DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 20, 2022

Administrator
Cook Community Hospital C&nc
10 Southeast Fifth Street
Cook, MN 55723

RE: CCN: 245392
Cycle Start Date: May 2, 2022

Dear Administrator:

On May 10, 2022, we notified you a remedy was imposed. On May 18, 2022 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 May 15, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 25, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 10, 2022, 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 May 2, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 15, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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

May 20, 2022

Administrator
Cook Community Hospital C&nc
10 Southeast Fifth Street
Cook, MN 55723

Re: Reinspection Results
Event ID: F2HU12

Dear Administrator:

On May 18, 2022 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 May 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
May 10, 2022

Administrator
Cook Community Hospital C&nc
10 Southeast Fifth Street
Cook, MN 55723

RE: CCN: 245392
Cycle Start Date: May 2, 2022

Dear Administrator:

On May 2, 2022, 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 a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 2, 2022, 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 E.

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 May 25, 2022.

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 May 25, 2022 August 2, 2022, (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 May 25, 2022, (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 $11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 2, 2022. 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. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care.

Therefore, Cook Community Hospital C&nc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 2, 2022. 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" and/ or "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 November 2, 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, Compliance Analyst
Minnesota Department of Health
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
	245392	A. BUILDING _____ B. WING _____	C 05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK COMMUNITY HOSPITAL C&NC	**10 SOUTHEAST FIFTH STREET COOK, MN 55723**

(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 4/27/22, through 5/2/221, an abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety at F689. The IJ began on 4/23/22, at 2:40 p.m. when the facility failed to correctly place a toileting sling to a resident by crossing the leg straps, resulting in R1 falling out of the lift. The director of nursing (DON) was informed of the IJ on 4/29/22, at 2:00 p.m. The IJ was removed on 5/2/22/22, at 3:18 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/2/22. The following complaint was found to be SUBSTANTIATED: H5392024C (MN82971) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/12/2022

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

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F 000	Continued From page 1 your verification.	F 000		
F 689 SS=K	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 follow the manufacturer's recommendation on the proper placement of a toileting sling for the overhead mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1, when she fell from the mechanical lift, resulting in a laceration to her head that required sutures. The immediate jeopardy (IJ) began on 4/23/22, at 2:40 p.m. when the facility failed to correctly place a toileting sling to a resident by crossing the leg straps, resulting in R1 falling out of the lift. The director of nursing (DON) was informed of the IJ on 4/29/22, at 2:00 p.m. The IJ was removed on 5/2/22/22, at 3:18 p.m. but non-compliance remained at the lower scope and severity of E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 689	0689: Immediately at 1430 on 4/29/22: DON began retraining and performing proper placement and use of Tollos toileting/hygiene slings, full slings, combi slings and ceiling lifts with competency checks for all Nursing Assistants and Licensed Nursing per manufacturer guidelines. Each current staff member were trained prior to starting their shift. The last staff member will be trained on 5/15/22 as she has not been on the schedule until this time. All other staff have been re-trained. The DON also created an updated Tollos Sling Assessment Competency test. New nursing assistants and licensed nursing will be provided the sling training per manufacturer guidelines with competency checks prior to beginning their orientation on the floor. QAPI was created 4/30/22: The QAPI will ensure the nursing staff are	5/15/22

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F 689	Continued From page 2 R1's Diagnosis List printed on 4/29/22, indicated R1's diagnoses included dementia with behavioral disturbances, scoliosis, pain, wheelchair dependence, weakness and repeated falls. R1's quarterly Minimum Data Set (MDS) dated 4/4/22, indicated R1 had long term and short term memory loss, was able to make herself understood and usually understood others, and was totally dependent on one staff for transfers. R1's care plan last reviewed 4/8/22, indicated R1 transferred with a mechanical lift, and staff could use two staff for transfers if R1 had behaviors. The care plan also indicated R1 had behaviors of hitting at staff, trying at bite at staff, and refusing meds and oral cares. On 4/23/22, at a progress note indicated at 2:40 p.m. R1 was being transferred with the ceiling lift and a toileting sling, she let go of the sling and fell to the floor. R1 was noted to have a 5 centimeter (cm) by 5 cm hematoma (occurs when an injury causes blood to collect and pool under the skin) with laceration to her head. R1 was sent to the emergency department (ED) where she required three staples to the laceration. On 4/23/22, an emergency department (ED) note indicated R1 was being transferred with a mechanical lift sling at approximately four to five feet in height, and the portion of the sling that supported R1's upper half of her body slid down and R1 fell to the floor. R1 struck her head on the ground. The ED report further indicated R1 reported some vision abnormalities, but had significant memory problems and dementia. R1 followed commands, R1's eyes were open, and	F 689	appropriately placing slings per retraining/manufacturer instructions, and using the assigned sling for each patient that have slings to ensure resident safety. Audits will be performed 5 x per week beginning the week of 5/2/22 x 6 weeks, then three times per week x 4 weeks, then ongoing as determined by the audit results. The MDS Coordinator/RN Educator, Nurse Manager or DON will perform the audits. All audit results will be reviewed by the DON to ensure compliance. On 4/29/22 and 4/30/22 -Resident R1 was reviewed by the DON to ensure she was assigned the appropriate sling and size based on weight, changes in condition, trunk control and behaviors. It was determined through this assessment process and due to her recent fall out of the sling on 4/23/22 that the safest option for R1 would be to change her to only be transferred with a Combi Sling, Size (M) with two assist of staff. This sling will provide improved stability and control to the resident during transfers. New Sling Assessment form was created by the DON and was completed for this sling assessment change. The new form is based on manufacturer recommendations and will be utilized going forward for all residents who have a sling need. R1's Care Plan, pocket care plan, and sling list were updated and the assessment was shared with all staff	

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F 689	Continued From page 3 R1's speech was unintelligible to clear simple words. R1 had bleeding and a hematoma from the right occipitoparietal region (back side upper area) of the skull. R1 was in no apparent distress. R1's right occipitoparietal skull had a hematoma and a three cm long ovoid (egg shaped) laceration. Three staples were placed to close the laceration. On 4/27/22, at 2:23 p.m. an overhead mechanical lift transfer was observed with R2 by nursing assistant (NA)-B and NA-C. R2 was transferred using the toileting sling. The leg straps under R2's legs were not crossed as recommended by the manufacturer. On 4/28/22, at 9:09 a.m. NA-D was interviewed and stated when using the full body lift sling, the leg straps were to be crossed. When using the toileting sling, staff did not cross the leg straps were not crossed because if the leg straps were crossed staff could not lower the resident's pants. On 4/28/22, at 9:33 a.m. registered nurse (RN)-A stated she was the nurse that came in to assess R1 following the fall from the lift. RN-A stated R1's head and shoulders were on the floor, and R1's legs were still in the sling, which was attached to the lift. RN-A stated NA-A reported to her R1 came out of the top of the sling. RN-A stated R1 was sent to the ED. On 4/28/22, at 9:45 a.m. trained medication aide (TMA)-A was interviewed. TMA-A stated the day R1 fell from the lift, she heard someone call for help and went into R1's room. TMA-A stated R1's head and shoulders were on the floor, and her feet were still in the lift sling. TMA-A stated nursing assistant (NA)-A told her R1 fell out of the	F 689	alerting them of the changes put in place. 4/30/22: All Five other residents who require the use of a sling, were reassessed by the DON utilizing the new Sling Assessment Form. Changes were made for each of those residents as described in the Removal Plan. All Pocket care plans, care plans and sling lists were updated with the changes and the staff were made aware by the DON. 4/30/22: All residents requiring a sling will be reviewed for continued appropriateness based on the manufacturer instructions and the Mechanical Lift and Patient Safety Policies which include a review for condition changes that potentially impact their ability to transfer, requests for a different sling and annually. A committee of The DON, MDS Coordinator/RN Educator, PT/OT representative and restorative will participate in these reassessments. The Sling Assessment form will be utilized during the assessments. 4/30/22: All new admissions requiring a sling assessment will have this completed upon admission following the Mechanical Lift and Patient Safety Policies. 4/30/22: Policies updated The DON reviewed and updated the Mechanical Lift and Patient Safety	

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F 689	Continued From page 4 lift. TMA-A stated it looked like the lift sling possibly was hooked to the lift incorrectly. TMA-A stated if the upper strap and hood neck guard were hooked too low, the resident's center of gravity was off, and the resident could flip out of the sling. On 4/28/22, at 10:45 a.m. NA-A was interviewed and stated she went to transfer R1 from the wheelchair to the bed to check and/or change the incontinent brief. NA-A stated she connected the six straps and the belt of the toileting sling. NA-A stated she told R1 to hang on to the straps. R1 was sitting up, held onto the straps for a few seconds and then let go. NA-A stated R1 stiffened and arched her back and came out of the sling onto the floor. NA-A stated when R1 arched, stiffened, and let go, this possibly set the center of gravity off. NA-A stated she did not know if R1 went over the top of the sling or through the bottom of the sling. NA-A stated she did not identify anything wrong with the lift or the sling. On 4/28/22, at 10:55 a.m. the director of nursing (DON) was interviewed and stated following R1's fall from the lift, they reenacted what could have happened. The DON stated R1's fall was a "fluke." The DON stated by the way it was described, R1 stiffened, let go of the sling and slid out. The DON stated they updated R1's care plan not to use a toileting sling, to only use a full body sling, and have two staff with ceiling lift transfers. The DON stated they had emailed all staff on R1's changes. The DON stated they did not identify anything that needed immediate education, and would review the incident with staff at the next staff meeting the third week of May. The DON stated the sling type and size	F 689	Policies to include the updated Sling Assessment form, with updates to the overall protocol. The ongoing Restorative monitoring of slings weekly form was included and the process which will be followed to ensure slings are in good repair, and are not frayed or worn. This will ensure another check of the slings as staff must inspect every sling before use, included previously in these policies.	

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	245392	A. BUILDING _____ B. WING _____	C 05/02/2022

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F 689	Continued From page 5	F 689		

used on residents was determined by restorative staff and physical therapy staff. The DON stated using either one staff or two staff was determined by an RN and restorative staff using the manufacturer's algorithm, and the determination was put into the care plan. The DON stated ceiling lift transfers were typically done with the assistance of one staff, unless the resident had behaviors or had recent changes, then two staff would transfer the resident. The DON stated the slings were checked weekly, and the lifts were checked monthly. The DON stated toileting slings could be used on residents who were incontinent, as it was easier to check and change incontinent residents.

On 4/28/22, at 2:25 p.m. the DON was interviewed again and stated if a resident let go of the lift sling, this would not mean the resident would fall out of the sling. The DON stated R1 had stiffened and arched her back, and obviously had some contributing factor to her fall. The DON stated letting go of the sling alone would not cause a resident to fall out of the toileting sling.

On 4/28/22, at 4:05 p.m. the Tollo ceiling lift and sling manufacturer's clinical education director (CED)-A was interviewed. CED-A stated the toileting sling was used for showers, toileting, or to check and change a resident for incontinence. CED-A stated the leg straps of the toileting sling must be crossed to keep the legs secure, and if they were not crossed, that could be why R1's legs were found tangled in the sling. CED-A stated the resident's arms should be on the outside of the sling to keep the resident from sliding through, but residents do not need to hold onto the sling. CED-A stated the manufacturer recommends using two staff when using the

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F 689	Continued From page 6	F 689		

overhead lift, but this depended on the facility's policy. CED-A further stated she had been a CED since 2009, and had not heard of a resident arching their back and falling out of a sling. CED-A stated staff could have had the sling straps connected to the lift incorrectly, or at the incorrect length. If the toileting sling leg straps were not crossed, the resident would not be held in the sling and could fall out of the sling. CED-A stated the sling chest strap needed to be snug, if not the resident could slip out. CED-A stated if a resident slipped out of a sling, either the sling was not appropriate for the resident, or the sling was not hooked up correctly to the ceiling lift.

On 4/29/22, at 10:56 a.m. NA-B was interviewed and stated when using the toileting sling on a resident, the straps are not to be crossed. NA-B stated if staff crossed the straps, it would be too difficult to lower the clothing to toilet a resident.

On 4/29/22, at 11:13 a.m. NA-C was interviewed and stated when using the toileting sling on a resident, the straps were not to be crossed to be able to put the resident on the toilet and lower the pants. NA-C further stated only residents who could hang on to the sling straps could use the toileting sling.

On 4/29/22, at 11:20 a.m. NA-E was interviewed and stated she had worked at the facility on and off for 27 years. NA-E stated the toileting sling leg straps were not crossed when going on the toilet to be able to lower the resident's pants. The sling was to be under the resident's arm and the chest strap held the resident in the sling.

On 4/29/22, at 11:26 a.m. NA-F, the restorative aide, stated when using a toileting sling, the

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straps were not crossed because that would make it difficult to pull a resident's pants up and down.

On 4/29/22, at 11:40 a.m. the DON stated when using a toileting sling, the straps need to be crossed. The DON stated this was how it was directed on the manufacturer's competency checklist.

On 4/29/22, at 11:45 a.m. the DON had NA-B demonstrate and explain how to apply a toileting sling. NA-B applied the sling to herself. NA-B stated and demonstrated the leg strap of the toileting sling went under the thigh and came up around the same thigh creating a seat. NA-B did not cross the straps as directed on the manufacturer's competency checklist.

On 4/29/22, at 11:50 a.m. CED-A was interviewed again. CED-A stated per the manufacturer's competency checklist, the straps on the toileting sling needed to be crossed. CED-A stated if this was not done, the resident would have the potential to fall from the sling.

On 4/29/22, at 12:15 p.m. NA-F demonstrated how to apply the toileting sling. NA-F demonstrated, but did not correctly cross the straps as directed on the competency checklist. NA-F stated when using the toileting sling, staff don't cross the straps because that would make it difficult to get residents' pants or incontinent brief up and down and provide pericare.

The manufacturer's Competency Assessment undated, directed when using the toileting sling, place leg straps evenly under each thigh. Cross leg straps evenly under each thigh. Cross leg

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loops by threading one strap through the red loop of opposite strap. Attach green or blue loops of leg straps to spreader bar. Attach red or yellow shoulder loops to shoulder hooks, raise the patient 1-2 inches above the surface. Stop- perform a safety check - ensure the loops are securely attached and the sling is positioned properly. Lift patient to intended surface.

The facility policy Mechanical Lifts with Algorithms Attached dated 4/13/21, directed staff operating the lifts were to ensure proper positioning of canvas/cloth slings. It was extremely important the slings were properly placed under the resident.
Before lifting the resident with the lift, make sure the loops of the sling are securely placed into the bottom of the hook of the lift.
One or two Person Transfers:
The nurse would evaluate the resident upon admission and with changes in medical, physical, or mental state using the ceiling lift algorithm to determine whether one or two person transfers were required with the ceiling lifts.
If a resident was combative and or aggressive, a two-person transfer was required.
If an aide is unable to successfully position the resident, a two-person transfer was necessary.
Anytime the aide felt uncomfortable to transfer a resident without assistance, use two people.

The Algorithm for Use of Ceiling Lifts revised 7/14, directed if the resident could not bear weight, if the resident was cooperative, did not have behaviors, was able to follow commands, had upper body strength and was able to sit up and hold on to the sling, staff may use one person assistance with the ceiling lift if compliant with physical therapy (PT) orders and the

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F 689	Continued From page 9 caregiver felt safe doing so. The IJ was removed on 5/2/22, when the facility reviewed and assessed all residents for the appropriateness of the use of a lift sling and correct sling size. Care plans, sling lists, and toileting plans were reviewed and updated. Licensed nurses and nursing assistants were provided manufacturer education, training for proper sling placement and use and competency assessments. Audits for appropriate use as per competency training would be performed five times a week for six weeks and then ongoing on a regular basis by the MDS/RN educator. Sling education would be provided upon hire and annually with competency testing. The Mechanical Lift policy was updated to include a sling assessment that would be completed by the MDS/RN educator, DON or nurse manager upon admission, with any condition changes, requests for sling assessment and quarterly. To ensure the resident has the safest sling for their specific needs. The Safe Patient Handling policy was updated to include the sling assessment and restorative nursing sling monitoring to be completed on a weekly basis. To ensure the slings are safe and in good condition. A quality assurance and performance improvement (QAPI) had been created to ensure that staff were correctly and appropriately utilizing slings during transfers and toileting. The MDS/RN educator and or the DON would provide ongoing audits for appropriate use as per competency training will be performed five times week for six weeks, then three times per week for four weeks, then ongoing as determined by audit results. This was verified through observations, interviews and document review.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2022

Administrator
Cook Community Hospital C&nc
10 Southeast Fifth Street
Cook, MN 55723

Re: State Nursing Home Licensing Orders
Event ID: F2HU11

Dear Administrator:

The above facility was surveyed on April 27, 2022 through May 2, 2022 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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, Compliance Analyst
Minnesota Department of Health
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
	00586	A. BUILDING: _____ B. WING _____	C 05/02/2022

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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 4/27/22, through 5/2/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5392024C (MN82971), with a licensing order issued at 4658.0520 Subp 2.B. 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 follow the manufacturer's recommendation on the proper placement of a toileting sling for the overhead mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1, when she fell from the	2 830	0830: Immediately at 1430 on 4/29/22: DON began retraining and performing proper placement and use of Tollos toileting/hygiene slings, full slings, combi slings and ceiling lifts with competency checks for all Nursing Assistants and	5/15/22

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2 830	Continued From page 2 mechanical lift, resulting in a laceration to her head that required sutures. The immediate jeopardy (IJ) began on 4/23/22, at 2:40 p.m. when the facility failed to correctly place a toileting sling to a resident by crossing the leg straps, resulting in R1 falling out of the lift. The director of nursing (DON) was informed of the IJ on 4/29/22, at 2:00 p.m. The IJ was removed on 5/2/22/22, at 3:18 p.m. but non-compliance remained at the lower scope and severity of E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Diagnosis List printed on 4/29/22, indicated R1's diagnoses included dementia with behavioral disturbances, scoliosis, pain, wheelchair dependence, weakness and repeated falls. R1's quarterly Minimum Data Set (MDS) dated 4/4/22, indicated R1 had long term and short term memory loss, was able to make herself understood and usually understood others, and was totally dependent on one staff for transfers. R1's care plan last reviewed 4/8/22, indicated R1 transferred with a mechanical lift, and staff could use two staff for transfers if R1 had behaviors. The care plan also indicated R1 had behaviors of hitting at staff, trying at bite at staff, and refusing meds and oral cares. On 4/23/22, at a progress note indicated at 2:40 p.m. R1 was being transferred with the ceiling lift and a toileting sling, she let go of the sling and fell to the floor. R1 was noted to have a 5 centimeter	2 830	Licensed Nursing per manufacturer guidelines. Each current staff member were trained prior to starting their shift. The last staff member will be trained on 5/15/22 as she has not been on the schedule until this time. All other staff have been re-trained. The DON also created an updated Tollos Sling Assessment Competency test. New nursing assistants and licensed nursing will be provided the sling training per manufacturer guidelines with competency checks prior to beginning their orientation on the floor. QAPI was created 4/30/22: The QAPI will ensure the nursing staff are appropriately placing slings per retraining/manufacturer instructions, and using the assigned sling for each patient that have slings to ensure resident safety. Audits will be performed 5 x per week beginning the week of 5/2/22 x 6 weeks, then three times per week x 4 weeks, then ongoing as determined by the audit results. The MDS Coordinator/RN Educator, Nurse Manager or DON will perform the audits. All audit results will be reviewed by the DON to ensure compliance. On 4/29/22 and 4/30/22 -Resident R1 was reviewed by the DON to ensure she was assigned the appropriate sling and size based on weight, changes in condition, trunk control and behaviors. It was determined through this assessment process and due to her recent fall out of the sling on 4/23/22 that the safest option	

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2 830	Continued From page 3 (cm) by 5 cm hematoma (occurs when an injury causes blood to collect and pool under the skin) with laceration to her head. R1 was sent to the emergency department (ED) where she required three staples to the laceration. On 4/23/22, an emergency department (ED) note indicated R1 was being transferred with a mechanical lift sling at approximately four to five feet in height, and the portion of the sling that supported R1's upper half of her body slid down and R1 fell to the floor. R1 struck her head on the ground. The ED report further indicated R1 reported some vision abnormalities, but had significant memory problems and dementia. R1 followed commands, R1's eyes were open, and R1's speech was unintelligible to clear simple words. R1 had bleeding and a hematoma from the right occipitoparietal region (back side upper area) of the skull. R1 was in no apparent distress. R1's right occipitoparietal skull had a hematoma and a three cm long ovoid (egg shaped) laceration. Three staples were placed to close the laceration. On 4/27/22, at 2:23 p.m. an overhead mechanical lift transfer was observed with R2 by nursing assistant (NA)-B and NA-C. R2 was transferred using the toileting sling. The leg straps under R2's legs were not crossed as recommended by the manufacturer. On 4/28/22, at 9:09 a.m. NA-D was interviewed and stated when using the full body lift sling, the leg straps were to be crossed. When using the toileting sling, staff did not cross the leg straps were not crossed because if the leg straps were crossed staff could not lower the resident's pants. On 4/28/22, at 9:33 a.m. registered nurse (RN)-A	2 830	for R1 would be to change her to only be transferred with a Combi Sling, Size (M) with two assist of staff. This sling will provide improved stability and control to the resident during transfers. New Sling Assessment form was created by the DON and was completed for this sling assessment change. The new form is based on manufacturer recommendations and will be utilized going forward for all residents who have a sling need. R1's Care Plan, pocket care plan, and sling list were updated and the assessment was shared with all staff alerting them of the changes put in place. 4/30/22: All Five other residents who require the use of a sling, were reassessed by the DON utilizing the new Sling Assessment Form. Changes were made for each of those residents as described in the Removal Plan. All Pocket care plans, care plans and sling lists were updated with the changes and the staff were made aware by the DON. 4/30/22: All residents requiring a sling will be reviewed for continued appropriateness based on the manufacturer instructions and the Mechanical Lift and Patient Safety Policies which include a review for condition changes that potentially impact their ability to transfer, requests for a different sling and annually. A committee of The DON, MDS Coordinator/RN Educator, PT/OT representative and	

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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 4 stated she was the nurse that came in to assess R1 following the fall from the lift. RN-A stated R1's head and shoulders were on the floor, and R1's legs were still in the sling, which was attached to the lift. RN-A stated NA-A reported to her R1 came out of the top of the sling. RN-A stated R1 was sent to the ED. On 4/28/22, at 9:45 a.m. trained medication aide (TMA)-A was interviewed. TMA-A stated the day R1 fell from the lift, she heard someone call for help and went into R1's room. TMA-A stated R1's head and shoulders were on the floor, and her feet were still in the lift sling. TMA-A stated nursing assistant (NA)-A told her R1 fell out of the lift. TMA-A stated it looked like the lift sling possibly was hooked to the lift incorrectly. TMA-A stated if the upper strap and hood neck guard were hooked too low, the resident's center of gravity was off, and the resident could flip out of the sling. On 4/28/22, at 10:45 a.m. NA-A was interviewed and stated she went to transfer R1 from the wheelchair to the bed to check and/or change the incontinent brief. NA-A stated she connected the six straps and the belt of the toileting sling. NA-A stated she told R1 to hang on to the straps. R1 was sitting up, held onto the straps for a few seconds and then let go. NA-A stated R1 stiffened and arched her back and came out of the sling onto the floor. NA-A stated when R1 arched, stiffened, and let go, this possibly set the center of gravity off. NA-A stated she did not know if R1 went over the top of the sling or through the bottom of the sling. NA-A stated she did not identify anything wrong with the lift or the sling. On 4/28/22, at 10:55 a.m. the director of nursing	2 830	restorative will participate in these reassessments. The Sling Assessment form will be utilized during the assessments. 4/30/22: All new admissions requiring a sling assessment will have this completed upon admission following the Mechanical Lift and Patient Safety Policies. 4/30/22: Policies updated The DON reviewed and updated the Mechanical Lift and Patient Safety Policies to include the updated Sling Assessment form, with updates to the overall protocol. The ongoing Restorative monitoring of slings weekly form was included and the process which will be followed to ensure slings are in good repair, and are not frayed or worn. This will ensure another check of the slings as staff must inspect every sling before use, included previously in these policies. The DON educated all staff on the updated policies during the re-education and competency trainings performed.	

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	00586	A. BUILDING: _____ B. WING _____	C 05/02/2022

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2 830	Continued From page 5 (DON) was interviewed and stated following R1's fall from the lift, they reenacted what could have happened. The DON stated R1's fall was a "fluke." The DON stated by the way it was described, R1 stiffened, let go of the sling and slid out. The DON stated they updated R1's care plan not to use a toileting sling, to only use a full body sling, and have two staff with ceiling lift transfers. The DON stated they had emailed all staff on R1's changes. The DON stated they did not identify anything that needed immediate education, and would review the incident with staff at the next staff meeting the third week of May. The DON stated the sling type and size used on residents was determined by restorative staff and physical therapy staff. The DON stated using either one staff or two staff was determined by an RN and restorative staff using the manufacturer's algorithm, and the determination was put into the care plan. The DON stated ceiling lift transfers were typically done with the assistance of one staff, unless the resident had behaviors or had recent changes, then two staff would transfer the resident. The DON stated the slings were checked weekly, and the lifts were checked monthly. The DON stated toileting slings could be used on residents who were incontinent, as it was easier to check and change incontinent residents. On 4/28/22, at 2:25 p.m. the DON was interviewed again and stated if a resident let go of the lift sling, this would not mean the resident would fall out of the sling. The DON stated R1 had stiffened and arched her back, and obviously had some contributing factor to her fall. The DON stated letting go of the sling alone would not cause a resident to fall out of the toileting sling. On 4/28/22, at 4:05 p.m. the Tollo ceiling lift and	2 830		

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2 830	Continued From page 6 sling manufacturer's clinical education director (CED)-A was interviewed. CED-A stated the toileting sling was used for showers, toileting, or to check and change a resident for incontinence. CED-A stated the leg straps of the toileting sling must be crossed to keep the legs secure, and if they were not crossed, that could be why R1's legs were found tangled in the sling. CED-A stated the resident's arms should be on the outside of the sling to keep the resident from sliding through, but residents do not need to hold onto the sling. CED-A stated the manufacturer recommends using two staff when using the overhead lift, but this depended on the facility's policy. CED-A further stated she had been a CED since 2009, and had not heard of a resident arching their back and falling out of a sling. CED-A stated staff could have had the sling straps connected to the lift incorrectly, or at the incorrect length. If the toileting sling leg straps were not crossed, the resident would not be held in the sling and could fall out of the sling. CED-A stated the sling chest strap needed to be snug, if not the resident could slip out. CED-A stated if a resident slipped out of a sling, either the sling was not appropriate for the resident, or the sling was not hooked up correctly to the ceiling lift. On 4/29/22, at 10:56 a.m. NA-B was interviewed and stated when using the toileting sling on a resident, the straps are not to be crossed. NA-B stated if staff crossed the straps, it would be too difficult to lower the clothing to toilet a resident. On 4/29/22, at 11:13 a.m. NA-C was interviewed and stated when using the toileting sling on a resident, the straps were not to be crossed to be able to put the resident on the toilet and lower the pants. NA-C further stated only residents who could hang on to the sling straps could use the	2 830		

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2 830	Continued From page 7 toileting sling. On 4/29/22, at 11:20 a.m. NA-E was interviewed and stated she had worked at the facility on and off for 27 years. NA-E stated the toileting sling leg straps were not crossed when going on the toilet to be able to lower the resident's pants. The sling was to be under the resident's arm and the chest strap held the resident in the sling. On 4/29/22, at 11:26 a.m. NA-F, the restorative aide, stated when using a toileting sling, the straps were not crossed because that would make it difficult to pull a resident's pants up and down. On 4/29/22, at 11:40 a.m. the DON stated when using a toileting sling, the straps need to be crossed. The DON stated this was how it was directed on the manufacturer's competency checklist. On 4/29/22, at 11:45 a.m. the DON had NA-B demonstrate and explain how to apply a toileting sling. NA-B applied the sling to herself. NA-B stated and demonstrated the leg strap of the toileting sling went under the thigh and came up around the same thigh creating a seat. NA-B did not cross the straps as directed on the manufacturer's competency checklist. On 4/29/22, at 11:50 a.m. CED-A was interviewed again. CED-A stated per the manufacturer's competency checklist, the straps on the toileting sling needed to be crossed. CED-A stated if this was not done, the resident would have the potential to fall from the sling. On 4/29/22, at 12:15 p.m. NA-F demonstrated how to apply the toileting sling. NA-F	2 830		

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2 830	Continued From page 8 demonstrated, but did not correctly cross the straps as directed on the competency checklist. NA-F stated when using the toileting sling, staff don't cross the straps because that would make it difficult to get residents' pants or incontinent brief up and down and provide pericare. The manufacturer's Competency Assessment undated, directed when using the toileting sling, place leg straps evenly under each thigh. Cross leg straps evenly under each thigh. Cross leg loops by threading one strap through the red loop of opposite strap. Attach green or blue loops of leg straps to spreader bar. Attach red or yellow shoulder loops to shoulder hooks, raise the patient 1-2 inches above the surface. Stop-perform a safety check - ensure the loops are securely attached and the sling is positioned properly. Lift patient to intended surface. The facility policy Mechanical Lifts with Algorithms Attached dated 4/13/21, directed staff operating the lifts were to ensure proper positioning of canvas/cloth slings. It was extremely important the slings were properly placed under the resident. Before lifting the resident with the lift, make sure the loops of the sling are securely placed into the bottom of the hook of the lift. One or two Person Transfers: The nurse would evaluate the resident upon admission and with changes in medical, physical, or mental state using the ceiling lift algorithm to determine whether one or two person transfers were required with the ceiling lifts. If a resident was combative and or aggressive, a two-person transfer was required. If an aide is unable to successfully position the resident, a two-person transfer was necessary. Anytime the aide felt uncomfortable to transfer a	2 830		

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2 830	Continued From page 9 resident without assistance, use two people. The Algorithm for Use of Ceiling Lifts revised 7/14, directed if the resident could not bear weight, if the resident was cooperative, did not have behaviors, was able to follow commands, had upper body strength and was able to sit up and hold on to the sling, staff may use one person assistance with the ceiling lift if compliant with physical therapy (PT) orders and the caregiver felt safe doing so. The IJ was removed on 5/2/22, when the facility reviewed and assessed all residents for the appropriateness of the use of a lift sling and correct sling size. Care plans, sling lists, and toileting plans were reviewed and updated. Licensed nurses and nursing assistants were provided manufacturer education, training for proper sling placement and use and competency assessments. Audits for appropriate use as per competency training would be performed five times a week for six weeks and then ongoing on a regular basis by the MDS/RN educator. Sling education would be provided upon hire and annually with competency testing. The Mechanical Lift policy was updated to include a sling assessment that would be completed by the MDS/RN educator, DON or nurse manager upon admission, with any condition changes, requests for sling assessment and quarterly. To ensure the resident has the safest sling for their specific needs. The Safe Patient Handling policy was updated to include the sling assessment and restorative nursing sling monitoring to be completed on a weekly basis. To ensure the slings are safe and in good condition. A quality assurance and performance improvement (QAPI) had been created to ensure that staff were correctly and appropriately utilizing slings during	2 830		

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2 830	Continued From page 10 transfers and toileting. The MDS/RN educator and or the DON would provide ongoing audits for appropriate use as per competency training will be performed five times week for six weeks, then three times per week for four weeks, then ongoing as determined by audit results. This was verified through observations, interviews and document review. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures related to staff transferring residents safely. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		