DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 1, 2021

Administrator
The Gardens At Foley LLC
253 Pine Street
Foley, MN 56329

RE: CCN: 245325
Cycle Start Date: September 23, 2021

Dear Administrator:

On October 14, 2021, we notified you a remedy was imposed. On November 3, 2021 the Minnesota Department(s) of Health and Public Safety 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 October 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 14, 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 September 23, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 1, 2021

Administrator
The Gardens At Foley Llc
253 Pine Street
Foley, MN 56329

Re: Reinspection Results
Event ID: T7M912

Dear Administrator:

On November 3, 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 November 3, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
October 14, 2021

Administrator
The Gardens At Foley Llc
253 Pine Street
Foley, MN 56329

RE: CCN: 245325
Cycle Start Date: September 23, 2021

Dear Administrator:

On September 23, 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 September 23, 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 D.

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 October 29, 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 29, 2021 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 23, 2021. This prohibition is not subject to appeal. 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.

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. <u>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.</u>

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, The Gardens At Foley Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 23, 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 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 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 March 23, 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.
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)

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT FOLEY LLC	**253 PINE STREET FOLEY, MN 56329**

(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 9/22/21 - 9/23/21, 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: H5325043C (MN76854), with deficiencies cited at F689, F726. 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. The survey resulted in immediate jeopardy when the facility failed to provide education that included staff return demonstration of lift use competency and failed to train staff on manufacturer's recommendations for connecting the lift slings to the lift after a resident fell out of a mechanical lift on 9/19/21. The IJ began on 9/19/21, and the immediacy was removed on 9/23/21. The above findings constituted substandard quality of care, and an extended survey was conducted on 9/23/21.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/15/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 SS=J	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 observation, interview and document review, the facility failed to ensure staff were competently trained to perform transfers using a mechanical (Hoyer) lift. This resulted in an immediate jeopardy (IJ) for R1 who fell from a Hoyer lift and sustained injuries during a transfer. This practice had the potential to affect all nine facility residents who used a mechanical lift for transfers. The IJ began on 9/19/21, when R1 fell out of a mechanical lift during transfer and the facility failed to provide education that included staff return demonstration of lift use competency and failed to train staff on manufacturer's recommendations for connecting the lift slings to the lift. The administrator and director of nursing (DON) were informed of the IJ on 9/22/21, at 6:16 p.m. The IJ was removed on 9/23/21, at 12:55 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. R1's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated he was severely cognitively impaired and required extensive assistance from	F 689	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	10/15/21

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F 689	Continued From page 2 two staff to transfer. R1's care plan dated 4/21/21, identified a self-care deficit related to Parkinson's disease, contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and dementia. The care plan directed staff to transfer R1 with a full body lift and two staff. R1's facility Progress Note (PN) dated 9/19/21, indicated staff used a mechanical lift to transfer him from his chair to the bed. While R1 was suspended in the air with the lift, staff lifted R1's legs up to put them on the bed and R1 slipped out of the lift sling and landed on the floor. The note indicated R1 hit his buttocks, back and head and sustained a skin tear to his elbow and a small cut behind his left ear. A Fall Scene Investigation Form dated 9/19/21, indicated R1 fell. Factors at the time of the fall were identified as "equipment malfunction." The form did not identify the equipment malfunction but indicated staff used the straps that made R1 "sit too straight up" causing him to slip out of the lift sheet. An untitled facility document dated 9/19/21, indicated staff education and training was provided on proper lift sheet use and how the straps used affected resident positioning. The document did not identify which staff received training. An e-mail dated 9/19/21, identified registered nurse (RN)-A updated the administrator R1 fell from a mechanical lift during a transfer in which he hit his elbow and head on a dresser. He sustained a skin tear to his elbow, a skin tear	F 689	F689 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure staff are appropriately trained to use mechanical lifts in accordance with manufacturer guidelines. -All Residents residing in the facility who require mechanical lifts for transfers have the potential to be affected if this requirement is not met. -The Plan of Care has been reviewed and updated as necessary for all residents who require a mechanical lift for transfers. -Supplemental education opportunities and competency sign off sheets were specifically created to fulfil the request to have additional staff training and return demonstrations completed for all necessary GAF staff who utilize mechanical lifts for resident care. Appropriate GAF Staff received additional education and were required to complete return demonstrations on how to use mechanical lifts in accordance with manufacturer recommendations. Education initiated on 9/22/21, was completed with all necessary GAF staff prior to working their next scheduled shift and has since been included in new hire orientation and annual training moving forward. -An audit was completed to ensure no other residents were affected. Policies, processes, and procedures were reviewed and revised as needed to ensure future instances are avoided.	

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F 689	Continued From page 3 behind his left ear, and a hematoma to the back of his head. The nursing assistants (NA)s who transferred R1 at the time of the incident demonstrated how they used the lift and how the incident occurred. Per the demonstration, it appeared when R1's legs were moved and lifted, this caused him to lean in the sling. As a result, he slid out of the sling and landed on his buttocks. A Progress Note dated 9/20/21, indicated the lift chair was removed from use until maintenance could inspect, sling was removed and R1 was evaluated for sling fit. Interventions: "agree with above. Facility protocol followed, management updated. Staff education and training on proper lift sheet use and strap use completed with staff in facility at time of incident." During observation on 9/22/21, at 2:36 p.m. RN-A was seated in an office chair with a mechanical lift sling underneath her. RN-A was demonstrating the use of the sling to a NA. A mechanical lift was not used for the demonstration, nor was the NA demonstrating use of the sling, only watching RN-A's demonstration. At 2:24 p.m. RN-A stated after R1 fell from the lift they started training staff on proper use and said it was a reiteration as staff training had been conducted a few weeks prior. RN-A stated she was in the building when R1 fell from the lift and said she thought the sling had been hooked up properly based on the training she received when the lifts were initially purchased. RN-A stated the day after the fall the team had a safe patient handling meeting and learned staff had not been hooking the slings to the lifts properly which could have resulted in R1 falling out of the sling.	F 689	-Necessary GAF staff have received training utilizing manufacturer instructions and/or guidelines. -Audits will be completed five (5) times per week for two (2) weeks; weekly for four (4) weeks; and monthly thereafter for three (3) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Deficient practice has been corrected, effective the time of submitting this POC.	

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F 689	Continued From page 4	F 689		

During interview on 9/22/21, at 2:48 p.m. with NA-A, NA-B and LPN-A, NA-A stated she had received training that day about how to hook up the straps correctly. NA-A stated prior to that day she had not received training in a while but said the facility had an annual skills training. NA-B stated she had received training about three weeks prior, after another resident had fallen out of a sling from the lift. Licensed practical nurse (LPN)-A stated prior to this week she had an update reviewing policies a few months ago but stated she had not received any recent training on lift or sling use. All three staff stated they were being taught something different than in the past related to positioning of the bottom straps when hooking the sling to the lift.

On 9/22/21, at 3:25 p.m. the DON stated after speaking to the two NA's involved in R1's incident it was determined that the bottom straps on the sling were not crisscrossed under R1's legs as recommended by the manufacturer and when the NA's maneuvered R1's legs, along with moving the lift, it was enough force for him to come out of the sling. The DON stated they started education that day but stated since then, they had determined they needed to educate differently. The DON stated after watching a video they had learned that staff had been hooking up the slings incorrectly since the lifts had been purchased more than five years ago. The DON stated they had staff competencies but said the competency did not specify crossing the straps as part of the competency. The DON stated after another resident had fallen out of a lift last month, they had completed a mechanical lift competency with all staff but only used a toileting sling and did not train on the use of a full body sling. The DON stated after the last fall they did not review the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT FOLEY LLC	253 PINE STREET FOLEY, MN 56329

(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 689	Continued From page 5	F 689		

instructional video because the previous fall involved an incorrect sling size.

On 9/22/21 at 3:58 p.m. RN-B stated she received training that day about how to hook up a sling to make it more secure. RN-B stated about a month ago, a resident had fallen out of a sling and they had a training that consisted of a meeting and management demonstrating the sling and lift but staff did not actually demonstrate how to hook up the sling. RN-B further stated the earlier training did not include the proper way to hook up a full body sling.

On 9/22/21, at 4:09 p.m. the DON stated the previous training had been a "mixture," and said some of the training was a one to one and some were in large groups. The DON said some staff demonstrated use of the mechanical lift and some were just talked through how to hook the sling to the lift.

On 9/22/21, at 4:15 p.m. the administrator stated all of the managers had been assisting on the floor regularly so there had been no reason to think staff were not using the slings correctly. The administrator stated when the previous resident fell from the lift it had been a separate issue, so they had not provided training on connecting the straps to the lift. The administrator stated they learned some staff had been connecting the straps of the sling to the Hoyer lift correctly and some staff had not since the lifts were purchased eight years prior.

A facility policy Lifting Machine, Using A Mechanical dated July 2017, indicated the procedure was to establish the general principles of safe lifting using a mechanical lifting device.

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	245325	A. BUILDING _____ B. WING _____	C 09/23/2021

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F 689	Continued From page 6 The policy directed staff to attach the sling straps according to the manufacturer's instructions. A document titled Hoyer Quickfit Deluxe Slings, undated directed the bottom straps be crossed under the resident prior to connecting them to the Hoyer lift. The IJ was removed on 9/23/21, at 12:55 p.m. when it was verified through observation and interview the facility had implemented a training program which included return demonstration of manufacturer's recommendations for connecting the straps of the Hoyer lift to the mechanical lift and all staff working had completed training or were scheduled to complete training prior to next scheduled shift.	F 689		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		10/15/21

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F 726	Continued From page 7 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure staff competencies related to the use of mechanical (Hoyer) lifts were evaluated resulting in a fall from a mechanical lift for 1 or 1 residents (R1) reviewed for accidents. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated he was severely cognitively impaired and required extensive assistance from two staff to transfer. R1's care plan dated 4/21/21, identified a self care deficit related to Parkinson's disease, contracture and dementia. The care plan directed staff to Provide extensive assistance from two staff using a full body lift. R1's facility Progress Note dated 9/19/21, indicated nursing assistants, (NA)-C and NA-D) were using a mechanical lift to transfer R1 from his chair to the bed. While R1 was in the air, staff lifted his legs up to put them on the bed and R1 slipped out of the lift sling and landed on the floor. R1 hit his buttocks, back and head and sustained a skin tear to his elbow and a small cut behind his	F 726	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is	

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F 726	Continued From page 8 left ear. An untitled facility document dated 9/19/21, indicated staff education and training was provided on proper lift sheet use and how the straps affected resident positioning. Facility documents titled Competency Assessment Lifting Machine, Using A Mechanical indicated the following: 8/25/21, competency indicated NA-A demonstrated competency using a mechanical lift which included; attach sling straps to the sling bar according to manufacturer's instructions. The competency assessment was signed NA-A and a second staff member. 8/26/21, competency indicated NA-C demonstrated competency using a mechanical lift which included; attach sling straps to the sling bar according to manufacturer's instructions. The competency assessment was signed NA-C and a second staff member. 9/4/21, competency indicated NA-D demonstrated competency using a mechanical lift which included; attach sling straps to the sling bar according to manufacturer's instructions. The competency assessment was signed NA-D and a second staff member. 9/6/21, competency indicated licensed practical nurse (LPN)-A demonstrated competency using a mechanical lift which included; attach sling straps to the sling bar according to manufacturer's instructions. The competency assessment was signed by LPN-A and a second staff member.	F 726	submitted as the facility's credible allegation of compliance. F726 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure staff are appropriately trained to use mechanical lifts in accordance with manufacturer guidelines. -All Residents residing in the facility who require mechanical lifts for transfers have the potential to be affected if this requirement is not met. -Supplemental education opportunities and competency sign off sheets were specifically created to fulfil the request to have additional staff training and return demonstrations completed for all necessary GAF staff who utilize mechanical lifts for resident care. Appropriate GAF Staff received additional education and were required to complete return demonstrations on how to use mechanical lifts in accordance with manufacturer recommendations. Education initiated on 9/22/21, was completed with all necessary GAF staff prior to working their next scheduled shift and has since been included in new hire orientation and annual training moving forward. -Policies, processes, and procedures were reviewed and revised as needed to ensure future instances are avoided. -Necessary GAF staff have received training utilizing manufacturer instructions and/or guidelines. -Audits will be completed five (5) times	

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F 726	Continued From page 9 On 9/22/21, at At 2:48 p.m. NA-A and LPN-A were interviewed. NA-A stated she had received training today on how to hook up the straps correctly. NA-A stated prior to that day she had not received training in a while but said the facility had an annual skills training. LPN-A stated prior to this week she had an update reviewing policies a few months ago but stated she had not received any recent training on lift or sling use. Both staff stated they were taught something different this week than in the past related to positioning of the bottom straps when hooking the sling to the lift. At 3:58 p.m. RN-B stated she received training that day about how to hook up a sling to make it more secure. RN-B stated about a month ago they had a training that consisted of a meeting and management demonstrating the sling and lift but staff did not actually demonstrate how to hook up the sling. RN-B further stated the earlier training did not include the proper way to hook up a sling as she learned today. At 4:09 p.m. the DON stated the previous training had been a "mixture," and said some of the training was a one on one and some were in large groups. The DON said some staff demonstrated and some were just talked through how to hook up the sling. A facility policy related to staff competency training was requested but none received.	F 726	per week for two (2) weeks; weekly for four (4) weeks; and monthly thereafter for three (3) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Deficient practice has been corrected, effective the time of submitting this POC.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 14, 2021

Administrator
The Gardens At Foley Llc
253 Pine Street
Foley, MN 56329

Re: State Nursing Home Licensing Orders
Event ID: T7M911

Dear Administrator:

The above facility was surveyed on September 22, 2021 through September 23, 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 only a suggestion 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	C 09/23/2021

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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 9/22/21 - 9/23/21, 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		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5325043C (MN76854) with a licensing order issued at 0830. 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	2 000		

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2 000	Continued From page 2 state form. 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 observation, interview and document review, the facility failed to ensure staff were competently trained to perform transfers using a mechanical (Hoyer) lift. This resulted in an immediate jeopardy (IJ) for R1 who fell from a Hoyer lift and sustained injuries during a transfer. This practice had the potential to affect all nine facility residents who used a mechanical lift for transfers. The IJ began on 9/19/21, when R1 fell out of a	2 830	corrected	10/15/21

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2 830	Continued From page 3	2 830		

mechanical lift during transfer and the facility failed to provide education that included staff return demonstration of lift use competency and failed to train staff on manufacturer's recommendations for connecting the lift slings to the lift. The administrator and director of nursing (DON) were informed of the IJ on 9/22/21, at 6:16 p.m. The IJ was removed on 9/23/21, at 12:55 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy.

R1's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated he was severely cognitively impaired and required extensive assistance from two staff to transfer. R1's care plan dated 4/21/21, identified a self-care deficit related to Parkinson's disease, contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and dementia. The care plan directed staff to transfer R1 with a full body lift and two staff.

R1's facility Progress Note (PN) dated 9/19/21, indicated staff used a mechanical lift to transfer him from his chair to the bed. While R1 was suspended in the air with the lift, staff lifted R1's legs up to put them on the bed and R1 slipped out of the lift sling and landed on the floor. The note indicated R1 hit his buttocks, back and head and sustained a skin tear to his elbow and a small cut behind his left ear.

A Fall Scene Investigation Form dated 9/19/21, indicated R1 fell. Factors at the time of the fall were identified as "equipment malfunction." The form did not identify the equipment malfunction but indicated staff used the straps that made R1

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2 830	Continued From page 4 "sit too straight up" causing him to slip out of the lift sheet. An untitled facility document dated 9/19/21, indicated staff education and training was provided on proper lift sheet use and how the straps used affected resident positioning. The document did not identify which staff received training. An e-mail dated 9/19/21, identified registered nurse (RN)-A updated the administrator R1 fell from a mechanical lift during a transfer in which he hit his elbow and head on a dresser. He sustained a skin tear to his elbow, a skin tear behind his left ear, and a hematoma to the back of his head. The nursing assistants (NA)s who transferred R1 at the time of the incident demonstrated how they used the lift and how the incident occurred. Per the demonstration, it appeared when R1's legs were moved and lifted, this caused him to lean in the sling. As a result, he slid out of the sling and landed on his buttocks. A Progress Note dated 9/20/21, indicated the lift chair was removed from use until maintenance could inspect, sling was removed and R1 was evaluated for sling fit. Interventions: "agree with above. Facility protocol followed, management updated. Staff education and training on proper lift sheet use and strap use completed with staff in facility at time of incident." During observation on 9/22/21, at 2:36 p.m. RN-A was seated in an office chair with a mechanical lift sling underneath her. RN-A was demonstrating the use of the sling to a NA. A mechanical lift was not used for the demonstration, nor was the NA demonstrating use of the sling, only watching	2 830		

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2 830	Continued From page 5 RN-A's demonstration. At 2:24 p.m. RN-A stated after R1 fell from the lift they started training staff on proper use and said it was a reiteration as staff training had been conducted a few weeks prior. RN-A stated she was in the building when R1 fell from the lift and said she thought the sling had been hooked up properly based on the training she received when the lifts were initially purchased. RN-A stated the day after the fall the team had a safe patient handling meeting and learned staff had not been hooking the slings to the lifts properly which could have resulted in R1 falling out of the sling. During interview on 9/22/21, at 2:48 p.m. with NA-A, NA-B and LPN-A, NA-A stated she had received training that day about how to hook up the straps correctly. NA-A stated prior to that day she had not received training in a while but said the facility had an annual skills training. NA-B stated she had received training about three weeks prior, after another resident had fallen out of a sling from the lift. Licensed practical nurse (LPN)-A stated prior to this week she had an update reviewing policies a few months ago but stated she had not received any recent training on lift or sling use. All three staff stated they were being taught something different than in the past related to positioning of the bottom straps when hooking the sling to the lift. On 9/22/21, at 3:25 p.m. the DON stated after speaking to the two NA's involved in R1's incident it was determined that the bottom straps on the sling were not crisscrossed under R1's legs as recommended by the manufacturer and when the NA's maneuvered R1's legs, along with moving the lift, it was enough force for him to come out of the sling. The DON stated they started education that day but stated since then, they had	2 830		

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(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 page 6	2 830		

determined they needed to educate differently. The DON stated after watching a video they had learned that staff had been hooking up the slings incorrectly since the lifts had been purchased more than five years ago. The DON stated they had staff competencies but said the competency did not specify crossing the straps as part of the competency. The DON stated after another resident had fallen out of a lift last month, they had completed a mechanical lift competency with all staff but only used a toileting sling and did not train on the use of a full body sling. The DON stated after the last fall they did not review the instructional video because the previous fall involved an incorrect sling size.

On 9/22/21 at 3:58 p.m. RN-B stated she received training that day about how to hook up a sling to make it more secure. RN-B stated about a month ago, a resident had fallen out of a sling and they had a training that consisted of a meeting and management demonstrating the sling and lift but staff did not actually demonstrate how to hook up the sling. RN-B further stated the earlier training did not include the proper way to hook up a full body sling.

On 9/22/21, at 4:09 p.m. the DON stated the previous training had been a "mixture," and said some of the training was a one to one and some were in large groups. The DON said some staff demonstrated use of the mechanical lift and some were just talked through how to hook the sling to the lift.

On 9/22/21, at 4:15 p.m. the administrator stated all of the managers had been assisting on the floor regularly so there had been no reason to think staff were not using the slings correctly. The administrator stated when the previous resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	C 09/23/2021

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2 830	Continued From page 7 fell from the lift it had been a separate issue, so they had not provided training on connecting the straps to the lift. The administrator stated they learned some staff had been connecting the straps of the sling to the Hoyer lift correctly and some staff had not since the lifts were purchased eight years prior. A facility policy Lifting Machine, Using A Mechanical dated July 2017, indicated the procedure was to establish the general principles of safe lifting using a mechanical lifting device. The policy directed staff to attach the sling straps according to the manufacturer's instructions. A document titled Hoyer Quickfit Deluxe Slings, undated directed the bottom straps be crossed under the resident prior to connecting them to the Hoyer lift. The IJ was removed on 9/23/21, at 12:55 p.m. when it was verified through observation and interview the facility had implemented a training program which included return demonstration of manufacturer's recommendations for connecting the straps of the Hoyer lift to the mechanical lift and all staff working had completed training or were scheduled to complete training prior to next scheduled shift. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to mechanical lift devices, proper training and accident prevention to assure proper competencies and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the	2 830		

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2 830	Continued From page 8 results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		