DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 23, 2023

Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

RE: CCN: 245364
Cycle Start Date: January 5, 2023

Dear Administrator:

On January 20, 2023, we notified you a remedy was imposed. On February 16, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 4, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 4, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 20, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 4, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 4, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Kamala Fiske-Downing

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2023

Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

Re: Reinspection Results
Event ID: LSR412

Dear Administrator:

On February 16, 2023 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 January 5, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
January 20, 2023

Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

RE: CCN: 245364
Cycle Start Date: January 5, 2023

Dear Administrator:

On January 5, 2023, a survey was completed at your facility by the Minnesota Department of Health 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) 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 February 4, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 4, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 4, 2023.

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.

This Department is also recommending that CMS impose:

• 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.

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 $11,292; 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.

If you have not achieved substantial compliance by February 4, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Annandale Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 4, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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" and/or 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 - Health Regulation Division 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 July 5, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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 electronic 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245364	A. BUILDING _____ B. WING _____	C 01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE CARE CENTER	500 PARK STREET EAST ANNANDALE, MN 55302

(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 1/03/23 through 1/05/23, 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: H53646615C (MN89223), with a deficiency cited at (F689). H53647175C (MN87590) with no deficiency. In addition related deficiencies were cited at F609 and F610. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		2/4/23

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

Electronically Signed | 01/27/2023

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F 609	Continued From page 1 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incident of potential neglect was reported immediately, within two hours, to the State Agency (SA) for 1 of 2 residents (R1) reviewed for accidents who slid from a lift and had a left shoulder fracture during provisions of care. Findings include: R1's significant change minimum data set (MDS) dated 10/23/22, indicated R1 required transfer with extensive assist of two, always incontinent of bladder and frequently incontinent of bowel. R1's Care Plan dated 10/3/22, indicated R1 was	F 609	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. F609- Reporting of Alleged Violations¿	

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F 609	Continued From page 2 at moderate risk for falls related to weakness, needing assistance with mobility, diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side. The care plan indicated R1 used a bed pan for toileting until toileting sling use was re-accessed for proper fit. A Resident Abuse/Neglect Investigation Report Form completed by the facility on 10/03/22, indicated on 10/03/22, at 3:30 p.m. R1 was being transferred from commode to wheelchair using Hoyer lift and toileting sling when R1 started to slide out of sling and fell to the floor. The report indicated R1 had left shoulder pain with movement and denied other pain. The report indicated no neglect or abuse was found and care plan, policies and procedures were followed and re-evaluating type of sling used-but sling in place was correct for lift and toileting. The report failed to indicate the SA was informed of the incident. A Office Visit note dated 10/06/22, indicated R1 was seen and had x-rays and was found to have a fracture of the left humeral neck (shoulder fracture). The note indicated an order for a arm splint and follow up in a week and increased Tylenol to 1,000 milligrams (mg) TID (three times a day) for the next week and resume current dose. During interview on 1/05/23, at 9:38 a.m. DON stated she should have reported the incident since the staff did not understand the use of the bed pan. The facility Abuse Prevention Plan Policy and Procedure dated 9/2021, indicated "The Administrator is notified immediately of any	F 609	Preparation, submission, and implementation of this plan of correction constitutes Annandale Care Centers written compliance for the deficiencies cited.¿ However, the submission of this plan of correction does not constitute an admission of or agreement with the facts and conclusions in the statement of deficiencies. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements. ¿ In response to the above stated citation Annandale Care Center has taken the following action(s): The applicable regulations and the facility□s Abuse and Vulnerable Adult Policy will be reviewed with all staff prior to next scheduled shift regarding the reporting requirements for any alleged violations involving potential abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property.¿An annual review of Abuse and Vulnerable Adult policy will continue to be conducted by all staff and as needed. Concerns will be brought to Quality Assurance Committee at least quarterly and as needed.¿ New hires will be trained on the Abuse and Vulnerable Adult policy during orientation. All allegations will be reviewed for timely reporting by Quality Assurance Committee on a quarterly basis ongoing in an effort to confirm continued compliance	

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F 609	Continued From page 3 suspected abuse. Immediately is defined as 'as soon as possible but no later than 24 hours after an incident'. Immediately means as soon as possible after discovery of the incident but no later than 2 hours after allegation is made. Social Services or other designated staff will immediately report to appropriate agencies." In addition the policy indicated neglect as a categories of abuse "Neglect: the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This presumes that instances of abuse/neglect of all residents, even those in a coma, cause physical harm or pain or mental anguish. (Active Neglect: conscious, intentional, willful deprivation. Passive Neglect: unintentional deprivation, unwilful.)."	F 609	and ensure resident safety. This deficiency will be corrected by February 4, 2023.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		2/4/23

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F 610	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of neglect for 1 of 2 residents (R1) reviewed for accidents who had fell from a toileting sling which resulted in a left shoulder fracture. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/23/22, indicated R1 had hemiplegia and anxiety. The MDS indicated R1 was cognitively impaired, did not reject care, transferred with extensive assist of two, was always incontinent of bladder and frequently incontinent of bowel. The MDS further indicated R1 had occasional pain and had one fall with major injury. R1's Care Plan dated 10/3/22 , indicated R1 was at moderate risk for falls related to weakness, needing assistance with mobility, diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side. The care plan indicated R1 used a bed pan for toileting until toileting sling use was re-assessed for proper fit. A Resident Abuse/Neglect Investigation Report Form completed by the facility on 10/03/22, indicated on 10/03/22, at 3:30 p.m. R1 was being transferred from commode to wheelchair using Hoyer lift and toileting sling when R1 started to slide out of sling and fell to the floor. The report indicated R1 had left shoulder pain with movement and denied other pain. The report indicated no neglect or abuse was found and care plan, policies and procedures were followed and	F 610	F610-Investigate/Prevent/Correct Alleged Violation¿ Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and constitutes the facility□s compliance. In response to the above stated citation Annandale Care Center has taken the following action(s): The facilities investigation process will be reviewed and revised as necessary implementing the use of CMS forms 358 and 359 to guide the investigation process.¿ Root cause analysis training will be provided to nurse managers to aid in thorough investigations.¿Review of the investigation process will also prevent this from happening to other residents. No other residents were found to be affected during investigation.¿ A new investigation/interview process will be implemented to ensure thorough investigations are completed.¿¿The new investigation/interview process includes	

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F 610	Continued From page 5 re-evaluating type of sling used but sling in place was correct for lift and toileting. A Office Visit note dated 10/06/22, indicated R1 was seen and had x-rays and was found to have a fracture of the left humeral neck (shoulder fracture). The note indicated an order for an arm splint, follow up in a week and increase Tylenol to 1,000 milligrams (mg) TID (three times a day) for the next week and resume current dose. During interview on 1/03/23, at 12:20 p.m. COTA-A stated she assessed R1 during the day and had no concerns with transfers using the toileting sling, but did not look at her later in the day or evening when staff expressed concerns with fatigue. COTA-A stated she was aware R1 was having weakness later in the day and added to R1's functional maintenance plan (FMP) to use the bed pan as needed (PRN) instead of toileting sling and commode for safety. During interview on 1/03/23, at 8:45 a.m. NA-D stated she was the NA working when R1 slipped out of the sling. NA-D stated the sling was too small and R1's legs started to slide out, even though the straps around her legs were criss-crossed, her bottom was sliding down. NA-D stated she thought they used the biggest toileting sling they had and was never told it was too small until after the incident. NA-D stated when the incident occurred she was new to working at the facility and was trained on the B-wing not the A-wing where R1 was on. During interview on 1/04/23, at 9:40 a.m. director of nursing (DON) stated, they checked the sling and R1's weight and according to the chart, the toileting sling was appropriate for R1. The DON	F 610	the addition of more extensive interviews, including staff not involved in incident and other residents that have potential to be affected by reported allegations. An in-depth review of care plan and all other documentation pertaining to residents plan of care will be reviewed and documented. All investigations will be reviewed for thorough completion by Quality Assurance Committee on a quarterly basis ongoing in an effort to confirm continued compliance and to ensure the investigative process considers all residents vulnerabilities. This deficiency will be corrected by February 4, 2023. ¿	

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F 610	Continued From page 6 stated she felt the incident occurred because R1 pulled her arm in and out of the sling and slid out and which resulted in the fall, adding, since the incident they have been using the bed pan. During interview on 1/04/23, at 1:24 p.m. NA-G stated he worked the evening shift and had been at the facility for over two years and never used the toileting sling on R1. NA-G stated he had heard staff state they were uncomfortable using the toileting sling. During interview on 1/04/23, at 1:33 p.m. NA-H stated she worked the evening shift and when she would use the toileting sling R1's arms and body would sink into the sling and it didn't look right and too small. NA-H stated she reported to the nurses, but therapy wanted us to use the toileting sling and it was on our Nursing Assistant Care Sheet to use the toileting sling. NA-H stated she was not surprised after a short leave and then returning to find out that R1 had slid out of her sling. In addition RA-H stated even though she reported her concerns to the nurses she never received any training or direction on transfers for R1 when she became fatigued and felt the new staff should all be trained on the proper way to complete transfers so the residents are safe. During interview 1/04/23, at 5:00 p.m. NA-I stated she worked the evening shift and when she transferred R1 the sling around her back did not fit her and she would just leave the leg straps un-crossed because she did not want to pinch her legs. NA-H further stated they communicated concerns to FM-A and nursing staff, but FM-A insisted they use the toileting sling for R1 and not the bed pan.	F 610		

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	245364	A. BUILDING _____ B. WING _____	C 01/05/2023

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F 610	Continued From page 7 During interview on 1/04/23, at 6:08 p.m. with NA-D who stated when she was transferring R1 she was not aware she could have used the bed pan and R1 probably slid through her toileting sling because she was tired and weak. During interview on 1/04/23, at 6:18 p.m. NA-J stated her and NA-D were the ones that transferred R1 when she slid out of her toileting sling adding, they knew her left arm had weakness and that when her arm slid through the sling, R1 could not hang on and fell to the floor. NA-J stated R1's weakness could have been the cause of her fall. NA-J added that they no longer use the toileting sling and use the bed pan for safety. During interview on 1/05/23, at 9:38 a.m. DON stated the COTA-A would train the staff working on the shift when she was there and not all 79 staff they had working. In addition, DON stated she did not understand why the two staff working with R1 did not know they could have used the bedpan the day of her incident since it was listed on her resident care sheet and they should be looking at that every day. In addition she was unaware who the COTA-A discussed the use of the bed pan with when R1 was weak according to the therapy note on 9/21/22, since she spoke to her nurse manager and the nurse manager was never informed of the collaboration that was listed in the COTA's documentation. In addition, the DON stated the FMA and care plan should have addressed the reason for using the bed pan for weakness and not just stating it was used PRN. An additional interview on 1/05/23, at 10:00 a.m. DON stated the facility investigation should have	F 610		

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F 610	Continued From page 8 been more thorough and included if R1 was fatigued during her fall from the toileting sling and why the bedpan was not being used that day. In addition, DON stated she can see the investigation focused on if the correct sling was used during the transfer and not if R1 might have been fatigued and the bedpan should have been used. The facility Investigation report lacked evidence the care plan and therapy notes were reviewed to ensure provisions of care were in place, staff were implementing appropriate care and treatment, all necessary staff were interviewed, and staff were determined to be competent. The facility Abuse Prevention Plan Policy and Procedure dated 9/2021, indicated "Resident and tenant incident reports are reviewed by staff to determine whether there is reasonable evidence to suspect abuse and/or neglect of a vulnerable adult. This includes identifying events such as suspicious bruising, injuries of an unknown source, of resident's occurrences, patterns and trends that may constitute abuse. "	F 610		
F 689 SS=G	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:	F 689		2/4/23

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F 689	Continued From page 9 Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented as care planned to prevent falls for 1 of 2 residents (R1) reviewed for accidents. This resulted in actual harm when R1 fell from a toileting sling and was diagnosed with a left shoulder fracture. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/23/22, indicated R1 had hemiplegia and anxiety. The MDS indicated R1 was cognitively impaired, did not reject care, transferred with extensive assist of two, was always incontinent of bladder and frequently incontinent of bowel. The MDS further indicated R1 had occasional pain and had one fall with major injury since admission. R1's Care Plan dated 10/3/22 , indicated R1 was at moderate risk for falls related to weakness, needed assistance with mobility, diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side. The care plan indicated R1 used a bed pan for toileting until toileting sling use was re-assessed for proper fit. A Resident Abuse/Neglect Investigation Report Form completed by the facility on 10/03/22, indicated on 10/03/22, at 3:30 p.m. R1 was being transferred from commode to wheelchair using Hoyer lift and toileting sling when R1 started to slide out of sling and fell to the floor. The report indicated R1 had left shoulder pain with movement and denied other pain. The report indicated no neglect or abuse was found and care plan, policies and procedures were followed and	F 689	F689 Free of Accident Hazards/Supervision/Devices Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and constitutes the facility's compliance. In response to the above stated citation Annandale Care Center has taken the following action(s): Toileting sling was removed from use on October 3, 2022 following the incident at issue and Resident's care plan was updated on October 3, 2022 to reflect this change. Resident was assessed by therapy for toileting and transfer abilities. All nursing staff will be trained with competency evaluations for use of full body lift. Full body lift slings, as opposed to split leg toileting lift slings, limit the potential impact of resident fatigue playing a role in transfer. Review of care plans to identify other residents that are transferred using a full body lift to ensure that it is appropriate for their current level of care. Residents are assessed on admission, quarterly and	

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F 689	Continued From page 10 facility was re-evaluating type of sling used, but sling in place was correct for lift and toileting. A Fax Form from the facility dated 10/03/22, at 4:23 p.m. to R1's physician indicated, at 3:50 p.m. R1 was being lifted with the hoyer lift using the toileting sling. When they were getting ready to lower her back to her wheelchair the NARs noticed R1 was slipping and before they could get the chair under her, she fell to the ground. R1 was assessed and stated her back, shoulder and head hit the ground. After being assessed, R1 was lifted to her bed using a hoyer lift and full body sling with compliants of pain in left shoulder with movement. She also complained of level 4 pain in left lateral thigh/lower flank area. There was a L shaped bruise in that area. Review of physician response fax was to monitor and update. An Office Visit note dated 10/06/22, indicated R1 was seen, had x-rays and was found to have a fracture of the left humeral neck (shoulder fracture). The note indicated an order for an arm splint and follow up in a week. Increased Tylenol to 1,000 milligrams (mg) TID (three times a day) for the next week and resume current dose. A CentraCare Clinic fax dated 10/07/22, indicated R1 continued to have increased left shoulder pain and Tramadol (used to treat pain) 50 mg one tablet every 6 hours as need. Review of Occupational Therapy (OT) and Certified Occupational Therapy Assistant (COTA)-A notes dated 8/19/22 through 10/04/22, indicated the following: On 8/19/22, OT indicated patient was educated	F 689	with significant changes to ensure that the plan of care is appropriate. Nursing staff will receive training on the importance of clear communication with therapy staff to ensure resident care plans are appropriately updated and implemented. The IDT will also add to morning meeting agenda to review any concerns brought up by therapy. Therapists will be given access to our EMR to put progress notes in regarding concerns or changes made to plan of care in order to better communicate with nursing. Toileting slings will no longer be used in facility. New lifts are being purchased with appropriate slings to allow for meeting toileting needs of our residents while limiting potential safety issues relating to resident fatigue. Competencies were developed to ensure that nursing staff can demonstrate safe and appropriate use of lifts and slings. Upon hire, annually and as needed competencies will be assessed and documented with nursing staff to ensure continued competency and identify training needs. Concerns will be brought to Quality Assurance committee at least quarterly for review. This deficiency will be corrected by February 4, 2023.	

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F 689	Continued From page 11 on benefit of trial with toilet sling for toileting. On 8/22/22, staff CNA (certified nursing assistant) training to continue use hoyer transfers with toilet sling during use of commode. Patient completes transfers with assist of two. Occupational therapy (OT) updates toilet sling transfers, criss crossing leg straps for improved bilateral lower extremity stability. On 9/07/22, OT indicated concerns from staff over the weekend with patient use of toileting sling. Consulted with licensed practical nurse (LPN)-A and NA-K regarding incident, [FM]-A present reporting staff were not using the toileting sling. The note indicated social services was informed of FM-A concern. In addition the note indicated the director of nursing (DON) was looking into larger slings for R1. On 9/12/22, COTA-A indicated writer collaborates with nursing regarding toilet transfers. Writer provided staff training to use toilet sling crossing leg straps for improved security. On 9/21/22, COTA -A indicated writer consulted with NA-K and night staff concerns of poor safety using toileting sling. NA-K reported concerned with R1's posture in toilet sling during the night with increased fatigue. The note then indicated R1 was able to maintain posture in toilet sling during the night and OT will upgrade Functional Maintenance Plan (FMP) and RN education and collaboration regarding toileting task using the bed pan. R1's Rehab Visions Occupational Therapy report also known as Functional Maintenance Plan	F 689		

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F 689	Continued From page 12 (FMP) dated 9/26/22, indicated R1 toileted with assist of two, toileting sling, and bedside commode. Use of bed pan as need (PRN). During observation and interview on 1/03/23, at 9:35 a.m. R1 was lying in bed and stated she had no pain. R1 stated she preferred to use the bedpan instead of the toileting sling. R1 then wanted to have her family member involved in the conversation so R1 used her Alexa device (virtual assistant technology) and called (FM)-A. FM-A stated he was informed the facility felt the cause of the fall on 10/03/22, was due to R1's left arm slipped through the toileting sling and then fell to the floor. FM-A stated he was upset because after the fall R1 no longer received therapy and she became private pay. FM-A stated he wanted R1 to use the commode and hoped she would eventually be able to come home. FM-A stated he was not informed R1 was experiencing fatigue in the evening, but some of the staff would not want to use the sling. He encouraged them to use it since he felt it was painful for R1 to use the bed pain. During interview on 1/03/23, at 12:20 p.m. COTA-A stated she assessed R1 during the day and had no concerns with transfers using the toileting sling, but did not look at R1 later in the day or evening when staff expressed concerns with fatigue. COTA-A stated she was aware R1 had weakness later in the day and added to R1's functional maintenance plan (FMP) to use the bed pan as needed (PRN) instead of toileting sling and commode for safety. In addition, COTA-A stated she trained the staff on the floor on how to use the toileting sling on R1 if they communicated they had concerns. When asked if there was any training documentation, COTA-A	F 689		

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F 689	Continued From page 13 stated she did not record the individual training's. During interview on 1/03/23, at 2:00 p.m. nursing assistant (NA)-A stated she had been working at the facility for over two years and always used the bed pan for R1's toileting needs and was never aware R1 used the toileting sling. During interview on 1/03/23, at 2:06 p.m. registered nurse manager (RN)-A stated she was aware the staff were reporting they were uncomfortable with using the toileting sling with R1 so she referred the concerns to the therapy department and felt if they assessed R1 to be safe using the toileting sling, then she felt it was safe. RN-A stated after R1 fell on 10/03/22, they were no longer using the toileting sling. RN-A confirmed, previous to the fall, she was not aware of PRN order to use bed pan if R1 was fatigued. During interview on 1/03/23, at 8:13 p.m. NA-B stated prior to R1's fall they used the toileting sling and felt it was small and R1's arms would go into the air. In addition, NA-B stated R1 would get tired in the evening and this had been reported to the nurses working. NA-B added, even though he voiced concerns of safety with the sling, he had not received any training on using the toileting sling with R1 and so would try to avoid the sling at any cost and just use the bed pan. NA-B stated he was not aware of the order to use the bed pan PRN if R1 was fatigued. During interview on 1/03/23, at 8:44 p.m. NA-C stated "I would not transfer [R1] using the toileting sling, it would pinch at the wrong angles" and "was not a big fan of the sling." During interview on 1/03/23, at 8:45 a.m. NA-D	F 689		

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F 689	Continued From page 14 stated she was the NA working when R1 slipped out of the sling. NA-D stated the sling was too small and R1's legs started to slide out, even though the straps around the legs were criss-crossed, her bottom was sliding down. NA-D stated she thought they used the biggest toileting sling they had and was never told it was too small until after the incident. NA-D stated when the incident occurred she was new to working at the facility and was trained on the B-wing not the A-wing where R1 was on. During interview on 1/04/23, at 9:40 a.m. DON stated, they checked the sling and R1's weight and according to the chart the toileting sling was appropriate for R1. The DON stated she felt the incident occurred because R1 pulled her arm in and out of the sling, slid out, and fell. Since the incident they have been using the bed pan. During interview on 1/04/23, 12:32 p.m. NA-F stated "to be honest I was never aware [R1] used a toileting sling and was never trained". NA-F stated she worked evenings and they had a lot of new staff and there had been no formal training on how to use the sling on R1. During interview on 1/04/23, at 1:24 p.m. NA-G indicated she worked evening shifts and had been at the facility for over two years and never used the toileting sling on R1. NA-G stated she had heard staff state they were uncomfortable using the toileting sling. During interview on 1/04/23, at 1:33 p.m. NA-H stated she worked the evening shift and when she would use the toileting sling R1's arms and body would sink into the sling. It didn't look right and was too small. NA-H stated she reported to	F 689		

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F 689	Continued From page 15 the nurses, but therapy wanted us to use the toileting sling and it was on our Nursing Assistant Care Sheet to use the toileting sling. NA-H stated she was not surprised after a short leave and then returning to find out that R1 had slid out of her sling. In addition RA-H stated even though she reported her concerns to the nurses she never received any training or direction on transfers for R1 when she became fatigued and felt the new staff should all be trained on the proper way to complete transfers so the residents were safe. During interview on 1/04/23, at 5:00 p.m. NA-I stated she worked the evening shift. When she transferred R1, the sling around her back did not fit her and she would just leave the leg straps un-crossed because she did not want to pinch her legs. NA-H further stated they communicated concerns to FM-A and nursing staff, but FM-A insisted they use the toileting sling for R1 and not the bed pan. During interview on 1/04/23, at 6:08 p.m. NA-D stated when she was transferring R1 she was not aware she could have used the commode (PRN when fatigued) and R1 probably slid through her toileting sling because she was tired and weak. During interview on 1/04/23, at 6:18 p.m. NA-J stated her and NA-D were the ones that transferred R1 when she slid out of her toileting sling adding, they knew her left arm had weakness and that when her arm slid through the sling, R1 could not hang on and fell to the floor. NA-J stated R1's weakness could have been the cause of her fall. NA-J added that they no longer used the toileting sling and used the bed pan for safety.	F 689		

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F 689	Continued From page 16 During interview on 1/05/23, at 9:38 a.m. DON stated the COTA-A would train the staff working on the shift when she was there but not all 79 staff. In addition, DON stated she did not understand why the two staff working with R1 did not know they could have used the bedpan the day of her incident since it was listed on her resident care sheet and they should be looking at that every day. In addition she was unaware who the COTA-A discussed the use of the bed pan with when R1 was weak according to the therapy note on 9/21/22, since she spoke to her nurse manager and the nurse manager was never informed of the collaboration that was listed in the COTA's documentation. In addition, the DON stated the FMP and care plan should have addressed the reason for using the bed pan for weakness and not just stating it was used PRN. The facility was unable to provide documentation of communication or education provided to staff regarding changes to R1 care plan. Although therapy had recommend using the bed pan when R1 was weak or tired and revised care plan treatment on 10/03/22, the facility staff were unaware of the intervention and transferred R1 using the toileting sling which resulted in a left humorous fracture. A facility policy Fall Protocol dated 9/2022, indicated "Realizing that not all falls can be prevented that the elderly population have multiple predispositions to falling and will fall, preventive measures shall be initiated when deemed appropriate to decrease the number of falls whenever possible." The policy further indicated if an assessment finds the resident at	F 689		

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F 689	Continued From page 17 risk the RN case manager will implement appropriate interventions and/or precautions on the care plan as an attempt to reduce the risk of falls or the risk of injury due to falls.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 20, 2023

Administrator
Annandale Care Center
500 Park Street East
Annandale, MN 55302

Re: State Nursing Home Licensing Orders
Event ID: LSR411

Dear Administrator:

The above facility was surveyed on January 3, 2023 through January 5, 2023 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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00951	A. BUILDING: _____ B. WING _____	C 01/05/2023

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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 1/03/23 through 1/05/23, 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: H53646615C (MN89223) with an order cited at 0830. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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 fall interventions were implemented as care planned to prevent falls for 1 of 2 residents (R1) reviewed for accidents. This resulted in actual harm when	2 830	Corrected	2/4/23

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2 830	Continued From page 2 R1 fell from a toileting sling and was diagnosed with a left shoulder fracture. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/23/22, indicated R1 had hemiplegia and anxiety. The MDS indicated R1 was cognitively impaired, did not reject care, transferred with extensive assist of two, was always incontinent of bladder and frequently incontinent of bowel. The MDS further indicated R1 had occasional pain and had one fall with major injury since admission. R1's Care Plan dated 10/3/22 , indicated R1 was at moderate risk for falls related to weakness, needed assistance with mobility, diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side. The care plan indicated R1 used a bed pan for toileting until toileting sling use was re-assessed for proper fit. A Resident Abuse/Neglect Investigation Report Form completed by the facility on 10/03/22, indicated on 10/03/22, at 3:30 p.m. R1 was being transferred from commode to wheelchair using Hoyer lift and toileting sling when R1 started to slide out of sling and fell to the floor. The report indicated R1 had left shoulder pain with movement and denied other pain. The report indicated no neglect or abuse was found and care plan, policies and procedures were followed and facility was re-evaluating type of sling used, but sling in place was correct for lift and toileting. A Fax Form from the facility dated 10/03/22, at 4:23 p.m. to R1's physician indicated, at 3:50 p.m. R1 was being lifted with the hoyer lift using the	2 830		

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2 830	Continued From page 3	2 830		

toileting sling. When they were getting ready to lower her back to her wheelchair the NARs noticed R1 was slipping and before they could get the chair under her, she fell to the ground. R1 was assessed and stated her back, shoulder and head hit the ground. After being assessed, R1 was lifted to her bed using a hoyer lift and full body sling with compliants of pain in left shoulder with movement. She also complained of level 4 pain in left lateral thigh/lower flank area. There was a L shaped bruise in that area. Review of physician response fax was to monitor and update.

An Office Visit note dated 10/06/22, indicated R1 was seen, had x-rays and was found to have a fracture of the left humeral neck (shoulder fracture). The note indicated an order for an arm splint and follow up in a week. Increased Tylenol to 1,000 milligrams (mg) TID (three times a day) for the next week and resume current dose.

A CentraCare Clinic fax dated 10/07/22, indicated R1 continued to have increased left shoulder pain and Tramadol (used to treat pain) 50 mg one tablet every 6 hours as need.

Review of Occupational Therapy (OT) and Certified Occupational Therapy Assistant (COTA)-A notes dated 8/19/22 through 10/04/22, indicated the following:

On 8/19/22, OT indicated patient was educated on benefit of trial with toilet sling for toileting.

On 8/22/22, staff CNA (certified nursing assistant) training to continue use hoyer transfers with toilet sling during use of commode. Patient completes transfers with assist of two. Occupational therapy (OT) updates toilet sling transfers, criss crossing

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2 830	Continued From page 4 leg straps for improved bilateral lower extremity stability. On 9/07/22, OT indicated concerns from staff over the weekend with patient use of toileting sling. Consulted with licensed practical nurse (LPN)-A and NA-K regarding incident, [FM]-A present reporting staff were not using the toileting sling. The note indicated social services was informed of FM-A concern. In addition the note indicated the director of nursing (DON) was looking into larger slings for R1. On 9/12/22, COTA-A indicated writer collaborates with nursing regarding toilet transfers. Writer provided staff training to use toilet sling crossing leg straps for improved security. On 9/21/22, COTA -A indicated writer consulted with NA-K and night staff concerns of poor safety using toileting sling. NA-K reported concerned with R1's posture in toilet sling during the night with increased fatigue. The note then indicated R1 was able to maintain posture in toilet sling during the night and OT will upgrade Functional Maintenance Plan (FMP) and RN education and collaboration regarding toileting task using the bed pan. R1's Rehab Visions Occupational Therapy report also known as Functional Maintenance Plan (FMP) dated 9/26/22, indicated R1 toileted with assist of two, toileting sling, and bedside commode. Use of bed pan as need (PRN). During observation and interview on 1/03/23, at 9:35 a.m. R1 was lying in bed and stated she had no pain. R1 stated she preferred to use the bedpan instead of the toileting sling. R1 then	2 830		

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2 830	Continued From page 5 wanted to have her family member involved in the conversation so R1 used her Alexa device (virtual assistant technology) and called (FM)-A. FM-A stated he was informed the facility felt the cause of the fall on 10/03/22, was due to R1's left arm slipped through the toileting sling and then fell to the floor. FM-A stated he was upset because after the fall R1 no longer received therapy and she became private pay. FM-A stated he wanted R1 to use the commode and hoped she would eventually be able to come home. FM-A stated he was not informed R1 was experiencing fatigue in the evening, but some of the staff would not want to use the sling. He encouraged them to use it since he felt it was painful for R1 to use the bed pain. During interview on 1/03/23, at 12:20 p.m. COTA-A stated she assessed R1 during the day and had no concerns with transfers using the toileting sling, but did not look at R1 later in the day or evening when staff expressed concerns with fatigue. COTA-A stated she was aware R1 had weakness later in the day and added to R1's functional maintenance plan (FMP) to use the bed pan as needed (PRN) instead of toileting sling and commode for safety. In addition, COTA-A stated she trained the staff on the floor on how to use the toileting sling on R1 if they communicated they had concerns. When asked if there was any training documentation, COTA-A stated she did not record the individual training's. During interview on 1/03/23, at 2:00 p.m. nursing assistant (NA)-A stated she had been working at the facility for over two years and always used the bed pan for R1's toileting needs and was never aware R1 used the toileting sling. During interview on 1/03/23, at 2:06 p.m.	2 830		

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2 830	Continued From page 6 registered nurse manager (RN)-A stated she was aware the staff were reporting they were uncomfortable with using the toileting sling with R1 so she referred the concerns to the therapy department and felt if they assessed R1 to be safe using the toileting sling, then she felt it was safe. RN-A stated after R1 fell on 10/03/22, they were no longer using the toileting sling. RN-A confirmed, previous to the fall, she was not aware of PRN order to use bed pan if R1 was fatigued. During interview on 1/03/23, at 8:13 p.m. NA-B stated prior to R1's fall they used the toileting sling and felt it was small and R1's arms would go into the air. In addition, NA-B stated R1 would get tired in the evening and this had been reported to the nurses working. NA-B added, even though he voiced concerns of safety with the sling, he had not received any training on using the toileting sling with R1 and so would try to avoid the sling at any cost and just use the bed pan. NA-B stated he was not aware of the order to use the bed pan PRN if R1 was fatigued. During interview on 1/03/23, at 8:44 p.m. NA-C stated "I would not transfer [R1] using the toileting sling, it would pinch at the wrong angles" and "was not a big fan of the sling." During interview on 1/03/23, at 8:45 a.m. NA-D stated she was the NA working when R1 slipped out of the sling. NA-D stated the sling was too small and R1's legs started to slide out, even though the straps around the legs were criss-crossed, her bottom was sliding down. NA-D stated she thought they used the biggest toileting sling they had and was never told it was too small until after the incident. NA-D stated when the incident occurred she was new to working at the facility and was trained on the	2 830		

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2 830	Continued From page 7 B-wing not the A-wing where R1 was on. During interview on 1/04/23, at 9:40 a.m. DON stated, they checked the sling and R1's weight and according to the chart the toileting sling was appropriate for R1. The DON stated she felt the incident occurred because R1 pulled her arm in and out of the sling, slid out, and fell. Since the incident they have been using the bed pan. During interview on 1/04/23, 12:32 p.m. NA-F stated "to be honest I was never aware [R1] used a toileting sling and was never trained". NA-F stated she worked evenings and they had a lot of new staff and there had been no formal training on how to use the sling on R1. During interview on 1/04/23, at 1:24 p.m. NA-G indicated she worked evening shifts and had been at the facility for over two years and never used the toileting sling on R1. NA-G stated she had heard staff state they were uncomfortable using the toileting sling. During interview on 1/04/23, at 1:33 p.m. NA-H stated she worked the evening shift and when she would use the toileting sling R1's arms and body would sink into the sling. It didn't look right and was too small. NA-H stated she reported to the nurses, but therapy wanted us to use the toileting sling and it was on our Nursing Assistant Care Sheet to use the toileting sling. NA-H stated she was not surprised after a short leave and then returning to find out that R1 had slid out of her sling. In addition RA-H stated even though she reported her concerns to the nurses she never received any training or direction on transfers for R1 when she became fatigued and felt the new staff should all be trained on the proper way to complete transfers so the residents	2 830		

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2 830	Continued From page 8 were safe. During interview on 1/04/23, at 5:00 p.m. NA-I stated she worked the evening shift. When she transferred R1, the sling around her back did not fit her and she would just leave the leg straps un-crossed because she did not want to pinch her legs. NA-H further stated they communicated concerns to FM-A and nursing staff, but FM-A insisted they use the toileting sling for R1 and not the bed pan. During interview on 1/04/23, at 6:08 p.m. NA-D stated when she was transferring R1 she was not aware she could have used the commode (PRN when fatigued) and R1 probably slid through her toileting sling because she was tired and weak. During interview on 1/04/23, at 6:18 p.m. NA-J stated her and NA-D were the ones that transferred R1 when she slid out of her toileting sling adding, they knew her left arm had weakness and that when her arm slid through the sling, R1 could not hang on and fell to the floor. NA-J stated R1's weakness could have been the cause of her fall. NA-J added that they no longer used the toileting sling and used the bed pan for safety. During interview on 1/05/23, at 9:38 a.m. DON stated the COTA-A would train the staff working on the shift when she was there but not all 79 staff. In addition, DON stated she did not understand why the two staff working with R1 did not know they could have used the bedpan the day of her incident since it was listed on her resident care sheet and they should be looking at that every day. In addition she was unaware who the COTA-A discussed the use of the bed pan with when R1 was weak according to the therapy	2 830		

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2 830	Continued From page 9 note on 9/21/22, since she spoke to her nurse manager and the nurse manager was never informed of the collaboration that was listed in the COTA's documentation. In addition, the DON stated the FMP and care plan should have addressed the reason for using the bed pan for weakness and not just stating it was used PRN. The facility was unable to provide documentation of communication or education provided to staff regarding changes to R1 care plan. Although therapy had recommend using the bed pan when R1 was weak or tired and revised care plan treatment on 10/03/22, the facility staff were unaware of the intervention and transferred R1 using the toileting sling which resulted in a left humorous fracture. A facility policy Fall Protocol dated 9/2022, indicated "Realizing that not all falls can be prevented that the elderly population have multiple predispositions to falling and will fall, preventive measures shall be initiated when deemed appropriate to decrease the number of falls whenever possible." The policy further indicated if an assessment finds the resident at risk the RN case manager will implement appropriate interventions and/or precautions on the care plan as an attempt to reduce the risk of falls or the risk of injury due to falls. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		