5/10/20, evaluated R1 at high risk for falling. Review of Progress Notes from 3/15/20, to 5/11/20, revealed R1 experienced increasing [MEDICAL CONDITION], hallucinations, delusions and confusion, being up and down during the night shift with increased frequency, at times walking/pacing the hallways, sometimes throughout the night, or sitting in a recliner/sleeping in the hallway/alcove, eventually requiring 1:1 monitoring/supervision. During telephone interview on 5/18/20, at 11:36 p.m. LPN-B indicated R1 had been a challenge almost every night prior to her last fall and stated she could not sit in a wheelchair comfortably and did not want to sit back in the wheelchair. LPN-B stated R1 would maybe sleep 20 minutes at a time and staff had to hold her hand constantly. LPN-B also confirmed R1 was to have the foot of her chair down when in the chair. LPN-B verified R1 required 1:1 supervision at the time of her fall. On 5/19/20, at 10:44 p.m. during a group interview, NA-F and NA-G verified R1 had been independent with ADL's but was at risk for falls. NA-F stated prior to a fall on 5/9/20, R1 had been on every 15 minute safety checks, however, after the fall she was on a 72 hour watch and someone was to be with her at all times. On 5/19/20, at 12:00 p.m. DON verified R1's aforementioned fall information and confirmed R1 was to be on 1:1 supervision after the fall on 5/9/20. DON indicated R1 should not have been left unattended on 5/11/20. DON also verified the foot of R1's recliner had been elevated at the time of her fall and should not have been. DON added they had tried finding extra staff to work 1:1 with R1 when she was experiencing falls and had been able to find staff to stay with her until 10:00 p.m. one evening and midnight one night, however had not been able to find additional staff to provide ongoing 1:1 supervision. During a follow up interview on 5/19/20, at 3:29 p.m. DON indicated after the fall on 5/11/20, R1 was sent to theER on [DATE], due to agitation and complaints of pain and burning, being diagnosed with [REDACTED]. DON indicated LPN-A had received education regarding following the care plan for R1. During a follow up interview on 5/20/20, at 1:21 p.m., DON indicated R1 had been on every 15 minutes safety checks prior to her fall on 5/9/20. DON stated the 15 minute safety checks were not effective, and she determined R1 required increased supervision and implemented 1:1 supervision at that time. R2 R2's [DIAGNOSES REDACTED]. R2's annual MDS dated [DATE], indicated R2 had severe cognitive impairment with continuous inattention and disorganized thinking. The MDS indicated R2 required assistance with bed mobility, transfer, walking, locomotion on and off unit, dressing, toilet use and personal hygiene. The MDS also indicated R2 had experienced two or more falls with injury and one fall with major injury since the previous assessment dated [DATE]. R2's Falls Care Area Assessment (CAA) dated 5/12/20, indicated R2 had a history of [REDACTED]. R2 received assistance with all ADL's related to cognition and mobility needs. R2 ambulated with staff assistance via assistive device and had bed and chair alarms in place for safety related to dementia, impulsivity and poor safety awareness and had periods of restlessness and anxiety. R2 did not always make needs known and needed cues and assistance. R2 was on a toileting schedule and ambulated often with staff. R2 was at risk for falls related to cognition, impulsivity and mobility needs. Staff were to monitor R2 and assist with mobility and toileting needs. R2's Care Plan indicated R2 had an ADL self-care performance deficit related to dementia without behavioral disturbance and directed staff to provide R2 contact guard assistance (CGA) for transfers with gait belt for ambulation in room and the corridor with the assist of 1-2 staff to follow with wheelchair as needed. The care plan listed R2 exhibited symptoms of anxiety/repetitive questioning, and intermittent confusion. The staff were directed to assist R2 into a recliner for comfort and when restless or unsettled. When in the recliner, the staff were directed to not elevate the feet unless R2 remained in the direct supervision of staff. The care plan further indicated R2 was high risk for falls related to confusion, gait/balance problems, and psychoactive drug use and directed staff to implement interventions, which included but were not limited to: -At least every 15 minute checks, ambulation/transfers CGA with transfer belt on, PT/OT (physical therapy/occupational therapy) evaluation, bed alarm at shoulder level, chair alarm, wheelchair alarm, bed at sitting level at tape marked on wall. -Monitor while in wheelchair -Door left open while resident in room -If appears restless or attempts to get out of bed after all emotional and physical needs are met get up and out of her room where she can be monitored more closely R2's Morse Fall Scale dated 5/4/20, evaluated R2 at high risk for falling. On 5/18/2020, at 3:53 p.m. R2 was observed being propelled in a high-backed wheelchair that both rocked and reclined by the physical therapist (PT)-A into the hallway of the facility from the courtyard. PA-A left R2 positioned in her wheelchair by the nurses' office. An alarm box was attached to the back of R2's Rock 'N Go wheelchair at shoulder level, on the right side. R2 wore gripper socks on her feet. LPN-E wheeled R2 up to a table in alcove area and sat next to her. At 4:13 p.m. LPN-E wheeled R2 into her room, assisted her to don a face mask and then returned R2 to the alcove table. Review of R2's Progress Notes (PN) from 3/1/20, to 5/21/20, indicated documentation describing R2 as restless, anxious, or unsettled, with behaviors described as being up and down ongoing multiple times throughout the night shift, sometimes as often as every 1-2 minutes. The progress notes identified R2 often spent time either awake or asleep in a wheelchair or recliner in the hallway between the hours of 9:00 p.m. and 7:00 a.m. and at times required 1:1 supervision/monitoring. The PN's also indicated R2 had some medication changes. R2's PN dated 4/1/20, at 6:11 a.m. indicated R2 does not sleep well in her bed at night. Once she wakes up to go to the bathroom, she is pretty much done laying in bed. Once she is awake, she will sit in the rock and go chair and she will doze off there. She sleeps well this way but is then on 1:1 monitoring through the remainder of the night, as she will sometimes try to stand up. Review of R2's Fall Scene Investigation and Root Cause Analysis forms indicates: -3/2/20, at 1:02 p.m. unwitnessed fall in room. R2 found on floor, right side of face on floor, right arm bent behind back, left arm out in front, both legs bent and in front of body. Recliner chair had the foot rest extended and the whole chair was leaning forward with foot rest on the floor and R2's bottom on the end of the chair. R2 sustained a goose egg to right side of forehead. Placed in chair with feet up, unable to get self out of chair independently. Interventions identified: update care plan for not putting feet up while unattended by staff. -3/31/20, at 4:30 p.m. near miss in hallway. R2 was seated in rock and go wheelchair and attempted to stand on own. R2 was leaning while standing, started to fall forward and was caught by staff before she could fall. It was determined R2's last time toileted (1:05 p.m.) was not appropriate to R2's every 2 hour toileting schedule. Interventions identified after fall included R2 toileted and 1:1 monitoring provided. -4/17/20, at 11:20 p.m. unwitnessed fall in room. R2's alarm was sounding and she was found on the floor next to her bed. R2 had indicated she thought it was time to get up. No injury was initially found at the time of the fall, however, R2 was later determined to have suffered a left humerus fracture. R2 fell when getting self out of bed thinking it was time to get up. Interventions identified: increase safety rounds to every 15 minutes, PT/OT evaluate shoulder pain, door open when in room, monitored when in wheelchair. -5/1/20, at 6:30 p.m. witnessed fall in hallway. R2's alarm sounded and she was observed to try to get up. The nurse directed R2 to sit down. R2 stood up and fell face first on the floor. Her left arm was in a sling due to previous fall. She landed face first and on her already broken left arm and sustained a scrape to the forehead and nose. R2 was attempting to get self up from chair and fell ; stated she needed to go to the bathroom. It was determined R2's last time toileted (3:30 p.m.) was not appropriate to R2's every two hour toileting schedule. Interventions identified: place wheeled walker in front of R2 when in rock and go, place within close proximity for supervision when in wheelchair, reinforced education regarding necessity to follow care-plan for toileting. During telephone interview, on 5/18/20, at 11:12 p.m. NA-A verified R2 was routinely up at night and indicated it was not uncommon she (NA-A) would be running from one door to the next and R2 would already be standing up. NA-A verified R2 broke her arm related to a fall and stated she always put R2's walker by the bed so at least she could be steadier if she got out of bed unsupervised. During telephone interview, on 5/18/20, at 11:36 p.m. LPN-B stated they had residents out in the common areas every night. LPN-B stated R2 was routinely up at night and indicated she was one of three residents currently up and seated in the hallway/alcove. LPN-B stated no residents required an official 1:1 at this time but indicated if residents were up, staff had to be on the hallway at all times and use their judgement to determine if the resident required constant supervision versus a check. LPN-B indicated the three residents currently up, including R2, required 15 minutes safety checks to visually ensure they were in bed, when not seated in the hallway due to their risk for falls. LPN-B indicated it could be difficult to provide the necessary supervision at staff break times and also indicated it was a juggling act when the NAs completed their rounds; the nurse supervised the other hallway. LPN-B stated if the residents who were at fall risk got up, they had to really move (to respond prior to a fall). LPN-B stated she thought R2 fell during the night shift when she broke her arm. LPN-B indicated R2 had not initially experienced pain in the arm and then the fracture was found after a few days. LPN-B indicated she thought R2 had gotten up by herself at night and stated she thought R2 had woken up and crawled out of bed and fell before staff could respond. At this time, LPN-B had to drop the phone to attend to R2 who she stated was leaning forward in the chair. When she returned to the interview, LPN-B indicated she did not remember if there were residents in the common area the night R2 fell . On 5/19/20, at 12:00 p.m. the DON verified R2's aforementioned fall information and confirmed R2 suffered a fall with humerus fracture on 4/17/20. DON also verified R2's care plan was not followed prior to the fall on 5/1/20, and the NA responsible had received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) disciplinary action. Record review lacked evidence of training completed for licensed and non-licensed nursing staff related to this concern. On 5/19/20, at 10:44 a.m. NA-F and NA-G indicated R2 needed to be supervised as she tried to get up on her own at times and required assistance with transfers. NA-F indicated R2 utilized a bed alarm, floor mat/alarm as well as a chair alarm to alert staff of her movements and also required every 15 minutes safety checks. NA-F stated if R2 started moving around or was getting antsy she usually needed to use the bathroom or to walk. NA-F and NA-G confirmed R2 was a resident they needed to keep an eye on due to unsafe transfers. They indicated on the night shift there were two NA's and if the NA's were busy, the nurse would have to cover or they would need to bring R2 along them to keep an eye on her. NA-F further indicated R2 had been up during the previous night shift. The Fall Prevention Policy reviewed/revised 12/17, indicated residents at risk for falls will be identified and minimized. The policy also directed all fall interventions put in place would be monitored for their continued placement and functioning by nurse staff and reported to IDT (interdisciplinary team) at QI (quality improvement) meetings. The immediate jeopardy that began on 5/11/20, was removed on 5/22/20, when the facility reassessed R2 and implemented interventions and staffing strategies to meet R2's care needs. Upon R1's return to the facility, R1 will be re-assessed and the care plan will be reviewed and revised as appropriate and a second staff member will be added if indicated. Additionally, the facility identified a responsible charge nurse to complete rounding to ensure 1:1 supervision for identified residents and the staffing that was in place, as well as education plan was identified and implemented for all licensed and non-licensed nursing staff.