DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2022

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: Event ID: OSWK11

Dear Administrator:

The above facility survey was completed on September 1, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/31/22 through 9/1/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52284389C (MN86343), with deficiencies cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure safe mechanical full body	F 689	The facility failed to ensure safe mechanical full body lift procedures were	9/15/22

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

Electronically Signed | 09/15/2022

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.

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F 689	Continued From page 1 lift procedures were followed per manufacturer's guidelines to prevent a fall during transfer for 1 of 3 residents (R1). Findings include: Review of the 8/30/22 at 9:16 a.m., report to the State Agency (SA) identified on 8/29/22 at 11:00 a.m., R1 had a fall from a Hoyer lift (sling-full body lift) while staff were lifting him. R1 was transferred to the Emergency Department (ED) for assessment of potential injuries immediately after the fall. Review of the 11/29/22 at 11:30 a.m., ED note identified R1 obtained a scalp laceration that did not require repair, and imaging scans of his head and neck for injury were negative. The minor scalp laceration was treated with antibiotic ointment and he was returned to the facility with orders to follow up with the nursing home provider. Review of the 8/29/22 at 11:00 a.m., facility Incident report detailed during transfer with a full body lift, the top left side of the sling slipped off the bracket resulting in R1 sliding head first from the sling. The document listed a rubber stopper that was located on the end of the lift bracket was not located in the right spot and the lift was taken out of service until it could be inspected by a service provider. R1's quarterly Minimum Data Set (MDS) assessment dated 7/13/22 identified severe cognitive impairment, mild depression, and he had displayed verbal behaviors toward staff 1-3 days during the review period. He required extensive assistance of 2 staff persons for all	F 689	followed per the manufacturer's guidelines to prevent a fall during a transfer for 1 or 3 residents. QAPI team members and staff involved completed a root cause analysis on 9/1/22 at 1:30pm to identify the contributing factors for the fall of the resident. The 4 Why process was used to determine the root cause/contributing factors. Two contributing factors were identified: 1. The no slip mat under the recliner was too wide for the chair and worn on one corner. 2. The staff used the residents feet to help guide the sling motion, when they hit the mat under the chair with the leg of the lift and were guiding the feet of the resident in a sling motion, that allowed the weight of the resident to shift; the tension was no longer on the green sling strap and the strap let loose. A plan was developed to address the contributing factors: 1. Training occurred on 9/1/22, 9/8/22, with the staff and additional training will be held on 9/15/22 and 9/21/22 on the lifts and lifting techniques. Competencies were also taken on the staff in the training session. 2. Training with videos and competency tests are set up electronically on an annual basis with all staff and all new hires. 3. Annual in person training will occur annually and is scheduled for 5/23/23 with the lift vendor. 4.Printed lift manuals are located for staff in each nursing station for easy access 5. Electronic copies of the lift manuals are also located on the facility share point for	

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F 689	Continued From page 2 activities of daily living, except eating which required supervision. R1 had diagnoses of progressive neurological conditions, neurogenic bladder, Alzheimer's disease, dementia, paraplegia, multiple sclerosis, anxiety disorder, depression, and a psychotic disorder. There were no falls documented during the assessment period. R1's current undated care plan identified staff were to use a stand lift with 2 person assistance for transfers, but the nursing assistant care plan identified a hoyer lift and 2 persons were needed for transfers. The care plan identified R1 as at risk for falls and he utilized a wheelchair for mobility. Observation of the EZ-Way Smart Lift identified as the lift from which R1 had fallen was located in a storage area with a sign identifying the lift was not to be used until inspected by the EZ lift service provider. The two metal hanger brackets attached to either side of the spreader bar each had a black rubber ring with a hard black rubber finger extending across the opening through which the sling loop was attached. The stopper on the what would have been located on the left upper side of the sling was out of position and slide midway back on the curved portion of the bracket. The metal brackets had a C shape that extended onto the bar portion of the bracket and left an open area of 1/4 inch. The rubber stopper was supposed to extend across the opening as an additional safety measure that was not required by the manufacturer. When staff were attaching the sling loops they were pushed past the rubber finger which helped to prevent the loop from sliding off the C shaped hanger. The lift was designated with a weight capacity of 600 lbs and	F 689	access as well. 6. Audits have been developed for observation on staff techniques that address the following areas: a. 2 staff members present b. Sling is positioned correctly on the patient c. Sling attached correctly to lift d. Sling straps located behind the safety device e. Lift operated correctly f. Lift did not encounter any obstacles when positioning around chair g. Patient guided into chair or bed per upper body Audits will occur 5 times per week for 21 days Results will be reported out and discussed at the monthly QAPI meeting	

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F 689	Continued From page 3 R1's weight was 264 lbs. Observation of the lift sheet utilized for R1 was intact with no areas of damage to the surface was noted. Observation and Interview on 8/31/22 at 9:20 a.m., with R1 denied any memory of having fallen from the lift, and denied any discomfort. R1 was seated in a high back wheelchair with the lift sheet beneath him and he reported staff had to help him when he moved from his chair. R1 was not able to answer questions and responded with limited word responses that failed to respond to a question. Interview on 8/31/22 at 9:45 a.m., with nursing assistant (NA)-A identified she and NA-B were transferring R1 from his bed when he fell out of the sling lift. NA-A reported they were using the portable EZ-Way Smart Lift instead of the ceiling lift because they needed to weight him and the ceiling lift did not have the ability to weight a resident. NA-A reported she and NA-B followed the procedure for positioning the sling under R1, made certain they were hooking the same colored loops onto the brackets of the lift, informed R1 what they were going to do, and lifted him off the bed. They obtained his weight and were going to transfer him into his recliner with NA-A located at R1's feet guiding his lower body and NA-B at R1's head controlling the lift, as they turned from the bed toward the recliner. NA-A reported there was no indication that anything was wrong when suddenly, there was a noise and the support strap on the left side of R1's head came loose and he slid from the lift to the floor hitting his head. NA-A stated the right side of the sling was still connected and they unhooked the right side so R1 could be lowered to the floor. NA-B immediately went to notify the	F 689		

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F 689	Continued From page 4 nurse and the nursing supervisor, registered nurse (RN)-A responded to the room. R1 was alert and stated his head hurt but not other injuries were noted. The nursing supervisor assessed R1, and due to his hitting his head, and his wife who was in attendance agreeing, he was placed onto a gurney and transported to the ED for further evaluation. NA-A reported she had received training on use of the different lifts and had previously completed a competency on using them, but did not recall when that had occurred. She stated she knew she had connected the lift straps correctly and had confirmed the colored loop to attach with NA-B when they were connecting the sling to the lift. She stated R1 was heavy and this made it more difficult to move the lift with him in it, but she was not certain what had happened as it happened so quickly. Immediately following the incident the sling was examined for any damage and none was noted. The loops were intact and there was no fraying or loose edges noted. NA-A reported following the incident the nursing supervisor had met with the nursing staff to discuss the incident. Interview on 8/31/22 at 9:50 a.m., with the Maintance/environmental services director (MS) who provided documentation of lift inspections which were completed twice a year by the company representative. He reported the most recent inspections took place in February and March of 2022. The MS reported when staff had a concern or a piece of equipment was broken the facility policy was to remove it from use until it can be inspected by the company representative. He reported that following the incident he had been notified, had come to inspect the lift, but the only thing he found was the one rubber stopper had moved out of position on the lift bar. The lift	F 689		

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F 689	Continued From page 5 was to remain out of service until the company representative could come to inspect it. Interview on 8/31/22 at 10:00 a.m., with RN-A reported she had been notified of R1's fall and had immediately responded to the room. When she arrived R1's upper body was on the floor, but his lower body with the crisscrossed straps was still attached to the lift. R1 was disconnected from the lift and the lift was moved out of the way. R1's body was resting on the legs of the lift and his head was at the edge of the rubber mat in front of the recliner. RN-A reported NA-A and NA-B had used the portable EZ Way Smart Lift to obtain R1's weight and they stated they had attached the sheet straps to the brackets on the lift, and the black stoppers were in place. RN-A stated she had interviewed NA-A & NA-B and there had been no indication of a problem until they heard a noise, and R1 began sliding toward the floor. RN-A reported R1 remained at his baseline for cognition and had no lose of consciousness. RN-A stated since R1 had hit his head it was decided to send him to the ED for evaluation. No additional injuries were discovered, other than the small head laceration which was treated with an antibiotic ointment. The immediate intervention was to use the ceiling lift for R1's transfers in his room, and utilize the w/c scale for weights. The root cause analysis was scheduled to be completed on 9/1/22 at 8:30 a.m., and the incident was also to be reviewed by the falls committee. RN-A identified the care plan had not yet been updated to changes for R1, but staff were aware and following the altered procedure for transfers and weights. RN-A confirmed immediately following the incident she and staff had talked about the lift and what could occur, but no system	F 689		

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F 689	Continued From page 6 wide retraining or review had been provided to facility nursing staff. Interview on 8/31/22 at 11:55 a.m., with NA-B confirmed she had been assisting NA-A to transfer R1 when he had fallen out of the lift. She identified she and NA-A had communicated as they were attaching the sling loops to the lift to make certain they used the same color so the lift sheet was level. NA-B reported the procedure they followed was to check the lift sheet for any tears or damage prior to placing the lift sheet under R1 and if any had been discovered the sheet would have been replaced and not used. NA-B reported they were using the portable lift rather than the ceiling lift to obtain a weight. NA-B stated she had doubled the sling loops on the bracket and made certain the rubber stoppers were in the correct position as that was part of the procedure she had learned. NA-B stated she had been at R1's head running the lift, and as the sling with R1 raised off the bed NA-A took R1's legs to move then off the bed, while she moved the lift back toward the recliner. As she was moving the lift back the leg of the lift hit the side of the rubber mat located under the recliner, she pushed the lift off the mat, pushed weight, heard a noise, looked up at the top of the lift and saw the sling loop coming off the bracket. NA-B stated she had attempted to grab R1 to prevent him from sliding out of the lift, but she was not able to stop him from falling to the floor. When R1 fell he hit the left side of his head on an unknown item which resulting in the area bleeding. R1 was still partially in the lift so the loop holding the right side of his upper body was disconnected and he was lowered to the floor. NA-B stated she immediately went to find the nurse and RN-A and the administrator responded.	F 689		

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F 689	Continued From page 7 RN-A assessed R1 for injury, disconnected his lower body from the lift, obtained a different lift sheet, which was positioned under R1 and the ceiling lift was utilized to lift him onto a gurney. R1's wife was in attendance but denied witnessing the incident, but was in agreement that he should be sent to the ED for evaluation. NA-B identified she had been employed at the facility for 7.5 years, and had observed multiple demonstrations on use of the different facility lifts, but had not completed a competency on their use. Following the incident staff, including NAs, TMA, supervisor, and RN on duty met to review the incident in an attempt to discover the cause of R1's fall. Immediate interventions implemented was the use of the ceiling lift for room transfers, and weights to be completed on the w/c scale. NA-B reported when the lift was inspected following the incident the rubber stopper had come unglued and slid partway back on the bracket and the rubber finger had broken off. Following the incident RN-A directed if staff needed to obtain a weight with a portable lift the resident was to be positioned above the bed, and if they wre to be transferred from the bed the ceiling lift was to be used. NA-B identified the incident was discussed with the staff on duty, but there had not been any review of the policy or procedure or additional education provided to the staff following the incident. Interview on 8/31/22 at 12:49 p.m., with the director of nursing (DON) identified the most recent education provided to nursing staff on use of Lifts had been completed on 5/24/22. The DON reported the EZ lift representative had come in July and demonstrated using the lifts which the facility had video taped to use for training of new hires. She reported the root cause analysis of	F 689		

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F 689	Continued From page 8 R1's fall had not yet been completed, but was scheduled to take place on 9/1/22 at 8:30 a.m.. She confirmed the facility had completed their investigation of the fall, had made a report to the SA as required, but had not provided any review or education to nursing staff on appropriate lift usage. Interview on 9/1/22 at 10:05 a.m., with the facility administrator and safety/quality nurse (RN)-B reported the rubber stoppers attached on the brackets of the EZ way Smart lifts were an accessory and not included on the required safety checks. They reported the EZ lift company had classified the rubber stoppers as an additional safety accessory, but they were not something that was necessary. Review of the manufacture's manual did not include the rubber stopper accessory. nor was it included on the safety check list that was completed twice yearly. The administrator reported she thought the rubber stoppers had been applied by the vendor, and RN-B reported she had attempted to discover when the device had been added, but was not able to produce any information. RN-B stated the stoppers had been added to the lifts in the past due to an unknown previous event, but there was no documentation available. Interview on 9/1/22 at 10:55 a.m., with the EZ lift service and sales representative reported some facilities had chosen to use the rubber stoppers on the sling type lifts, but they were not a factory installed accessory on a sling lift due to the configuration of the lift brackets. The EZ lift service and sales representative identified the stoppers were not included on the routine safety checks and were actually a part that was provided for the other type of sit to stand lifts. The	F 689		

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F 689	Continued From page 9 representative referenced the manufacture EZ lift manual on page 6-7, item #4 which gave a step by step direction on safely using the EZ Way Smart Lift and reported the incident would not have occurred if the procedure had been followed by staff. Review of the September 2021, Safe Patient & Resident Handling Policy identified staff were to complete and document training at the time of hire, annually, and as necessary to correct improper use/understanding of resident transfers. Training methods used included in-service education, competency assessment, program review and computer based learning.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 8/31/22 through 9/1/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/15/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52284389C (MN86343), with a licensing order issued at 0830. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure safe mechanical full body lift procedures were followed per manufacturer's guidelines to prevent a fall during transfer for 1 of 3 residents (R1). Findings include: Review of the 8/30/22 at 9:16 a.m., report to the State Agency (SA) identified on 8/29/22 at 11:00 a.m., R1 had a fall from a Hoyer lift (sling-full body lift) while staff were lifting him. R1 was transferred to the Emergency Department (ED)	2 830	The facility failed to ensure safe mechanical full body lift procedures were followed per the manufacturer's guidelines to prevent a fall during a transfer for 1 or 3 residents. QAPI team members and staff involved completed a root cause analysis on 9/1/22 at 1:30pm to identify the contributing factors for the fall of the resident. The 4 Why process was used to determine the root cause/contributing factors. Two contributing factors were identified: 1. The no slip mat under the recliner was too	9/15/22

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2 830	Continued From page 3 for assessment of potential injuries immediately after the fall. Review of the 11/29/22 at 11:30 a.m., ED note identified R1 obtained a scalp laceration that did not require repair, and imaging scans of his head and neck for injury were negative. The minor scalp laceration was treated with antibiotic ointment and he was returned to the facility with orders to follow up with the nursing home provider. Review of the 8/29/22 at 11:00 a.m., facility Incident report detailed during transfer with a full body lift, the top left side of the sling slipped off the bracket resulting in R1 sliding head first from the sling. The document listed a rubber stopper that was located on the end of the lift bracket was not located in the right spot and the lift was taken out of service until it could be inspected by a service provider. R1's quarterly Minimum Data Set (MDS) assessment dated 7/13/22 identified severe cognitive impairment, mild depression, and he had displayed verbal behaviors toward staff 1-3 days during the review period. He required extensive assistance of 2 staff persons for all activities of daily living, except eating which required supervision. R1 had diagnoses of progressive neurological conditions, neurogenic bladder, Alzheimer's disease, dementia, paraplegia, multiple sclerosis, anxiety disorder, depression, and a psychotic disorder. There were no falls documented during the assessment period. R1's current undated care plan identified staff were to use a stand lift with 2 person assistance for transfers, but the nursing assistant care plan	2 830	wide for the chair and worn on one corner. 2. The staff used the residents feet to help guide the sling motion, when they hit the mat under the chair with the leg of the lift and were guiding the feet of the resident in a sling motion, that allowed the weight of the resident to shift; the tension was no longer on the green sling strap and the strap let loose. A plan was developed to address the contributing factors: 1. Training occurred on 9/1/22, 9/8/22, with the staff and additional training will be held on 9/15/22 and 9/21/22 on the lifts and lifting techniques. Competencies were also taken on the staff in the training session. 2. Training with videos and competency tests are set up electronically on an annual basis with all staff and all new hires. 3. Annual in person training will occur annually and is scheduled for 5/23/23 with the lift vendor. 4.Printed lift manuals are located for staff in each nursing station for easy access 5. Electronic copies of the lift manuals are also located on the facility share point for access as well. 6. Audits have been developed for observation on staff techniques that address the following areas: a. 2 staff members present b. Sling is positioned correctly on the patient c. Sling attached correctly to lift d. Sling straps located behind the safety device e. Lift operated correctly f. Lift did not encounter any obstacles	

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2 830	Continued From page 4 identified a hoyer lift and 2 persons were needed for transfers. The care plan identified R1 as at risk for falls and he utilized a wheelchair for mobility. Observation of the EZ-Way Smart Lift identified as the lift from which R1 had fallen was located in a storage area with a sign identifying the lift was not to be used until inspected by the EZ lift service provider. The two metal hanger brackets attached to either side of the spreader bar each had a black rubber ring with a hard black rubber finger extending across the opening through which the sling loop was attached. The stopper on the what would have been located on the left upper side of the sling was out of position and slide midway back on the curved portion of the bracket. The metal brackets had a C shape that extended onto the bar portion of the bracket and left an open area of 1/4 inch. The rubber stopper was supposed to extend across the opening as an additional safety measure that was not required by the manufacturer. When staff were attaching the sling loops they were pushed past the rubber finger which helped to prevent the loop from sliding off the C shaped hanger. The lift was designated with a weight capacity of 600 lbs and R1's weight was 264 lbs. Observation of the lift sheet utilized for R1 was intact with no areas of damage to the surface was noted. Observation and Interview on 8/31/22 at 9:20 a.m., with R1 denied any memory of having fallen from the lift, and denied any discomfort. R1 was seated in a high back wheelchair with the lift sheet beneath him and he reported staff had to help him when he moved from his chair. R1 was not able to answer questions and responded with limited word responses that failed to respond to a question.	2 830	when positioning around chair g. Patient guided into chair or bed per upper body Audits will occur 5 times per week for 21 days Results will be reported out and discussed at the monthly QAPI meeting	

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2 830	Continued From page 5 Interview on 8/31/22 at 9:45 a.m., with nursing assistant (NA)-A identified she and NA-B were transferring R1 from his bed when he fell out of the sling lift. NA-A reported they were using the portable EZ-Way Smart Lift instead of the ceiling lift because they needed to weight him and the ceiling lift did not have the ability to weight a resident. NA-A reported she and NA-B followed the procedure for positioning the sling under R1, made certain they were hooking the same colored loops onto the brackets of the lift, informed R1 what they were going to do, and lifted him off the bed. They obtained his weight and were going to transfer him into his recliner with NA-A located at R1's feet guiding his lower body and NA-B at R1's head controlling the lift, as they turned from the bed toward the recliner. NA-A reported there was no indication that anything was wrong when suddenly, there was a noise and the support strap on the left side of R1's head came loose and he slid from the lift to the floor hitting his head. NA-A stated the right side of the sling was still connected and they unhooked the right side so R1 could be lowered to the floor. NA-B immediately went to notify the nurse and the nursing supervisor, registered nurse (RN)-A responded to the room. R1 was alert and stated his head hurt but not other injuries were noted. The nursing supervisor assessed R1, and due to his hitting his head, and his wife who was in attendance agreeing, he was placed onto a gurney and transported to the ED for further evaluation. NA-A reported she had received training on use of the different lifts and had previously completed a competency on using them, but did not recall when that had occurred. She stated she knew she had connected the lift straps correctly and had confirmed the colored loop to attach with NA-B when they were	2 830		

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2 830	Continued From page 6 connecting the sling to the lift. She stated R1 was heavy and this made it more difficult to move the lift with him in it, but she was not certain what had happened as it happened so quickly. Immediately following the incident the sling was examined for any damage and none was noted. The loops were intact and there was no fraying or loose edges noted. NA-A reported following the incident the nursing supervisor had met with the nursing staff to discuss the incident. Interview on 8/31/22 at 9:50 a.m., with the Maintance/environmental services director (MS) who provided documentation of lift inspections which were completed twice a year by the company representative. He reported the most recent inspections took place in February and March of 2022. The MS reported when staff had a concern or a piece of equipment was broken the facility policy was to remove it from use until it can be inspected by the company representative. He reported that following the incident he had been notified, had come to inspect the lift, but the only thing he found was the one rubber stopper had moved out of position on the lift bar. The lift was to remain out of service until the company representative could come to inspect it. Interview on 8/31/22 at 10:00 a.m., with RN-A reported she had been notified of R1's fall and had immediately responded to the room. When she arrived R1's upper body was on the floor, but his lower body with the crisscrossed straps was still attached to the lift. R1 was disconnected from the lift and the lift was moved out of the way. R1's body was resting on the legs of the lift and his head was at the edge of the rubber mat in front of the recliner. RN-A reported NA-A and NA-B had used the portable EZ Way Smart Lift to obtain R1's weight and they stated they had	2 830		

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2 830	Continued From page 7 attached the sheet straps to the brackets on the lift, and the black stoppers were in place. RN-A stated she had interviewed NA-A & NA-B and there had been no indication of a problem until they heard a noise, and R1 began sliding toward the floor. RN-A reported R1 remained at his baseline for cognition and had no lose of consciousness. RN-A stated since R1 had hit his head it was decided to send him to the ED for evaluation. No additional injuries were discovered, other than the small head laceration which was treated with an antibiotic ointment. The immediate intervention was to use the ceiling lift for R1's transfers in his room, and utilize the w/c scale for weights. The root cause analysis was scheduled to be completed on 9/1/22 at 8:30 a.m., and the incident was also to be reviewed by the falls committee. RN-A identified the care plan had not yet been updated to changes for R1, but staff were aware and following the altered procedure for transfers and weights. RN-A confirmed immediately following the incident she and staff had talked about the lift and what could occur, but no system wide retraining or review had been provided to facility nursing staff. Interview on 8/31/22 at 11:55 a.m., with NA-B confirmed she had been assisting NA-A to transfer R1 when he had fallen out of the lift. She identified she and NA-A had communicated as they were attaching the sling loops to the lift to make certain they used the same color so the lift sheet was level. NA-B reported the procedure they followed was to check the lift sheet for any tears or damage prior to placing the lift sheet under R1 and if any had been discovered the sheet would have been replaced and not used. NA-B reported they were using the portable lift rather than the ceiling lift to obtain a weight.	2 830		

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2 830	Continued From page 8 NA-B stated she had doubled the sling loops on the bracket and made certain the rubber stoppers were in the correct position as that was part of the procedure she had learned. NA-B stated she had been at R1's head running the lift, and as the sling with R1 raised off the bed NA-A took R1's legs to move then off the bed, while she moved the lift back toward the recliner. As she was moving the lift back the leg of the lift hit the side of the rubber mat located under the recliner, she pushed the lift off the mat, pushed weight, heard a noise, looked up at the top of the lift and saw the sling loop coming off the bracket. NA-B stated she had attempted to grab R1 to prevent him from sliding out of the lift, but she was not able to stop him from falling to the floor. When R1 fell he hit the left side of his head on an unknown item which resulting in the area bleeding. R1 was still partially in the lift so the loop holding the right side of his upper body was disconnected and he was lowered to the floor. NA-B stated she immediately went to find the nurse and RN-A and the administrator responded. RN-A assessed R1 for injury, disconnected his lower body from the lift, obtained a different lift sheet, which was positioned under R1 and the ceiling lift was utilized to lift him onto a gurney. R1's wife was in attendance but denied witnessing the incident, but was in agreement that he should be sent to the ED for evaluation. NA-B identified she had been employed at the facility for 7.5 years, and had observed multiple demonstrations on use of the different facility lifts, but had not completed a competency on their use. Following the incident staff, including NAs, TMA, supervisor, and RN on duty met to review the incident in an attempt to discover the cause of R1's fall. Immediate interventions implemented was the use of the ceiling lift for room transfers, and weights to be completed on the w/c scale.	2 830		

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2 830	Continued From page 9 NA-B reported when the lift was inspected following the incident the rubber stopper had come unglued and slid partway back on the bracket and the rubber finger had broken off. Following the incident RN-A directed if staff needed to obtain a weight with a portable lift the resident was to be positioned above the bed, and if they wre to be transferred from the bed the ceiling lift was to be used. NA-B identified the incident was discussed with the staff on duty, but there had not been any review of the policy or procedure or additional education provided to the staff following the incident. Interview on 8/31/22 at 12:49 p.m., with the director of nursing (DON) identified the most recent education provided to nursing staff on use of Lifts had been completed on 5/24/22. The DON reported the EZ lift representative had come in July and demonstrated using the lifts which the facility had video taped to use for training of new hires. She reported the root cause analysis of R1's fall had not yet been completed, but was scheduled to take place on 9/1/22 at 8:30 a.m.. She confirmed the facility had completed their investigation of the fall, had made a report to the SA as required, but had not provided any review or education to nursing staff on appropriate lift usage. Interview on 9/1/22 at 10:05 a.m., with the facility administrator and safety/quality nurse (RN)-B reported the rubber stoppers attached on the brackets of the EZ way Smart lifts were an accessory and not included on the required safety checks. They reported the EZ lift company had classified the rubber stoppers as an additional safety accessory, but they were not something that was necessary. Review of the manufacture's manual did not include the rubber stopper	2 830		

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2 830	Continued From page 10 accessory. nor was it included on the safety check list that was completed twice yearly. The administrator reported she thought the rubber stoppers had been applied by the vendor, and RN-B reported she had attempted to discover when the device had been added, but was not able to produce any information. RN-B stated the stoppers had been added to the lifts in the past due to an unknown previous event, but there was no documentation available. Interview on 9/1/22 at 10:55 a.m., with the EZ lift service and sales representative reported some facilities had chosen to use the rubber stoppers on the sling type lifts, but they were not a factory installed accessory on a sling lift due to the configuration of the lift brackets. The EZ lift service and sales representative identified the stoppers were not included on the routine safety checks and were actually a part that was provided for the other type of sit to stand lifts. The representative referenced the manufacture EZ lift manual on page 6-7, item #4 which gave a step by step direction on safely using the EZ Way Smart Lift and reported the incident would not have occurred if the procedure had been followed by staff. Review of the September 2021, Safe Patient & Resident Handling Policy identified staff were to complete and document training at the time of hire, annually, and as necessary to correct improper use/understanding of resident transfers. Training methods used included in-service education, competency assessment, program review and computer based learning. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and	2 830		

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2 830	Continued From page 11 implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or designee, should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		