Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 30, 2023

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512
Cycle Start Date: May 22, 2023

Dear Administrator:

On June 7, 2023, we notified you a remedy was imposed. On June 28, 2023 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 June 16, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 22, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 7, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 22, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2023

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: Reinspection Results
Event ID: BR4B12

Dear Administrator:

On June 28, 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 May 22, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 7, 2023

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512
Cycle Start Date: May 22, 2023

Dear Administrator:

On May 22, 2023, 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 May 22, 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 E.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 22, 2023.

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 June 22, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 22, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 22, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, First Care Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 22, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 22, 2023 (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:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	C 05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/18/23, 5/19/23 and 5/22/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55122234C (MN93511) with a deficiency cited at F689. The following complaints were reviewed with no deficiencies: H55122290C (MN93312) H55122291C (MN84943) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. The immediate jeopardy began on 5/9/23, when R1 fell from the Hoyer lift during provision of care. The facility failed to thoroughly investigate and identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred. The IJ was identified on 5/19/23. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 12:34 p.m. on 5/19/23. The IJ was removed on 5/22/23.	F 000		

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

Electronically Signed | 06/16/2023

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 The above findings constituted substandard quality of care, and an extended survey was conducted on 5/22/23.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate and analyze hazards following a resident fall from a Hoyer lift resulting in a laceration to the elbow and hematoma on the head. A second, near miss incident occurred one week later for the same resident (R1) using the same lift. This resulted in an immediate jeopardy for R1. The immediate jeopardy began on 5/9/23, when R1 fell from the Hoyer lift during provision of care. The facility failed to thoroughly investigate and identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred. The IJ was identified on 5/19/23. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 12:34 p.m. on 5/19/23. The IJ was removed on 5/22/23, but non-compliance remained at the lower scope and severity level 2, which indicated no actual harm with potential for more than minimal harm that is	F 689	Plan of Correction Implemented (In addition to the items listed in IJ Removal Plan): New Fall Standard work developed to be followed to ensure all areas are completed to assess, investigate, and complete thorough root cause analysis. Mechanical Lift Standard Work development in accordance with Volaro uses manual. Safe Patient Handling policy reviewed and updated. Staff educated at staff meetings on 6/7 and 6/8 on use of both full body and EZ stand lifts. Videos from Volaro site demonstrating use lifts viewed at meeting. Manuals for both types of lifts are	6/16/23

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F 689	Continued From page 2 not immediate jeopardy. Findings include: R1's admission Minimum Data Set dated 3/9/23, identified intact cognition and indicated he required total assistance from two staff for transfers. R1's care plan dated 4/26/23, identified decreased independence and the need for assistance with activities of daily living due to limited mobility. The care plan directed staff to use a full body mechanical lift to perform transfers. R1's facility Progress Notes identified the following: -5/9/23, recorded as a late entry on 5/22/23, at 1:03 a.m. following surveyor inquiry, indicated R1 was on his left side on the floor. The mechanical lift tipped as he was being transferred. R1 had a small open area on his left elbow, Steri-strips applied and a small bump on the back of his head. The lift was removed from use at that time. The progress note was written by licensed practical nurse (LPN)-A. -5/9/23, recorded as a late entry on 5/16/23, writer arrived in room and R1 was on the floor on his side. R1 had fallen when the lift tipped. R1 was checked for injuries, had a cut on his left elbow and a small bump on the back of his head. Lift removed from use. -5/10/23, recorded as a late entry on 5/16/23, interdisciplinary team review identified contributing cause of the fall: mechanical lift tipped during transfer. Staff and resident interviewed and confirmed correct use of equipment. Maintenance found the latching	F 689	available on device and in locker room for reference. Root Cause Analysis form implemented for investigating falls. Staff will complete a return demonstration to verify their competency in using Volaro EZ stand lift. Staff will complete related Educare training at time of hire and annually. New slings received so all residents have their own designated sling to ensure the proper size is being used. Safe Transfer Form was placed in each resident’s closet to list the type of assistance and assistive devices needed for transfers. All residents using a mechanical lift have the size of their sling included on the form. Monitoring Compliance: Completing Root Cause Analysis form and Fall Standard Work will be utilized to investigate all falls and near misses. The Tracer Observation Form will be completed by DON, or designee, monthly and as needed to verify staff competency and understanding of safety with equipment use. Staff will complete a return demonstration at the time of hiring and at least once in a	

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F 689	Continued From page 3 mechanism for the lift legs did not catch as it should. Part ordered to fix. The lift was removed from service to have maintenance assess/fix. -5/17/23, recorded as a late entry on 5/21/23, following surveyor inquiry: Near miss fall: nursing assistant (NA) reported to nursing staff that mechanical lift was making odd noises as staff was using machine to lift resident from bed. NA reported lifting arm of machine appears off center as well. NA reported that resident was laid back down in bed and a different lift was used to safely transfer R1. Nursing instructed NA to put lift out of service to prevent further use. A handwritten note by NA-A indicated on 5/9/23, while lifting R1 in the mechanical lift, on the way to the commode the lift tipped over and R1 fell hitting his head on the commode and his elbow on the floor. NA-A wrote she was trying to pull the wheelchair back as another staff lifted him up and was attempting to pull the lift back before turning it toward the commode. NA-A wrote R1 was hooked up correctly and was not moving around. NA-A wrote, R1 "was not moving around, the hoyer [mechanical lift] tipped from his weight. I believe [R1] should not be using that type of hoyer machine and should switch to the other we have been using since." A facility document titled, EH (Essentia Health) SNF (skilled nursing facility) Vulnerable Adult (VA) Template dated 5/15/23, indicated on 5/9/23, R1 fell due to a lift tipping over. The document indicated maintenance was involved due to equipment involvement and indicated R1 did not feel safe using any of the lifts. The document indicated all staff involved in the incident should be interviewed as well as staff who normally work	F 689	calendar year. The IDT member/members will review all falls day of or the day following the fall depending on time it occurred, and again at completion of Root Cause Analysis to ensure all areas have been addressed. DON, or designee, will complete audits on use of proper size slings. Maintenance staff will continue to check lifts monthly and as needed to ensure they are in working order. Maintenance staff will contact the manufacturer when appropriate for guidance with repairs. Responsible Person: Kristi Mienert, Director of Nursing of Essentia Health First Care Living Center Date of Correction Completion: Competency Testing for lifts will be completed prior to staff using mechanical lifts for the first time and annually. Staff received education on 6/7/23 and 6/8/23. Education will be repeated on 7/12/23 & 7/13/23 or sooner if necessary. The audits and tracers initiated and listed in the plan of correction will continue.	

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F 689	Continued From page 4 with the resident and determine if education, coaching or corrective action needed to be implemented. The document further indicated all staff would be educated on use of lifts and potential issues. An e-mail dated 5/22/23, from registered nurse (RN)-A to the administrator and the DON identified the following: "below completed 5/10/23 - 5/14/23." - R1 reported staff helped him get in the lift sling as they usually did. They had the commode to the side and as they were going from the wheelchair to the commode, NA-B was lifting him up, the legs were wide like they usually do and when he was moving toward the commode, it just tipped over. R1 stated it surprised all of them and said he was on his left side with the lift on his right side. R1 said his elbow hurt at first and he could tell he bumped his head. - NA-B reported they needed to transfer R1 to the commode. NA-B said she opened the legs of the lift and lifted R1 up. NA-B reported all seemed to be going well and when she was moving the lift so she could get R1 on the commode the lift tipped, landing partially on R1. NA-B said they helped get the lift off R1 and called for the nurse. - NA-A reported while lifting R1 in the mechanical lift, on the way to the commode the lift tipped over and R1 fell hitting his head on the commode and his elbow on the floor. NA-A said he was hooked up correctly and the legs were open. NA-A said R1 had not been moving around and said she believed the lift tipped due to R1's weight. An e-mail dated 5/22/23, indicated maintenance noted the locking mechanism on the legs of the	F 689		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

lift were worn and likely caused the lift to tip as the legs would have closed during the transfer.

During observation and interview on 5/18/23, at 1:14 p.m. R1 was seated outside the dining room in a standard wheelchair. R1 stated on 5/9/23, two staff were transferring him from the wheelchair to the commode. R1 said when they went to move sideways, one leg turned in and "we swiveled a little and we all went down." R1 stated they were in a tangled heap with the lift between them. R1 said he got a cut on his elbow and a big bump on the back of his head. R1 said he had a few aches and pains from the fall. R1 stated, "Yesterday the same thing happened, I didn't fall, we caught it in time." R1 said staff started lifting him and turning and said as the lift was raised it kind of turned to one side. R1 said when the staff tried to turn, the lift over balanced. R1 said staff went and got another lift to complete the transfer. R1 said three staff were assisting him, NA-C, NA-B, who was assisting on 5/9/23, when the lift tipped over, and a third NA. R1 said when the first incident occurred, he was seated in his wheelchair next to the second bed when staff started to push him in the lift toward where the commode was sitting, "then it happened." At 3:55 p.m. R1 described the position of the wheelchair and the commode in the room at the time of the fall. R1 said he was seated in the wheelchair between the two beds and said the commode was in the "pathway" near the bathroom (approximately 8 feet away). R1 said the staff were pushing the lift to the commode and when they started to make the turn the lift tipped over. R1 confirmed he was not interviewed by the facility following the second incident on 5/17/23.

During interview on 5/18/23, at 1:29 p.m. NA-C

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	245512	A. BUILDING _____ B. WING _____	C 05/22/2023

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F 689	Continued From page 6 stated the previous day R1 was hooked up to the mechanical lift and said three NAs were present including herself. NA-C said they started to lift R1 and as soon as she lifted him up, the lift tipped. NA-C stated the head of R1's bed was upright and that was the only thing that kept him from falling. NA-C stated they lowered R1 back to the bed and went and got a different lift. NA-C stated she had not received any training on lifts following the incident on 5/9/23, and said she was only told to use three staff. NA-C confirmed the lift used was lift number six and confirmed it was the same lift used during the fall on 5/9/23. NA-C stated she had reported the incident to the nurse on the floor. During interview on 5/18/23, at 1:34 p.m. NA-D stated she was aware of the incident involving R1 falling from the lift. NA-D said she had not received any training following the incident and said all the lifts in the facility could be used for any resident who required the use of a lift. During interview on 5/18/23, at 2:07 p.m. LPN-A said he was called to R1's room after the fall on 5/9/23. LPN-A stated according to the NAs, the lift tipped over and R1 landed on the floor. LPN-A said R1 had a cut on his elbow and a bump on his head. LPN-A said the lift was taken out of R1's room and a different lift was used to get him up off the floor. LPN-A said the lift had not been removed from the floor and said there was nothing wrong with the lift, R1 "was too heavy for it." LPN-A said after the incident staff were told to be more careful when using the lifts. During interview on 5/18/23, at 1:38 p.m. the DON stated she had received a text message the evening of 5/9/23, that R1 had fallen out of the lift.	F 689		

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F 689	Continued From page 7 The DON said staff removed the lift from the floor right away and confirmed the lift was lift number six. The DON stated maintenance took the lift and inspected it and determined the mechanism that secured the legs was not working and if something bumped the leg during a transfer the leg could close. The DON stated the lift was repaired and tested and put back into use however, the DON indicated the lift had not been tested to ensure worked correctly. The DON said on 5/17/23, staff said the lift was "loud" when using it so she and maintenance again removed it from the floor. On 5/18/23, at 1:49 p.m. the maintenance worker (MW) stated all the mechanical lifts received routine inspections each month to include checking bolts, breaks, controls, pivots, etc. The MW said after R1 fell, he identified the lift used during the transfer had a manual bar that opened and closed the legs and the "notches" were worn. The MW said the parts were ordered and replaced. The MW said the whole machine had been checked out and was put back on the floor. MW said he became aware on 5/18/23, there was a problem with the lifting part and said the lift was an older lift. During interview on 5/18/23, at 2:31 p.m. RN-A stated after the fall on 5/9/23, she contacted both of the NAs involved to ask what happened. RN-A said the NAs said R1 was hooked up, they started lifting him up and when bringing him over to the next surface the lift tipped over. RN-A stated NA-B told her she did not know what had happened so the lift was sent to maintenance to inspect it and see if something needed to be fixed. RN-A said maintenance looked at the lift and said the only way it could have tipped over	F 689		

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F 689	Continued From page 8 was if the legs closed so he replaced the parts. RN-A stated she had not been aware there was a second incident with lift number six until this morning, so the lift was again put out of service this morning (5/18/23). RN-A stated an LPN reported to her that staff were transferring R1 and the lift was making some noise so they lowered him back down, unhooked him and used a different lift. RN-A stated she had not spoken to the staff involved. The DON was present and stated staff told her the lift had been making a weird noise during the incident on 5/17/23, but did not remember who had told her. The DON stated she had not asked R1 about the incident. When asked about staff education following the two incidents, the DON said for a couple of shifts the nurses had watched transfers but said there was no documentation. The DON said she was planning to do staff education at the next staff meeting in June. The DON further stated there was no evidence NA-As concern about R1's safety when using lift number six had been addressed. RN-A and the DON stated they felt the issue had been addressed when maintenance replaced the part on the lift. Despite facility's documented interviews with staff involved in the lift incidents detailing the incorrect use of the lift (transporting resident in lift), the facility failed to identify concern, interview resident for more details and contact Hoyer Lift manufacturer following lift failures. On 5/19/23, at 10:24 a.m. the facility's customer service representative (CSR) for the Volaro lifts used in the facility was interviewed. The CSR stated typically when they heard of a lift tipping, it was due to the legs being closed or if the lift was positioned too close to the bed and staff turned	F 689		

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F 689	Continued From page 9 and pushed the resident, the weight would start to pull the lift over especially if the resident was too heavy. The CSR stated the lifts were not designed to transport any distance, only surface to surface and if staff transported a resident too far in the lift it could create a "situation." On 5/19/23, at 10:59 a.m. NA-F stated when transferring a resident in the mechanical lift she would bring the chair or commode to the resident. NA-F stated she would not transport a resident more than 5 feet in the lift. The Volaro 4 Series Operators Manual, safety notes indicated The Volaro lift is designed for patient lift only. Using the lift for transport can create an unsafe patient handling situation. Facility policy, Fall Standard Work, undated, indicated the following: Review Devices in use/involved in fall and determine if location of device played a factor, if device was used by resident/staff properly, ensure device is working properly and if any adjustments need to be made involve maintenance staff or therapy staff as appropriate. The immediate jeopardy that began on 5/9/23, was removed on 5/22/23, when the facility identified and assessed all residents who utilized a mechanical lift for safety, completed a thorough analysis of the incidents on 5/9/23 and 5/17/23, completed an inspection of all lifts in the facility and completed training with staff to include return demonstration of the correct use of mechanical lifts and implemented a plan to educate all staff prior to working with the lifts.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2023

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: State Nursing Home Licensing Orders
Event ID: BR4B11

Dear Administrator:

The above facility was surveyed on May 18, 2023 through May 22, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00461	A. BUILDING: _____ B. WING _____	C 05/22/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/18/23, 5/19/23 and 5/22/23, 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, and the following licensing order was issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H55122234C (MN93511) with a licensing order issued at 0830. H55122290C (MN93312) H55122291C (MN84943) 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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate and analyze hazards following a resident fall from a Hoyer lift resulting in a laceration to the elbow and hematoma on the head. A second, near miss incident occurred one week later for the same resident (R1) using the same lift. This resulted in an immediate jeopardy for R1.	2 830	Plan of Correction Implemented (In addition to the items listed in IJ Removal Plan): New Fall Standard work developed to be followed to ensure all areas are completed to assess, investigate, and complete thorough root cause analysis.	6/16/23

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2 830	Continued From page 3 The immediate jeopardy began on 5/9/23, when R1 fell from the Hoyer lift during provision of care. The facility failed to thoroughly investigate and identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred. The IJ was identified on 5/19/23. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 12:34 p.m. on 5/19/23. The IJ was removed on 5/22/23, but non-compliance remained at the lower scope and severity level 2, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimum Data Set dated 3/9/23, identified intact cognition and indicated he required total assistance from two staff for transfers. R1's care plan dated 4/26/23, identified decreased independence and the need for assistance with activities of daily living due to limited mobility. The care plan directed staff to use a full body mechanical lift to perform transfers. R1's facility Progress Notes identified the following: -5/9/23, recorded as a late entry on 5/22/23, at 1:03 a.m. following surveyor inquiry, indicated R1 was on his left side on the floor. The mechanical lift tipped as he was being transferred. R1 had a small open area on his left elbow, Steri-strips applied and a small bump on the back of his head. The lift was removed from use at that time. The progress note was written by licensed practical nurse (LPN)-A. -5/9/23, recorded as a late entry on 5/16/23, writer arrived in room and R1 was on the floor on	2 830	Mechanical Lift Standard Work development in accordance with Volaro uses manual. Safe Patient Handling policy reviewed and updated. Staff educated at staff meetings on 6/7 and 6/8 on use of both full body and EZ stand lifts. Videos from Volaro site demonstrating use lifts viewed at meeting. Manuals for both types of lifts are available on device and in locker room for reference. Root Cause Analysis form implemented for investigating falls. Staff will complete a return demonstration to verify their competency in using Volaro EZ stand lift. Staff will complete related Educare training at time of hire and annually. New slings received so all residents have their own designated sling to ensure the proper size is being used. Safe Transfer Form was placed in each resident’s closet to list the type of assistance and assistive devices needed for transfers. All residents using a mechanical lift have the size of their sling included on the form. Monitoring Compliance: Completing Root Cause Analysis form and Fall Standard Work will be utilized to	

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2 830	Continued From page 4 his side. R1 had fallen when the lift tipped. R1 was checked for injuries, had a cut on his left elbow and a small bump on the back of his head. Lift removed from use. -5/10/23, recorded as a late entry on 5/16/23, interdisciplinary team review identified contributing cause of the fall: mechanical lift tipped during transfer. Staff and resident interviewed and confirmed correct use of equipment. Maintenance found the latching mechanism for the lift legs did not catch as it should. Part ordered to fix. The lift was removed from service to have maintenance assess/fix. -5/17/23, recorded as a late entry on 5/21/23, following surveyor inquiry: Near miss fall: nursing assistant (NA) reported to nursing staff that mechanical lift was making odd noises as staff was using machine to lift resident from bed. NA reported lifting arm of machine appears off center as well. NA reported that resident was laid back down in bed and a different lift was used to safely transfer R1. Nursing instructed NA to put lift out of service to prevent further use. A handwritten note by NA-A indicated on 5/9/23, while lifting R1 in the mechanical lift, on the way to the commode the lift tipped over and R1 fell hitting his head on the commode and his elbow on the floor. NA-A wrote she was trying to pull the wheelchair back as another staff lifted him up and was attempting to pull the lift back before turning it toward the commode. NA-A wrote R1 was hooked up correctly and was not moving around. NA-A wrote, R1 "was not moving around, the hoyer [mechanical lift] tipped from his weight. I believe [R1] should not be using that type of hoyer machine and should switch to the other we have been using since."	2 830	investigate all falls and near misses. The Tracer Observation Form will be completed by DON, or designee, monthly and as needed to verify staff competency and understanding of safety with equipment use. Staff will complete a return demonstration at the time of hiring and at least once in a calendar year. The IDT member/members will review all falls day of or the day following the fall depending on time it occurred, and again at completion of Root Cause Analysis to ensure all areas have been addressed. DON, or designee, will complete audits on use of proper size slings. Maintenance staff will continue to check lifts monthly and as needed to ensure they are in working order. Maintenance staff will contact the manufacturer when appropriate for guidance with repairs. Responsible Person: Kristi Mienert, Director of Nursing of Essentia Health First Care Living Center Date of Correction Completion: Competency Testing for lifts will be completed prior to staff using mechanical	

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2 830	Continued From page 5 A facility document titled, EH (Essentia Health) SNF (skilled nursing facility) Vulnerable Adult (VA) Template dated 5/15/23, indicated on 5/9/23, R1 fell due to a lift tipping over. The document indicated maintenance was involved due to equipment involvement and indicated R1 did not feel safe using any of the lifts. The document indicated all staff involved in the incident should be interviewed as well as staff who normally work with the resident and determine if education, coaching or corrective action needed to be implemented. The document further indicated all staff would be educated on use of lifts and potential issues. An e-mail dated 5/22/23, from registered nurse (RN)-A to the administrator and the DON identified the following: "below completed 5/10/23 - 5/14/23." - R1 reported staff helped him get in the lift sling as they usually did. They had the commode to the side and as they were going from the wheelchair to the commode, NA-B was lifting him up, the legs were wide like they usually do and when he was moving toward the commode, it just tipped over. R1 stated it surprised all of them and said he was on his left side with the lift on his right side. R1 said his elbow hurt at first and he could tell he bumped his head. - NA-B reported they needed to transfer R1 to the commode. NA-B said she opened the legs of the lift and lifted R1 up. NA-B reported all seemed to be going well and when she was moving the lift so she could get R1 on the commode the lift tipped, landing partially on R1. NA-B said they helped get the lift off R1 and called for the nurse. - NA-A reported while lifting R1 in the mechanical	2 830	lifts for the first time and annually. Staff received education on 6/7 and 6/8. Education will be repeated on 7/12 & 7/13 or sooner if necessary. The audits and tracers initiated and listed in the plan of correction will continue.	

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	00461	A. BUILDING: _____ B. WING _____	C 05/22/2023

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2 830	Continued From page 6 lift, on the way to the commode the lift tipped over and R1 fell hitting his head on the commode and his elbow on the floor. NA-A said he was hooked up correctly and the legs were open. NA-A said R1 had not been moving around and said she believed the lift tipped due to R1's weight. An e-mail dated 5/22/23, indicated maintenance noted the locking mechanism on the legs of the lift were worn and likely caused the lift to tip as the legs would have closed during the transfer. During observation and interview on 5/18/23, at 1:14 p.m. R1 was seated outside the dining room in a standard wheelchair. R1 stated on 5/9/23, two staff were transferring him from the wheelchair to the commode. R1 said when they went to move sideways, one leg turned in and "we swiveled a little and we all went down." R1 stated they were in a tangled heap with the lift between them. R1 said he got a cut on his elbow and a big bump on the back of his head. R1 said he had a few aches and pains from the fall. R1 stated, "Yesterday the same thing happened, I didn't fall, we caught it in time." R1 said staff started lifting him and turning and said as the lift was raised it kind of turned to one side. R1 said when the staff tried to turn, the lift over balanced. R1 said staff went and got another lift to complete the transfer. R1 said three staff were assisting him, NA-C, NA-B, who was assisting on 5/9/23, when the lift tipped over, and a third NA. R1 said when the first incident occurred, he was seated in his wheelchair next to the second bed when staff started to push him in the lift toward where the commode was sitting, "then it happened." At 3:55 p.m. R1 described the position of the wheelchair and the commode in the room at the time of the fall. R1 said he was seated in the wheelchair between the two beds and said the commode	2 830		

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2 830	Continued From page 7 was in the "pathway" near the bathroom (approximately 8 feet away). R1 said the staff were pushing the lift to the commode and when they started to make the turn the lift tipped over. R1 confirmed he was not interviewed by the facility following the second incident on 5/17/23. During interview on 5/18/23, at 1:29 p.m. NA-C stated the previous day R1 was hooked up to the mechanical lift and said three NAs were present including herself. NA-C said they started to lift R1 and as soon as she lifted him up, the lift tipped. NA-C stated the head of R1's bed was upright and that was the only thing that kept him from falling. NA-C stated they lowered R1 back to the bed and went and got a different lift. NA-C stated she had not received any training on lifts following the incident on 5/9/23, and said she was only told to use three staff. NA-C confirmed the lift used was lift number six and confirmed it was the same lift used during the fall on 5/9/23. NA-C stated she had reported the incident to the nurse on the floor. During interview on 5/18/23, at 1:34 p.m. NA-D stated she was aware of the incident involving R1 falling from the lift. NA-D said she had not received any training following the incident and said all the lifts in the facility could be used for any resident who required the use of a lift. During interview on 5/18/23, at 2:07 p.m. LPN-A said he was called to R1's room after the fall on 5/9/23. LPN-A stated according to the NAs, the lift tipped over and R1 landed on the floor. LPN-A said R1 had a cut on his elbow and a bump on his head. LPN-A said the lift was taken out of R1's room and a different lift was used to get him up off the floor. LPN-A said the lift had not been removed from the floor and said there was	2 830		

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2 830	Continued From page 8 nothing wrong with the lift, R1 "was too heavy for it." LPN-A said after the incident staff were told to be more careful when using the lifts. During interview on 5/18/23, at 1:38 p.m. the DON stated she had received a text message the evening of 5/9/23, that R1 had fallen out of the lift. The DON said staff removed the lift from the floor right away and confirmed the lift was lift number six. The DON stated maintenance took the lift and inspected it and determined the mechanism that secured the legs was not working and if something bumped the leg during a transfer the leg could close. The DON stated the lift was repaired and tested and put back into use however, the DON indicated the lift had not been tested to ensure worked correctly. The DON said on 5/17/23, staff said the lift was "loud" when using it so she and maintenance again removed it from the floor. On 5/18/23, at 1:49 p.m. the maintenance worker (MW) stated all the mechanical lifts received routine inspections each month to include checking bolts, breaks, controls, pivots, etc. The MW said after R1 fell, he identified the lift used during the transfer had a manual bar that opened and closed the legs and the "notches" were worn. The MW said the parts were ordered and replaced. The MW said the whole machine had been checked out and was put back on the floor. MW said he became aware on 5/18/23, there was a problem with the lifting part and said the lift was an older lift. During interview on 5/18/23, at 2:31 p.m. RN-A stated after the fall on 5/9/23, she contacted both of the NAs involved to ask what happened. RN-A said the NAs said R1 was hooked up, they started lifting him up and when bringing him over	2 830		

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2 830	Continued From page 9 to the next surface the lift tipped over. RN-A stated NA-B told her she did not know what had happened so the lift was sent to maintenance to inspect it and see if something needed to be fixed. RN-A said maintenance looked at the lift and said the only way it could have tipped over was if the legs closed so he replaced the parts. RN-A stated she had not been aware there was a second incident with lift number six until this morning, so the lift was again put out of service this morning (5/18/23). RN-A stated an LPN reported to her that staff were transferring R1 and the lift was making some noise so they lowered him back down, unhooked him and used a different lift. RN-A stated she had not spoken to the staff involved. The DON was present and stated staff told her the lift had been making a weird noise during the incident on 5/17/23, but did not remember who had told her. The DON stated she had not asked R1 about the incident. When asked about staff education following the two incidents, the DON said for a couple of shifts the nurses had watched transfers but said there was no documentation. The DON said she was planning to do staff education at the next staff meeting in June. The DON further stated there was no evidence NA-As concern about R1's safety when using lift number six had been addressed. RN-A and the DON stated they felt the issue had been addressed when maintenance replaced the part on the lift. Despite facility's documented interviews with staff involved in the lift incidents detailing the incorrect use of the lift (transporting resident in lift), the facility failed to identify concern, interview resident for more details and contact Hoyer Lift manufacturer following lift failures. On 5/19/23, at 10:24 a.m. the facility's customer	2 830		

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2 830	Continued From page 10 service representative (CSR) for the Volaro lifts used in the facility was interviewed. The CSR stated typically when they heard of a lift tipping, it was due to the legs being closed or if the lift was positioned too close to the bed and staff turned and pushed the resident, the weight would start to pull the lift over especially if the resident was too heavy. The CSR stated the lifts were not designed to transport any distance, only surface to surface and if staff transported a resident too far in the lift it could create a "situation." On 5/19/23, at 10:59 a.m. NA-F stated when transferring a resident in the mechanical lift she would bring the chair or commode to the resident. NA-F stated she would not transport a resident more than 5 feet in the lift. The Volaro 4 Series Operators Manual, safety notes indicated The Volaro lift is designed for patient lift only. Using the lift for transport can create an unsafe patient handling situation. Facility policy, Fall Standard Work, undated, indicated the following: Review Devices in use/involved in fall and determine if location of device played a factor, if device was used by resident/staff properly, ensure device is working properly and if any adjustments need to be made involve maintenance staff or therapy staff as appropriate. The immediate jeopardy that began on 5/9/23, was removed on 5/22/23, when the facility identified and assessed all residents who utilized a mechanical lift for safety, completed a thorough analysis of the incidents on 5/9/23 and 5/17/23, completed an inspection of all lifts in the facility and completed training with staff to include return demonstration of the correct use of mechanical lifts and implemented a plan to educate all staff	2 830		

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2 830	Continued From page 11 prior to working with the lifts. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to safe patient handling with the use of mechanical lifts to assure proper procedures are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these procedures 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.	2 830		