Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 17, 2024

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

RE: CCN: 245512
Cycle Start Date: April 26, 2024

Dear Administrator:

On May 3, 2024, we notified you a remedy was imposed. On May 16, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 13, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 18, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 3, 2024, 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 April 26, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 17, 2024

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

Re: Reinspection Results
Event ID: 1LQH12

Dear Administrator:

On May 16, 2024 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 April 26, 2024. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
May 3, 2024

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

RE: CCN: 245512
Cycle Start Date: April 26, 2024

Dear Administrator:

On April 26, 2024, 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 April 26, 2024, 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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 18, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 18, 2024, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)).

They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 18, 2024, (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 April 26, 2024. 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.

If you have not achieved substantial compliance by May 18, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, First Care Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 18, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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 April 26, 2024. 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, Regional Operations Supervisor, 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 October 26, 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:

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
202-795-7490

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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
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 04/26/2024

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 4/24/24 through 4/26/24, 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: H55123255C (MN102594) with a deficiency cited at F689 with a scope and severity of Immediate Jeopardy. The immediate jeopardy (IJ) began on 4/17/24, when R1 fell while being transferred in a full body mechanical lift that tipped over during provision of care. The facility failed to identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred. Additional transfer observations identified manufacturer's guidelines were not followed for safe use. The IJ was identified on 4/25/24. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 5:05 p.m. on 4/25/24. The IJ was removed on 4/26/24 at 3:22 p.m., 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. The above findings constituted substandard quality of care, and an extended survey was conducted on 4/26/24. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/13/2024

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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FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

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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 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 ensure safe transfer while utilizing a mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1. The immediate jeopardy began on 4/17/24, when R1 fell while being transferred in a full body mechanical lift that tipped over during provision of care. The facility failed to identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred. Additional transfer observations identified manufacturer's guidelines were not followed for safe use. The IJ was identified on 4/25/24. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 5:05 p.m. on 4/25/24. The IJ was removed on 4/26/24 at 3:22	F 689	[Disclaimer: This Plan of Correction (POC) constitutes this facility□s written allegation of compliance for the deficiencies cited but does not constitute an admission of agreement by the facility that a deficiency existed or was cited correctly. This POC is submitted to meet federal and state legal requirements.] Corrective action completed for those residents found to have been affected by the deficient practice. All staff, who use mechanical lift, completed a return demonstration of proper lift use using the Volaro PC450/HD450 checklist to verify	5/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 Continued From page 2

p.m., 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 Resident Face Sheet identified diagnosis that included chronic pain, depression, obesity and long term use of anticoagulants (blood thinners). R1's annual Minimum Data Set dated 2/28/24, identified intact cognition and indicated he was dependent on staff for transfers.

R1's care plan dated 4/23/24, identified the use of a full body mechanical lift for transfers and lift sling size 2 extra large (XL), updated 4/19/24. The care plan identified a fall on 4/17/24, while in the mechanical lift involving two nursing assistants (NA)'s performing the transfer resulting in bruising and scrapes to the right side of R1's body. The care plan indicated staff were provided education on use of the full body lift and indicated a nurse was to be present in the room during transfers with two NA's performing the transfer to observe for safety and correct use of the lift. The care plan further indicated R1 had trauma induced signs and symptoms of nervousness and anxiety due to a previous fall from the lift.

R1's Resident Progress Note dated 4/17/24, indicated two NA's were assisting R1 with transfer from bed to wheelchair using a full body mechanical lift. One NA was moving R1 from the bed to the chair and attempted to open the legs of the lift and the lift started to tip while R1 was in it. R1 fell with the lift and hit his head on the floor. 4/18/24, Resident Progress Note indicated the interdisciplinary team reviewed the fall and

F 689

competency of use. General Procedure Guide for Training found in the user's manual. During the return demonstration, reinforced with all staff, the importance of placement for lift device, starting and ending destination placement, to minimize movement of lift machine to maintain resident and staff safety during transfer, techniques to maintain optimal function of battery and lift.

Licensed staff will be present to observe all transfers of R1 with mechanical lift and redirect staff if needed. Observations will be reviewed by QAPI and adjusted as needed.

Reinforced with all staff, who use mechanical lift, to lock the brakes of wheelchair and lift, and expansion of legs on lift to maintain balance at correct times during transfer process (when applicable, in accordance with manufacturer guidelines for use).¿Enhanced focus, and specific/specialized plan, for expansion of legs for R1 when using PC450/HD450, given that weight is upper threshold of manufacturer stated capacity.

All staff, who use mechanical lift, completed competency testing with return demonstration utilizing manufacturer□s checklist prior to transferring residents with mechanical lift. All staff who perform transfers with R1 completed a return demonstration for transfer of R1 with license staff supervising to verify knowledge and ability to transfer R1 safely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 3 identified the contributing cause of the fall as; equipment tipped, staff reported R1 adjusted himself while in the lift when the lift was being moved out from under the bed to extend the legs. R1 reported the legs of the split leg sling were not crossed as recommended by the manufacturer because it caused him discomfort. Further root cause analysis indicated staff had used an XL sling and based on R1's current measurements the sling size should have been changed to a 2XL. Interventions to prevent recurrence included removing the lift from service. Facility document titled Mechanical Lift 4/17/24, Incident and OHFC (office of health facility complaints) Report indicated R1 fell while in full body mechanical lift sling during transfer from bed to his wheelchair. Lift tipped and R1 landed on the floor. Verified R1's weight was within range of the lift, R1's weight increased from 395 pounds to 413 pounds between January 2024, and 4/16/24, and sling size was updated to 2XL based on the weight gain. A nurse must be in the room for all transfers of R1 until further notice. Staff involved were interviewed. All transfers with the lift must be observed by a nurse to verify competency prior to using a lift without supervision. Lift involved was immediately removed from service and brought to maintenance, not to be used until cleared by maintenance. The incident occurred while staff were transferring R1. Staff were unable to extend the legs of the lift under R1's bed and as staff moved the lift clear of the bed to allow base to be extended, R1 adjusted himself in the lift causing the lift to tip over. R1 landed on his butt on the floor and hit his head on the floor. Staff reported R1 would not allow the straps on the sling to be criss crossed as recommended by the	F 689	All licensed staff completed competency testing, with return demonstration of proper lift use, reviewed mechanical lift standard work, and fall standard work to ensure knowledge and understanding of process.¿¿ The facility identified other residents having the potential to be affected by the same deficient practice. Reinforce: Nursing will check resident room for correct sling type and size weekly on bath day and sign off in EMAR.¿The annual skills fair will include competency training on use of lift, equipment concerns, sling fitment, and post fall process.¿¿ For any falls which occur during a transfer, licensed staff will be present for any transfers occurring during the 24 hours immediately after the fall to validate the correct process and appropriate type of transfer is being used. The IDT team will review and discuss fall documentation, investigate root cause, make recommendations to reduce the risk of future falls and inventions to help prevent injuries. The following measures were put in place, or systemic changes made, to ensure that the deficient practice will not recur.	

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F 689	Continued From page 4 manufacturer. R1 also had an 18 pound weight gain over the past few months and XL sling was no longer appropriate. Reported indicated facility took the following action: Sling size was updated to 2XL based on the weight gain, staff were competency tested on full body mechanical lift and educated prior to working their next shift. Care plan was updated to include three staff present during R1's transfers to include a licensed staff member. Maintenance inspected the lift used during the transfer that resulted in the fall and removed some hair that had been hindering movement in the wheels. During interview on 4/24/24 at 1:36 p.m., R1 asked, "Are you here about the ride I took? I hit my tailbone, it hurt so bad, but they did an X-ray and nothing was broken." R1 stated the staff had lifted him up off the bed and were going to swing the lift over and must have swung it a little too fast because it went over." R1 indicated the wheelchair was between the bed and the closet and said, "I was in it [the lift] and when they started turning to put me in the chair, that's when it hit [tipped over]." R1 stated he was scared the last time the lift had tipped during a transfer but said, "I'm getting used to it now." R1 stated he was scared it was going to happen again, and it did, indicated he was afraid and said, "It will probably be more serious next time." During interview on 4/24/24 at 1:58 p.m., NA-A stated on 4/17/24, when the lift had tipped over during R1's transfer, she had been behind the wheelchair while NA-B was running the lift. NA-A said the legs on the lift were closed until it cleared the bed and when NA-B opened the legs the lift started tipping. NA-A stated she had not assisted with the transfer, only stood behind the chair.	F 689	Battery monitoring system now allows for logged last in/last out rotation of all 12 batteries. ¿ Residents using full body lifts for transfers will be reassessed to verify the correct size sling is used for transfers when completing quarterly MDS, with significant changes, and as needed. All residents care planned to use full body lift for transfers will have proper sling in their room with tag identifying as their sling. The tag will include their name and size. The tag and sling will be inspected on bath day and as needed. Facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: 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, weekly and as needed to verify staff competency and understanding of safety with equipment use until 4 weeks of 100% compliance then monthly until QAPI approves discontinuing monthly audits. Staff will complete a return demonstration at the time of hiring and at least once in a calendar year.¿¿	

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	245512	A. BUILDING ______ B. WING ______	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 5 NA-A further stated the straps of the sling that go between R1's legs had not been crossed as recommended by the manufacturer and said staff had not been doing it for a long time because R1 did not like it that way. NA-A stated since the fall staff now crossed the sling between R1's legs and kept the legs of the lift open during the entire transfer. During interview on 4/24/24 at 2:06 p.m., registered nurse (RN)-A stated on 4/17/24, she had been called to R1's room and found him on the ground next to his wheelchair. RN-A said she was told staff had been transferring R1 from his bed to the wheelchair and the lift had tipped. RN-A said staff reported they could not open the legs of the lift while it was under the bed and when they pulled out the lift and tried to open the legs, the lift tipped over. RN-A stated one staff should have been operating the lift and the second staff should have been holding onto the handles of the sling to assist with guiding during the transfer. RN-A stated R1 had a trapeze to assist with movement in bed and the legs were under the bed and interfered with opening the legs of the lift. RN-A said since the incident occurred, staff had received more training and said everyone had been educated and said a nurse was observing transfers in R1's room. RN-A further stated R1 should have been assessed for a new sling during his assessment period in February 2024, and said at that time he may have needed a new sling size. During interview on 4/24/24 at 2:49 p.m., the lift company's representative stated other than a mechanical issue, the only way a lift could tip over was if the resident's weight was centered on the outside of one of the legs which would cause the	F 689	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, including effectiveness of interventions. IDT will continue to review until an effective intervention has been identified. Falls will be reviewed with quarterly MDS and significant changes. ¿¿¿¿¿ DON, or designee, will complete audits on use of proper size slings quarterly, and as needed. Maintenance staff will continue to check lifts monthly and as needed to ensure they are in working order, utilizing the manufacturer□s recommendations, guide/s and log templates. 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 and Compliance: 5/13/24	

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F 689	Continued From page 6	F 689		

lift to become unbalanced. The representative stated debris in the wheels may make the lift harder to push but would not cause it to tip over. The representative indicated using the incorrect sling would only affect comfort but would not affect the balance of the lift and said if the resident was attempting to re-adjust in the sling there was no way they could get enough leverage to get themselves outside the area where the legs are balanced. He added, they trained staff to make turns with the legs open but they should be able to safely turn the lift with the legs closed. The lift representative stated unless something on the lift failed, user error was usually the cause of a lift tipping over and if the lift tipped over it would have been during the maneuvering and a leg getting hung up on something.

During interview on 4/24/24 at 3:37 p.m., NA-B stated she had been assisting with the transfer when the lift tipped over with R1 in it. NA-B stated she had been operating the lift and said as she pulled the lift back it tipped over. NA-B stated she could not fully extend the legs under the bed and when she tried to extend them they got stuck and the lift tipped.

During interview on 4/24/24 at 3:50 p.m., the lift used during the transfer that resulted in R1's fall was observed with maintenance worker (MW)-A. The lift was a Volaro PC 450 Series. MW-A indicated there had been some hair stuck in the wheels and said he had removed some small strands. MW-A stated it had not been a significant amount of hair and said everything else had been in good working condition with no other mechanical concerns identified.

During observation and interview on 4/25/24 at

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F 689	Continued From page 7	F 689		

11:25 a.m., NA-C and NA-D prepared to transfer R1 from his bed to wheelchair using the full body mechanical lift. NA-C moved the bed away from the wall so the legs of the trapeze would not interfere and they hooked the straps of the sling to the mechanical lift. When the lift was raised the battery was observed to be low powered and a sling strap came unhooked from the machine. NA-C stated he visualized the straps after hooking them up but did not pull on the straps to ensure they were secure. NA-C and NA-D secured the strap and completed the transfer. RN-B was present in the room to observe the transfer and did not intervene or question the low power warning or when the strap came undone from the lift.

During interview on 4/25/24 at 12:39 p.m., R1 stated each fall he had from the lift occurred when staff were turning him so he told the staff to eliminate turning the lift when he was in it to avoid more falls. R1 said during the transfer at 11:25 a.m. staff had the sling hooked up right but when it got weight on it, the strap came unhooked and out of his hand as he had been holding onto the straps. R1 stated it was okay this time because he was over the bed, but said it was "nerve wracking" because the strap could have come off when he was not over the bed and he could have fallen again.

During observation on 4/25/24 at 12:49 p.m., NA-E and NA-B prepared to transfer R1 in the mechanical lift while RN-A observed. R1 verbalized he did not want staff to have to turn the lift "whatsoever." The staff placed R1 in his wheelchair with his back to the bed and lifted him straight up and pulled him backward approximately 6-8 feet, removed the chair and

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F 689	Continued From page 8	F 689		

pushed him the same distance back to the bed. During the transfer the lift was moving very slowly and NA-E acknowledged the battery light was red indicating it was not fully charged. RN-A did not intervene during the transfer even though NA-D and NA-B did not follow manufacturers recommendations to move the resident in the lift the shortest possible distance nor did RN-A suggest the battery be replaced when staff identified it was low. During the transfer R1 stated, "I don't want to fall on my head again."

During interview on 4/25/24 at 12:58 p.m., RN-A stated the competency checklist indicated if the lift battery was low staff were supposed to stop and change it before transferring the resident. RN-A said she had not intervened because she did not want to "step on their toes."

During interview on 4/25/24 at 1:02 p.m., NA-E stated she had received competency testing after R1's last fall on 4/17/24. NA-E said she was aware the checklist said to change the battery if it was reading low but she did not want to stop the transfer to change it. NA-E said if the battery would have died she would have called for help.

During interview on 4/25/24 at 3:11 p.m., the director of nursing (DON) stated the reason they had implemented having a third person in the room during R1's transfers was to ensure his safety by adding another set of eyes. The DON stated if the third person identified something staff were not doing correctly she would have expected them to intervene. The DON indicated if the battery was low, staff should have lowered R1 back down and got a new battery.

Volaro Series 4 Lift Operator's Manual dated

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F 689	Continued From page 9	F 689		

3/2019 included the following Safety Notes:
- the Volaro lift is designed for patient transfer only. Using the lift for transport can create an unsafe patient handling situation.
- legs must be fully extended in the wide position when lifting a patient or resident.
- Make sure all four loops from the sling are properly "nested" in the bottom of the hooks before lifting or transferring the resident. Also make sure all four retainer springs are functioning correctly.

Volaro PC450 General Procedure Guide for Training indicated:
- Have assistant stand on opposite side of bed to assist with transfer.
- Position wheelchair at foot of bed.
- Make sure power pac indicator does not indicate a low power pac. (if so, replace)
- Make sure the correct sized sling is to be applied.
- Check that the legs are in the widest position, where applicable. If base position must remain in narrow position, make sure the lift area between the bed and chair are clear of any obstacles. Widen once clear from bed.
- Attach straps on the sling with strap "nesting" in the bottom of the hook. Remember with a divided leg sling, the straps at the thigh area must be criss crossed before lifting.
- As you begin to left the resident from the bed, once there is tension on the straps check to make sure all four loops are still nested in the bottom of the hooks before lifting.

The immediate jeopardy that began on 4/17/24, was removed on 4/26/24, when the facility implemented the following actions which were verified through interview and observation.

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F 689	Continued From page 10 - R1's bed will be moved away from trapeze for transfers with mechanical lift. - The wheelchair will be placed at the end of the bed to allow minimal movement of the lift. - Straps will be checked to make sure all four strap loops are nested in hooks. - Therapy evaluation for safe and appropriate transfer process. - Retrain all staff who use Full Body Mechanical Lift to ensure proper use of Lift for R1 along with return demonstration for all staff working and for oncoming staff prior to their next scheduled shift. - Observe a minimum of one transfer for each resident using a full body lift. If concerns/issues are identified observation will be repeated. - Any resident with significant change in weight, physical ability, cognitive ability will have therapy evaluate for safe and appropriate transfer process. - Maintenance inspection of the hooks on all mechanical lifts. - Mechanical lift competency will include section of "if no" for staff observing to enter actions to correct staff with just in time education. - DON, or designee, will utilize all steps of the competency steps in checklist for competency testing, per manufacturers recommendations, using return demonstration of all staff using mechanical lift in both the operator and assist position prior to their next shift. - DON, or designee, will competency test with return demonstration, per manufacturers recommendations, all licensed staff for supervision of staff using a mechanical lift. - All staff will have education and knowledge verification on troubleshooting items. - Review and revise Mechanical Lift Standard Work as needed per policy.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 1LQH11

Dear Administrator:

The above facility was surveyed on April 24, 2024 through April 26, 2024 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, Regional Operations Supervisor, 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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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 04/26/2024

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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 4/24/24 through 4/26/24, 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 have reviewed these orders and

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H55123255C (MN102594) 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.	2 000		

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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 observation, interview and document review the facility failed to ensure safe transfer while utilizing a mechanical lift for 1 of 3 residents (R1) reviewed for accidents. Findings Include: R1's Resident Face Sheet identified diagnosis that included chronic pain, depression, obesity and long term use of anticoagulants (blood thinners). R1's annual Minimum Data Set dated 2/28/24, identified intact cognition and indicated	2 830	Corrected	5/13/24

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2 830	Continued From page 3 he was dependent on staff for transfers. R1's care plan dated 4/23/24, identified the use of a full body mechanical lift for transfers and lift sling size 2 extra large (XL), updated 4/19/24. The care plan identified a fall on 4/17/24, while in the mechanical lift involving two nursing assistants (NA)'s performing the transfer resulting in bruising and scrapes to the right side of R1's body. The care plan indicated staff were provided education on use of the full body lift and indicated a nurse was to be present in the room during transfers with two NA's performing the transfer to observe for safety and correct use of the lift. The care plan further indicated R1 had trauma induced signs and symptoms of nervousness and anxiety due to a previous fall from the lift. R1's Resident Progress Note dated 4/17/24, indicated two NA's were assisting R1 with transfer from bed to wheelchair using a full body mechanical lift. One NA was moving R1 from the bed to the chair and attempted to open the legs of the lift and the lift started to tip while R1 was in it. R1 fell with the lift and hit his head on the floor. 4/18/24, Resident Progress Note indicated the interdisciplinary team reviewed the fall and identified the contributing cause of the fall as; equipment tipped, staff reported R1 adjusted himself while in the lift when the lift was being moved out from under the bed to extend the legs. R1 reported the legs of the split leg sling were not crossed as recommended by the manufacturer because it caused him discomfort. Further root cause analysis indicated staff had used an XL sling and based on R1's current measurements the sling size should have been changed to a 2XL. Interventions to prevent recurrence included removing the lift from service.	2 830		

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	00461	A. BUILDING: ______ B. WING ______	C 04/26/2024

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2 830	Continued From page 4 Facility document titled Mechanical Lift 4/17/24, Incident and OHFC (office of health facility complaints) Report indicated R1 fell while in full body mechanical lift sling during transfer from bed to his wheelchair. Lift tipped and R1 landed on the floor. Verified R1's weight was within range of the lift, R1's weight increased from 395 pounds to 413 pounds between January 2024, and 4/16/24, and sling size was updated to 2XL based on the weight gain. A nurse must be in the room for all transfers of R1 until further notice. Staff involved were interviewed. All transfers with the lift must be observed by a nurse to verify competency prior to using a lift without supervision. Lift involved was immediately removed from service and brought to maintenance, not to be used until cleared by maintenance. The incident occurred while staff were transferring R1. Staff were unable to extend the legs of the lift under R1's bed and as staff moved the lift clear of the bed to allow base to be extended, R1 adjusted himself in the lift causing the lift to tip over. R1 landed on his butt on the floor and hit his head on the floor. Staff reported R1 would not allow the straps on the sling to be criss crossed as recommended by the manufacturer. R1 also had an 18 pound weight gain over the past few months and XL sling was no longer appropriate. Reported indicated facility took the following action: Sling size was updated to 2XL based on the weight gain, staff were competency tested on full body mechanical lift and educated prior to working their next shift. Care plan was updated to include three staff present during R1's transfers to include a licensed staff member. Maintenance inspected the lift used during the transfer that resulted in the fall and removed some hair that had been hindering movement in the wheels.	2 830		

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During interview on 4/24/24 at 1:36 p.m., R1 asked, "Are you here about the ride I took? I hit my tailbone, it hurt so bad, but they did an X-ray and nothing was broken." R1 stated the staff had lifted him up off the bed and were going to swing the lift over and must have swung it a little too fast because it went over." R1 indicated the wheelchair was between the bed and the closet and said, "I was in it [the lift] and when they started turning to put me in the chair, that's when it hit [tipped over]." R1 stated he was scared the last time the lift had tipped during a transfer but said, "I'm getting used to it now." R1 stated he was scared it was going to happen again, and it did, indicated he was afraid and said, "It will probably be more serious next time."

During interview on 4/24/24 at 1:58 p.m., NA-A stated on 4/17/24, when the lift had tipped over during R1's transfer, she had been behind the wheelchair while NA-B was running the lift. NA-A said the legs on the lift were closed until it cleared the bed and when NA-B opened the legs the lift started tipping. NA-A stated she had not assisted with the transfer, only stood behind the chair. NA-A further stated the straps of the sling that go between R1's legs had not been crossed as recommended by the manufacturer and said staff had not been doing it for a long time because R1 did not like it that way. NA-A stated since the fall staff now crossed the sling between R1's legs and kept the legs of the lift open during the entire transfer.

During interview on 4/24/24 at 2:06 p.m., registered nurse (RN)-A stated on 4/17/24, she had been called to R1's room and found him on the ground next to his wheelchair. RN-A said she was told staff had been transferring R1 from his bed to the wheelchair and the lift had tipped.

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RN-A said staff reported they could not open the legs of the lift while it was under the bed and when they pulled out the lift and tried to open the legs, the lift tipped over. RN-A stated one staff should have been operating the lift and the second staff should have been holding onto the handles of the sling to assist with guiding during the transfer. RN-A stated R1 had a trapeze to assist with movement in bed and the legs were under the bed and interfered with opening the legs of the lift. RN-A said since the incident occurred, staff had received more training and said everyone had been educated and said a nurse was observing transfers in R1's room. RN-A further stated R1 should have been assessed for a new sling during his assessment period in February 2024, and said at that time he may have needed a new sling size.

During interview on 4/24/24 at 2:49 p.m., the lift company's representative stated other than a mechanical issue, the only way a lift could tip over was if the resident's weight was centered on the outside of one of the legs which would cause the lift to become unbalanced. The representative stated debris in the wheels may make the lift harder to push but would not cause it to tip over. The representative indicated using the incorrect sling would only affect comfort but would not affect the balance of the lift and said if the resident was attempting to re-adjust in the sling there was no way they could get enough leverage to get themselves outside the area where the legs are balanced. He added, they trained staff to make turns with the legs open but they should be able to safely turn the lift with the legs closed. The lift representative stated unless something on the lift failed, user error was usually the cause of a lift tipping over and if the lift tipped over it would have been during the maneuvering and a

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leg getting hung up on something.

During interview on 4/24/24 at 3:37 p.m., NA-B stated she had been assisting with the transfer when the lift tipped over with R1 in it. NA-B stated she had been operating the lift and said as she pulled the lift back it tipped over. NA-B stated she could not fully extend the legs under the bed and when she tried to extend them they got stuck and the lift tipped.

During interview on 4/24/24 at 3:50 p.m., the lift used during the transfer that resulted in R1's fall was observed with maintenance worker (MW)-A. The lift was a Volaro PC 450 Series. MW-A indicated there had been some hair stuck in the wheels and said he had removed some small strands. MW-A stated it had not been a significant amount of hair and said everything else had been in good working condition with no other mechanical concerns identified.

During observation and interview on 4/25/24 at 11:25 a.m., NA-C and NA-D prepared to transfer R1 from his bed to wheelchair using the full body mechanical lift. NA-C moved the bed away from the wall so the legs of the trapeze would not interfere and they hooked the straps of the sling to the mechanical lift. When the lift was raised the battery was observed to be low powered and a sling strap came unhooked from the machine. NA-C stated he visualized the straps after hooking them up but did not pull on the straps to ensure they were secure. NA-C and NA-D secured the strap and completed the transfer. RN-B was present in the room to observe the transfer and did not intervene or question the low power warning or when the strap came undone from the lift.

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During interview on 4/25/24 at 12:39 p.m., R1 stated each fall he had from the lift occurred when staff were turning him so he told the staff to eliminate turning the lift when he was in it to avoid more falls. R1 said during the transfer at 11:25 a.m. staff had the sling hooked up right but when it got weight on it, the strap came unhooked and out of his hand as he had been holding onto the straps. R1 stated it was okay this time because he was over the bed, but said it was "nerve wracking" because the strap could have come off when he was not over the bed and he could have fallen again.

During observation on 4/25/24 at 12:49 p.m., NA-E and NA-B prepared to transfer R1 in the mechanical lift while RN-A observed. R1 verbalized he did not want staff to have to turn the lift "whatsoever." The staff placed R1 in his wheelchair with his back to the bed and lifted him straight up and pulled him backward approximately 6-8 feet, removed the chair and pushed him the same distance back to the bed. During the transfer the lift was moving very slowly and NA-E acknowledged the battery light was red indicating it was not fully charged. RN-A did not intervene during the transfer even though NA-D and NA-B did not follow manufacturers recommendations to move the resident in the lift the shortest possible distance nor did RN-A suggest the battery be replaced when staff identified it was low. During the transfer R1 stated, "I don't want to fall on my head again."

During interview on 4/25/24 at 12:58 p.m., RN-A stated the competency checklist indicated if the lift battery was low staff were supposed to stop and change it before transferring the resident. RN-A said she had not intervened because she did not want to "step on their toes."

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During interview on 4/25/24 at 1:02 p.m., NA-E stated she had received competency testing after R1's last fall on 4/17/24. NA-E said she was aware the checklist said to change the battery if it was reading low but she did not want to stop the transfer to change it. NA-E said if the battery would have died she would have called for help.

During interview on 4/25/24 at 3:11 p.m., the director of nursing (DON) stated the reason they had implemented having a third person in the room during R1's transfers was to ensure his safety by adding another set of eyes. The DON stated if the third person identified something staff were not doing correctly she would have expected them to intervene. The DON indicated if the battery was low, staff should have lowered R1 back down and got a new battery.

Volaro Series 4 Lift Operator's Manual dated 3/2019 included the following Safety Notes:
- the Volaro lift is designed for patient transfer only. Using the lift for transport can create an unsafe patient handling situation.
- legs must be fully extended in the wide position when lifting a patient or resident.
- Make sure all four loops from the sling are properly "nested" in the bottom of the hooks before lifting or transferring the resident. Also make sure all four retainer springs are functioning correctly.

Volaro PC450 General Procedure Guide for Training indicated:
- Have assistant stand on opposite side of bed to assist with transfer.
- Position wheelchair at foot of bed.
- Make sure power pac indicator does not indicate a low power pac. (if so, replace)

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2 830	Continued From page 10 - Make sure the correct sized sling is to be applied. - Check that the legs are in the widest position, where applicable. If base position must remain in narrow position, make sure the lift area between the bed and chair are clear of any obstacles. Widen once clear from bed. - Attach straps on the sling with strap "nesting" in the bottom of the hook. Remember with a divided leg sling, the straps at the thigh area must be criss crossed before lifting. - As you begin to left the resident from the bed, once there is tension on the straps check to make sure all four loops are still nested in the bottom of the hooks before lifting. 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		