Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2023

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: CCN: 245604
Cycle Start Date: March 14, 2023

Dear Administrator:

On April 19, 2023, we notified you a remedy was imposed. On June 23, 2023 the Minnesota Departments of Health and Public Safety 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 8, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 8, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 3, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 8, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 8, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2023

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

Re: Reinspection Results
Event ID: 3U7F12, T6KQ12, HIVC12

Dear Administrator:

On May 12, 2023, May 24, 2023, and June 13, 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 surveys completed on March 14, 2023, March 30, 2023, and May 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
May 24, 2023

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: CCN: 245604
Cycle Start Date: March 14, 2023

Dear Administrator:

On April 19, 2023, we informed you of imposed enforcement remedies.

On May 17, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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 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 8, 2023.

This Department continues to recommend 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 8, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 8, 2023.

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.

As we notified you in our letter of April 19, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 8, 2023.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 an"E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division 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 September 14, 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

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.

INFORMAL DISPUTE RESOLUTION/ 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 24, 2023

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

Re: State Nursing Home Licensing Orders
Event ID: HIVC11

Dear Administrator:

The above facility was surveyed on May 17, 2023 through May 17, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	C 05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

(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 5/17/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H56042240C (MN93541) with no deficiencies. The following complaint was reviewed. H56042235C (MN93521) with a deficiency issued at F689. 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.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		6/3/23

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

Electronically Signed | 05/31/2023

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 689	Continued From page 1 by: Based on observation, interview, and record review the facility failed to assess interventions to provide safe mechanical lift transfers resulting in fracture of distal radius and failed to follow the revised care plan to prevent impaired healing and further injury for 1 of 4 residents (R1) reviewed for accidents. Findings include: R1's care plan dated 1/26/23 indicated R1 required the assistance of one staff member with transfers, gait belt and railings. Mechanical standing lift with assistance of one staff member as needed (PRN). The care plan did not indicate any interventions for staff to monitor R1's left arm, R1's week side following CVA), with the use of the EZ-stand R1's significant change Minimum Data Set (MDS) dated 2/26/23 indicated R1 had moderate cognitive impairment. R1's diagnoses included congestive heart failure, cerebral vascular accident (stroke) anxiety, depression, and chronic kidney disease. R1 required one staff member for physical assistance with transfers, and extensive assistance of one for activities of daily living. R1's progress note dated 5/9/23 at 1:11 p.m. indicated R1 and staff reported that R1's left elbow was bumped on the doorframe when R1 was being pushed out of her room by staff to the bathroom on the EZ-stand (mechanical standing lift). R1 complained of significant pain to her left elbow with slight swelling, no bruising or skin tears noted. The area was extremely tender to touch.	F 689	It is the policy, and intention, of Auburn Manor to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicaid and Medicare programs and, as required, are submitted as the facility's credible allegations of compliance. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should remedies be imposed. 1. A new template has been created for therapy and nursing staff (RN Care Coordinators and nurses) to use when determining the level of assistance needed for a resident's transfers. This template not only includes the different transfer type and the number of people the transfer requires for safety, it also includes if there are any specific individualizations needed for the resident to ensure safe transfers (example □ specific staff placement due to resident weakness, etc.). Information on this template will be transferred and included in the NAR plan of care for staff to follow. 2. Nursing staff (RN Care Coordinators and nurses) and therapy staff will be trained on the use of this template. RN Care Coordinators will be trained on how to document on the NAR plan of care. 3. NAR plan of care for all residents	

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F 689	Continued From page 2 R1's progress note dated 5/9/23 at 10:22 p.m. indicated R1 reported pain to her left elbow, but stated her elbow was not as painful as her left wrist was with movement.There was bruising to her left wrist, but no excessive swelling. A Minnesota Adult Abuse Report Center report dated 5/10/23 at 2:20 p.m. indicated a nursing assistant (NA) was transferring R1 with an EZ stand machine (standing mechanical lift). R1's left elbow always is positioned further out than the right arm and NA steered the machine into R1's bathroom and inadvertently made contact with the doorway frame. R1's X-ray report dated 5/10/23 indicated R1's left forearm demonstrated a cortical offset at the very distal radius which might represent a fracture. R1's progress note dated 5/10/23 at 1:59 p.m. indicated R1's x-ray results returned with very subtle distal fracture. The Nurse Practitioner (NP) was updated, and ace bandage applied pending further orders. R1's progress note dated 5/10/23 at 3:43 p.m. indicated per physician, R1 was to wear a left wrist splint with a 2-3-inch ACE wrap over it up to mid forearm, keep in place at all times. Non-weight bearing to left arm for 4-6 weeks. PT to evaluate to assess for transfers. R1's progress note dated 5/11/23 at 10:44 a.m. indicated Physical Therapy (PT) evaluation was completed following the injury to the left wrist and orders for non-weight bearing of the left wrist. R1 needed moderate assistance with bed mobility and maximum assistance with pivot transfer from	F 689	have been updated to include information on whether transfer is standard or has individualization for the resident. If there is individualization, that information has been added to the NAR plan of care. 4. The procedures for standing lift use and mechanical lift use has been updated to specify that staff need to follow the resident's plan of care which includes any individualization to the transfer necessary for the safety of the resident. All Nursing staff (nurses, TMAs, NARs) will be trained on the updated procedures. 5. Ongoing compliance will be monitored by the DON via audits of resident transfers. The DON will complete 3 transfer audits per month for 3 months, then will complete 1 transfer audit per quarter for 2 quarters.	

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F 689	Continued From page 3	F 689		

her bed to her wheelchair. PT recommended mobility bars on bed to allow her to assist more with transfers and bed mobility. Resident transfers from wheelchair to toilet with grabbers with minimum assistance of one staff member. Staff to use assistance of two staff for in her room from wheelchair to and from bed or recliner. Ambulation program on hold at this time.

R1's care plan dated 5/15/23 indicated R1 required assistance of one staff member with a gait belt and grab bars in the bathroom for toileting. R1's wheelchair was to be at a 90-degree angle (face the wall) and ask R1 to count to 30 when she stands up, so staff can remove pants before pivoting. R1 required the assistance of two staff members when transferring from wheelchair to bed or recliner in her room.

R1's nurse aide daily sheet dated 5/17/23 under the column titled Special Instructions R1 was non-weight bearing with her left hand and had "changes in transfers."

During an interview on 5/17/23 at 9:20 a.m. R1 stated she was being transferred in the lift to the bathroom and her elbow hit the doorway. R1 stated "My arm just hung out too far." She stated the staff were still using that lift and her arm hurts as she must hold on to the bars on the lift during the transfer.

During an interview on 5/17/23 at 11:42 a.m. NA-C (a student in training), stated she assisted NA-B with transferring R1 earlier in the day from her bed to the bathroom with the EZ-Stand. NA-C could not recall how R1's left arm was placed during the transfers. NA-C stated there

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F 689	Continued From page 4 was no discussion about R1's arm during the cares. During an interview on 5/17/23 at 11:53 a.m. NA-D stated the staff have been using the EZ-Stand. NA-D stated R1 held onto the grab bars of the EZ-Stand with both hands, but was tolerating well. During an observation on 5/17/23 at 12:02 p.m. R1 put on her call light to use the bathroom. R1 needed to be transferred out of her recliner. NA-B told R1 she was going to get the EZ-Stand. 1. NA-B used the remote to get R1's recliner in the most upright position. 2. NA-B placed the harness around R1's back and secured R1's feet on the platform with the leg straps. 3. R1 had her right arm on the EZ-Stand grab bar. 4. NA-B used the lift and lifted R1 about 2 inches. 5. NA-B noticed R1 was not hanging onto the lift grab bar with her left hand and told R1 to hold on with her left arm. R1 attempted, but winced in pain. 6. The surveyor stopped the transfer. 7. R1 was seated back into the recliner. The social worker (SW)-A witnessed the transfer. During an interview on 5/17/23 at 12:08 p.m. NA-B stated it was "o.k." to use the lift with R1 stating "Nursing assistants can always go up on transfer at their digression, but never down." She stated using a lift had always been the practice at the facility if the NA's feel it was appropriate and R1 was weak or did not feel well. NA-B stated she was aware R1 was currently an assistance of two members and denied seeing on the care plan that it was o.k. to use an EZ-Stand following R1's fracture her wrist. During an interview on 5/17/23 at 2:30 p.m.	F 689		

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F 689	Continued From page 5 Physical Therapist (PT)-A stated she assessed R1 on 5/11/23 and the transfer orders were assistance of two staff members and a gait belt with standing and pivoting. PT-A stated R1 was not to use the EZ-stand because R1 was unable to stand still and would need to use both hands to provide stability during the transfer. Prior to the injury R1 was assist of one staff member and a gait belt with the use of the EZ-stand as needed for extreme weakness. PT-A stated she was not aware staff were not using the least restrictive technique for transfers. If staff were going to use the lift in an emergency then nursing should be notified as to why the resident needed the lift so a re-assessment could be done. PT-A stated the staff were trained and should always use caution with arms, legs, and cords. During an interview on 5/17/23 at 2:47 p.m. registered nurse (RN)-A stated prior to the wrist fracture R1 was assist of 1, but staff could use the EZ-Stand as needed depending on the condition of the resident. "As a general rule at the facility, staff can go up on transfers, but now down." RN-A stated if staff change a transfer they must report to nursing. RN-A stated following the wrist fracture R1 was supposed to pivot transfer with two staff. The EZ-Stand was not to be used. RN-A was not aware staff were using the stand. RN-A stated the reason R1's left arm stuck out more during the EZ-stand transfers was because R1 had left sided weakness from her previous stroke. RN-A indicated an assessment had not been completed or care plan interventions to reduce the risk of injury to R1's left arm while using the standing lift. During an interview on 5/17/23 at 3:00 p.m. NA-E stated prior to the fractured wrist she would	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	C 05/17/2023

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F 689	Continued From page 6 transfer R1 by herself with a gait belt. NA-E stated it would depend on how she thought R1's condition was at the time of the transfers if she used the EZ-stand. NA-E was aware that R1's transfer had changed and was now assist of two and no EZ-stand. During an interview on 5/17/23 at 3:18 p.m. the director of nursing (DON) stated she was unaware that R1's left arm stuck out of the EZ-stand further than the other, until she was interviewing staff as part of the investigation following the broken wrist. The DON indicated there were no interventions to prevent injury to R1's weak arm during lift transfers. The DON stated the staff were to follow the care plan and if they had questions they were to reach out to the nurse. During an interview on 5/18/23 at 3:24 p.m. NA-A stated when R1 moved to the unit in 1/2023 she was an assist of one pivot transfer, shortly thereafter R1 became difficult for one person, so the NA's changed her to a pivot transfer with two staff members. NA-A stated probably in 3/2023 the staff used the EZ-stand for all transfer because R1 was resistive with staff upon transfers. NA-A stated R1 had never been able to hold on firmly to the EZ-Stand as her elbow "pops out from the stroke and she is not able to fully straighten her left arm out and it sticks out more." NA-A stated there were not interventions for R1's left arm on the care plan, stating the staff were just aware of this with R1. NA-A stated she never reported any concerns with R1 to the nursing staff. NA-A stated the staff must always follow the care plan. A facility process titled, Nursing Services	F 689		

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F 689	Continued From page 7 Process: Mechanical Stand and Left Procedure undated indicated employees must follow the residents plan of care. The resident's hands are to be placed on the outside of the harness and ask residents to hold onto the handlebars. A facility training skills checklist dated 8/17 indicated for the mechanical stand the staff is to verify the care and obtain assistance from another team member if indicated. When using the stand, the staff is carefully guide the lift to chair/bed/wheelchair. Watch that all arms, legs, and tubing are safe. A facility policy titled Person-centered Care Planning, indicated the care will include services that are furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.	F 689		

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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 5/17/23, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with no deficiency issued H56042240C (MN93541). The following complaint was reviewed. H56042235C (MN93521) 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	2 000		

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2 000	Continued From page 2 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. 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 record review the facility failed to assess interventions to provide safe mechanical lift transfers resulting in fracture of distal radius and failed to follow the revised care plan to prevent impaired healing and further injury for 1 of 4 residents (R1) reviewed for accidents.	2 830	Corrected	6/3/23

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2 830	Continued From page 3 Findings include: R1's care plan dated 1/26/23 indicated R1 required the assistance of one staff member with transfers, gait belt and railings. Mechanical standing lift with assistance of one staff member as needed (PRN). The care plan did not indicate any interventions for staff to monitor R1's left arm, R1's week side following CVA), with the use of the EZ-stand R1's significant change Minimum Data Set (MDS) dated 2/26/23 indicated R1 had moderate cognitive impairment. R1's diagnoses included congestive heart failure, cerebral vascular accident (stroke) anxiety, depression, and chronic kidney disease. R1 required one staff member for physical assistance with transfers, and extensive assistance of one for activities of daily living. R1's progress note dated 5/9/23 at 1:11 p.m. indicated R1 and staff reported that R1's left elbow was bumped on the doorframe when R1 was being pushed out of her room by staff to the bathroom on the EZ-stand (mechanical standing lift). R1 complained of significant pain to her left elbow with slight swelling, no bruising or skin tears noted. The area was extremely tender to touch. R1's progress note dated 5/9/23 at 10:22 p.m. indicated R1 reported pain to her left elbow, but stated her elbow was not as painful as her left wrist was with movement.There was bruising to her left wrist, but no excessive swelling. A Minnesota Adult Abuse Report Center report dated 5/10/23 at 2:20 p.m. indicated a nursing assistant (NA) was transferring R1 with an EZ	2 830		

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2 830	Continued From page 4 stand machine (standing mechanical lift). R1's left elbow always is positioned further out than the right arm and NA steered the machine into R1's bathroom and inadvertently made contact with the doorway frame. R1's X-ray report dated 5/10/23 indicated R1's left forearm demonstrated a cortical offset at the very distal radius which might represent a fracture. R1's progress note dated 5/10/23 at 1:59 p.m. indicated R1's x-ray results returned with very subtle distal fracture. The Nurse Practitioner (NP) was updated, and ace bandage applied pending further orders. R1's progress note dated 5/10/23 at 3:43 p.m. indicated per physician, R1 was to wear a left wrist splint with a 2-3-inch ACE wrap over it up to mid forearm, keep in place at all times. Non-weight bearing to left arm for 4-6 weeks. PT to evaluate to assess for transfers. R1's progress note dated 5/11/23 at 10:44 a.m. indicated Physical Therapy (PT) evaluation was completed following the injury to the left wrist and orders for non-weight bearing of the left wrist. R1 needed moderate assistance with bed mobility and maximum assistance with pivot transfer from her bed to her wheelchair. PT recommended mobility bars on bed to allow her to assist more with transfers and bed mobility. Resident transfers from wheelchair to toilet with grabbers with minimum assistance of one staff member. Staff to use assistance of two staff for in her room from wheelchair to and from bed or recliner. Ambulation program on hold at this time. R1's care plan dated 5/15/23 indicated R1 required assistance of one staff member with a	2 830		

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2 830	Continued From page 5 gait belt and grab bars in the bathroom for toileting. R1's wheelchair was to be at a 90-degree angle (face the wall) and ask R1 to count to 30 when she stands up, so staff can remove pants before pivoting. R1 required the assistance of two staff members when transferring from wheelchair to bed or recliner in her room. R1's nurse aide daily sheet dated 5/17/23 under the column titled Special Instructions R1 was non-weight bearing with her left hand and had "changes in transfers." During an interview on 5/17/23 at 9:20 a.m. R1 stated she was being transferred in the lift to the bathroom and her elbow hit the doorway. R1 stated "My arm just hung out too far." She stated the staff were still using that lift and her arm hurts as she must hold on to the bars on the lift during the transfer. During an interview on 5/17/23 at 11:42 a.m. NA-C (a student in training), stated she assisted NA-B with transferring R1 earlier in the day from her bed to the bathroom with the EZ-Stand. NA-C could not recall how R1's left arm was placed during the transfers. NA-C stated there was no discussion about R1's arm during the cares. During an interview on 5/17/23 at 11:53 a.m. NA-D stated the staff have been using the EZ-Stand. NA-D stated R1 held onto the grab bars of the EZ-Stand with both hands, but was tolerating well. During an observation on 5/17/23 at 12:02 p.m. R1 put on her call light to use the bathroom. R1 needed to be transferred out of her recliner.	2 830		

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2 830	Continued From page 6 NA-B told R1 she was going to get the EZ-Stand. 1. NA-B used the remote to get R1's recliner in the most upright position. 2. NA-B placed the harness around R1's back and secured R1's feet on the platform with the leg straps. 3. R1 had her right arm on the EZ-Stand grab bar. 4. NA-B used the lift and lifted R1 about 2 inches. 5. NA-B noticed R1 was not hanging onto the lift grab bar with her left hand and told R1 to hold on with her left arm. R1 attempted, but winced in pain. 6. The surveyor stopped the transfer. 7. R1 was seated back into the recliner. The social worker (SW)-A witnessed the transfer. During an interview on 5/17/23 at 12:08 p.m. NA-B stated it was "o.k." to use the lift with R1 stating "Nursing assistants can always go up on transfer at their digression, but never down." She stated using a lift had always been the practice at the facility if the NA's feel it was appropriate and R1 was weak or did not feel well. NA-B stated she was aware R1 was currently an assistance of two members and denied seeing on the care plan that it was o.k. to use an EZ-Stand following R1's fracture her wrist. During an interview on 5/17/23 at 2:30 p.m. Physical Therapist (PT)-A stated she assessed R1 on 5/11/23 and the transfer orders were assistance of two staff members and a gait belt with standing and pivoting. PT-A stated R1 was not to use the EZ-stand because R1 was unable to stand still and would need to use both hands to provide stability during the transfer. Prior to the injury R1 was assist of one staff member and a gait belt with the use of the EZ-stand as needed for extreme weakness. PT-A stated she was not aware staff were not using the least restrictive technique for transfers. If staff were going to use the lift in an emergency then nursing should be	2 830		

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2 830	Continued From page 7 notified as to why the resident needed the lift so a re-assessment could be done. PT-A stated the staff were trained and should always use caution with arms, legs, and cords. During an interview on 5/17/23 at 2:47 p.m. registered nurse (RN)-A stated prior to the wrist fracture R1 was assist of 1, but staff could use the EZ-Stand as needed depending on the condition of the resident. "As a general rule at the facility, staff can go up on transfers, but now down." RN-A stated if staff change a transfer they must report to nursing. RN-A stated following the wrist fracture R1 was supposed to pivot transfer with two staff. The EZ-Stand was not to be used. RN-A was not aware staff were using the stand. RN-A stated the reason R1's left arm stuck out more during the EZ-stand transfers was because R1 had left sided weakness from her previous stroke. RN-A indicated an assessment had not been completed or care plan interventions to reduce the risk of injury to R1's left arm while using the standing lift. During an interview on 5/17/23 at 3:00 p.m. NA-E stated prior to the fractured wrist she would transfer R1 by herself with a gait belt. NA-E stated it would depend on how she thought R1's condition was at the time of the transfers if she used the EZ-stand. NA-E was aware that R1's transfer had changed and was now assist of two and no EZ-stand. During an interview on 5/17/23 at 3:18 p.m. the director of nursing (DON) stated she was unaware that R1's left arm stuck out of the EZ-stand further than the other, until she was interviewing staff as part of the investigation following the broken wrist. The DON indicated there were no interventions to prevent injury to	2 830		

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2 830	Continued From page 8 R1's weak arm during lift transfers. The DON stated the staff were to follow the care plan and if they had questions they were to reach out to the nurse. During an interview on 5/18/23 at 3:24 p.m. NA-A stated when R1 moved to the unit in 1/2023 she was an assist of one pivot transfer, shortly thereafter R1 became difficult for one person, so the NA's changed her to a pivot transfer with two staff members. NA-A stated probably in 3/2023 the staff used the EZ-stand for all transfer because R1 was resistive with staff upon transfers. NA-A stated R1 had never been able to hold on firmly to the EZ-Stand as her elbow "pops out from the stroke and she is not able to fully straighten her left arm out and it sticks out more." NA-A stated there were not interventions for R1's left arm on the care plan, stating the staff were just aware of this with R1. NA-A stated she never reported any concerns with R1 to the nursing staff. NA-A stated the staff must always follow the care plan. A facility process titled, Nursing Services Process: Mechanical Stand and Left Procedure undated indicated employees must follow the residents plan of care. The resident's hands are to be placed on the outside of the harness and ask residents to hold onto the handlebars. A facility training skills checklist dated 8/17 indicated for the mechanical stand the staff is to verify the care and obtain assistance from another team member if indicated. When using the stand, the staff is carefully guide the lift to chair/bed/wheelchair. Watch that all arms, legs, and tubing are safe. A facility policy titled Person-centered Care	2 830		

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2 830	Continued From page 9 Planning, indicated the care will include services that are furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 830		

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F 000	INITIAL COMMENTS On 5/17/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H56042240C (MN93541) with no deficiencies. The following complaint was reviewed. H56042235C (MN93521) with a deficiency issued at F689. 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.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		6/3/23

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

Electronically Signed | 05/31/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	C 05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

(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 1 by: Based on observation, interview, and record review the facility failed to assess interventions to provide safe mechanical lift transfers resulting in fracture of distal radius and failed to follow the revised care plan to prevent impaired healing and further injury for 1 of 4 residents (R1) reviewed for accidents. Findings include: R1's care plan dated 1/26/23 indicated R1 required the assistance of one staff member with transfers, gait belt and railings. Mechanical standing lift with assistance of one staff member as needed (PRN). The care plan did not indicate any interventions for staff to monitor R1's left arm, R1's week side following CVA), with the use of the EZ-stand R1's significant change Minimum Data Set (MDS) dated 2/26/23 indicated R1 had moderate cognitive impairment. R1's diagnoses included congestive heart failure, cerebral vascular accident (stroke) anxiety, depression, and chronic kidney disease. R1 required one staff member for physical assistance with transfers, and extensive assistance of one for activities of daily living. R1's progress note dated 5/9/23 at 1:11 p.m. indicated R1 and staff reported that R1's left elbow was bumped on the doorframe when R1 was being pushed out of her room by staff to the bathroom on the EZ-stand (mechanical standing lift). R1 complained of significant pain to her left elbow with slight swelling, no bruising or skin tears noted. The area was extremely tender to touch.	F 689	It is the policy, and intention, of Auburn Manor to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicaid and Medicare programs and, as required, are submitted as the facility's credible allegations of compliance. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should remedies be imposed. 1. A new template has been created for therapy and nursing staff (RN Care Coordinators and nurses) to use when determining the level of assistance needed for a resident's transfers. This template not only includes the different transfer type and the number of people the transfer requires for safety, it also includes if there are any specific individualizations needed for the resident to ensure safe transfers (example □ specific staff placement due to resident weakness, etc.). Information on this template will be transferred and included in the NAR plan of care for staff to follow. 2. Nursing staff (RN Care Coordinators and nurses) and therapy staff will be trained on the use of this template. RN Care Coordinators will be trained on how to document on the NAR plan of care. 3. NAR plan of care for all residents	

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F 689	Continued From page 2 R1's progress note dated 5/9/23 at 10:22 p.m. indicated R1 reported pain to her left elbow, but stated her elbow was not as painful as her left wrist was with movement.There was bruising to her left wrist, but no excessive swelling. A Minnesota Adult Abuse Report Center report dated 5/10/23 at 2:20 p.m. indicated a nursing assistant (NA) was transferring R1 with an EZ stand machine (standing mechanical lift). R1's left elbow always is positioned further out than the right arm and NA steered the machine into R1's bathroom and inadvertently made contact with the doorway frame. R1's X-ray report dated 5/10/23 indicated R1's left forearm demonstrated a cortical offset at the very distal radius which might represent a fracture. R1's progress note dated 5/10/23 at 1:59 p.m. indicated R1's x-ray results returned with very subtle distal fracture. The Nurse Practitioner (NP) was updated, and ace bandage applied pending further orders. R1's progress note dated 5/10/23 at 3:43 p.m. indicated per physician, R1 was to wear a left wrist splint with a 2-3-inch ACE wrap over it up to mid forearm, keep in place at all times. Non-weight bearing to left arm for 4-6 weeks. PT to evaluate to assess for transfers. R1's progress note dated 5/11/23 at 10:44 a.m. indicated Physical Therapy (PT) evaluation was completed following the injury to the left wrist and orders for non-weight bearing of the left wrist. R1 needed moderate assistance with bed mobility and maximum assistance with pivot transfer from	F 689	have been updated to include information on whether transfer is standard or has individualization for the resident. If there is individualization, that information has been added to the NAR plan of care. 4. The procedures for standing lift use and mechanical lift use has been updated to specify that staff need to follow the resident's plan of care which includes any individualization to the transfer necessary for the safety of the resident. All Nursing staff (nurses, TMAs, NARs) will be trained on the updated procedures. 5. Ongoing compliance will be monitored by the DON via audits of resident transfers. The DON will complete 3 transfer audits per month for 3 months, then will complete 1 transfer audit per quarter for 2 quarters.	

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F 689	Continued From page 3	F 689		

her bed to her wheelchair. PT recommended mobility bars on bed to allow her to assist more with transfers and bed mobility. Resident transfers from wheelchair to toilet with grabbers with minimum assistance of one staff member. Staff to use assistance of two staff for in her room from wheelchair to and from bed or recliner. Ambulation program on hold at this time.

R1's care plan dated 5/15/23 indicated R1 required assistance of one staff member with a gait belt and grab bars in the bathroom for toileting. R1's wheelchair was to be at a 90-degree angle (face the wall) and ask R1 to count to 30 when she stands up, so staff can remove pants before pivoting. R1 required the assistance of two staff members when transferring from wheelchair to bed or recliner in her room.

R1's nurse aide daily sheet dated 5/17/23 under the column titled Special Instructions R1 was non-weight bearing with her left hand and had "changes in transfers."

During an interview on 5/17/23 at 9:20 a.m. R1 stated she was being transferred in the lift to the bathroom and her elbow hit the doorway. R1 stated "My arm just hung out too far." She stated the staff were still using that lift and her arm hurts as she must hold on to the bars on the lift during the transfer.

During an interview on 5/17/23 at 11:42 a.m. NA-C (a student in training), stated she assisted NA-B with transferring R1 earlier in the day from her bed to the bathroom with the EZ-Stand. NA-C could not recall how R1's left arm was placed during the transfers. NA-C stated there

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F 689	Continued From page 4 was no discussion about R1's arm during the cares. During an interview on 5/17/23 at 11:53 a.m. NA-D stated the staff have been using the EZ-Stand. NA-D stated R1 held onto the grab bars of the EZ-Stand with both hands, but was tolerating well. During an observation on 5/17/23 at 12:02 p.m. R1 put on her call light to use the bathroom. R1 needed to be transferred out of her recliner. NA-B told R1 she was going to get the EZ-Stand. 1. NA-B used the remote to get R1's recliner in the most upright position. 2. NA-B placed the harness around R1's back and secured R1's feet on the platform with the leg straps. 3. R1 had her right arm on the EZ-Stand grab bar. 4. NA-B used the lift and lifted R1 about 2 inches. 5. NA-B noticed R1 was not hanging onto the lift grab bar with her left hand and told R1 to hold on with her left arm. R1 attempted, but winced in pain. 6. The surveyor stopped the transfer. 7. R1 was seated back into the recliner. The social worker (SW)-A witnessed the transfer. During an interview on 5/17/23 at 12:08 p.m. NA-B stated it was "o.k." to use the lift with R1 stating "Nursing assistants can always go up on transfer at their digression, but never down." She stated using a lift had always been the practice at the facility if the NA's feel it was appropriate and R1 was weak or did not feel well. NA-B stated she was aware R1 was currently an assistance of two members and denied seeing on the care plan that it was o.k. to use an EZ-Stand following R1's fracture her wrist. During an interview on 5/17/23 at 2:30 p.m.	F 689		

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F 689	Continued From page 5 Physical Therapist (PT)-A stated she assessed R1 on 5/11/23 and the transfer orders were assistance of two staff members and a gait belt with standing and pivoting. PT-A stated R1 was not to use the EZ-stand because R1 was unable to stand still and would need to use both hands to provide stability during the transfer. Prior to the injury R1 was assist of one staff member and a gait belt with the use of the EZ-stand as needed for extreme weakness. PT-A stated she was not aware staff were not using the least restrictive technique for transfers. If staff were going to use the lift in an emergency then nursing should be notified as to why the resident needed the lift so a re-assessment could be done. PT-A stated the staff were trained and should always use caution with arms, legs, and cords. During an interview on 5/17/23 at 2:47 p.m. registered nurse (RN)-A stated prior to the wrist fracture R1 was assist of 1, but staff could use the EZ-Stand as needed depending on the condition of the resident. "As a general rule at the facility, staff can go up on transfers, but now down." RN-A stated if staff change a transfer they must report to nursing. RN-A stated following the wrist fracture R1 was supposed to pivot transfer with two staff. The EZ-Stand was not to be used. RN-A was not aware staff were using the stand. RN-A stated the reason R1's left arm stuck out more during the EZ-stand transfers was because R1 had left sided weakness from her previous stroke. RN-A indicated an assessment had not been completed or care plan interventions to reduce the risk of injury to R1's left arm while using the standing lift. During an interview on 5/17/23 at 3:00 p.m. NA-E stated prior to the fractured wrist she would	F 689		

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F 689	Continued From page 6 transfer R1 by herself with a gait belt. NA-E stated it would depend on how she thought R1's condition was at the time of the transfers if she used the EZ-stand. NA-E was aware that R1's transfer had changed and was now assist of two and no EZ-stand. During an interview on 5/17/23 at 3:18 p.m. the director of nursing (DON) stated she was unaware that R1's left arm stuck out of the EZ-stand further than the other, until she was interviewing staff as part of the investigation following the broken wrist. The DON indicated there were no interventions to prevent injury to R1's weak arm during lift transfers. The DON stated the staff were to follow the care plan and if they had questions they were to reach out to the nurse. During an interview on 5/18/23 at 3:24 p.m. NA-A stated when R1 moved to the unit in 1/2023 she was an assist of one pivot transfer, shortly thereafter R1 became difficult for one person, so the NA's changed her to a pivot transfer with two staff members. NA-A stated probably in 3/2023 the staff used the EZ-stand for all transfer because R1 was resistive with staff upon transfers. NA-A stated R1 had never been able to hold on firmly to the EZ-Stand as her elbow "pops out from the stroke and she is not able to fully straighten her left arm out and it sticks out more." NA-A stated there were not interventions for R1's left arm on the care plan, stating the staff were just aware of this with R1. NA-A stated she never reported any concerns with R1 to the nursing staff. NA-A stated the staff must always follow the care plan. A facility process titled, Nursing Services	F 689		

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F 689	Continued From page 7 Process: Mechanical Stand and Left Procedure undated indicated employees must follow the residents plan of care. The resident's hands are to be placed on the outside of the harness and ask residents to hold onto the handlebars. A facility training skills checklist dated 8/17 indicated for the mechanical stand the staff is to verify the care and obtain assistance from another team member if indicated. When using the stand, the staff is carefully guide the lift to chair/bed/wheelchair. Watch that all arms, legs, and tubing are safe. A facility policy titled Person-centered Care Planning, indicated the care will include services that are furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.	F 689		

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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 5/17/23, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with no deficiency issued H56042240C (MN93541). The following complaint was reviewed. H56042235C (MN93521) 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	2 000		

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2 000	Continued From page 2 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. 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 record review the facility failed to assess interventions to provide safe mechanical lift transfers resulting in fracture of distal radius and failed to follow the revised care plan to prevent impaired healing and further injury for 1 of 4 residents (R1) reviewed for accidents.	2 830	Corrected	6/3/23

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2 830	Continued From page 3 Findings include: R1's care plan dated 1/26/23 indicated R1 required the assistance of one staff member with transfers, gait belt and railings. Mechanical standing lift with assistance of one staff member as needed (PRN). The care plan did not indicate any interventions for staff to monitor R1's left arm, R1's week side following CVA), with the use of the EZ-stand R1's significant change Minimum Data Set (MDS) dated 2/26/23 indicated R1 had moderate cognitive impairment. R1's diagnoses included congestive heart failure, cerebral vascular accident (stroke) anxiety, depression, and chronic kidney disease. R1 required one staff member for physical assistance with transfers, and extensive assistance of one for activities of daily living. R1's progress note dated 5/9/23 at 1:11 p.m. indicated R1 and staff reported that R1's left elbow was bumped on the doorframe when R1 was being pushed out of her room by staff to the bathroom on the EZ-stand (mechanical standing lift). R1 complained of significant pain to her left elbow with slight swelling, no bruising or skin tears noted. The area was extremely tender to touch. R1's progress note dated 5/9/23 at 10:22 p.m. indicated R1 reported pain to her left elbow, but stated her elbow was not as painful as her left wrist was with movement.There was bruising to her left wrist, but no excessive swelling. A Minnesota Adult Abuse Report Center report dated 5/10/23 at 2:20 p.m. indicated a nursing assistant (NA) was transferring R1 with an EZ	2 830		

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2 830	Continued From page 4 stand machine (standing mechanical lift). R1's left elbow always is positioned further out than the right arm and NA steered the machine into R1's bathroom and inadvertently made contact with the doorway frame. R1's X-ray report dated 5/10/23 indicated R1's left forearm demonstrated a cortical offset at the very distal radius which might represent a fracture. R1's progress note dated 5/10/23 at 1:59 p.m. indicated R1's x-ray results returned with very subtle distal fracture. The Nurse Practitioner (NP) was updated, and ace bandage applied pending further orders. R1's progress note dated 5/10/23 at 3:43 p.m. indicated per physician, R1 was to wear a left wrist splint with a 2-3-inch ACE wrap over it up to mid forearm, keep in place at all times. Non-weight bearing to left arm for 4-6 weeks. PT to evaluate to assess for transfers. R1's progress note dated 5/11/23 at 10:44 a.m. indicated Physical Therapy (PT) evaluation was completed following the injury to the left wrist and orders for non-weight bearing of the left wrist. R1 needed moderate assistance with bed mobility and maximum assistance with pivot transfer from her bed to her wheelchair. PT recommended mobility bars on bed to allow her to assist more with transfers and bed mobility. Resident transfers from wheelchair to toilet with grabbers with minimum assistance of one staff member. Staff to use assistance of two staff for in her room from wheelchair to and from bed or recliner. Ambulation program on hold at this time. R1's care plan dated 5/15/23 indicated R1 required assistance of one staff member with a	2 830		

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2 830	Continued From page 5 gait belt and grab bars in the bathroom for toileting. R1's wheelchair was to be at a 90-degree angle (face the wall) and ask R1 to count to 30 when she stands up, so staff can remove pants before pivoting. R1 required the assistance of two staff members when transferring from wheelchair to bed or recliner in her room. R1's nurse aide daily sheet dated 5/17/23 under the column titled Special Instructions R1 was non-weight bearing with her left hand and had "changes in transfers." During an interview on 5/17/23 at 9:20 a.m. R1 stated she was being transferred in the lift to the bathroom and her elbow hit the doorway. R1 stated "My arm just hung out too far." She stated the staff were still using that lift and her arm hurts as she must hold on to the bars on the lift during the transfer. During an interview on 5/17/23 at 11:42 a.m. NA-C (a student in training), stated she assisted NA-B with transferring R1 earlier in the day from her bed to the bathroom with the EZ-Stand. NA-C could not recall how R1's left arm was placed during the transfers. NA-C stated there was no discussion about R1's arm during the cares. During an interview on 5/17/23 at 11:53 a.m. NA-D stated the staff have been using the EZ-Stand. NA-D stated R1 held onto the grab bars of the EZ-Stand with both hands, but was tolerating well. During an observation on 5/17/23 at 12:02 p.m. R1 put on her call light to use the bathroom. R1 needed to be transferred out of her recliner.	2 830		

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	00335	A. BUILDING: _____ B. WING _____	C 05/17/2023

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2 830	Continued From page 6 NA-B told R1 she was going to get the EZ-Stand. 1. NA-B used the remote to get R1's recliner in the most upright position. 2. NA-B placed the harness around R1's back and secured R1's feet on the platform with the leg straps. 3. R1 had her right arm on the EZ-Stand grab bar. 4. NA-B used the lift and lifted R1 about 2 inches. 5. NA-B noticed R1 was not hanging onto the lift grab bar with her left hand and told R1 to hold on with her left arm. R1 attempted, but winced in pain. 6. The surveyor stopped the transfer. 7. R1 was seated back into the recliner. The social worker (SW)-A witnessed the transfer. During an interview on 5/17/23 at 12:08 p.m. NA-B stated it was "o.k." to use the lift with R1 stating "Nursing assistants can always go up on transfer at their digression, but never down." She stated using a lift had always been the practice at the facility if the NA's feel it was appropriate and R1 was weak or did not feel well. NA-B stated she was aware R1 was currently an assistance of two members and denied seeing on the care plan that it was o.k. to use an EZ-Stand following R1's fracture her wrist. During an interview on 5/17/23 at 2:30 p.m. Physical Therapist (PT)-A stated she assessed R1 on 5/11/23 and the transfer orders were assistance of two staff members and a gait belt with standing and pivoting. PT-A stated R1 was not to use the EZ-stand because R1 was unable to stand still and would need to use both hands to provide stability during the transfer. Prior to the injury R1 was assist of one staff member and a gait belt with the use of the EZ-stand as needed for extreme weakness. PT-A stated she was not aware staff were not using the least restrictive technique for transfers. If staff were going to use the lift in an emergency then nursing should be	2 830		

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2 830	Continued From page 7 notified as to why the resident needed the lift so a re-assessment could be done. PT-A stated the staff were trained and should always use caution with arms, legs, and cords. During an interview on 5/17/23 at 2:47 p.m. registered nurse (RN)-A stated prior to the wrist fracture R1 was assist of 1, but staff could use the EZ-Stand as needed depending on the condition of the resident. "As a general rule at the facility, staff can go up on transfers, but now down." RN-A stated if staff change a transfer they must report to nursing. RN-A stated following the wrist fracture R1 was supposed to pivot transfer with two staff. The EZ-Stand was not to be used. RN-A was not aware staff were using the stand. RN-A stated the reason R1's left arm stuck out more during the EZ-stand transfers was because R1 had left sided weakness from her previous stroke. RN-A indicated an assessment had not been completed or care plan interventions to reduce the risk of injury to R1's left arm while using the standing lift. During an interview on 5/17/23 at 3:00 p.m. NA-E stated prior to the fractured wrist she would transfer R1 by herself with a gait belt. NA-E stated it would depend on how she thought R1's condition was at the time of the transfers if she used the EZ-stand. NA-E was aware that R1's transfer had changed and was now assist of two and no EZ-stand. During an interview on 5/17/23 at 3:18 p.m. the director of nursing (DON) stated she was unaware that R1's left arm stuck out of the EZ-stand further than the other, until she was interviewing staff as part of the investigation following the broken wrist. The DON indicated there were no interventions to prevent injury to	2 830		

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2 830	Continued From page 8 R1's weak arm during lift transfers. The DON stated the staff were to follow the care plan and if they had questions they were to reach out to the nurse. During an interview on 5/18/23 at 3:24 p.m. NA-A stated when R1 moved to the unit in 1/2023 she was an assist of one pivot transfer, shortly thereafter R1 became difficult for one person, so the NA's changed her to a pivot transfer with two staff members. NA-A stated probably in 3/2023 the staff used the EZ-stand for all transfer because R1 was resistive with staff upon transfers. NA-A stated R1 had never been able to hold on firmly to the EZ-Stand as her elbow "pops out from the stroke and she is not able to fully straighten her left arm out and it sticks out more." NA-A stated there were not interventions for R1's left arm on the care plan, stating the staff were just aware of this with R1. NA-A stated she never reported any concerns with R1 to the nursing staff. NA-A stated the staff must always follow the care plan. A facility process titled, Nursing Services Process: Mechanical Stand and Left Procedure undated indicated employees must follow the residents plan of care. The resident's hands are to be placed on the outside of the harness and ask residents to hold onto the handlebars. A facility training skills checklist dated 8/17 indicated for the mechanical stand the staff is to verify the care and obtain assistance from another team member if indicated. When using the stand, the staff is carefully guide the lift to chair/bed/wheelchair. Watch that all arms, legs, and tubing are safe. A facility policy titled Person-centered Care	2 830		

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2 830	Continued From page 9 Planning, indicated the care will include services that are furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 830		