

Electronically delivered August 20, 2020

Administrator Central Health Care 444 North Cordova Le Center, MN 56057

RE: CCN: 245401

Cycle Start Date: July 2, 2020

Dear Administrator:

On July 24, 2020, we notified you a remedy was imposed. On August 12, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 13, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 8, 2020 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 24, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2020. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Frig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically delivered

August 20, 2020

Administrator Central Health Care 444 North Cordova Le Center, MN 56057

Re: Reinspection Results

Event ID: CZFY12

Dear Administrator:

On August 12, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 2, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Pris

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

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Electronically Submitted July 24, 2020

Administrator Central Health Care 444 North Cordova Le Center, MN 56057

RE: CCN: 245401

Cycle Start Date: July 2, 2020

Dear Administrator:

On July 2, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 2, 2020, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 8, 2020.

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.

Central Health Care July 24, 2020 Page 2

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 8, 2020 (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 August 8, 2020, (42 CFR 488.417 (b)).

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Central Health Care is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 2, 2020. 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

Central Health Care July 24, 2020 Page 3

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001 Email: elizabeth.silkey@state.mn.us

Phone: 651-201-3784

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

Central Health Care July 24, 2020 Page 4 verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 2, 2021 (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.

Central Health Care July 24, 2020 Page 5

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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:

Central Health Care July 24, 2020 Page 6

> 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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Pais

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 08/04/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		045404		_		1	c
NAME OF F	PROVIDER OR SUPPLIER	245401	B. WING		FREET ADDRESS, CITY, STATE, ZIP CODE	07/0	02/2020
NAME OF F	ROVIDER OR SUPPLIER				14 NORTH CORDOVA		
CENTRA	L HEALTH CARE				E CENTER, MN 56057		
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	completed at your finvestigation. Your f	an abbreviated survey was acility to conduct a complaint facility was found not to be in CFR Part 483, Requirements Facilities.					
		laint was found to be 401033C. Deficiency issued					
	The survey resulted in an Immediate Jeopardy (IJ) at F689 when R1 had fallen out of a mechanical lift. The IJ began on 6/28/20, at 12:00 p.m. and the immediacy was removed on 7/2/20, at 2:18 p.m.						
	In addition, an externo 7/2/20.	nded survey was completed					
	as your allegation of Department's acception enrolled in ePOC, yat the bottom of the	f correction (POC) will serve if compliance upon the otance. Because you are our signature is not required if first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with azards/Supervision/Devices 1)(2)	F 6	89			7/13/20
	§483.25(d) Acciden The facility must en						

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

Electronically Signed 07/28/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 689	§483.25(d)(1) The as free of accidents. §483.25(d)(2)Each supervision and as accidents. This REQUIREMED by: Based on observareview, the facility guidelines to ensuimplemented for the form of 1 resident (R1). In an immediate jet from the mechanic non-displaced (in the knee) fracture to affect six other R9) who utilized more to affect six other R9) who utilized more to affect six other R9) who utilized more factorial assistant (NA)-A with mechanical lift and safety guidelines, sling to the floor. To find the floor of nursing (DON) at 5:30 p.m. The Letter of the lower scope and severity that is not immediate. R1 was admitted to the medical recordingly and the floor of included chronic known as a superior for the floor of the medical recordingly and the medical recordingly an	resident environment remains to hazards as is possible; and an resident receives adequate esistance devices to prevent entered ation, interview and document failed to follow manufacturer's resafety measures were the use of a mechanical lift for 1. This deficient practice resulted expardy (IJ) for R1, who fell call lift and sustained a calignment) distal femur (near entered the potential residents (R4, R5, R6, R7, R8, techanical lifts. 1/28/20, at 12:00 p.m. when the failed to follow manufacturer causing R1 with a defailed to follow manufacturer causing R1 to fall out of the entered the administrator and director were notified of the IJ on 7/1/20, J. was removed on 7/2/20, at r., non-compliance remained at and severity level G, isolated, y, which indicate actual harm	F 6	This plan of correction conwritten allegation of compliadeficiencies cited. Submiss of correction is not an admideficiency existed or that it accurately. This plan of consubmitted to meet state and guidelines. The facility will identify othe having the potential to be a 7/2/2020. 1. Transfer needs on all respect to determine mode of transfer. 2. All Care Plans have been updated to reflect resident transfer. 3. All new Admissions are prior to admission for mobil status and evaluated/scree upon admission. Nursing staff received the feducation; "Temporary action plans Invacare slings arrive/Universides."	ance for the sion of this plan ission that the is cited rection is defederal ar residents ffected by sidents has be correct an reviewed and mode of are-screened lity and transfer ned by therapy following	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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Redaim was un ler ex an an im ex Reino we ne pla with more repeated by the beautiful part of the beautiful part of the beautiful part of the part of the beautiful part of the	the femur fracture eview of the quart ted 6/17/20, indice pairment, modera as clear, usually u	knee pain and non-displaced erly Minimum Data Set (MDS) cated R1 had severe cognitive ate difficulty hearing, speech inderstood and usually red vision requiring corrective able to walk and required ee of two staff for bed mobility, ce on two staff for transfers IDS further indicated R1 had e of motion (ROM) in the lower int care plan dated 6/23/20, inpaired mobility related to f motion, advanced age, and ance with mobility. The care ed R1 would safely transfer otal assistance and utilizes a medium size	F 689	Checklist- " Mechanical Lift Policy " Universal Sling Placement & Littransfer Observation " Temporary Sling placement and " Staff viewed Video Invacare Lift Slings Demo on YouTube (link: https:/youtu.be/sr2zt_hkGGA) betw " 7/7/20-7/13/2020. " Invacare Lift & Sling placement competency performed with return demonstration between 7/7/20-7/13 All staff are now trained and competency will now be utilized in orientation packet as part of staff competency/resident safe handling hire which will include the Policy for Invacare Sling use. The facility implemented the following measures &/or systemic changes: " Invacare Lift & Sling placement competency will now be utilized in orientation packet as part of staff competency will now be utilized in orientation packet as part of staff competency will now be utilized in orientation packet as part of staff competency/resident safe handling hire. " Facility has implemented using brand of lift (Invacare) facility is purchasing lift slings specific to lift manufacturer specifications. " Facility has purchased an addit Invacare lift in order to assure all lift are met. " The facility has ordered a new cradle from Invacare with safety clipting the purchased and the process of	d sizing ts & reen _ state and sizing ts & reen _ state and state	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 689	Review of a progree p.m. indicated LPN from her bed to a s mechanical lift. LPN NA-A was maneuve leg strap of the sline mechanical lift and buttocks and her he mechanical lift. LPN immediately for hel ROM in bilateral up left lower extremity. R1 when bending the large bump on the R1's vital signs wer called and transpor room (ER) at 12:30 Review of a hospital physician progress R1 was evaluated a lift and had a large contusion which ap traumatic injury. A contusion which approvide who saw Faview of a progree p.m. indicated R1 where right knee which acetaminophen. R1 had difficulty movin provider who saw Faview of a progree p.m. indicated R1 where right knee which acetaminophen. R1 had difficulty movin provider who saw Faview of a progree p.m. indicated R1 where right knee which acetaminophen. R1 had difficulty movin provider who saw Faview of a progree p.m. indicated R1 where right knee which acetaminophen indicated R1 where	As note dated 6/28/20, at 1:32 And NA-A were lifting R1 tationary chair with a N-A was operating the lift while ering R1, when the right lower g slipped off the prong on the R1 fell to the floor hitting her ead against the leg of the N-A summoned RN-A p. ROM was assessed with full per extremities as well as the Limited ROM noted in right complained of right knee pain eg. R1 started to develop a back, right side of the head. e stable. The ambulance was ted R1 to the local emergency p.m. for further evaluation. al emergency department (ED) note dated 6/28/20, indicated after a fall from a mechanical posterior (back side) scalp peared to be her only computerized tomography (CT) d which showed no evidence de skull) abnormality. R1 had r than mild soreness over the on and returned to the nursing	F	689	The facility has developed a policy Invacare sling use and will assess residents requiring floor lift transfer appropriate sling size by utilizing th Resident Sling Assessment tool: *measuring the residents shoulder width and factoring in weight. *the size of the sling will be marked sling. *the date when the sling was put in service; *the residents name will be marked sling. *Sling size guidelines are posted in linen closet *Resident name and sling size is posted the resident's closet. *Reviewed Invacare Sling Policy win nursing staff on 7/2/2020. *Invacare Sling Policy will be included new hire packets. The facility plans to monitor its performance to make sure that the solutions are sustained. This plan head surance committee utilizing the AQAPI on 7/7/2020 and quarterly thereafter. "The Charge nurse is conducting observation audits per shift 7 days/ongoing until resurvey, with quarter audits ongoing until assurance that compliance is met. "DON or designee will conduct saudits daily 7 days/wk, to ensure the	s for e and hip I on the to I on the each osted in th led in as quality d HOC g 2 lift wk, ly sling	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	bend and move it; not hurt any more Review of a progrep.m. indicated R1 pain and increased get out of bed for some pain. On 6/29/20, a received from NP-right knee to be do acetaminophen do 1000 mg three tim Review of a radiologindicated R1 had a shaft (near the kneed advised facility to sof leg. R1 left facility returning on 6/30/2 splinted. Review of a ED ph 6/29/20, at 5:04 p. fracture and no oth was applied and R Review of an invest the facility director after interviewing sabove incident, as the mechanical lift was the result of h quick and not doin the loops on the sl hooks. All staff we checking to ensure	and R1 told him her knee did now than before the fall. Ses note dated 6/28/20, at 8:47 continued to have right knee dileg swelling, and refused to supper. A message was left for (NP)-C of the continued knee at 8:48 a.m. an order was C for a portable X-ray of R1's one that day and to increase her use from 650 milligrams (mg) to see a day and as needed. Segy report dated 6/29/20, an acute (new) distal femoral see) fracture. Progress note set:14 p.m. indicated NP-C send R1 to the ER for splinting try by ambulance at 4:17 p.m., 20, at 2:01 a.m. with right leg sysician progress note dated m. confirmed R1's distal femurater injuries; a right leg splint 1 was returned to the facility. Stigative report dated 6/29/20, of nursing (DON) indicated staff and investigating the well as inspecting the sling and a she concluded the incident uman error; staff being too g all of the checks to ensure ing were fully seated on the reprovided education on the steep of the stage were shows as well as having three thooks as well as having three and the stage were shows as well as having three and the stage were shows as well as having three and the stage were shows as well as having three thooks as well as having three and the stage were shows as well as having three stages.	F6	689	resident has the correct sling assig x 1 week, then weekly until resurve periodic audits ongoing until assurathat compliance is met. "All audits will be reviewed by th D.O.N. If concerns are found retrain with potential disciplinary action will taken.	y, with ance e ning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 689	staff assist with all conduct audits for a manufacturer's instance (Invacare) and the reviewed during the included safety me mechanical lift. During observation 4:55 p.m., R1 was room. When intervincident she stated R1 stated she hurt shoulder. During observation 10:40 a.m. R1 was with her right leg was groin to toes, propphad pain in her fee. During telephone in a.m. LPN-A, who a stated they were godinner. They put the loops. "Out of hoops to make sure stated she was ope at the head of the lind LPN-A stated NA-A lift. LPN-A added, "the bed and pulled popped and she fee head on the leg of During a telephone a.m. NA-A stated be the straps on the Head of the Head of the leg of the straps on the Head of the Head on the leg of the straps on the Head of the Head on the Head of the Head on the Head of the Head on the Head on the Head of the Head on the Head on the Head of the Head on	mechanical lift transfers and compliance. The tructions for the mechanical lift sling (Proactive) had not been to DON's investigation, that asures for the use of the and interview on 7/1/20, at resting in the recliner in her iewed R1 about the above, "They threw me on the floor." her leg, her head and her and interview on 7/2/20, at resting on her back in bed wrapped in elastic wrap from bed on a pillow. R1 stated she that at this time at this time there are always pull down on the eling under her and attached habit, I always pull down on the eling the lift so was standing iff where the controls were. A was maneuvering R1 in the last away, the right leg loop ll to the ground and hit her	F 6	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED	
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F 689	cues." NA-A stated waited until R1 was inches. NA-A state NA-A then guided I her in the chair for I remember is her I During a telephone a.m. RN-A stated safter R1 fell. Stated R1's room, the slin and she focused he laying on the floor. During an interview stated she was at the heard a commotion check on it. She re NA-A saying, "we cand they were tight removed from the I	she did a visual check and s up off the bed a couple of d, "We both did visual checks." R1's legs over the bed to put lunch. "It happened so fast, all nitting her head on the floor." In interview on 7/1/20, at 11:00 he was summoned to help by the time she arrived to g was removed from the lift er attention on R1 who was a con 7/1/20, at 11:05 a.m. RN-B he facility for training and an in R1's room, so went to called either or both LPN-A or checked them [the sling loops] a." By then the sling had been ift and the lift pushed out of the she left to start paperwork for	F 68	99		
	DON conducted a with the Invacare li Proactive mesh sliid during R1's fall on re-enactment, it ap mesh sling were se hooks, and with ter weight on the loops loop could simply sused reusable mes vendor other than the Invacare and sling stated the Proactive	re-enactment of the incident ft, model RPA600-1 and ng, both which were used 6/28/20 at noon. During peared as if the loops on the eated properly in the swivel bar nsion from the resident's of the sling, it is unlikely the slip off during transfer. Facility is slings from a different he lift vendor. Lift brand is brand is Proactive. The DON we sling was "universal" and any brand mechanical lift.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
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F 689	The DON provided Maintenance Manudate 9/08. According guidelines: Invacar specifically designed with Invacare patie other manufacturer component of Invacording these products is lifts warranty. Use the by the individual's condividual that is be sling attachments and replaced, to enattached before the stationary object (b) Warning: Invacare use with Invacare of the patient do not undifferent manufacturer that way" in the matter that way" in the matter that the provided Compatibility docurindicated: throughout the stationary object of the patient do not undifferent manufacturer that way in the matter that way in the matter that the provided compatibility docurindicated: throughout the provided compatibility docurindicated: throughout the patient of the provided compatibility docurindicated: throughout the provided compatibility docurindicated: thro	Owner's Operator and all for the Invacare lift, revision and to section I - general e transfer slings are ed to be used in conjunction and lifts. Slings designed by a sare not to be utilized as a care's patient lift system. Use is prohibited and will void the the sling that is recommended doctor, nurse or medical amfort and safety of the each time the sling is removed as patient is removed from a ped, chair, or commode). In slings are made specifically for Patient Lifts. For the safety of use slings and patient lifts of urers. Interview on 7/1/20, at 2:10 owner service (CS)-D stated, and Invacare lifts and slings; no are made specifically for each time the sling share made specifically for eatient Lifts. For the safety of use slings and patient lifts of urers. Finterview on 7/1/20, at 2:10 owner service (CS)-D stated, and Invacare lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lifts and slings; no are made specifically for each lift and slings; no are made specifically for each lift and slings; no are made specifically for each lift and slings; no are made specifically for each lift and slings; no are made specifically for each lift and slings; no are made specifically for each lift and slings; no are made specifically for each lift and slings are made specifically for each	F 68				
	Compatibility docur indicated: throughor changed in style, si because of the gromarket. Many man accept the interchaliability factors or for	ment, undated, which					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 689	using an interchange manufacturer's received the solution to a para a lower cost. Some slings are designed with are: Invacare, Graham Field, Joer The DON provided instruction manual, check the patient's maximum weight oweight does not exweight capacity. During a telephone p.m., when asked fourther service retell by looking at all was, she stated, "win a box and the size is noted or She further stated in of the sling, you would be sized. There were three more three mor	geable sling in place of a ommended sling can provide tients specific requirements at a of the lifter brands that our d to be used interchangeably Drive, Bestcare, Medline,	F 68	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 689	include a sling assindividual safe slin mechanical lifts. During an observar R4 was being translavacare mechanical was by manufactur transferred from bestaff person observar checklist that guid Proactive sling was unknown if it included that transferred from bestaff person observar R5 was being translavacare mechanical was by manufactur transferred from bestaff person observation of the checklist that guid Proactive sling was unknown if it included that it included the size of the could hold up to 60. During an interview indicated there we stating what sling stated when she duse on a resident.	dessment, to determine the g size to be utilized with the stion on 7/1/20, at 10:00 a.m. sferred by two staff using an cal lift. The sling being utilized rer Proactive. R4 was ed to wheelchair while a third ved utilizing a new safety ed the process. The tag on the s not readable due to wear; ded the size of the sling. Ition on 7/1/20, at 11:40 a.m., sferred by two staff using an cal lift. The sling being utilized rer Proactive. R5 was ed to wheelchair while a third ved utilizing a new safety ed the process. The tag on the s not readable due to wear; ded the size of the sling. Ition on 7/1/20, from 2:20 p.m. R4, R5, R6, R7, R8 and R9 was Proactive slings placed under The tag on the Proactive slings due to wear; unknown if they of the sling, with with the Proactive sling which indicated it		889			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	by the weight of the indicated that at time size, she would plate resident to see if it resident. NA-B consumer not readable, plan for residents of sling to use for emechanical lift. NA guidance or direction residents that utilized indicted all of the slifts were the Proact lifts utilized were In During an interview indicated there were indicating what slin NA-C indicated she the resident, rather the resident to the son the slings were the nurse aide she size of sling to use a mechanical lift. In on guidance or direction guidance or direction indicated all slings undicated all slings undicated were Invacation. During an interview indicated there were indicating what slin LPN-B stated she couse on a resident. It the slings were not the nurse aide care	e resident. NA-B further nes if she was unsure what ce the sling next to the was long enough for that firmed the labels on the slings NA-B confirmed the NA care lid not have a designated size ach resident, who utilized a care lid not have a designated size ach resident, who utilized a care lid not have a designated size ach resident, who utilized a care lid not size sling to use for the mechanical lifts. NA-B also ings used for the mechanical vacare and Medline brands. If on 7/1/20, at 2:15 p.m. NA-C is no guidelines or policies gize to use for residents. If add not go by the weight of she would visualize the size of sling. NA-C confirmed the label not readable. NA-C confirmed the side of the mechanical lifts. NA-C also sed for the mechanical lifts are and Medline brands. If on 7/1/20, at 2:30 p.m. LPN-B is no guidelines or policies gize to use for residents. If and the mechanical lifts are and Medline brands. If on 7/1/20, at 2:30 p.m. LPN-B is no guidelines or policies gize to use for residents. If the labels on readable. LPN-B confirmed the labels on readable.	F 68	9		

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F 689	resident who utilize verified there was resident size sling to us mechanical lifts. LF slings used for the Proactive brand an were Invacare and During an interview indicated there were indicating sling size stated when she deresident, she would resident to a sling, by the weight of the sling size to use. Not sling size to use. Not sling size to use indicating size. Note a mechanical lift. No guidance or direction residents who utilized also indicted all of the mechanical lifts were wearned to size of sling to use a mechanical lift. No guidance or direction residents who utilized so indicted all of the mechanical lifts were wearned to size of sling to use a mechanical lifts were were sidents who utilized so indicted all of the mechanical lifts were were were sidents.	d a mechanical lift. LPN-B no guidance or direction on se for residents who utilized PN-B also indicted all of the mechanical lifts were d the mechanical lifts utilized	F6	89			
	indicated there wer indicating sling size stated when she do use on a resident sof the resident to a not go by the weigh confirmed the tags readable label on the confirmed the nurs	on 7/1/20, at 2:50 p.m. NA-E e no guidelines or policies to use for residents. NA-E etermined what size sling to he would just visualize the size sling. NA-E indicated she did at of the resident. NA-E on the slings did not have a nem indicating a size. NA-E e aide care plan for residents gnated size sling to use for					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	each resident who NA-E verified there on what size sling tutilized mechanical the slings used for Proactive brand and were Invacare and During an interview DON and the admit that were being use R1, R4, R5, R6, R7 by their weight for splan of care as well DON indicated there this. (Although the indicated residents mechanical lift were information was no record or plan of care administrator confird different brand of simanufacturers of Pimechanical lift man Medline. The DON they thought that is use universal slings manufacturers, ever instructions for each warned against this Proactive slings cut that were not readar DON stated that the according to the resising, but also confit the medical records.	utilized a mechanical lift. was no guidance or direction o use for residents who lifts. NA-E also indicted all of the mechanical lifts were d the mechanical lifts utilized Medline brands. on 7/1/20, at 3:00 p.m. the nistrator indicated the slings ed with the mechanical lifts for 7, R8 and R9 were assessed sizing, and were included in the las the NA care sheets. The re was a policy that confirmed DON and administrator who utilized a sling with a re assessed for size, this t included in the medical are). The DON and med the staff were utilizing a lings (universal) that included roactive and 2 different nufactures of Invacare and and administrator indicated was ok to interchange and s with different mechanical lift en though the manufacturers h of these mechanical lifts s. The DON did verify that the rrently being utilized had labels able due to being warn off. The re policy was to utilize slings sident's weight for sizing of the remed this was not identified in	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 689	reviewed for the me which indicated the met inspection crite 1. All nuts, bolts, 2. Oil leaks, cylind 3. Handles, whee 4. Hooks and cha 5. Frame & welds Facility policy titled Mechanical Lift Slir 1. Mechanical lifts transferred with a r properly transfer a the sling applied m person. Please be transfer a person s 2. Size of sling a. Small fits r b. Medium fits c. Large fits d. X-Large fits 3. If in doubt which with the nurse in cheabilitation staff, residents, revised 1. Nursing staff in rehabilitation staff, residents' needs foongoing basis. Staft transferring and lift Such assessments a. Resident's	pyer Lift Inspection was ponths of May and June 2020, Invacare lift model RPA600-1 eria of: clips and pins der, valve, pump, lever ls breaks lins and pins der, valve, pump, lever ls breaks lins and person to be large, undated, indicated: a allow a person to be loninimum of physical effort. To person with a mechanical lift list be of a size that fits the laware of the size needed to lafety. Lesidents 58-140 pounds are residents 140 to 200 pounds les residents 200 - 400 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 200 - 400 pounds large/or resident care plan. Lesidents 38-140 mounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 400 - 600 pounds large/or resident care plan. Lesidents 58-140 pounds large/or resident care plan. Lesidents 58-140 pounds large/or resident care plan. Lesidents 58-140 pounds large/or resident large	F 6	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 689	e. Cognitive f. Whether cooperative with s g. The resid including restoring abilities. 2. Staff responsi be trained in the u lifting devices. 3. Staff will be of using mechanical for adherence to p regarding use of etechniques. 4. Enough slings residents in need, 5. All equipment exceed guidelines resident safety. Facility policy title "Limited Lift" date 1. The resident I a safe working en The policy is to be staff that perform handling. 2. Initial screenin residents to asses status. 3. Resident tran- care plan time fra 4. Resident tran- daily worksheets of transfer needs. 5. Should a resid resident is deeme	status; the resident is usually	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 689	type) lift will be used medically appropriate EMS will be notified off the floor. 6. This policy is to Failure to adhere to disciplinary action in the floor. 7. Signature space employee. The immediate jeor was removed on 7/conducted assessing utilized mechanical appropriate size of the facility included care plan, and reserve proper use of the mechanical appropriate size of the facility ordered new manufacturers of the utilized (Invacare as implemented 3 assift transfers, until the were implemented in noncompliance remove severity level G, isone in the floor.	ge 15 d. If the resident is not te to transfer off the floor, I and will transfer the resident be followed at all times. The policy will result in the policy will result in the forth by this policy. The for administrator, DON and coardy that began on 6/28/20, 2/20, when the facility ments on all residents that lifts, to determine the sling according to their weight. If the sling size in the resident ducated staff on the safe and the slings recommended by the mechanical lifts being and Medline). The facility ist of staff with all mechanical the new slings arrive. Audits for compliance. However, the mained at the lower scope and slated, scope and severity, all harm that is not IJ.	F 6	89				



Electronically delivered July 22, 2020

Administrator Central Health Care 444 North Cordova Le Center, MN 56057

Re: State Nursing Home Licensing Orders

Event ID: CZFY11

Dear Administrator:

The above facility was surveyed on July 1, 2020 through July 2, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

Central Health Care July 24, 2020 Page 2

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:

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

Email: elizabeth.silkey@state.mn.us

Phone: 651-201-3784

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficition herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of tlack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted to deterr Licensure. Your fac	S: an abbreviated survey was mine compliance with State ility was found not in MN State Licensure.				
	The following comp substantiated:	laint found to be				

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

07/28/20 **Electronically Signed**

TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L COM		X3) DATE S	SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTRAL HEALTH CARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 #H5401033C 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	7.110 1 27.11	or contraction	BENTI TO THOMBET.	A. BUILDING:				
CENTRAL HEALTH CARE (X4) ID PREFIX TAG CONTINUED FROM PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE) (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 #H5401033C 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			00800	B. WING				
CENTRAL HEALTH CARE LE CENTER, MN 56057 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 #H5401033C 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	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
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#H5401033C 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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE	
the electronic documents. 21665 MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's guidelines to ensure safety measures were implemented for the use of a mechanical lift or 1 of 1 resident (R1). This deficient practice resulted in an immediate jeopardy (IJ) for R1, who fell from the mechanical lift and sustained a non-displaced (in alignment) distal femur (near the knee) fracture. This practice had the potential to affect six other residents (R4, R5, R6, R7, R8, R9) who utilized mechanical lifts. The J began on 6/28/20, at 12:00 p.m. when licensed practical nurse (LPN)-A and nursing assistant (NA)-A were transferring R1 with a mechanical lift and failed to follow manufacturer safety guidelines, causing R1 to fall out of the sling to the floor. The administrator and director of nursing (DON) were notified of the IJ on 7/1/120,	21665	#H5401033C The facility is enrolle signature is not requage of state form. Although no plan of required that the fact the electronic document of the electronic document. Although no plan of required that the fact the electronic document of the electronic document. Although me must functional, comfort a environment, allowing personal belonging. This MN Requirement by: Based on observation review, the facility fact guidelines to ensure implemented for the of 1 resident (R1). The in an immediate ject from the mechanical non-displaced (in althe knee) fracture. To affect six other realized mechanical lift and safety guidelines, calling to the floor. The signature of the floor of the floor of the floor. The floor of the floor. The floor of the floor. The floor of t	ed in ePOC and therefore a uired at the bottom of the first correction is required, it is cility acknowledge receipt of ments. Deprivate Physical Environment as provide a safe, clean, able, and homelike physical ing the resident to use to the extent possible. This not met as evidenced on, interview and document ailed to follow manufacturer's exafety measures were a use of a mechanical lift for 1 This deficient practice resulted apardy (IJ) for R1, who fell al lift and sustained a lignment) distal femur (near This practice had the potential exidents (R4, R5, R6, R7, R8, echanical lifts. 28/20, at 12:00 p.m. when urse (LPN)-A and nursing are transferring R1 with a failed to follow manufacturer ausing R1 to fall out of the ne administrator and director		written allegation of compliance for deficiencies cited. Submission of thi of correction is not an admission that deficiency existed or that it is cited accurately. This plan of correction is submitted to meet state and federal guidelines. The facility will identify other resident having the potential to be affected by 7/2/2020. 1. Transfer needs on all residents have been evaluated to determine correct of transfer. 2. All Care Plans have been reviewed.	our the is plan at the s out the set mode	7/13/20	

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 2 of 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		00800	B. WING		07/02/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
CENTRA	L HEALTH CARE	444 NORT	H CORDOV	A	
		LE CENTE	ER, MN 560	57	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETE
21665	Continued From page 2		21665		
	2:18 p.m. however, non-compliance remained at the lower scope and severity level G, isolated, scope and severity, which indicate actual harm that is not immediate jeopardy.			3. All new Admissions are pre-screprior to admission for mobility and status and evaluated/screened by upon admission.	transfer
	Findings include: R1 was admitted on 12/31/18. R1's face sheet in			Nursing staff received the followin education;	g
	the medical record indicated diagnoses that included chronic kidney disease, hypertension (high blood pressure), muscle weakness, osteoarthritis, right knee pain and non-displaced right femur fracture.			" Temporary action plan for 48hrs Invacare slings arrive/Universal SI Checklist- " Mechanical Lift Policy " Universal Sling Placement & Lift	ing
	Review of the quarterly Minimum Data Set (MDS) dated 6/17/20, indicated R1 had severe cognitive impairment, moderate difficulty hearing, speech was clear, usually understood and usually understands; impaired vision requiring corrective lenses. R1 was not able to walk and required extensive assistance of two staff for bed mobility, and total dependence on two staff for transfers and toileting. The MDS further indicated R1 had impairment of range of motion (ROM) in the lower extremities. Review of the current care plan dated 6/23/20, indicated R1 had impaired mobility related to weakness, range of motion, advanced age, and			Observation "Temporary Sling placement and "Staff viewed Video Invacare Lifts Slings Demo on YouTube (link: https:/youtu.be/sr2zt_hkGGA) bets "7/7/20-7/13/2020. "Invacare Lift & Sling placement competency performed with return demonstration between 7/7/20-7/1 All staff are now trained and comp "Invacare Lift & Sling placement competency will now be utilized in orientation packet as part of staff competency/resident safe handling hire which will include the Policy for	sizing & ween _ 3/2020. betent. g upon
	plan further indicate with two staff with to mechanical lift. R1 mechanical lift sling. Review of a vulnera report dated 6/28/20, at 12:00 p. assistant (NA)-A we	utilizes a medium size		Invacare Sling use. The facility implemented the follow measures &/or systemic changes: "Invacare Lift & Sling placement competency will now be utilized in orientation packet as part of staff competency/resident safe handling hire.	

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 3 of 17

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
					С	
		00800	B. WING		1	2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	AL HEALTH CARE		H CORDOV			
		LE CENTE	R, MN 560	57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
21665	5 Continued From page 3		21665			
21005	the transfer to the obecame dislodged in mechanical lift resusing to the floor. Repain and obtained a Immediately followin nurse (RN)-A and Rand R1 was transfe further assessment. Review of a progresport, indicated LPN from her bed to a simechanical lift. LPN NA-A was maneuve leg strap of the sling mechanical lift and buttocks and her hemechanical lift. LPN immediately for help ROM in bilateral up left lower extremity. R1 when bending the large bump on the R1's vital signs were called and transpor room (ER) at 12:30 Review of a hospital physician progress R1 was evaluated a lift and had a large contusion which aptraumatic injury. A complaints other of intracranial (inside no complaints other	hair, the lower sling strap from the hook on the liting in R1 falling out of the licomplained of right knee in bump on the head. In the incident, registered the licomplained of the licomplained of the licomplained of the knee and head injury. It is note dated 6/28/20, at 1:32 of the knee and head injury. It is note dated 6/28/20, at 1:32 of the knee and head injury. It is note dated 6/28/20, at 1:32 of the knee and head injury. It is note dated 6/28/20, at 1:32 of the knee and head injury. It is note dated 6/28/20, at 1:32 of the knee and the right lower graph of the prong on the lift while ening R1, when the right lower graph of the lift while ening R1, when the right lower graph of the kneed against the leg of the lift while ening R1 to the floor hitting her extremities as well as the limited ROM noted in right complained of right knee pain eg. R1 started to develop a back, right side of the head. The ambulance was ted R1 to the local emergency p.m. for further evaluation. If emergency department (ED) note dated 6/28/20, indicated after a fall from a mechanical posterior (back side) scalp peared to be her only computerized tomography (CT) of which showed no evidence e skull) abnormality. R1 had than mild soreness over the on and returned to the nursing	21005	"Facility has implemented using obrand of lift (Invacare) facility is purchasing lift slings specific to lift manufacturer specifications. "Facility has purchased an addition Invacare lift in order to assure all lare met. "The facility has ordered a new lift from Invacare with safety clips and replace upon arrival at facility. The facility plans to monitor its performance to make sure that the solutions are sustained. This plan been evaluated and reported to the assurance committee utilizing the QAPI on 7/7/2020 and quarterly the "The Charge nurse is conducting observation audits per shift 7 days ongoing until resurvey, with quarter audits ongoing until assurance the compliance is met. "DON or designee will conduct sli audits daily 7 days/wk, to ensure the resident has the correct sling assign to the stress of the survey periodic audits ongoing until assurance is met. "All audits will be reviewed by the lif concerns are found retraining with potential disciplinary action will be	enal ift needs t cradle d will e has e quality Ad HOC ereafter. 2 lift s/wk, erly t ng he gnment ey, with rance D.O.N. th	

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 4 of 17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00800	B. WING		1	<i>2</i> /2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L HEALTH CARE		TH CORDOV ER, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 4	21665			
	p.m. indicated R1 wher right knee which acetaminophen. R1 had difficulty movin provider who saw F The provider indicatracture to R1's right bend and move it; anot hurt any more rep.m. indicated R1 copain and increased get out of bed for some practitioner (I pain. On 6/29/20, a received from NP-C right knee to be don acetaminophen dos	ss note dated 6/28/20, at 5:41 was having increased pain in h was only partially relieved by 's right knee was swollen and g it. RN-C contacted the R1 in the ER earlier on 6/28/20. Ited he was not suspicious of a at leg because she was able to and R1 told him her knee did now than before the fall. It is note dated 6/28/20, at 8:47 continued to have right knee leg swelling, and refused to upper. A message was left for NP)-C of the continued knee to 8:48 a.m. an order was a continued to have right knee to the fall of the continued knee to 8:48 a.m. an order was a continued to increase her see from 650 milligrams (mg) to see a day and as needed.				
	indicated R1 had an shaft (near the knew dated 6/29/20, at 4: advised facility to so of leg. R1 left facility returning on 6/30/20 splinted.	gy report dated 6/29/20, n acute (new) distal femoral e) fracture. Progress note 14 p.m. indicated NP-C end R1 to the ER for splinting y by ambulance at 4:17 p.m., 0, at 2:01 a.m. with right leg				
	6/29/20, at 5:04 p.n fracture and no oth was applied and R2	n. confirmed R1's distal femur er injuries; a right leg splint I was returned to the facility. tigative report dated 6/29/20,				
		of nursing (DON) indicated taff and investigating the				

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 5 of 17

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00800	B. WING		1	2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L HEALTH CARE		H CORDOVA ER, MN 5604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	above incident, as we the mechanical lift, was the result of hu quick and not doing the loops on the slin hooks. All staff were checking to ensure fully placed on the last staff assist with all reconduct audits for communicaturer's inst (Invacare) and the reviewed during the included safety mean mechanical lift. During observation 4:55 p.m., R1 was room. When intervincident she stated, R1 stated she hurt shoulder. During observation 10:40 a.m. R1 was with her right leg we groin to toes, propphad pain in her feet. During telephone in a.m. LPN-A, who as stated they were godinner. They put the loops. "Out of hoops to make sure stated she was ope at the head of the li LPN-A stated NA-A lift. LPN-A added,"	well as inspecting the sling and she concluded the incident aman error; staff being too all of the checks to ensure and were fully seated on the exprovided education on the loops on the sling were nooks as well as having three mechanical lift transfers and compliance. The ructions for the mechanical lift sling (Proactive) had not been a DON's investigation, that assures for the use of the same and interview on 7/1/20, at resting in the recliner in her ewed R1 about the above "They threw me on the floor." her leg, her head and her and interview on 7/2/20, at resting on her back in bed rapped in elastic wrap from ed on a pillow. R1 stated she	21665	DEFICIENC!)		

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 6 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00800	B. WING		I	C 02/2020
	PROVIDER OR SUPPLIER	444 NORT	DRESS, CITY, S TH CORDOV ER, MN 5608			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21665	popped and she fel head on the leg of the bead on the leg of the bead on the leg of the bead on the leg of the straps on the He "We made sure the cues." NA-A stated waited until R1 was inches. NA-A stated waited until R1 was inches. NA-A stated NA-A then guided Fher in the chair for I I remember is her he During a telephone a.m. RN-A stated slafter R1 fell. Stated R1's room, the sling and she focused he laying on the floor. During an interview stated she was at the heard a commotion check on it. She reconstructed she was at the heard a commotion check on it.	I to the ground and hit her he lift." interview on 7/1/20, at 10:55 oth her and LPN-A checked over with the "curly cues." and straps were firmly in the curly she did a visual check and up off the bed a couple of d, "We both did visual checks." R1's legs over the bed to put unch. "It happened so fast, all litting her head on the floor." interview on 7/1/20, at 11:00 he was summoned to help by the time she arrived to g was removed from the lift er attention on R1 who was on 7/1/20, at 11:05 a.m. RN-B he facility for training and in R1's room, so went to called either or both LPN-A or necked them [the sling loops] "By then the sling had been ft and the lift pushed out of the he left to start paperwork for	21665			

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 7 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00900			C 07/02/2020	
		00800			07/0	2/2020
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S TH CORDOV	STATE, ZIP CODE A		
CENTRA	L HEALTH CARE		ER, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 7	21665			
	loop could simply stused reusable mess vendor other than the Invacare and sling is stated the Proactive could be used with. The DON provided Maintenance Manual date 9/08. According guidelines: Invacare specifically designed with Invacare patier other manufacturers component of Invacof these products is lifts warranty. Use the bythe individual's dassistant for the contindividual that is better stationary object (by Warning: Invacare stationary object (by Warning: Invacare stationary object (by Warning: Invacare of the patient do not undifferent manufacturer that way" in the main The DON provided Compatibility document.	lip off during transfer. Facility h slings from a different ne lift vendor. Lift brand is brand is Proactive. The DON e sling was "universal" and any brand mechanical lift. Owner's Operator and all for the Invacare lift, revision in g to section I - general e transfer slings are d to be used in conjunction in the lifts. Slings designed by some are not to be utilized as a care's patient lift system. Use is prohibited and will void the she sling that is recommended doctor, nurse or medical infort and safety of the inglifted. Be sure to check the each time the sling is removed sure that it is properly a patient is removed from a fed, chair, or commode). In slings are made specifically for the each time the sling is removed from a fed, chair, or commode). In slings are made specifically for the safety of se slings and patient lifts of the service (CS)-D stated, and Invacare lifts and slings; no service (CS)-D stated, and Invacare lifts and slings; no service Sling and Hoist ment, undated, which				
	changed in style, siz	ut the years, slings have ze, material, and design wing competition in the current				

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 8 of 17

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00800	B. WING		1	2/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CENTRA	AL HEALTH CARE		TH CORDOV ER, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	market. Many many accept the interchal liability factors or fo self-interest. However assessment done busing an interchange manufacturer's received the solution to a part a lower cost. Some slings are designed with are: Invacare, I Graham Field, Joer The DON provided instruction manual, check the patient's maximum weight caweight does not exceed weight capacity. During a telephone p.m., when asked Foustomer service retell by looking at a Fous	ufacturers are very reluctant to negability of slings due to r simple marketing ver, with a thorough risk by a competent assessor, leable sling in place of a sommended sling can provide tients specific requirements at of the lifter brands that our to be used interchangeably Drive, Bestcare, Medline, ns, etc. Proactive full body sling undated, which indicated: weight and the slings apacity. Ensure the patient's ceed the sling's maximum Interview on 7/1/20, at 3:30 Proactive manufacturer expresentative how one could Proactive sling, what size it hen you got them, they came e was on the box." Asked if the sling and she stated no. In order to determine the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it. Interview on the control of the size uld need to measure it.	21665			

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 9 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED	
		00800	B. WING		I	C 02/2020
	PROVIDER OR SUPPLIER	444 NORT	DRESS, CITY, S H CORDOVA ER, MN 5605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21665	medium sling. The R8 and R9 did not read the medical records include a sling asset individual safe sling mechanical lifts. During an observation R4 was being trans Invacare mechanical was by manufacture transferred from be staff person observed checklist that guide Proactive sling was unknown if it included During an observation R5 was being trans Invacare mechanical was by manufacture transferred from be staff person observed checklist that guide Proactive sling was unknown if it included Proactive sling was unknown if it included Proactive sling was unknown if it included During an observation 2:45 p.m., R1, R4 observed to have P them for transfer. Twere not readable coincluded the size of exception of one Procould hold up to 600. During an interview	d slings) indicated R1 utilized a care plan for R4, R5, R6, R7, reflect a sling size. In addition, of for these residents did not resident, to determine the size to be utilized with the size of the sling utilized ar Proactive. R4 was downwelchair while a third and utilizing a new safety downwelchair while a third and the size of the sling. If on on 7/1/20, at 11:40 a.m., ferred by two staff using an all lift. The sling being utilized ar Proactive. R5 was downwelchair while a third and to wheelchair while a third and to wheelchair while a third and the process. The tag on the not readable due to wear; and the size of the sling. If on on 7/1/20, from 2:20 p.m. A, R5, R6, R7, R8 and R9 was roactive slings placed under the tag on the Proactive slings due to wear; unknown if they the sling, with with the roactive sling which indicated it	21665			

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 10 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
711012111	or correction.	DETTI TO THOTHOMBET.	A. BUILDING:			
		00800	B. WING		07/0	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L HEALTH CARE		H CORDOV			
			ER, MN 5605	57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 10	21665			
	stated when she de use on a resident si of the resident to a by the weight of the indicated that at tim size, she would place resident to see if it resident. NA-B conference not readable, plan for residents dof sling to use for explanting the slight to the slight to use for explanting the slight the slight to use for explanting the slight to use for	stermined what size sling to the would just visualize the size sling; indicating she did not go resident. NA-B further les if she was unsure what the sling next to the was long enough for that firmed the labels on the slings NA-B confirmed the NA care id not have a designated size lach resident, who utilized a lach resident and there was no lach resident and the mechanical wacare and Medline brands.				
	indicated there were indicating what sling NA-C indicated she the resident, rather the resident to the son the slings were resident to the size of sling to use a mechanical lift. No guidance or dire residents who utilize indicted all slings us were Proactive brar utilized were Invacational puring an interview indicated there were indicating what sling LPN-B stated she duse on a resident. L	on 7/1/20, at 2:15 p.m. NA-C e no guidelines or policies g size to use for residents. did not go by the weight of she would visualize the size of sling. NA-C confirmed the label not readable. NA-C confirmed ets did not have a designated for each resident who utilized IA-C verified that there was ction on sling size to use for ed mechanical lifts. NA-C also sed for the mechanical lifts and and the mechanical lifts are and Medline brands. on 7/1/20, at 2:30 p.m. LPN-B e no guidelines or policies g size to use for residents. letermined what size sling to LPN-B confirmed the labels on readable. LPN-B confirmed				

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 11 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
711101 12/111	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00800	B. WING		07/0	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L HEALTH CARE		TH CORDOV			
			ER, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 11	21665			
21003	the nurse aide care have a designated resident who utilize verified there was now what size sling to us mechanical lifts. LP slings used for the resident were Invacare and During an interview indicated there were indicating sling size stated when she deresident, she would resident to a sling. It by the weight of the sling size to use. Now slings did not have indicating size. Nacare plan for reside size of sling to use a mechanical lift. No guidance or direction residents who utilize also indicted all of the mechanical lifts were mechanical lifts utilised mechanical lifts utilised. During an interview.	plan for residents did not size of sling to use for each d a mechanical lift. LPN-B to guidance or direction on se for residents who utilized tN-B also indicted all of the mechanical lifts were d the mechanical lifts were d the mechanical lifts utilized Medline brands. on 7/1/20, at 2:40 p.m. NA-D to no guidelines or policies to use for residents. NA-D extermined size sling for a light visualize the size of the NA-D indicated she did not go resident to determine the A-D confirmed the tags on the areadable label on them D confirmed the nurse aide nts did not have a designated for each resident who utilized IA-D verified there was no on on what size sling to use for the mechanical lifts. The NA he slings used for the re Proactive brand and the fized were Invacare and	21003			
	indicated there were indicating sling size stated when she de use on a resident so of the resident to a not go by the weigh confirmed the tags readable label on the size of the resident to a not go by the weigh confirmed the tags readable label on the size of the size o	to use for residents. NA-E stermined what size sling to the would just visualize the size sling. NA-E indicated she did to f the resident. NA-E on the slings did not have a the mindicating a size. NA-E and aide care plan for residents				

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 12 of 17

Minneso	<u>ita Department of He</u>	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00800	B. WING		07/0) 2/2020
			<u>I</u>		1 0170	LILULU
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
I CENTRAL HEALTH CARE		TH CORDOV ER, MN 560				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	did not have a designeach resident who NA-E verified there on what size sling to utilized mechanical the slings used for Proactive brand and were Invacare and During an interview DON and the admit that were being use R1, R4, R5, R6, R7 by their weight for splan of care as well DON indicated there this. (Although the I indicated residents mechanical lift were information was not record or plan of care administrator confir different brand of signal manufacturers of P mechanical lift manufacturers of P mechanical lift manufacturers, ever instructions for each warned against this Proactive slings cut that were not read a DON stated that the according to the resising, but also confit the medical records	gnated size sling to use for utilized a mechanical lift. was no guidance or direction of use for residents who lifts. NA-E also indicted all of the mechanical lifts were did the mechanical lifts utilized Medline brands. on 7/1/20, at 3:00 p.m. the histrator indicated the slings and with the mechanical lifts for 7, R8 and R9 were assessed sizing, and were included in the as the NA care sheets. The e was a policy that confirmed DON and administrator who utilized a sling with a erassessed for size, this tincluded in the medical are). The DON and med the staff were utilizing a lings (universal) that included roactive and 2 different ufactures of Invacare and and administrator indicated was ok to interchange and as with different mechanical lift on though the manufacturers hof these mechanical lifts and the staff were utilized had labels able due to being warn off. The policy was to utilize slings sident's weight for sizing of the remed this was not identified in sor plan of care.	21665			
		the mechanical lifts are by maintenance staff. The				

6899

Minnesota Department of Health STATE FORM

If continuation sheet 13 of 17 CZFY11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	00800	B. WING		07/0	2/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CENTRAL HEALTH CARE	444 NORT	H CORDOV	Α.		
JENTIAE HEAETH JAKE	LE CENTE	ER, MN 5605	57		
PREFIX (EACH DEFICIENCY	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
reviewed for the mode which indicated the met inspection crite 1. All nuts, bolts, of 2. Oil leaks, cyling 3. Handles, wheel 4. Hooks and cha 5. Frame & welds 4. Hooks and cha 5. Frame & welds 5. Frame & welds 6. Mechanical Lift Sling 1. Mechanical Lift Sling 1. Mechanical Lift stransferred with a magnetic properly transfer a person. Please be a stransfer a person set 2. Size of sling a. Small fits resident stransfer in doubt which with the nurse in chemical staff, stresidents, revised 1. Nursing staff in rehabilitation staff, stresidents' needs for ongoing basis. Staft transferring and lifting Such assessments a. Resident's	oyer Lift Inspection was onths of May and June 2020, Invacare lift model RPA600-1 eria of: clips and pins der, valve, pump, lever lls breaks ins , paint condition, sharp edges Procedure for Using ags, undated, indicated: a allow a person to be ininimum of physical effort. To person with a mechanical lift ust be of a size that fits the aware of the size needed to afety. esidents 58-140 pounds are residents 140 to 200 pounds are sidents 200 - 400 pounds are sidents 400 - 600 pounds are sidents 400 - 600 pounds are sidents 400 - 600 pounds are sidents 400, indicated: conjunction with the shall assess individual are transfer assistance on an are fiveled with the care plan. Safe Lifting and Movement of dated 8/09, indicated: conjunction with the shall assess individual are transfer assistance on an are fiveled of the care plan. Shall include: preferences for assistance; mobility (degree of size; aring ability;	21665			

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 14 of 17

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00800	B. WING		1	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L HEALTH CARE		H CORDOV			
LE CENT			ER, MN 560	57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 14	21665			
	f. Whether the cooperative with stands of the resident including restoring abilities. 2. Staff responsible trained in the uselfiting devices. 3. Staff will be obsusing mechanical liftor adherence to portegarding use of experiments of the residents in need, with the residents in n	e resident is usually				
	"Limited Lift" dated 1. The resident has a safe working envioled the policy is to be a staff that perform of handling. 2. Initial screening residents to assess status. 3. Resident transficate plan time fram 4. Resident transficate plan time fram 4. Resident transficate plan time fram 5. Should a resider resident will be first resident is deemed transfer off the floor type) lift will be used	Resident Handling Policy 1/13/20, indicated: andling policy exists to ensure fronment for resident handlers. reviewed and signed by all remay perform resident gwill be completed on all transfer and ambulation for status will be reviewed via the and on an as needed basis. For status will be written on the inform the staff of appropriate the assessed by a nurse. If the medically appropriate to recommend to the resident is not attention to the floor, a mechanical lift (Hoyer due to transfer off the floor,				

Minnesota Department of Health

STATE FORM 6899 CZFY11 If continuation sheet 15 of 17

			A. BUILDING.		(X3) DATE SURVEY COMPLETED	
			С			
		00800	B. WING		1	<i>2</i> /2020
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CENTRAL HEALTH CARE			H CORDOVA			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665 C	Continued From pag	ge 15	21665			
o 6 F d 7	EMS will be notified and will transfer the resident off the floor. 6. This policy is to be followed at all times. Failure to adhere to the policy will result in disciplinary action set forth by this policy. 7. Signature spaces for administrator, DON and employee. The immediate jeopardy that began on 6/28/20, was removed on 7/2/20, when the facility conducted assessments on all residents that utilized mechanical lifts, to determine the appropriate size of sling according to their weight. The facility included the sling size in the resident care plan, and re-educated staff on the safe and proper use of the mechanical lift and slings. The facility ordered new slings recommended by the manufacturers of the mechanical lifts being utilized (Invacare and Medline). The facility implemented 3 assist of staff with all mechanical lift transfers, until the new slings arrive. Audits were implemented for compliance. However, the noncompliance remained at the lower scope and severity level G, isolated, scope and severity, which indicate actual harm that is not IJ.					
w c u a T c p fa m u ir lii w n s						
d re s a T a o re p fu	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review policies and procedures and re-educate staff on the proper use of mechanical lifts/slings according to the manufactures safety instructions. The DON, or designees could conduct periodic audits to ensure ongoing compliance and safety of the use of the mechanical lifts. The DON could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen					

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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21665	Continued From pa	age 16	21665			

Minnesota Department of Health