

Electronically delivered August 31, 2021

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

RE: CCN: 245090

Cycle Start Date: July 15, 2021

Dear Administrator:

On August 5, 2021, we notified you a remedy was imposed. On August 23, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 16, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 20, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 5, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Flig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically delivered

August 31, 2021

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Re: Reinspection Results

Event ID: CEBV12

#### Dear Administrator:

On August 23, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 15, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically Submitted August 5, 2021

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

RE: CCN: 245090

Cycle Start Date: July 15, 2021

#### Dear Administrator:

On July 15, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On July 15, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of G.

#### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 20, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

Pleasant Manor LLC August 5, 2021 Page 2

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 20, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 20, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pleasant Manor LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

Pleasant Manor LLC August 5, 2021 Page 3

correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

### **DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your

Pleasant Manor LLC August 5, 2021 Page 4 verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 15, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

### APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Pleasant Manor LLC August 5, 2021 Page 5

> Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

#### APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

Pleasant Manor LLC August 5, 2021 Page 6

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245090	B. WING			C <b>07/15/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021	<sup>2</sup> CODE	<u>                                     </u>	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 000	survey was conducted was found to be NO requirements of 42 Requirements for L.  The survey resulted (IJ) at F689 when the manufacturer's guident measures where in mechanical lift for 2 who utilized a full bound fell from the most fracture to left tibia. The IJ began on 6/removed on 7/15/2.  The above findings quality of care, and conducted on 7/15/2.  The following compound for the following compound for the following compound for the following compound for the form. Your electron be used as verificat.  Upon receipt of an on-site revisit of your first size of the form. Your electron for the form of the form of the form of the form. Your electron for the form of the form	5/21, a standard abbreviated sted at your facility. Your facility. Tin compliance with the CFR 483, Subpart B, Long Term Care Facilities of in an Immediate Jeopardy the facility failed to follow delines to ensure safety inplemented for the use of a 2 of 2 resident (R2 and R4) tody lift. This deficient practice rediate jeopardy (IJ) for R2, rechanical lift and sustained a (a long bone in the lower leg). 12/21, and the immediacy was 1.  It is constituted substandard an extended survey was 1/21.  Colaints was found to be 1/2074516), with a deficiency of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required the first page of the CMS-2567 ric submission of the POC will tion of compliance.  Cacceptable electronic POC, an ur facility may be conducted to	FC				
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE			(X6) DATE

Electronically Signed 08/06/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245090	B. WING _			C <b>15/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021	<u> </u>	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 000		ge 1 Intial compliance with the en attained in accordance with	F 00	00		
F 689 SS=J	F 689 Free of Accident Hazards/Supervision/Devices		F 68	9		8/6/21
	supervision and assaccidents. This REQUIREMENT	resident receives adequate sistance devices to prevent				
	review, the facility facility facility for guidelines to ensure implemented for the	tion, interview and document ailed to follow manufacturer's e safety measures were use of a mechanical lift for 2 and R4) who utilized a full body		Residents R2 and R4's slings we reviewed and replaced with prope that are of correct size and follow manufacturer guidelines.		
	lift. This deficient primmediate jeopardy	ractice resulted in an (IJ) for R2, who fell from the sustained a fracture to left		All like residents that utilize mechalifts with slings were reviewed to ethe proper size and manufacturer guidelines are being met.		
	nursing assistants ( transferring R2 with follow manufacture to fall out of the slin administrator and d notified of the IJ on was removed on 7/ non-compliance rer severity level G, isc	12/21, at 6:45 p.m. when (NA)-A and (NA)-B were a mechanical lift and failed to r safety guidelines, causing R2 to the floor. The lirector of nursing (DON) were 7/14/21, at 5:56 p.m. The IJ 15/21, at 3:47 p.m. however, mained at the lower scope and plated, scope and severity, all harm that is not immediate		Facility Mechanical Lift Policy and Resident Handling Policy were revand remain current. All facility Nur Therapy and Agency staff were re-educated on the proper use of mechanical lift slings including prosizing, proper brand of sling, locat slings within the facility, and proper information for each resident on fagroup sheets.  Administrator or designee will com	viewed sing, oper ion of lift er sling acility	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245090	B. WING				C 1 <b>5/2021</b>
	PROVIDER OR SUPPLIER  NT MANOR LLC			27	TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021	1 01/	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	diagnoses of fractumultiple sclerosis (Nand spinal cord) an legs and lower body. R2's quarterly Minimassessment dated cognitively intact, wision, clear speech was able to underston two staff for tranand wheelchair to be staff for bed mobilit personal hygiene. R2's plan of care, with 10/10/21, indicatedOn 4/8/20, R2 warelated to inability to Intervention dated 6 brand name of a maphysical therapy/oc a program with regarderation in mobility paraplegia. Intervention dated 6 brand name of a maphysical therapy/oc a program with regarderation in mobility paraplegia. Intervention dated 6 brand name of a maphysical therapy/oc a program with regarderation in mobility paraplegia. Intervention dated 6 brand name of a maphysical therapy/oc a program with regarderation in mobility paraplegia. Intervention dated 6 brand 1 brand	ted on 7/14/21, indicated re of the upper end of left tibia, MS) (a disease of the brain d paraplegia (paralysis of the y).  mum Data Set (MDS) 7/7/21, indicated R2 was ith adequate hearing and n, she understood others and tand. R2 had total dependence sfers from bed to wheelchair red, and assistance of one y, dressing, toileting and  with date range of 4/8/20, to the following: as identified as a fall risk or transfer without assistance. S/21/21, included: hoyer (a echanical lift) with two staff; cupational therapy to establish and to preferences and MS. The plan identified that R2 had y related to MS and intions dated 4/8/20, included: ent in bed and in/out of bed via transfers with two staff and s straps; wishes straps to be and not crossed between	F 6	89	audits of correct sling usage, including size, manufacturer and group sheer ensure that the correct sling size is These audits will be completed on residents five times per week for for weeks, weekly for three months, as follow-up with QAPI committee.  Date certain for deficiency correction 7/16/2021.	ets to listed. five our and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245090	B. WING		07	C / <b>15/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 27 BRAND AVENUE FARIBAULT, MN 55021		/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	R2's room at 6:45 pon the floor with NA pillow. R2 was on hof her. R2 was alert pain. NA-A stated F two staff and fell ou R2's head and it did no bruising noted to assisted to bed via  Progress note date indicated R2 could medications, morni and therefore was to the local hospital at transferred onto the complained of leg aleg was not specific subsequently transito a metro hospital.  Admission note from 6/13/21, indicated Faltered mental statu pressure. R2 was do (when the body's redamages it's own ti R2 fell out of hoyer developed left lower of motion. Due to R sensitive with all moobtained which reveleg. Non-operative recommended and left knee/leg.  During an interview	d nurse (RN)-A was called to o.m. and observed R2 laying A-B holding her head on a per back with legs out in front and orientated, and denied R2 was being transferred by at of the sling. One staff caught anot hit the floor. There was a back or buttocks. R2 was mechanical lift and four staff.  Ind 6/13/21, at 2:43 p.m. anot be awakened for morning any vital signs or noon lunch transferred by ambulance to a 1:35 p.m. As R2 was a ambulance stretcher, she and buttock pain (left or right and buttock pain (left	F6	89			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245090	B. WING		07	C 7/ <b>15/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021		713/2321	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	about her fall last in me out of the hoyer tibia," but did not kin R2 went on to say ther when she was wheelchair in her sidd everything right used] out of me." Fago the facility was her. R2 stated the liday, once to get he to put her to bed in any problems prior.  During an interview (NA)-C stated R2 hif any other resident pointed out R4's slibrand sling; white cobserved sitting on the common area at During an interview (NA)-A stated she li R2's transfer on 6/2 her sling from whee when R2 fell out of feet to the floor. NA a particular way an wanted the straps is crisscrossed between onto some of the sindyer. NA-A stated from home and did sling. NA-A did not sling, adding "I was her head." NA-A stated."	g a left leg brace. When asked nonth, R2 stated "they dropped r; hence I broke my leg, my now why or how it happened. hat the straps looked right to being lifted out of her ling." As far as I can tell, they It scared the [profanity 2 added she was told a week going to order a new sling for noyer was used on her twice a r up in the morning and once the evening and had not had	F 6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245090	B. WING				C <b>15/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021	DE	<u> </u>	10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE	
F 689	helped lift R2 three NA-A stated she ha lift when she started could not recall who During a telephone p.m., RN-A stated sright after the fall. VR2 was sitting on the her back and her leher that the strap of fell out of the sling. NA's reenact what the problem with it. RN-sling and they were her own sling and dading "R2 is very them (staff) to use there pretty well	or four times prior to this. d training for the mechanical d working at the facility but to trained her.  interview on 7/14/21, at 12:32 the was called to R2's room when she entered the room, he floor with a pillow behind gs out in front of her. NA's told in the lift came loose and R2 RN-A stated she had the two they did and didn't see any A inspected the straps on the intact. RN-A stated R2 used didn't know the brand name, particular about how she wants the sling." "She's hooked in we watched them do this ed if there were any written	F 6	89				

PLEASANT MANOR LLC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021  (X5)	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED		
PLEASANT MANOR LLC  PHEASANT MANOR LLC  CALLE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 6 don't think they crisscrossed the straps under her legs - that gets her butt up. If they did not do that, she would fall right out of the sling.' Neither R2 or FM-A knew the brand name of R2's sling from home, adding there was no identifying information on it anymore.  During an interview on 7/14/21, a 1:45 p.m., physical therapy assistant (PTA)-D was asked about R2's physical therapy (PT) Evaluation & Plan of Treatment report dated 6/24/21. According to the report, a referral was made to PT by nursing following R2's fall. PT was to: evaluate patient bed mobility without overhead trapeze and safety of "basket style hoyer lift." Following the evaluation, the clinical impression by the physical therapist indicated "basket sling was being used prior to the fall, and remains safe after fall if implemented by qualified individuals." The PT description of the sling as incongruous with the actual sling utilized by R2 which was a split leg sling and not a basket style sling, PTA-D stated she had never seen the sling or observed R2 being moved with the lift/sling. Since another therapist had written the note and was unavailable, she could not offer more information.  During observation, the facility had three Volaro brand mechanical lifts available for resident use, one on each unit. Each lift had four hooks. The manufacturer of the Volaro lift was SMT Health			245090	B. WING			C 17/15/2021		
FREFIX TAG    (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG					27 BRAND AVENUE		1710/2021		
don't think they crisscrossed the straps under her legs - that gets her butt up. If they did not do that, she would fall right out of the sling." Neither R2 or FM-A knew the brand name of R2's sling from home, adding there was no identifying information on it anymore.  During an interview on 7/14/21, a 1:45 p.m., physical therapy assistant (PTA)-D was asked about R2's physical therapy (PT) Evaluation & Plan of Treatment report dated 6/24/21.  According to the report, a referral was made to PT by nursing following R2's fall. PT was to: evaluate patient bed mobility without overhead trapeze and safety of "basket style hoyer lift." Following the evaluation, the clinical impression by the physical therapist indicated "basket sling was being used prior to the fall, and remains safe after fall if implemented by qualified individuals." The PT description of the sling was incongruous with the actual sling utilized by R2 which was a split leg sling and not a basket style sling. PTA-D stated she had never seen the sling or observed R2 being moved with the lift/sling. Since another therapist had written the note and was unavailable, she could not offer more information.  During observation, the facility had three Volaro brand mechanical lifts available for resident use; one on each unit. Each lift had four hooks. The manufacturer of the Volaro lift was SMT Health	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	COMPLÉTION		
dated 3/2019, titled "safety notes" indicated: use only Volaro slings and accessories designed for use with the Volaro lift models.  During an interview on 7/14/21, at 3:20 p.m. the DON stated after R2's fall, PT verified that the	F 689	don't think they cris legs - that gets her she would fall right FM-A knew the bra home, adding there on it anymore.  During an interview physical therapy as about R2's physical Plan of Treatment in According to the re PT by nursing follow evaluate patient be trapeze and safety Following the evaluate patient be trapeze and safety Following the evaluate physical there was being used privafter fall if implemed The PT description with the actual sling split leg sling and in stated she had nev R2 being moved with the actual sling split leg sling and in stated she had nev R2 being moved with the actual sling split leg sling and in stated she had nev R2 being moved with the actual sling split leg sling and in stated she had nev R2 being moved with the actual sling split leg sling and in stated she had nev R2 being moved with the actual sling split leg sling and in stated she had nev R2 being moved with the actual sling split leg sling and in stated 3/2019, titled only Volaro slings a use with the Volaro During an interview	scrossed the straps under her butt up. If they did not do that, out of the sling." Neither R2 or nd name of R2's sling from a was no identifying information on 7/14/21, a 1:45 p.m., sistant (PTA)-D was asked I therapy (PT) Evaluation & report dated 6/24/21. port, a referral was made to wing R2's fall. PT was to: d mobility without overhead of "basket style hoyer lift." lation, the clinical impression rapist indicated "basket sling or to the fall, and remains safe anted by qualified individuals." of the sling was incongruous goutilized by R2 which was a not a basket style sling. PTA-D are seen the sling or observed with the lift/sling. Since another on the note and was bould not offer more information.  The facility had three Volaro ifts available for resident use; each lift had four hooks. The envolation of the operators manual area safety notes indicated: use and accessories designed for lift models.  To 7/14/21, at 3:20 p.m. the		589				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245090	B. WING		07	C 7/ <b>15/2021</b>
_	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021	•	113/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE
F 689	Volaro mechanical and PT said it was own sling; "we want the right one based time." The DON state continued with the sof R2's personal sliusing the lift and sliusing the lift and sliusing the lift and sliusing the lift and sliusing the incide supposed to verify the shift, but didn't know done.  During same intervithere was no proof, her leg during the facing during the facing during the facing during the state occurred during the the local hospital, of metro hospital. Whe practice to use any Volaro lift, the DON a potential safety rispersonal sling with from the lift. She indonew slings from the and this was verified slip. However, sling manufacturer continuntil Volaro brand so 7/14/21. The DON of been switched out, be switched out un R2's request. R2 in	ge 7  lift and R2's personal sling, okay to continue to use R2's ted to make sure the sling was on information we had at the sted after the fall, they same lift process and the use ng because PT evaluated R2 ng and said it was okay. When been new training for the staff nt, the DON stated PT was training for two staff on each of for certain if that had been seen, the DON stated she felt nor did she believe R2 broke all on 6/12/21, adding R2 had lity all day on 6/12/21 and leg on a door frame and broke a transfer from the facility to refrom the local hospital to the en asked if it was acceptable manufacturers sling with the stated she was not aware of sk with a resident using their the facility lift until after R1 fell dicated the facility ordered by Volaro company on 7/7/21, d by reviewing the packing s not specified by the nued to be used for R2 and R4 lings arrived to the facility on confirmed the sling for R2 would not til the morning of 7/15/21, at formed staff she did not want antil her regular lift transfer in	F 6	89		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245090	B. WING _			C / <b>15/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	p.m., Volaro represe March 2020, she was mechanical lifts wit asked if she looked to her in the chape she saw any non-varied what should be used you use Volaro-mad VR-F, the rationale ensure the safety of manufacturer. Safe Operator's Manual dated 3/2019, indicand accessories delift models.  During an interview PTA-D stated when training for the nurse R2's, they usually the evening shifts and However according that had not been of acknowledged she manufacturer specific be used with their I know that R2's slin by the Volaro manufacturer mechanical states.	e interview on 7/14/21, at 4:04 sentative (VR)-F stated in vent through each of the facility th maintenance staff. When d at the slings also, VR-F at the slings that were brought I that day and did not recall if volaro slings. VR-F stated ufacturer says for slings are ed. If you receive a Volaro lift nufactured sling." According to being the company could not of a sling made by another ety notes in the Manufacturer for Volaro Mechanical Lift, eated to use only Volaro slings esigned for use with the Volaro of the volaro through the through the day and those staff after an incident like rained two staff on the day and those staff trained other staff. If to another therapists notes, done after R2's fall. PTA-D was not aware of the iffication that only their slings ifts. Additionally, PTA-D did not g was not one recommended	F 68	9		
	NA-B who was the in R2's fall, stated I "she fell out of the still on the hooks."	second staff member involved he did not know how R2 fell; left side, but the straps were NA-B acknowledged there on R2's sling than there were				

NAME OF PROVIDER OR SUPPLIER  PLEASANT MANOR LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
PLEASANT MANOR LLC    SUMMARY STATEMENT OF DEFICIENCIES   FARIBAULT, MN 55021			245090	B. WING		07	C 7/ <b>15/2021</b>		
F 689  Continued From page 9 hooks on the Volaro lift, adding that R2 held onto the extra ones with her hands. After R2 fell, NA-B stated she was placed in bed for the night by staff and the mechanical lift. NA-B did not recall if he received training on the use of the Volaro lift when he started employment at the facility.  During an observation on 7/15/21, at 10:04 a.m. in R2's room, R2 was lying in bed on the new SMT sling. NA-C and NA-D hooked up the four straps on the sling to the four hooks on the Volaro mechanical lift. NA-C operated the mechanical lift and NA-D guided R2 to the wheelchair.  During an interview on 7/15/21, at 10:21 a.m. the administrator stated it was following a different incident that occurred on 7/5/21, with another resident that she became aware of Volaro's					27 BRAND AVENUE		710/2021		
hooks on the Volaro lift, adding that R2 held onto the extra ones with her hands. After R2 fell, NA-B stated she was placed in bed for the night by staff and the mechanical lift. NA-B did not recall if R2 had pain when she was returned to bed. NA-B did not recall if he received training on the use of the Volaro lift when he started employment at the facility.  During an observation on 7/15/21, at 10:04 a.m. in R2's room, R2 was lying in bed on the new SMT sling. NA-C and NA-D hooked up the four straps on the sling to the four hooks on the Volaro mechanical lift. NA-C operated the mechanical lift and NA-D guided R2 to the wheelchair.  During an interview on 7/15/21, at 10:21 a.m. the administrator stated it was following a different incident that occurred on 7/5/21, with another resident that she became aware of Volaro's	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE		
with the Volaro lifts. It was at that time she was informed by the facility regional nurse consultant there was a potential safety risk if slings not specified by the manufacturer were used. Once that was identified, the facility did an audit of all 14 residents who used the mechanical lift and discovered R2 and R4 did not have the correct slings. New slings were ordered for R2 and R4 from the Volaro mechanical lift company which arrived to the facility on 7/14/21. The administrator admitted that from 7/5/21, to 7/14/21, the facility continued to use slings not specified by the manufacturer for R2 and R4, resulting in the potential for harm.  During interviews on 7/15/21, at 3:20 p.m., training was verified as having occurred for	F 689	hooks on the Volar the extra ones with stated she was pla and the mechanical had pain when she not recall if he receivolaro lift when he facility.  During an observation R2's room, R2 with SMT sling. NA-C a straps on the sling mechanical lift. NA and NA-D guided Find During an interview administrator state incident that occurresident that she be specification to utility with the Volaro lifts informed by the fact there was a potent specified by the mathat was identified, 14 residents who utility discovered R2 and slings. New slings from the Volaro mearrived to the facility administrator admi 7/14/21, the facility specified by the material was incompleted by the m	o lift, adding that R2 held onto her hands. After R2 fell, NA-B ced in bed for the night by staff al lift. NA-B did not recall if R2 was returned to bed. NA-B did eived training on the use of the started employment at the started employment at the started employment at the divide the four to the four hooked up the four to the four hooks on the Volaro-C operated the mechanical lift R2 to the wheelchair.  If on 7/15/21, at 10:21 a.m. the dit was following a different red on 7/5/21, with another ecame aware of Volaro's ize only slings designed for use. It was at that time she was cility regional nurse consultant it anufacturer were used. Once the facility did an audit of all ised the mechanical lift and R4 did not have the correct were ordered for R2 and R4 echanical lift company which by on 7/14/21. The sted that from 7/5/21, to continued to use slings not anufacturer for R2 and R4, ential for harm.		89				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION  NG		COMPLETED		
		245090	B. WING		07	C 7/ <b>15/2021</b>		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021		710/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 689	shift. Evening staff (LPN)-B, (LPN)-C, (NA)-H; all articulat the training plan (e recommended sling sling from another and correct size was they went into R2's part of the training.  R4  R4's facesheet prindiagnoses of chrondiabetes.  R4's quarterly Miniassessment dated cognitively intact, wision, and clear spassistance of two stransfers from bed to bed; extensive a for dressing, toileting R4's plan of care dafall risk related to would be safe and identified as having related to obesity. Transfers using the not indicate the typ During an interview (NA)-C stated R4 in "Med Care" brands that she was using hospitalization. R4	interviewed included (RN)-B, (NA)-E, (NA)-F, (NA)-G, and ted the training as described in .g., only manufacturer gs can be used, cannot use a hospital or ambulance service as to be utilized). Staff stated room for demonstration as	F6	89				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245090	B. WING			C <b>07/15/2021</b>	
	PROVIDER OR SUPPLIER			S' 2'	TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE FARIBAULT, MN 55021	017	15/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 689	DON stated R4 had metro hospital when hospitalized. The D been ordered from R4 and it arrived 7/ utilizing the new on During an interview administrator stated incident that occurring resident that she be recommendation to for use with the Volwas informed by the consultant there was lings not recomme were used. Once the did an audit of all 14 mechanical lift and the correct sling. A from the Volaro mearrived to the facility to be utilized for R4. The immediate jeon was removed on 7/ audited the 14 resid lifts for the correct sremoved all non-SN circulation. All other inventoried, and ad ordered from the mhad a "lift mobility s NA care sheets were and care plans were	lity.  on 7/14/21, at 4:15 p.m., the dispension a series had recently been ON stated a new sling had the Volaro manufacturer for 14/21, and R4 would be e.  on 7/15/21, at 10:21 a.m. the dist was following a different ed on 7/5/21, with another exame aware of Volaro's utilize only slings designed aro lifts. It was at that time she as a potential safety risk if ended by the manufacturer lat was identified, the facility 4 residents who used the discovered R4 did not have new sling was ordered for R4 chanical lift company which y on 7/14/21, and was stated	F 6	\$89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245090	B. WING				C 1 <b>5/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021	ODE	017	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD I	BE	(X5) COMPLETION DATE
F 689	therapy staff regard location and color of included how a staff sling size to use per and PT/OT staff conext shift worked. A completed a knowle staff to ensure the ethe next shift worked completed a physicion five residents, five weeks and then we months with follow-Administrator or degroup sheets being size five times per veekly thereafter for needed education would review the retheir next meeting. The next QAPI (qualimprovement) meeducation would be for all new agency sincorporated into or hires. However, the the lower scope and	sing and physical/occupational ling correct sling brand, size, coding system. The education of member can find the correct of the group sheet. All nursing empleted this education prior to administrator or designee edge quiz with all educated education was sustained for ed. Administrator or designee all audit of correct sling usage we times per week for four ekly thereafter for three up or needed education. Signee completed an audit of up-to-date with correct sling week for four weeks and then or three months with follow-up on. The safety committee sident safe handling policy at Audits would be reviewed at lity assurance performance ting. Correct sling size put in agency training binder	F6	89			



Electronically delivered August 5, 2021

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

Re: State Nursing Home Licensing Orders

Event ID: CEBV11

#### Dear Administrator:

The above facility was surveyed on July 14, 2021 through July 15, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Pleasant Manor LLC August 5, 2021 Page 2

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 08/17/2021 FORM APPROVED

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00500			07/4	
NAME OF	PROVIDER OR SUPPLIER	00568		STATE, ZIP CODE	07/1	5/2021
	NT MANOR LLC	27 BRAND	, ,	TATE, ZII OODE		
			LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and	nether a violation has been				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Pla plan of correction yo	TS: I, a complaint survey was acility by surveyors from the tent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders a when they will be completed.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/06/21 **Electronically Signed** 

STATE FORM 6899 CEBV11 If continuation sheet 1 of 14

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′ ′		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00568	B. WING		07/1	; 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PLEASANT MANOR LLC			O AVENUE LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	The following comp SUBSTANTIATED: a licensing order is: Minnesota Department the State Licensing Federal software. The state state of the findings of the findings which a statute after the state of the findings which a statute after the state of the Suggested of the Minnesota Department of State lice of the Minnesota Department of Heavyou electronically, is necessary for State lice of the Minnesota Department of Heavyou electronically, is necessary for State lice of the Minnesota Department of Heavyou electronically, is necessary for State lice of the Minnesota Department of Heavyou electronic State lice of the Minnesota Department of the Minnesota Department of the meding completion be corrected prior to the Minnesota Depis enrolled in ePOC	plaint was found to be H5090089C (MN74516) with sued at 4658.0520.  The ent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for the assigned tag number efft column entitled "ID Prefix attute/rule out of compliance is the "To Comply" portion of the state are in violation of the state attement, "This Rule is not met be allowing the surveyor's findings Method of Correction and a participate in the electronic insure orders consistent with				

Minnesota Department of Health STATE FORM

6899 CEBV11 If continuation sheet 2 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
		00568	B. WING			5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PLEASA	NT MANOR LLC	27 BRAND		04		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	LT, MN 5502	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 2	2 830			
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			8/6/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observation review, the facility for guidelines to ensure implemented for the of 2 resident (R2 ar lift. This deficient primmediate jeopardy mechanical lift and tibia (a long bone in The IJ began on 6/2)	ent is not met as evidenced on, interview and document ailed to follow manufacturer's e safety measures were use of a mechanical lift for 2 and R4) who utilized a full body actice resulted in an (IJ) for R2, who fell from the sustained a fracture to left a the lower leg).  12/21, at 6:45 p.m. when NA)-A and (NA)-B were		Residents R2 and R4's slings were reviewed and replaced with proper that are of correct size and follow manufacturer guidelines.  All like residents that utilize mechalifts with slings were reviewed to e the proper size and manufacturer guidelines are being met.  Facility Mechanical Lift Policy and Resident Handling Policy were reviewed.	r slings anical nsure Safe riewed	
	transferring R2 with follow manufacture to fall out of the slin administrator and d notified of the IJ on was removed on 7/	a mechanical lift and failed to r safety guidelines, causing R2		and remain current. All facility Nur Therapy and Agency staff were re-educated on the proper use of mechanical lift slings including pro sizing, proper brand of sling, locati slings within the facility, and prope information for each resident on fa	sing, per ion of lift r sling	

Minnesota Department of Health STATE FORM

ATE FORM CEBV11 If continuation sheet 3 of 14

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A DITH DING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X2)		(X3) DATE SURVEY COMPLETED	
	A. BUILDING	•	С		
00568	B. WING		07/15/	/2021	
NAME OF PROVIDER OR SUPPLIER STREET A	DDRESS, CITY,	STATE, ZIP CODE			
PLEASANT MANOR LLC	ND AVENUE ULT, MN 550	21			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830 Continued From page 3	2 830				
severity level G, isolated, scope and severity, which indicate actual harm that is not immediate jeopardy.  Findings include:  R2's facesheet printed on 7/14/21, indicated diagnoses of fracture of the upper end of left tibia multiple sclerosis (MS) (a disease of the brain and spinal cord) and paraplegia (paralysis of the legs and lower body).  R2's quarterly Minimum Data Set (MDS) assessment dated 7/7/21, indicated R2 was cognitively intact, with adequate hearing and vision, clear speech, she understood others and was able to understand. R2 had total dependence on two staff for transfers from bed to wheelchair and wheelchair to bed, and assistance of one staff for bed mobility, dressing, toileting and personal hygiene.  R2's plan of care, with date range of 4/8/20, to 10/10/21, indicated the following:On 4/8/20, R2 was identified as a fall risk related to inability to transfer without assistance. Intervention dated 6/21/21, included: hoyer (a brand name of a mechanical lift) with two staff; physical therapy/occupational therapy to establis a program with regard to preferences and MSOn 4/8/20, the care plan identified that R2 had alteration in mobility related to MS and paraplegia. Interventions dated 4/8/20, included: assist with movement in bed and in/out of bed via hoyer. Assist with transfers with two staff and hoyer lift. R2 checks straps; wishes straps to be crossed under legs and not crossed between legsThe care plan did not indicate that R2 used her	e e	group sheets.  Administrator or designee will con audits of correct sling usage, inclusize, manufacturer and group sheensure that the correct sling size in These audits will be completed or residents five times per week for tweeks, weekly for three months, a follow-up with QAPI committee.  Date certain for deficiency correct 7/15/2021.	iding ets to s listed. n five our and		

Minnesota Department of Health

STATE FORM CEBV11 If continuation sheet 4 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00568	B. WING			5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	indicated registered R2's room at 6:45 pon the floor with NA pillow. R2 was on hof her. R2 was alert pain. NA-A stated F two staff and fell ou R2's head and it did no bruising noted to assisted to bed via  Progress note date indicated R2 could medications, morniand therefore was the local hospital at transferred onto the complained of leg a leg was not specific subsequently transit to a metro hospital.	d 6/12/21, at 7:45 p.m. If nurse (RN)-A was called to o.m. and observed R2 laying a B holding her head on a er back with legs out in front and orientated, and denied R2 was being transferred by at of the sling. One staff caught anot hit the floor. There was a back or buttocks. R2 was mechanical lift and four staff.  d 6/13/21, at 2:43 p.m.  not be awakened for morning any vital signs or noon lunch ransferred by ambulance to 1:35 p.m. As R2 was a ambulance stretcher, she and buttock pain (left or right and in progress note). R2 was ferred from the local hospital				
	6/13/21, indicated Faltered mental statupressure. R2 was d (when the body's redamages it's own ti R2 fell out of hoyer developed left lowe of motion. Due to R	R2 was transferred due to us, fever and low blood liagnosed with severe sepsis esponse to an infection ssue). Notes further indicated on 6/12, and subsequently r extremity pain with any range '2's left leg being very				
	obtained which revelleg. Non-operative recommended and left knee/leg.	ovement, an xray was ealed a tibia fracture of the left management was a brace was placed on R2's on 7/14/21, at 10:35 a.m.,				

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 5 of 14

	OVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE COMP	
		A. BOILDING.		C	<u>.</u>
00	568	B. WING			, 5/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PLEASANT MANOR LLC	27 BRANI	<b>AVENUE</b>			
PLEASANT MANOR LLC	FARIBAU	LT, MN 5502	1		
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
observed R2 in her room, so wheelchair, wearing a left leabout her fall last month, R2 me out of the hoyer; hence tibia," but did not know why R2 went on to say that the sher when she was being lift wheelchair in her sling." As did everything right. It scare used] out of me." R2 added ago the facility was going to her. R2 stated the hoyer waday, once to get her up in the put her to bed in the ever any problems prior to this.  During an interview on 7/14 (NA)-C stated R2 had her of any other residents had the pointed out R4's sling which brand sling; white cloth with observed sitting on the sling the common area at the ental During an interview on 7/14 (NA)-A stated she had been R2's transfer on 6/12/21; she her sling from wheelchair to when R2 fell out of the sling feet to the floor. NA-A stated a particular way and describ wanted the straps under he crisscrossed between them onto some of the straps tha hoyer. NA-A stated R2's slir from home and did not know whaling, adding "I was just wor her head." NA-A stated R2 is ling, adding "I was just wor her head." NA-A stated R2 is ling, adding "I was just wor her head." NA-A stated R2 is ling, adding "I was just wor her head." NA-A stated R2 is ling, adding "I was just wor her head." NA-A stated R2 is ling, adding "I was just wor her head." NA-A stated R2 is ling, adding "I was just wor her head." NA-A stated R2 is ling.	eg brace. When asked 2 stated "they dropped I broke my leg, my or how it happened. straps looked right to ed out of her far as I can tell, they at the [profanity she was told a week order a new sling for is used on her twice a ne morning and once ning and had not had welved to was a "Med Care" gold trim. R4 was gin her wheelchair in trance of the facility.  1/21, at 12:05 p.m., helping (NA)-B with he was guiding R2 in bed with her hands in falling about three d R2 wanted her sling bed R2's nuances: she r legs and not , and wanted to hold the did not hook to the nig was her own sling with brand of the cried about catching	2 830			

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 6 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			,
		00568	B. WING		07/15/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PLEASANT MANOR LLC			O AVENUE LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	helped lift R2 three NA-A stated she hal lift when she started could not recall who During a telephone p.m., RN-A stated sright after the fall. VR2 was sitting on the her back and her leher that the strap of fell out of the sling. NA's reenact what problem with it. RN sling and they were her own sling and cadding "R2 is very them (staff) to use there pretty well!'before." When aske instructions for R2's preferences, RN-A RN-A reported the boon.  During an interview at 12:40 p.m., R2 a were playing cards used to be a person R2 when R2 lived a ordered the sling on mechanical lift at he sling had eight strasix of the eight stralift. R2 liked to hold weren't used. R2 st straps under her legover her legs becaustated, "I have no in	or four times prior to this. Indicate the facility but the description of the mechanical distribution of the was called to R2's room. Interview on 7/14/21, at 12:32 where was called to R2's room. When she entered the room, the floor with a pillow behind the general of the room of the lift came loose and R2. RN-A stated she had the two they did and didn't see any representation. A stated R2 used didn't know the brand name, coarticular about how she wants the sling." "She's hooked in the we watched them do this the strain of the room of the watched them do this the strain of the room of the strain of the watched them do this the sling."	2 830			

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		C	
		00568	B. WING			5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PLEASANT MANOR LLC			DAVENUE LT, MN 5502	11		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	legs - that gets her she would fall right FM-A knew the branch home, adding there on it anymore.  During an interview physical therapy as about R2's physical Plan of Treatment of According to the report by nursing follow evaluate patient be trapeze and safety Following the evaluate physical there was being used pricafter fall if impleme The PT description with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the actual sling split leg sling and not stated she had nev R2 being moved with the volaro buring an interview DON stated after R staff performed R2 s	butt up. If they did not do that, out of the sling." Neither R2 or and name of R2's sling from was no identifying information on 7/14/21, a 1:45 p.m., sistant (PTA)-D was asked therapy (PT) Evaluation & eport dated 6/24/21. Doort, a referral was made to wing R2's fall. PT was to: d mobility without overhead of "basket style hoyer lift." ation, the clinical impression apist indicated "basket sling or to the fall, and remains safe anted by qualified individuals." of the sling was incongruous the sling was incongruous to the sling was incongruous to the lift/sling. Since another the note and was and the lift/sling. Since another the facility had three Volaro if savailable for resident use; ach lift had four hooks. The evolaro lift was SMT Health tion of the operators manual "safety notes" indicated: use and accessories designed for	2 830			

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 8 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00568	B. WING		07/1	5/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PLEASA	NT MANOR LLC	27 BRAND	D AVENUE LT, MN 5502	<b>11</b>		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
2 630	own sling; "we want the right one based time." The DON state continued with the sof R2's personal sliusing the lift and sliusing the rich there had been out of the facions.  During same intervithere was no proof, her leg during the facion could have hit her it." The DON stated occurred during the the local hospital, of metro hospital. Whe practice to use any Volaro lift, the DON a potential safety rispersonal sling with from the lift. She income with slings from the and this was verified slip. However, sling manufacturer continuatil Volaro brand so 7/14/21. The DON of been switched out, be switched out un R2's request. R2 in	ted to make sure the sling was on information we had at the sted after the fall, they same lift process and the use ing because PT evaluated R2 ing and said it was okay. When been new training for the staff int, the DON stated PT was training for two staff on each in for certain if that had been seen, the DON stated she felt in nor did she believe R2 broke all on 6/12/21, adding R2 had lity all day on 6/12/21 and leg on a door frame and broke it the fracture could have transfer from the facility to in from the local hospital to the en asked if it was acceptable manufacturers sling with the stated she was not aware of sk with a resident using their the facility lift until after R1 fell dicated the facility ordered a Volaro company on 7/7/21, if do yreviewing the packing is not specified by the nued to be used for R2 and R4 lings arrived to the facility on confirmed the sling for R4 had but the sling for R2 would not til the morning of 7/15/21, at formed staff she did not want until her regular lift transfer in	2 830			
		interview on 7/14/21, at 4:04 entative (VR)-F stated in				

Minnesota Department of Health

STATE FORM CEBV11 If continuation sheet 9 of 14

PRINTED: 08/17/2021 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00568	B. WING		07/1	5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PLEASA	NT MANOR LLC		AVENUE	)- <b>1</b>		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	LT, MN 5502	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From page 9 2 830					
	mechanical lifts with asked if she looked at to her in the chapel she saw any non-Venthale what should be use you use Volaro-mar VR-F, the rationale ensure the safety of manufacturer. Safe Operator's Manual dated 3/2019, indicand accessories de lift models.					
	and accessories designed for use with the Volaro					

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 10 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00568	B. WING			C 1 <b>5/2021</b>
NAME OF PROVIDER OR	SUPPLIER			STATE, ZIP CODE	•	
PLEASANT MANOR	LLC	27 BRAND FARIBAUI	) AVENUE _T, MN 5502	21		
PREFIX (EACH I	DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
not recall in Volaro lift of facility.  During an in R2's root SMT sling straps on a mechanical and NA-D.  During an administratincident the resident the specification with the Volinformed by there was specified by the training should be resulting in training was evening should be shift. Ever (LPN)-B, (NA)-H; all the training was the shift of the shift o	when she if he rece when he observation, R2 w. NA-C and the sling al lift. NA-guided F interview at occurring the facility of the facility of the facility of the man the potential of the facility of the facilit	was returned to bed. NA-B did ived training on the use of the started employment at the new of NA-D hooked up the four to the four hooks on the Volaro-C operated the mechanical lift at the was following a different ed on 7/5/21, at 10:21 a.m. the dit was following a different ed on 7/5/21, with another exame aware of Volaro's ze only slings designed for use. It was at that time she was illity regional nurse consultant al safety risk if slings not unufacturer were used. Once the facility did an audit of all sed the mechanical lift and R4 did not have the correct were ordered for R2 and R4 chanical lift company which y on 7/14/21. The sted that from 7/5/21, to continued to use slings not unufacturer for R2 and R4, ential for harm.  In 7/15/21, at 3:20 p.m., das having occurred for on duty prior to the start of their interviewed included (RN)-B, (NA)-E, (NA)-F, (NA)-G, and ed the training as described in g., only manufacturer gs can be used, cannot use a	2 830			

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 11 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00568	B. WING		07/1	5/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From page 11		2 830				
	and correct size wa	nospital or ambulance service s to be utilized). Staff stated room for demonstration as					
	R4						
		ted on 7/15/21, indicated ic pain, heart disease and					
	assessment dated so cognitively intact, we vision, and clear speassistance of two si transfers from bed to bed; extensive as	mum Data Set (MDS) 5/6/21, indicated R4 was ith adequate hearing and eech. R4 required extensive taff for moving in bed and to wheelchair and wheelchair esistance of one or two staff g and personal hygiene.					
	a fall risk related to would be safe and f identified as having related to obesity. T transfers using the	ated 1/13/21, indicated R4 was impaired mobility and R4 free from falls. R4 was an alteration in mobility wo staff were to assist with hoyer lift. The care plan did to of sling utilized for R4.					
	(NA)-C stated R4 has "Med Care" brand sthat she was using hospitalization. R4 was the control of	on 7/14/21, at 11:17 a.m. ad her own sling which was a sling; white cloth with gold trim since returning from a recent was observed sitting on the lair in the common area at the lity.					
	DON stated R4 had metro hospital when	on 7/14/21, at 4:15 p.m., the been using a sling from a re she had recently been ON stated a new sling had					

Minnesota Department of Health

STATE FORM 6899 CEBV11 If continuation sheet 12 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00568	B. WING		_	C 1 <b>5/2021</b>		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  27 BRAND AVENUE  FARIBAULT, MN 55021								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
2 830	been ordered from R4 and it arrived 7/ utilizing the new one During an interview administrator stated incident that occurresident that she be recommendation to for use with the Volawas informed by the consultant there was lings not recommendation to for use with the volawas informed by the consultant there was lings not recommended an audit of all 14 mechanical lift and the correct sling. A from the Volaro mearrived to the facility to be utilized for R4.  The immediate jeop was removed on 7/ audited the 14 resid lifts for the correct stremoved all non-SN circulation. All other inventoried, and adordered from the mhad a "lift mobility s NA care sheets were and care plans were status. Education won-going for all nurs therapy staff regard location and color coincluded how a staff sling size to use peand PT/OT staff color.	the Volaro manufacturer for 14/21, and R4 would be e.  on 7/15/21, at 10:21 a.m. the dit was following a different ed on 7/5/21, with another ecame aware of Volaro's utilize only slings designed aro lifts. It was at that time she e facility regional nurse as a potential safety risk if ended by the manufacturer eat was identified, the facility 4 residents who used the discovered R4 did not have new sling was ordered for R4 chanical lift company which y on 7/14/21, and was stated	2 830					

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			0		_	,
		00568	B. WING		07/1	<i>,</i> 5/2021
NAME OF I	PROVIDER OF SLIPPLIED		DRESS CITY O	STATE ZIP CODE	. 0.71	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  27 BRAND AVENUE					
PLEASA	NT MANOR LLC		T, MN 5502	21		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From pace completed a knowle staff to ensure the ensure the enthe next shift worke completed a physic on five residents, five weeks and then we months with follow-Administrator or degroup sheets being size five times per very weekly thereafter for needed education would review the restheir next meeting, the next QAPI (quaimprovement) meet education would be for all new agency sincorporated into or hires. However, the the lower scope and severity, that is not IJ.  SUGGESTED MET Director of Nursing develop, review, an procedures to ensure utilized following material pools of the policies designee could develop ensure ongoing cordesignee could procedures audit fincompliance.	ge 13  edge quiz with all educated education was sustained for ed. Administrator or designee al audit of correct sling usage we times per week for four ekly thereafter for three up or needed education. signee completed an audit of up-to-date with correct sling week for four weeks and then or three months with follow-up in. The safety committee sident safe handling policy at Audits would be reviewed at lity assurance performance ting. Correct sling size put in agency training binder	2 830	DEFICIENCY)		
	(21) days.	TOOTHILOTION. TWEITLY-OHE				

6899

Minnesota Department of Health STATE FORM