Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 1, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: CCN: 245490
Cycle Start Date: September 13, 2023

Dear Administrator:

On September 29, 2023, we notified you a remedy was imposed. On October 24, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 14, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 14, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 29, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 13, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 14, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 1, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Re: Reinspection Results
Event ID: UNRO12

Dear Administrator:

On October 24, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 13, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

September 29, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: CCN: 245490
Cycle Start Date: September 13, 2023

Dear Administrator:

On September 13, 2023, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On September 13, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 14, 2023.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 14, 2023, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 14, 2023, (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. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Oak Hills Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 13, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 13, 2024 (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:

<u>Steven.Delich@cms.hhs.gov</u>

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING ______ B. WING ______	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 9/7/23, 9/11/23, 9/12/23,and 9/13/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.

The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ (F689) began on 8/16/23, when R2 fell from the lift during a transfer sustaining a major head injury and right upper arm fracture after two nursing assistants (NAs) failed to follow manufacturers safety instructions. Additionally, failed to determine the cause of the incident, continued to use the lift without a thorough inspection of the lift to determine safe for use, failed to contact the manufacturer, and failed to provide retraining and competency for staff using the lift. The Administrator, and director of nursing (DON) were notified of the IJ on 9/12/23 at 5:20 p.m. The IJ was removed on 9/13/23 at 2:15 p.m.

The above findings constituted Substandard Quality of Care and an extended survey was conducted on 9/13/23.

The following complaint was reviewed: H54905106C (MN00096488) with deficiences cited at F689 and F609.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/03/2023

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

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		10/6/23

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F 609	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to immediately report an allegation of neglect to the State Agency (SA) for 1 of 3 residents (R2) reviewed for accidents. R2 fell from full body mechanical lift during a transfer resulting in a fractured arm and head injury with staples. Findings include: R2's fall incident report dated 8/16/23 at 9:52 a.m. indicated R2 was found lying across the legs of the hoyer (mechanical full body lift) on the floor with feet facing the toilet and head by the tub. R2 was noted to have a moderate amount of blood coming from the back of her head. Nursing assistants (NA)s stated that R2 was in mechanical lift sling when a loop came undone and the resident fell to the floor. R2 was unable to describe the incident. R2 was assisted to a sitting position and noted to have some pain to the right upper arm and a large part of scalp open on the right back side of head. R2 was transported by ambulance to the emergency department (ED). R2's ED notes dated 8/16/23 at 10:15 a.m., indicated R2's injuries from the fall included a fracture of the right humerus (long bone of the upper arm) and traumatic head injury with multiple lacerations. In review of the facility reported incidents (FRIs) to the SA, there was no incident report for R2's fall that potentially involved neglect of care givers or equipment failure that was submitted.	F 609	F609 Reporting of Alleged Viloations Corrective Action: Oak Hills has updated the Vulnerable Adult Reporting Guidelines policy to include incidents resulting in serious bodily injury to be reported immediately, regardless if the care plan is being followed or not. Vulnerable Adult Reporting Guidelines are located at all nursing stations. All nursing staff will be educated on the policy update at the skills fair on 10/4/2023. Actual/Proposed Completion Date: 10/6/2023 Person Responsible for Correction and Monitoring: Administrator, DON, LSW	

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F 609	Continued From page 3	F 609		

During an interview on 9/11/23 at 11:00 a.m., the director of nursing (DON) indicated she was aware of R2's fall and injuries that occurred on 8/16/23, but was not in the facility at that time. The assistant DON (ADON) and administrator investigated that incident. The DON stated the incident was not reported to the SA.

During an interview on 9/11/23 at 12:10 p.m., the licensed social worker (LSW) indicated she was aware of R2's fall and injuries on 8/16/23. She did not feel it was reportable to the SA because they could not determine the NAs had done anything wrong.

During an interview on 9/11/23 at 3:30 p.m., the ADON indicated she was aware of R2's fall and injuries on 8/16/23 but the interdisciplinary team (IDT) did not think it was reportable to the SA.

During an interview on 9/11/23 at 1:30 p.m. the Administrator confirmed the incident was not reported to the SA. Further explained they did not report the incident to the SA because they "did not find that anyone had done anything wrong" and the care plan was followed.

Facility's Abuse Policy and Procedure dated 11/3/22, included the following:
The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident's property, are reported immediately, but no later than 2 hours after the allegation is made if the events involve abuse or result in a serious bodily injury.
Serious Bodily Injury: The term "serious bodily injury" is defined as an injury involving extreme

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F 609	Continued From page 4 physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. Serious Bodily Injury Reporting - 2 Hour Limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but no later than 2 hours after forming the suspicion. The Facility's Vulnerable Adult Reporting Guidelines last updated 11/3/22, included the following: The Administrator, Director of Nursing, Director of Social Services and/or other members of the interdisciplinary team will be responsible for completing a report to the Office of Health Facility Complaints (OHFC) via web reporting if the "resident incident" meets the reportable criteria. OHFC required reports to be submitted immediately or within 2 hours if abuse or serious bodily injury occurred. The investigation of the incident needs to be completed within 5 working days.	F 609		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		10/14/23

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F 689 Continued From page 5

by:
Based on interview, and document review the facility failed to safely use a mechanical lift per manufacture instruction to transfer 1 of 1 residents (R2) who required a mechanical lift for transfers. This resulted in R2 falling from a lift, sustaining major injuries. R2 subsequently died 10 days following the fall. In addition the facility failed to conduct a thorough investigation to determine the cause of the fall from the lift. This resulted in immediate jeopardy (IJ) for R2.

The IJ began on 8/16/23, at approximately 9:30 a.m. when R2 fell from the lift during a transfer sustaining a major head injury and right upper arm fracture after two nursing assistants (NAs) were transferring a resident using the mechanical lift. The facility failed to determine the cause of the incident, continued to use the lift without a thorough inspection of the lift to determine safe for use, failed to contact the manufacturer, and failed to provide retraining and competency for staff using the lift. The administrator, director of nursing (DON), and registered nurse case manager (RN)-A were notified of the immediate jeopardy on 9/12/23, at 5:20 p.m. The immediate jeopardy was removed on 9/13/23, at 2:15 p.m. but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy.

Findings Include:

R2's Diagnosis Report identified diagnoses of delusional disorders, essential tremors, encephalopathy (any brain disease that alters brain function or structure), and muscle weakness.

F 689

F689 Free of Accident Hazards/Supervision/Devices

Corrective Action:

We have identified the residents that transfer with a Hoyer lift. A review of assessments has been completed on all residents that are care planned to use the Hoyer lift. This was completed to ensure proper sling size. This was completed on 9/12/23 by nurse managers. All slings were found to be in compliance according to the residents care plan. All slings were found to be in good condition according to manufacturing guidelines.

We have also identified that all residents in the facility have potential for injury as our policy and protocol is to utilize a Hoyer lift to get people up from falls.

An assessment was completed on R2 on 8/16/23, care plan was reviewed by RN Case Manager and it was deemed that R2 was in the correct sling. Education to NA-A and NA-B was provided immediately by RN Case Manager. NA-A and NA-B were able to demonstrate proper operation of the hoyer lift and sling placement. In addition, Staff Development RN assigned all direct care staff a safe lift video to review and to be completed by September 30, 2023. Staff Development Director/ADON also met with NA-A and NA-B immediately after the incident and NA-A and NA-B were able to

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	245490	A. BUILDING ______ B. WING ______	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH NEW ULM, MN 56073**

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R2's care plan last revised on, 2/6/23 identified R2 was not ambulatory and required two staff assist with Hoyer (full body mechanical lift) and medium sling.

R2's quarterly Minimum Data Set (MDS) dated 5/30/23, indicated R2 had moderate cognitive impairment. R2 required total dependence of two staff assist with transfers.

R2's Mobility/Transfer Evaluation dated 6/10/23, indicated R2 required two-person assist with full body mechanical lift with large sling for transfers. R2's care plan dated 2/6/23, was not revised to reflect the change in sling size. At the time of R2's fall on 8/16/23 the care plan and mobility evaluation were inconsistent.

R2's fall incident report dated 8/16/23 at 9:52 a.m. indicated R2 was found lying across the legs of the hoyer (mechanical full body lift) on the floor with feet facing the toilet and head by the tub. R2 was noted to have a moderate amount of blood coming from the back of her head. Nursing assistants (NA)s stated that R2 was in mechanical lift sling when a loop came undone and the resident fell to the floor. R2 was unable to describe the incident. R2 was assisted to a sitting position and noted to have some pain to the right upper arm and a large part of scalp "reflected" (sik) on the right back side of head. R2 was transported by ambulance to the emergency department (ED).

R2's nursing progress notes dated 8/16/23 at 10:10 a.m., indicated registered nurse (RN-B) responded to the fall. R2's progress note included the details as documented in the incident report,

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correctly state the proper procedure to transfer a resident safely via a hoyer lift. Staff Development/ADON reviewed the lifting machine, using a mechanical lift policy immediately after the incident with no updates needed at that time.

The hoyer lift that was involved in the incident was removed from the floor the evening of 9/12/23 by the Staff Development Director/ADON and will not be used until after further inspection by the EZ Way representative and has been deemed safe.

Staff Development Director/ADON completed EZ Way competencies on proper operation starting 9/12/23. A message has been sent out to all direct care staff on 9/12/23 informing them that they need to complete their competencies with an RN prior to lift operation. We continue to ensure all direct care staff competencies are completed prior to lift operations.

Prior to using the Hoyer lift, all new hires, including contracted staff will be required to complete Hoyer lift competencies. This includes per manufactured guidelines; operators will watch the training video, read through the manual, complete the competency checklist/quiz, and demonstrate competency to an RN before use with resident. The competency checklist includes proper placement of sling under resident, proper process to attaching sling to Hoyer lift and proper process of removal of sling under

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F 689	Continued From page 7 adding R2 was transferred to the ED at 9:30 a.m.. R2's post incident Mobility/Transfer Evaluation dated 8/16/23 at 4:35 p.m. indicated R2's sling size was changed from a large to medium. R2's ED notes dated 8/16/23 at 10:15 a.m., indicated R2's injuries from the fall included a fracture of the right humerus (long bone of the upper arm) and traumatic head injury with multiple lacerations. R2's hospice progress note dated 8/16/23 at 2:53 p.m., indicated R2 was in bed with right arm in a sling, bruising noted on upper arm/shoulder, staples intact on back right side of head, R2 stated she was "terrible". R2 wants to get out of bed and reported severe pain when turned. R2's progress note dated 8/26/23 at 3:45 a.m., indicated R2's time of death was on 8/26/23, at 1:17 a.m. A typed interview summary dated 8/16/23 at 12:00 p.m., authored by assistant director of nursing (ADON) indicated upon review of the initial documentation of the incident and interviews with NA-A and NA-B, no apparent root cause could be determined. R2's care plan was identified as being followed. Review of R2's medical record and fall incident report dated 8/16/23 at 9:52 a.m., did not identify the size of the sling that was used at the time of the fall. Facility's undated investigation documentation and maintenance records did not indicate the lift and lift slings used when the fall occurred, were	F 689	resident. In addition, lift manuals are attached to the Hoyer lift and available at all nurses station. DON consulted with the Safety Program Coordinator from EZ Way and scheduled an EZ Way in-service with the EZ Way Rep on 9/15/2023. Education was provide to direct care staff, maintenance staff and contracted therapy staff. The in-service was recorded and assigned via Relias to all direct care staff that was not in attendance at the in-service. EZ Way rep will conduct an annual in-service at Oak Hills. Administrator scheduled a Safe Patient Handling In-Service for October with Diamond Insurance Company. The facility was already planning an annual competencies skills fair including lift equipment on 10/4/23 and 10/18/23. Oak Hills is contracted with EZ Way for the EZ Way Safety Program. EZ Way inspections are completed every 6 months and results will be reported to the following Safety Meeting. Our policy has been updated to report any incidents with a lift to the EZ Way representative. Per recommendation from EZ Way rep and manufacture guidelines, lifts are inspected every 6 months and as needed. EZ Way rep verified that monthly inspections are not required. In accordance to manufacture guidelines, staff are educated during competencies on proper process of removal of lift or sling from use if there is a function concern noted until a	

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removed from operation and inspected for safety and malfunction.

During a phone interview on 9/7/23, at 2:25 p.m., NA-C indicated that "a few weeks ago" R2 fell out of the full body mechanical lift, hit her head, and died days later. Further indicated it was because of a faulty lift but the facility never took the lift out of service. NA-C stated the same lift involved in R2's fall was currently being used to transfer residents. NC-C indicated one other resident used the lift on the unit and the lift would also be used to transfer residents off the floor after a fall.

During an interview on 9/11/23 at 12:20 p.m., NA-B indicated she was one of the two NAs assisting R2 with transferring in and out of the tub on 8/16/23. They had transferred R2 into the tub and unhooked the sling for bathing. Once the bath was completed, NA-B was on one side of R2 and NA-A was on the other side of her. They connected both the upper and lower sling loops to the hooks on the lift cross bar on the side that they stood on. They raised R2 over the tub, lifted her feet over the side of the tub, and proceeded to back the lift up to go towards her chair. The left lower loop came off and the right side stayed intact causing R2 to slide out of the sling onto her right side. We were not able to catch her, R2's head "bounced" off the side of the tub and she fell to the floor. R2 was in "shock and pain". They (NA-B and NA-A) did not stop and check loop placement once R2 was suspended in the air. "R2 was suspended for about 15 seconds before she fell out." NA-B stated it was "a mystery" on how it happened. NA-B had to give a statement to nurse as to what happened afterward and "thought" they were using a medium sling but could not be sure. NA-B verified the lift was never

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proper inspection can be conducted. We have updated our policy that any equipment that has been involved in an incident is taken out of use until inspected by the manufacturer and has been deemed safe and has been put back in use by the manufacturer and facility.

A spreadsheet has been created to track competencies that will be tracked and completed on an ongoing basis by Staff Development/ADON. Audits of the spreadsheet will be conducted by DON monthly and reported to QAPI.

Audits will be completed on Hoyer lift transfers on 1 staff per shift weekly x 4 weeks. Audits will then be completed on Hoyer lift transfers on 1 staff per shift monthly x 3 month. Results will be reported to the monthly QAPI and safety meeting, and quarterly QA meeting.

Actual/Proposed Completion Date:

10/14/2023

Person Responsible for Correction and Monitoring:

Administrator, DON, Staff Development Director/ADON, LSW

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F 689	Continued From page 9 taken out of service and remained in use. During an interview on 9/11/23 at 12:45 p.m., NA-A indicated she was assisting NA-B with R2's transfer out of the bath when the fall out of the lift sling occurred. She thought they had both checked the strap placement but the incident "happened so fast we thought the strap broke". NA-A indicated both her and NA-B met with nurses to "walk though it" (the incident). NA-A was still not sure what happened to cause R2 to fall out of the lift. During an interview on 9/11/23 at 3:55 p.m., RN-A stated she was involved in the incident investigation. RN-A indicated after the incident, she went to the tub room, interviewed the NAs involved, looked at the mechanical lift, and sent the information to the administrator. Later that day there was a meeting that included the NA's involved and the ADON. NA's told us what happened and "chit chatted about the lift" and were not able to determine why the loop fell off of the lift causing the resident to fall out of the sling. RN-A indicated she was not sure if there were any other actions taken except the ADON had assigned a video for staff to watch by the end of September. During an interview on 9/11/23 at 12:10 p.m., the licensed social worker (LSW) indicated she was involved in the incident investigation. LSW indicated both NAs involved in the transfer reported the sling loops were secure. Both of their statements were consistent with each other. The LSW thought maybe, when moving R2's leg out the tub, the loop may have "jolted loose" but determined R2's care plan was followed. LSW reported maintenance looked at the mechanical	F 689		

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lift and the sling but did not provide any further details of what was "looked at".

During an interview on 9/11/23 at 4:10 p.m., Maintenance-A indicated he was not aware of the fall from the mechanical lift until today. He had not removed any mechanical lifts from service or inspected them. He heard that the sling straps may have been put on wrong which caused the fall but was not sure. Maintenance-A indicated the normal process is to have the manufacturer come in every six months to inspect the lifts. Maintenance-A stated the last routine maintenance check on the lifts was completed 4/18/23.

During an interview on 9/12/23 at 11:55 a.m., maintenance-B indicated he was notified about the fall and was asked to look at the mechanical lift. He was in the meeting to discuss his findings and stated he drew them a picture of the hooks on the mechanical lift bar. Further explained the lift that was being used when the fall occurred was the only lift in the facility with the extra safety feature of the long hook and if the loops were hooked correctly, it is "impossible for it [the sling loop] to fall off, it is against the law of physics". Even if the sling loop was not completely in the notch of the hook, once weight was on it, it would slip on the bar but still would not slip off the hook. Concluded, "the only way that [sling loop] could have fallen off is if it was put on the top of the bar, instead of under the safety hook, and if the lift was jolted, then it would slip off". Maintenance-B stated this was explained to the group in the fall follow-up meeting however, there was no facility documentation of his statement.

During a phone interview on 9/12/23 at 10:35

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F 689	Continued From page 11 a.m., EZ-Way lift representative (LR)-A indicated she was not aware of any lift related incidents at the facility. The facility will usually call the lift manufacturer if there is an incident related to a lift. The manufacturer right away would send a service technician out to the facility to inspect the lift and set up a staff in-service on proper lift use. Further indicated usually a fall from a lift happens because staff forget to hook a loop up or do not pay attention thinking they had both loops hooked but only had loop attached. LR-A stated, "If the sling loops are hooked correctly, gravity should hold the loop in place, it doesn't just fall off". During interview on 9/12/23 at 1:13 p.m., NA-D indicated they received training on the mechanical lifts during her initial orientation and observed other NAs use the lifts. NA-D denied demonstrating skills or taking a test related to use of body slings and mechanical lifts to a nurse or case manager. During an interview on 9/12/23 at 11:45 a.m., RN-C stated staff received mechanical lift training from staff development and "on the floor training by other [NAs] and I answer questions if they ask". RN-C indicated she had not completed competency testing for the lift with any of the nursing staff. During an interview on 9/12/23 at 12:05 p.m., RN-D indicated new NAs are trained by the staffing development person. RN-D further indicated she had not completed competency testing for the lift with any of the nursing staff. During an interview on 9/12/23 at 4:05 p.m., the staffing development coordinator (SDC) indicated following the incident, she assigned all	F 689		

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nursing staff a video on how to properly use the mechanical lifts. The video training was to be completed by the end of September. She had planned to schedule a skills fair for this Fall and use of mechanical lifts would be on the agenda. Verified NA-A, NA-B, and any other nursing staff had not received additional training or a competency evaluation after R2's fall from the lift. She Was not sure if they had watched the video as of the time of the interview. SDC indicated the lift would also be used to transfer residents off the floor after a fall.

During an interview on 9/12/23 at 11:10 a.m., DON stated she had just received some new information regarding the 8/16/23 fall that R2's "foot got caught under the tub so they had to lift it over so, maybe that is what happened" DON was not sure why that would make the loops fall off. DON stated the facility usually completed at skills fair however, had not completed mechanical lift training for the past few years because of COVID. DON explained a new staff development person was hired three months prior to the incident, but does not know what competencies had been done or where they would be stored if they were done. RN case managers were responsible for making sure the NAs were competent in using the mechanical lifts.

On 9/12/23, the facility was not able to provide any mechanical lift training and competency records for any nursing staff.

During an interview on 9/12/23 at 3:42 p.m., administrator said maintenance looked at the mechanical lift after the fall and was told that there was nothing wrong with the lift. Administrator stated there "was no way the sling

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F 689	Continued From page 13	F 689		

could have fallen off." The NAs involved were "adamant" they had hooked the sling up correctly. As a result the facility determined "everything was followed" and we did not figure out what happened to cause R2's fall out of the lift. No further action was taken.

Facility "Lifting Machine, Using a Mechanical" Policy last reviewed 8/17/23, directed the following: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. Attach sling straps to sling bar, according to manufacturer's instructions. Make sure the sling is securely attached to the clips and that it is properly balanced. Before resident is lifted, double check the security of the sling attachment. Examine all hooks, clips or fasteners. Check the stability of the straps. Ensure that the sling bar is securely attached and sound. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. Slowly lift the resident. Only lift as high as necessary to complete the transfer. Gently support the resident as he or she is moved, but do NOT support any weight.

Manufacturer's recommendations for the full body mechanical lift last reviewed on 6/14/23, included for safe operation, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients(residents). When lifting a patient push the UP button on the hand control to initiate the upward motion of the lift. Continue the upward motion until there is tension on the legs of the

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F 689	Continued From page 14 sling, making sure all loops on the sling are securely hooked on the hanger bars. When transferring the patient, ensure there are no obstructions in the path of travel and pull or push the lift using the operator's handles on the lift mast. Users must accept full responsibility for checking the condition of all slings and harnesses before each and every use on a patient. The IJ that began on 8/16/23 at 9:30 a.m. was removed on 9/13/23 at 2:15 p.m. when it could be verified the facility implemented the following actions: the involved mechanical lift was removed from service until the manufacturer inspected and deemed it safe for use; policy was revised to include that any equipment that is involved in an incident will be taken out of service until inspected and deemed safe by the manufacturer; and training with competencies completed with all staff prior to their next shift.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 29, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Re: State Nursing Home Licensing Orders
Event ID: UNRO11

Dear Administrator:

The above facility was surveyed on September 7, 2023, through September 13, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 9/7/23, 9/11/23, 9/12/23, and 9/13/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date

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	00041	A. BUILDING: ______ B. WING ______	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH NEW ULM, MN 56073**

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when they will be completed.

The following complaint was reviewed.
H54905106C (MN00096488) with a licensing order issued at 0830

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to safely use a mechanical lift per manufacture instruction to transfer 1 of 1 residents (R2) who required a mechanical lift for transfers. This resulted in R2 falling from a lift, sustaining major injuries. R2 subsequently died 10 days following the fall. In addition the facility failed to conduct a thorough investigation to determine the cause of the fall from the lift. This resulted in immediate jeopardy (IJ) for R2. The IJ began on 8/16/23, at approximately 9:30	2 830	Corrected	10/6/23

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a.m. when R2 fell from the lift during a transfer sustaining a major head injury and right upper arm fracture after two nursing assistants (NAs) were transferring a resident using the mechanical lift. The facility failed to determine the cause of the incident, continued to use the lift without a thorough inspection of the lift to determine safe for use, failed to contact the manufacturer, and failed to provide retraining and competency for staff using the lift. The administrator, director of nursing (DON), and registered nurse case manager (RN)-A were notified of the immediate jeopardy on 9/12/23, at 5:20 p.m. The immediate jeopardy was removed on 9/13/23, at 2:15 p.m. but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy.

Findings Include:

R2's Diagnosis Report identified diagnoses of delusional disorders, essential tremors, encephalopathy (any brain disease that alters brain function or structure), and muscle weakness.

R2's care plan last revised on, 2/6/23 identified R2 was not ambulatory and required two staff assist with Hoyer (full body mechanical lift) and medium sling.

R2's quarterly Minimum Data Set (MDS) dated 5/30/23, indicated R2 had moderate cognitive impairment. R2 required total dependence of two staff assist with transfers.

R2's Mobility/Transfer Evaluation dated 6/10/23, indicated R2 required two-person assist with full body mechanical lift with large sling for transfers.

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R2's care plan dated 2/6/23, was not revised to reflect the change in sling size. At the time of R2's fall on 8/16/23 the care plan and mobility evaluation were inconsistent.

R2's fall incident report dated 8/16/23 at 9:52 a.m. indicated R2 was found lying across the legs of the hoyer (mechanical full body lift) on the floor with feet facing the toilet and head by the tub. R2 was noted to have a moderate amount of blood coming from the back of her head. Nursing assistants (NA)s stated that R2 was in mechanical lift sling when a loop came undone and the resident fell to the floor. R2 was unable to describe the incident. R2 was assisted to a sitting position and noted to have some pain to the right upper arm and a large part of scalp "reflected" (sik) on the right back side of head. R2 was transported by ambulance to the emergency department (ED).

R2's nursing progress notes dated 8/16/23 at 10:10 a.m., indicated registered nurse (RN-B) responded to the fall. R2's progress note included the details as documented in the incident report, adding R2 was transferred to the ED at 9:30 a.m..

R2's post incident Mobility/Transfer Evaluation dated 8/16/23 at 4:35 p.m. indicated R2's sling size was changed from a large to medium.

R2's ED notes dated 8/16/23 at 10:15 a.m., indicated R2's injuries from the fall included a fracture of the right humerus (long bone of the upper arm) and traumatic head injury with multiple lacerations.

R2's hospice progress note dated 8/16/23 at 2:53 p.m., indicated R2 was in bed with right arm in a sling, bruising noted on upper arm/shoulder,

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staples intact on back right side of head, R2 stated she was "terrible". R2 wants to get out of bed and reported severe pain when turned.

R2's progress note dated 8/26/23 at 3:45 a.m., indicated R2's time of death was on 8/26/23, at 1:17 a.m.

A typed interview summary dated 8/16/23 at 12:00 p.m., authored by assistant director of nursing (ADON) indicated upon review of the initial documentation of the incident and interviews with NA-A and NA-B, no apparent root cause could be determined. R2's care plan was identified as being followed.

Review of R2's medical record and fall incident report dated 8/16/23 at 9:52 a.m., did not identify the size of the sling that was used at the time of the fall.

Facility's undated investigation documentation and maintenance records did not indicate the lift and lift slings used when the fall occurred, were removed from operation and inspected for safety and malfunction.

During a phone interview on 9/7/23, at 2:25 p.m., NA-C indicated that "a few weeks ago" R2 fell out of the full body mechanical lift, hit her head, and died days later. Further indicated it was because of a faulty lift but the facility never took the lift out of service. NA-C stated the same lift involved in R2's fall was currently being used to transfer residents. NC-C indicated one other resident used the lift on the unit and the lift would also be used to transfer residents off the floor after a fall.

During an interview on 9/11/23 at 12:20 p.m., NA-B indicated she was one of the two NAs

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assisting R2 with transferring in and out of the tub on 8/16/23. They had transferred R2 into the tub and unhooked the sling for bathing. Once the bath was completed, NA-B was on one side of R2 and NA-A was on the other side of her. They connected both the upper and lower sling loops to the hooks on the lift cross bar on the side that they stood on. They raised R2 over the tub, lifted her feet over the side of the tub, and proceeded to back the lift up to go towards her chair. The left lower loop came off and the right side stayed intact causing R2 to slide out of the sling onto her right side. We were not able to catch her, R2's head "bounced" off the side of the tub and she fell to the floor. R2 was in "shock and pain". They (NA-B and NA-A) did not stop and check loop placement once R2 was suspended in the air. "R2 was suspended for about 15 seconds before she fell out." NA-B stated it was "a mystery" on how it happened. NA-B had to give a statement to nurse as to what happened afterward and "thought" they were using a medium sling but could not be sure. NA-B verified the lift was never taken out of service and remained in use.

During an interview on 9/11/23 at 12:45 p.m., NA-A indicated she was assisting NA-B with R2's transfer out of the bath when the fall out of the lift sling occurred. She thought they had both checked the strap placement but the incident "happened so fast we thought the strap broke". NA-A indicated both her and NA-B met with nurses to "walk though it" (the incident). NA-A was still not sure what happened to cause R2 to fall out of the lift.

During an interview on 9/11/23 at 3:55 p.m., RN-A stated she was involved in the incident investigation. RN-A indicated after the incident, she went to the tub room, interviewed the NAs

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involved, looked at the mechanical lift, and sent the information to the administrator. Later that day there was a meeting that included the NA's involved and the ADON. NA's told us what happened and "chit chatted about the lift" and were not able to determine why the loop fell off of the lift causing the resident to fall out of the sling. RN-A indicated she was not sure if there were any other actions taken except the ADON had assigned a video for staff to watch by the end of September.

During an interview on 9/11/23 at 12:10 p.m., the licensed social worker (LSW) indicated she was involved in the incident investigation. LSW indicated both NAs involved in the transfer reported the sling loops were secure. Both of their statements were consistent with each other. The LSW thought maybe, when moving R2's leg out the tub, the loop may have "jolted loose" but determined R2's care plan was followed. LSW reported maintenance looked at the mechanical lift and the sling but did not provide any further details of what was "looked at".

During an interview on 9/11/23 at 4:10 p.m., Maintenance-A indicated he was not aware of the fall from the mechanical lift until today. He had not removed any mechanical lifts from service or inspected them. He heard that the sling straps may have been put on wrong which caused the fall but was not sure. Maintenance-A indicated the normal process is to have the manufacturer come in every six months to inspect the lifts. Maintenance-A stated the last routine maintenance check on the lifts was completed 4/18/23.

During an interview on 9/12/23 at 11:55 a.m., maintenance-B indicated he was notified about

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the fall and was asked to look at the mechanical lift. He was in the meeting to discuss his findings and stated he drew them a picture of the hooks on the mechanical lift bar. Further explained the lift that was being used when the fall occurred was the only lift in the facility with the extra safety feature of the long hook and if the loops were hooked correctly, it is "impossible for it [the sling loop] to fall off, it is against the law of physics". Even if the sling loop was not completely in the notch of the hook, once weight was on it, it would slip on the bar but still would not slip off the hook. Concluded, "the only way that [sling loop] could have fallen off is if it was put on the top of the bar, instead of under the safety hook, and if the lift was jolted, then it would slip off". Maintenance-B stated this was explained to the group in the fall follow-up meeting however, there was no facility documentation of his statement.

During a phone interview on 9/12/23 at 10:35 a.m., EZ-Way lift representative (LR)-A indicated she was not aware of any lift related incidents at the facility. The facility will usually call the lift manufacturer if there is an incident related to a lift. The manufacturer right away would send a service technician out to the facility to inspect the lift and set up a staff in-service on proper lift use. Further indicated usually a fall from a lift happens because staff forget to hook a loop up or do not pay attention thinking they had both loops hooked but only had loop attached. LR-A stated, "If the sling loops are hooked correctly, gravity should hold the loop in place, it doesn't just fall off".

During interview on 9/12/23 at 1:13 p.m., NA-D indicated they received training on the mechanical lifts during her initial orientation and observed other NAs use the lifts. NA-D denied demonstrating skills or taking a test related to use

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of body slings and mechanical lifts to a nurse or case manager.

During an interview on 9/12/23 at 11:45 a.m., RN-C stated staff received mechanical lift training from staff development and "on the floor training by other [NAs] and I answer questions if they ask". RN-C indicated she had not completed competency testing for the lift with any of the nursing staff.

During an interview on 9/12/23 at 12:05 p.m., RN-D indicated new NAs are trained by the staffing development person. RN-D further indicated she had not completed competency testing for the lift with any of the nursing staff.

During an interview on 9/12/23 at 4:05 p.m., the staffing development coordinator (SDC) indicated following the incident, she assigned all nursing staff a video on how to properly use the mechanical lifts. The video training was to be completed by the end of September. She had planned to schedule a skills fair for this Fall and use of mechanical lifts would be on the agenda. Verified NA-A, NA-B, and any other nursing staff had not received additional training or a competency evaluation after R2's fall from the lift. She Was not sure if they had watched the video as of the time of the interview. SDC indicated the lift would also be used to transfer residents off the floor after a fall.

During an interview on 9/12/23 at 11:10 a.m., DON stated she had just received some new information regarding the 8/16/23 fall that R2's "foot got caught under the tub so they had to lift it over so, maybe that is what happened" DON was not sure why that would make the loops fall off. DON stated the facility usually completed at skills

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fair however, had not completed mechanical lift training for the past few years because of COVID. DON explained a new staff development person was hired three months prior to the incident, but does not know what competencies had been done or where they would be stored if they were done. RN case managers were responsible for making sure the NAs were competent in using the mechanical lifts.

On 9/12/23, the facility was not able to provide any mechanical lift training and competency records for any nursing staff.

During an interview on 9/12/23 at 3:42 p.m., administrator said maintenance looked at the mechanical lift after the fall and was told that there was nothing wrong with the lift. Administrator stated there "was no way the sling could have fallen off." The NAs involved were "adamant" they had hooked the sling up correctly. As a result the facility determined "everything was followed" and we did not figure out what happened to cause R2's fall out of the lift. No further action was taken.

Facility "Lifting Machine, Using a Mechanical" Policy last reviewed 8/17/23, directed the following: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. Attach sling straps to sling bar, according to manufacturer's instructions. Make sure the sling is securely attached to the clips and that it is properly balanced. Before resident is lifted, double check the security of the sling attachment. Examine all hooks, clips or fasteners. Check the stability of the straps. Ensure that the sling bar is securely attached and

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sound. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. Slowly lift the resident. Only lift as high as necessary to complete the transfer. Gently support the resident as he or she is moved, but do NOT support any weight.

Manufacturer's recommendations for the full body mechanical lift last reviewed on 6/14/23, included for safe operation, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients(residents). When lifting a patient push the UP button on the hand control to initiate the upward motion of the lift. Continue the upward motion until there is tension on the legs of the sling, making sure all loops on the sling are securely hooked on the hanger bars. When transferring the patient, ensure there are no obstructions in the path of travel and pull or push the lift using the operator's handles on the lift mast. Users must accept full responsibility for checking the condition of all slings and harnesses before each and every use on a patient.

The IJ that began on 8/16/23 at 9:30 a.m. was removed on 9/13/23 at 2:15 p.m. when it could be verified the facility implemented the following actions: the involved mechanical lift was removed from service until the manufacturer inspected and deemed it safe for use; policy was revised to include that any equipment that is involved in an incident will be taken out of service until inspected and deemed safe by the manufacturer; and training with competencies completed with all staff prior to their next shift.

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SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise Mechanical lift policy to ensure a thorough inspection of equipment is completed per manufacturer instruction following any incident involving the lift. Contact the manufacturer to report the incident. Provide immediate training and competency evaluation to NA-A and NA-B and other staff using the EZ lift. Ensure the competency checklist/training is followed per manufacturers guidelines. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.