Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2023

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: April 7, 2023

Dear Administrator:

On April 20, 2023, we notified you a remedy was imposed. On May 9, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 2, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 5, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of April 20, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 7, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 11, 2023

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Re: Reinspection Results
Event ID: E9GG12

Dear Administrator:

On May 9, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 7, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
April 20, 2023

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: April 7, 2023

Dear Administrator:

On April 7, 2023, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On April 7, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 5, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 5, 2023, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2023,(42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; 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.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has

been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Carondelet Village Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 7, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and

conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	C 04/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(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 4/4/23 through 4/7/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The IJ began on 3/29/23, at approximately 4:45 p.m. when R1 fell from a mechanical lift when two aides did not follow the care plan and facility policy resulting in R1's death. The interim administrator, administrator, director of nursing (DON), and clinical coordinator (CC)-A, were notified of the immediate jeopardy on 4/6/23, at 5:18 p.m. The immediate jeopardy was removed on 4/7/23, at 1:34 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 4/7/23 The following complaints were reviewed: H56179874C (MN00092380) (MN00092397) with a deficiency cited 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	F 000		

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

Electronically Signed | 04/27/2023

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

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F 000	Continued From page 1 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 manufacturer recommendations were followed for a mechanical lift transfers and failed to a comprehensive assessment residents safety when using a mechanical lift. This resulted in immediate jeopardy (IJ) when one sling loop detached resulting in head injury, broken neck, and death. In addition the facility failed to comprehensively assess for sling style and size to ensure safe transfers for 1 of 8 residents (R2) that used a full body mechanical lift. The IJ began on 3/29/23, at approximately 4:45 p.m. when R1 fell from a mechanical lift when two aides did not follow the care plan and facility policy resulting in R1's death. The interim administrator, administrator, director of nursing (DON), and clinical coordinator (CC)-A, were notified of the immediate jeopardy on 4/6/23, at 5:18 p.m. The immediate jeopardy was removed on 4/7/23, at 1:34 p.m. but non compliance	F 689	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. R1 was transferred to the hospital on 3/29/2023 and discharged from Carondelet Village Care Center on 3/30/2023.	5/2/23

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F 689	Continued From page 2 remained at a lower scope and severity of an D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings Include: A facility reported incident (FRI) dated 3/29/23, at 4:45 p.m. indicated that R1 was being transferred from bed to wheelchair via a Golvo full body mechanical lift. The report indicated that during the transfer one of the loops of the sling (a fabric device that directly hooks to the lift that provides patient stability) slipped off the lift hook resulting in R1 falling out of the sling and onto the floor. R1 sustained a laceration to the back of the head and R1 was transferred to the hospital. R1's face sheet identified diagnoses of dementia, unspecified Alzheimer's disease, and osteoporosis. R1's quarterly Minimum Data Set (MDS) dated 12/22/22, indicated R1 had severe cognitive impairment. R1 required total dependence of two staff assist with transfers. R1's Resident Transfer Assessment dated 12/17/22, indicated R1 required two person assist for a full body mechanical lift for transfers. The assessment indicated R1 weighed 96.9 pounds (lbs.). Further indicated R1 required three different style slings: a universal sling size medium slim (99-154 lbs.), amputee sling size medium (88-132 lbs.), high back sling size medium (88-176 lbs.) The assessment did not specify which style sling R1 was to use and had the wrong size sling according to her weight. R1's care plan revision, dated 10/3/22, identified	F 689	A resident transfer assessment was completed for R2 by the DON on 4/5/2023. The care plan and care guide were then updated to reflect the appropriate size sling per manufacturers recommendations. A facility audit of all residents with a mechanical lift transfer was completed on 4/5/2023 by the Clinical Administrator. All residents with a mechanical lift transfer were reassessed to identify the correct sling size and type and the care plan and care guides were updated to reflect the results per manufacturers recommendations. The Full Body Mechanical Lift Policy was reviewed and updated to include further guidance regarding which type of slings are used in the facility as well as the sizing guide for each type of sling. On 3/29/2023 the facility completed transfer education with all nursing and therapy staff which included checking lift equipment to ensure it is in functioning order and reeducated on the need to ensure that two staff must be present throughout the entire transfer; review of the care guide for resident□s current transfer status and sling sizing; and that the transfer surface is within the shortest distance possible from the original transfer surface. On 4/6/2023 education was initiated with all nursing and therapy staff on how to identify the difference between a universal sling and a high back sling. Pictures depicting the difference between these	

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F 689	Continued From page 3 R1 was non-ambulatory. R1 required assist of two staff with a full body mechanical lift and a MEDIUM sized sling to transfer. R1's care plan did not identify the style of the sling as indicated in her transfer assessment. R1's care guide (abbreviated care plan for direct care staff) dated 3/28/23, indicated R1 required assist of 2 with the use of a full body lift, and an (orange) small size sling, which was inconsistent with the care plan. R1's nursing progress notes dated 3/29/23 at 4:45 p.m. indicated R1 had a fall from the mechanical full body lift. When (registered nurse (RN-A)) arrived, R1 was lying on the floor on her right side between the lift's leg. (NA-A and NA-B) said they don't know how it happened. R1 had two cuts on the backside of her head that measured 2.0 centimeters (cm) x 0.5 cm, and 1.0 cm by 0.5 cm. Bruising noted to the right side of R1's face. Intervention based on root cause analysis: education given on total lift and sit to stand machine by director of nursing (DON) to all employees on duty. During a phone interview on 4/5/23, at 2:14 p.m., family member (FM)-A stated R1 had died this morning from her traumatic injury sustained from the lift transfer. FM-A indicated R1 was completely bruised on one whole side of her body, on her arms and legs and suffered horribly. During a phone interview on 4/5/23, at 2:28 p.m. family member (FM)-B stated she had filed grievances about lift transfers being completed with only one staff; she did not get timely responses. FM-B explained she was at the facility on 3/29/23 and left at 3:15 p.m. When FM-B left	F 689	two slings has been posted in each neighborhood area when the lifts are stored. Verbal education was also initiated regarding the sizing of the slings and that the sizes have been written directly on the sling. This education was initiated verbally with all staff as they started their next shift and return demonstration of competency was assessed with all staff at that time by completing a Lift Skills Checklist by care center management team or designee prior to initiating cares. All licensed staff were reeducated on the Resident Transfer Assessment policy to ensure assessments to be completed with the accurate sling style and size on 4/6/2023 and ongoing education was completed at the start of the staff□s next shift. Random audits will be completed weekly x 12 weeks by the Clinical Administrator/designee to ensure ongoing compliance of the staffs understanding of the manufacturer□s recommendations of the sling size and type. Audits will be completed on the resident transfer assessments per the RAI MDS schedule to ensure the assessment information is accurate and is reflected correctly on the plan of care and care guide. These audits will be brought to the facility Quality Assurance Committee for review.	

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F 689	Continued From page 4 R1 was dressed and had just been laid down in bed. FM-B indicated that she received a call from her brother reporting that R1 had fallen. FM-B arrived back at the facility around 5:45 p.m. R1 was lying in bed actively bleeding from her head and a pool of blood on the floor. FM-B stated the DON informed her R1 had fallen about 3 feet from the lift. FM-B stated she informed and instructed the DON that R1 needed to be transferred to the hospital after she visualized the extent of R1's injuries. A summary record, M Health Fairview, University of Minnesota Medical Center (UMMC) admission date, 3/30/23. Record indicated that R1 sustained a T1 compression fracture (a type of broken bone that can cause your vertebrae to collapse, making them shorter), a C2 left transverse process fracture (cervical spine fracture), left distal vertebral artery dissection (occurs when a tear forms in one of the blood vessels running up the back of your neck), and a scalp laceration that required stitches. Further indicated that R1 was initially sent to Woodwinds emergency department (ED), although ultimately sent to UMMC for further work up. R1 went unresponsive on 3/31/23 and palliative care was initiated. R1 was pronounced dead on 4/5/23 at 10:08 a.m. During a phone interview on 4/4/23, at 3:59 p.m., NA-A indicated that on 3/29/23 at 4:15 p.m. she and NA-B went into R1's room to transfer R1 from the bed to wheelchair. NA-A explained she was in charge of making sure R1 was in the sling correctly; she was the spotter. NA-B was in charge of the operation of the lift. NA-A reported they placed the sling under R1 then had attached the four pieces of the sling loops to the lift and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 made sure it was fastened correctly; they completed a "pause for a cause" (double checking the loop positioning prior to the transfer). NA-A then informed NA-B she was going to get R1's wheelchair from the bathroom. While NA-A was getting the wheelchair from the bathroom, NA-B moved the lift backwards away from the bed while R1 was suspended in the air by the sling. NA-A reported NA-B had the lift all the way into the hallway of the room (5 feet) as she was trying to get the chair from the bathroom. When she (NA-A) was in the bathroom R1 fell out of the lift. NA-A indicated the full body mechanical lifts did not require two staff to complete the entire transfer (inconsistent with facility policy). NA-A indicated that R1 was moved too far, too quickly. However, NA-A could not confirm what was happening prior to the fall as she was in the bathroom and could not visualize R1. During a phone interview on 4/4/23 at 4:26 p.m. NA-B reported during R1's transfer on 3/29/23, NA-A connected R1 to the lift, verified placement of the sling loops on the machine. NA-B then pulled the machine out from underneath the bed. NA-A walked away and went into the bathroom, and she (NA-B) continued to pull the lift backward towards the hallway approximately 5 feet. NA-B explained in the process, the loop from the right side of the sling came off the lift, causing R1 to fall out of the sling onto the floor. NA-A was not in visual eyesight or R1's reach when the incident occurred. NA-B explained R1's wheelchair was always in the bathroom, so someone always had to step away when getting the wheelchair during the transfer. NA-B indicated R1 was transferred back to bed using the same type of sling that she had fallen from; NA-B was not aware of the difference between a high back sling and a	F 689		

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F 689	Continued From page 6 universal sling. During a phone interview on 4/5/23, at 11:33 a.m. registered nurse (RN)-A indicated that she entered the room on 3/29/23 just before supper, after hearing screaming. RN-A found R1 on the ground between the lift legs. RN-A indicated NA-A had not witnessed the fall because NA-A had gone into the bathroom to get the wheelchair during lift transfer. RN-A indicated that she applied pressure to R1's head with a washcloth to try and stop the bleeding. RN-A stated, the lift and sling were immediately removed from service. RN-A and the DON transferred R1 from the floor back to R1's bed using a different full body lift and a different universal lift sling. RN-A could not articulate the difference between a high back and universal slings. During a phone interview on 4/5/23, at 12:29 p.m. lift representative (LR)-B indicated the lift, and the sling were inspected by the manufacturer. There was no equipment failure identified and it could only have been operator error. During a phone interview on 4/5/23, at 11:07 a.m. LR-A stated, when moving the full body lift around, this could cause the sling to go back and forth with or without someone in the lift. It's best practice and has always been the company's expectation to have two people when transferring with a full body mechanical lift. One person acts as the operator and the other as the spotter. The spotter would be observing the situation including the loop latch and providing protection and compensation to the patient. To ensure safety during the transfer, it is too much for one person to do alone. LR-A stated R1's fall could have been prevented had a second person or spotter	F 689		

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F 689	Continued From page 7 been there to lead the lift and the movement of the sling. During an interview on 4/6/23, at 12:16 p.m. DON stated that NA-A and NA-B did not follow the facility policy when both aides were not in visual line of site during the full body lift transfer with R1. Additionally, R1's wheelchair the shortest distance possible from the transfer (R1 would have had to pushed in the lift while suspended to the transfer surface versus turning the lift to the transfer surface). DON expected staff to follow manufacturer's recommendations and facility policy when transferring residents with mechanical lifts. R2 R2's face sheet indicated diagnoses of dementia with other behavioral disturbance, Alzheimer's disease, delusional disorder, and anxiety disorder. R2's quarterly MDS assessment dated 1/20/23, indicated R2 has severe cognitive impairment and was dependent on two or more staff with transfers. R2's quarterly Resident Transfer Assessment, dated 1/14/23, indicated R2 weighed 104.4 lbs. The assessment indicated R1 incorrectly identified R2 required a medium universal sling (132 to 198 lbs.); according to R2's weight the R2 required the universal medium slim sling (99-154 lbs.) Assessment further identified R2 required a medium full back sling (88-176 lbs). The assessment did not specifically identify which sling was appropriate for R2.	F 689		

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F 689	Continued From page 8 R2's care plan revision date 11/23/22, indicated R2 was transferred with a full body mechanical lift with two staff and directed to use medium slim sling. R2's undated care guide directed staff to use a yellow medium slim sling (however indicated the wrong color of yellow, the corresponding sling was gray). During an observation on 4/4/23, at 12:29 p.m., R2 was transferred via full body mechanical lift with a medium yellow high back sling from the chair to the bed. This was completed by NA-C and NA-D. The sling used was not in accordance with the care plan. During an interview on 4/5/23, at 9:33 a.m. clinical coordinator (CC)-A indicated the DON completed all of the Resident Transfer Assessments (that were not referred to therapy). The care plan and care guide were then updated to reflect the size sling; care guides were updated daily with any changes. CC-A reviewed R2's record, CC-A stated R2's assessment identified all three sling styles (universal, high back, and amputee sling) for R2, but did not specifically identify which sling R2 required and/or appropriate for transfers. CC-A was unable to articulate which sling should be used for any residents when all three slings were identified on the assessment. During an interview on 4/6/23, at 12:16 p.m. DON stated that R2 was transferred on 4/4/23, with the wrong size sling. R2 should have been transferred with the high back medium slim gray sling. During interview on 4/4/23 at 12:18 p.m.	F 689		

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F 689	Continued From page 9 occupational therapist (OT-A) indicated sling sizes were determined by weight and sometimes physical attributes such as being an amputee. OT-A stated there were not any other contributing factors when choosing universal sling versus high back. During interview on 4/4/23 on 2:58 physical therapist (PT-A) indicated the therapy staff is at times involved in sling determination. When therapy completed the lift assessments they would determine sling sized based on resident weights. Therapy would then fill out an interdisciplinary team communication sheet, the clinical coordinator would put it in the care plan. Facility used small, medium, and large size slings. PT-A stated that the facility had only been using universal slings and not high back or amputee slings. During interview on 4/4/23 at 3:05 Director of Therapy (DOT-A) indicated an unawareness of the facility's sling inventory and would need to verify what size and style slings were on hand. DOT-A was unable to articulate an indication for a high back sling. DOT-A indicated staff need to reference the color coded chart on the lift for what sling to use. DOT-A explained if a resident's weight was not accurate to the size or if manufactures recommendations were not followed then serious risks can occur. During an interview on 4/5/23, at 9:56 a.m. DON could not articulate the difference between the styles of the slings and indication of use. Further indicated that the facility was not completing individualized comprehensive assessments for the appropriate lift sling size and style and confirmed all residents care plans and care	F 689		

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F 689	Continued From page 10 guides were not accurate for identification of sling style and size. Facility policy Resident Transfer Assessment Policy dated April 2018 indicates that the assessment is to be completed by a licensed nurse or therapist. Licensed nurse or therapist will review documentation, interview direct caregivers, and observe a transfer of the resident. If the resident requires a mechanical lift the resident will be assessed for proper sling or harness using the manufactures guidelines. This will be noted in the assessment. The policy indicates that assist of two staff are required for all residents requiring a full mechanical lift. Facility "Mechanical Lift Transfer Policy" dated November 2018 directed the following: staff to always follow manufacturer's recommendation for the proper use of the equipment and slings. Two staff must remain present through the process of the transfer until the lift is no longer engaged and sling straps are unhooked. Staff are not to leave the resident out of visual line of site while the resident is attached to the lift. Further directs staff to place a wheelchair or other equipment, which the resident is to be transferred to, within the shortest distance possible from the bed, facing the head of the bed. Residents cannot be left hooked to the mechanical lift unless staff are present or directly visualizing. Manufacturer's recommendations for Universal and high-backed slings, dated 2020, indicated, "It is important to choose the correct size in order to achieve the highest level of comfort and safety. A sling which is too large increases the risk of the patient sliding out of it, while one which is too small can cut into the groin and cause	F 689		

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F 689	Continued From page 11 discomfort." Manufacturer instructions for the Liko Golvo lift dated 2017 included Before lifting always make certain that: -the lift strap is not twisted or worn and that it can move freely in and out of the lift unit; · the lifting accessories is selected appropriately in terms of type, size, material and design with regard to the patient's needs; ·the lifting accessory is correctly applied to the lifting equipment; ·the lifting accessory is correctly and securely applied to the patient, so that no personal injury can occur; ·the sling's strap loops are correctly fastened to the slingbar hooks when the sling strap is extended, but before the patient is lifted from the underlying surface. Never leave a patient unattended in a lifting situation! The immediate jeopardy that began on 3/29/23, was removed on 4/7/23, when it was verified the facility implemented the following: -The facility reviewed and revised the full body mechanical lift policy to include directives on completing the comprehensive assessment for sling sizes and styles. -The facility comprehensively assessed all residents who utilized full body lifts in accordance with the manufacturers recommendations. -The facility revised care plans and care guides based on the comprehensive assessment for all residents who utilized full body lifts. -The facility educated all nursing staff on required two staff assist for full body transfers, double checking the position of the loops, completing comprehensive assessments for sling style and	F 689		

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F 689	Continued From page 12 size, and on the types of slings and sizes. In addition, staff completed competency tested.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 20, 2023

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: E9GG11

Dear Administrator:

The above facility was surveyed on April 4, 2023 through April 7, 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.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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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 4/4/23 through 4/7/23 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	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H56179874C (MN00092397) (MN00092380) with a licensing order issued at F689 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure manufacturer recommendations were followed for a mechanical lift transfers and failed to a comprehensive assessment residents safety when using a mechanical lift. This resulted in immediate jeopardy (IJ) when one sling loop detached resulting in head injury, broken neck, and death. In addition the facility failed to comprehensively assess for sling style and size to ensure safe	2 830	corrected	5/2/23

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2 830	Continued From page 3 transfers for 1 of 8 residents (R2) that used a full body mechanical lift. The IJ began on 3/29/23, at approximately 4:45 p.m. when R1 fell from a mechanical lift when two aides did not follow the care plan and facility policy resulting in R1's death. The interim administrator, administrator, director of nursing (DON), and clinical coordinator (CC)-A, were notified of the immediate jeopardy on 4/6/23, at 5:18 p.m. The immediate jeopardy was removed on 4/7/23, at 1:34 p.m. but non compliance remained at a lower scope and severity of an D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings Include: A facility reported incident (FRI) dated 3/29/23, at 4:45 p.m. indicated that R1 was being transferred from bed to wheelchair via a Golvo full body mechanical lift. The report indicated that during the transfer one of the loops of the sling (a fabric device that directly hooks to the lift that provides patient stability) slipped off the lift hook resulting in R1 falling out of the sling and onto the floor. R1 sustained a laceration to the back of the head and R1 was transferred to the hospital. R1's face sheet identified diagnoses of dementia, unspecified Alzheimer's disease, and osteoporosis. R1's quarterly Minimum Data Set (MDS) dated 12/22/22, indicated R1 had severe cognitive impairment. R1 required total dependence of two staff assist with transfers. R1's Resident Transfer Assessment dated 12/17/22, indicated R1 required two person assist	2 830		

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2 830	Continued From page 4 for a full body mechanical lift for transfers. The assessment indicated R1 weighed 96.9 pounds (lbs.). Further indicated R1 required three different style slings: a universal sling size medium slim (99-154 lbs.), amputee sling size medium (88-132 lbs.), high back sling size medium (88-176 lbs.) The assessment did not specify which style sling R1 was to use and had the wrong size sling according to her weight. R1's care plan revision, dated 10/3/22, identified R1 was non-ambulatory. R1 required assist of two staff with a full body mechanical lift and a MEDIUM sized sling to transfer. R1's care plan did not identify the style of the sling as indicated in her transfer assessment. R1's care guide (abbreviated care plan for direct care staff) dated 3/28/23, indicated R1 required assist of 2 with the use of a full body lift, and an (orange) small size sling, which was inconsistent with the care plan. R1's nursing progress notes dated 3/29/23 at 4:45 p.m. indicated R1 had a fall from the mechanical full body lift. When (registered nurse (RN-A)) arrived, R1 was lying on the floor on her right side between the lift's leg. (NA-A and NA-B) said they don't know how it happened. R1 had two cuts on the backside of her head that measured 2.0 centimeters (cm) x 0.5 cm, and 1.0 cm by 0.5 cm. Bruising noted to the right side of R1's face. Intervention based on root cause analysis: education given on total lift and sit to stand machine by director of nursing (DON) to all employees on duty. During a phone interview on 4/5/23, at 2:14 p.m., family member (FM)-A stated R1 had died this morning from her traumatic injury sustained from	2 830		

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2 830	Continued From page 5 the lift transfer. FM-A indicated R1 was completely bruised on one whole side of her body, on her arms and legs and suffered horribly. During a phone interview on 4/5/23, at 2:28 p.m. family member (FM)-B stated she had filed grievances about lift transfers being completed with only one staff; she did not get timely responses. FM-B explained she was at the facility on 3/29/23 and left at 3:15 p.m. When FM-B left R1 was dressed and had just been laid down in bed. FM-B indicated that she received a call from her brother reporting that R1 had fallen. FM-B arrived back at the facility around 5:45 p.m. R1 was lying in bed actively bleeding from her head and a pool of blood on the floor. FM-B stated the DON informed her R1 had fallen about 3 feet from the lift. FM-B stated she informed and instructed the DON that R1 needed to be transferred to the hospital after she visualized the extent of R1's injuries. A summary record, M Health Fairview, University of Minnesota Medical Center (UMMC) admission date, 3/30/23. Record indicated that R1 sustained a T1 compression fracture (a type of broken bone that can cause your vertebrae to collapse, making them shorter), a C2 left transverse process fracture (cervical spine fracture), left distal vertebral artery dissection (occurs when a tear forms in one of the blood vessels running up the back of your neck), and a scalp laceration that required stitches. Further indicated that R1 was initially sent to Woodwinds emergency department (ED), although ultimately sent to UMMC for further work up. R1 went unresponsive on 3/31/23 and palliative care was initiated. R1 was pronounced dead on 4/5/23 at 10:08 a.m.	2 830		

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2 830	Continued From page 6 During a phone interview on 4/4/23, at 3:59 p.m., NA-A indicated that on 3/29/23 at 4:15 p.m. she and NA-B went into R1's room to transfer R1 from the bed to wheelchair. NA-A explained she was in charge of making sure R1 was in the sling correctly; she was the spotter. NA-B was in charge of the operation of the lift. NA-A reported they placed the sling under R1 then had attached the four pieces of the sling loops to the lift and made sure it was fastened correctly; they completed a "pause for a cause" (double checking the loop positioning prior to the transfer). NA-A then informed NA-B she was going to get R1's wheelchair from the bathroom. While NA-A was getting the wheelchair from the bathroom, NA-B moved the lift backwards away from the bed while R1 was suspended in the air by the sling. NA-A reported NA-B had the lift all the way into the hallway of the room (5 feet) as she was trying to get the chair from the bathroom. When she (NA-A) was in the bathroom R1 fell out of the lift. NA-A indicated the full body mechanical lifts did not require two staff to complete the entire transfer (inconsistent with facility policy). NA-A indicated that R1 was moved too far, too quickly. However, NA-A could not confirm what was happening prior to the fall as she was in the bathroom and could not visualize R1. During a phone interview on 4/4/23 at 4:26 p.m. NA-B reported during R1's transfer on 3/29/23, NA-A connected R1 to the lift, verified placement of the sling loops on the machine. NA-B then pulled the machine out from underneath the bed. NA-A walked away and went into the bathroom, and she (NA-B) continued to pull the lift backward towards the hallway approximately 5 feet. NA-B explained in the process, the loop from the right side of the sling came off the lift, causing R1 to fall out of the sling onto the floor. NA-A was not in	2 830		

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2 830	Continued From page 7 visual eyesight or R1's reach when the incident occurred. NA-B explained R1's wheelchair was always in the bathroom, so someone always had to step away when getting the wheelchair during the transfer. NA-B indicated R1 was transferred back to bed using the same type of sling that she had fallen from; NA-B was not aware of the difference between a high back sling and a universal sling. During a phone interview on 4/5/23, at 11:33 a.m. registered nurse (RN)-A indicated that she entered the room on 3/29/23 just before supper, after hearing screaming. RN-A found R1 on the ground between the lift legs. RN-A indicated NA-A had not witnessed the fall because NA-A had gone into the bathroom to get the wheelchair during lift transfer. RN-A indicated that she applied pressure to R1's head with a washcloth to try and stop the bleeding. RN-A stated, the lift and sling were immediately removed from service. RN-A and the DON transferred R1 from the floor back to R1's bed using a different full body lift and a different universal lift sling. RN-A could not articulate the difference between a high back and universal slings. During a phone interview on 4/5/23, at 12:29 p.m. lift representative (LR)-B indicated the lift, and the sling were inspected by the manufacturer. There was no equipment failure identified and it could only have been operator error. During a phone interview on 4/5/23, at 11:07 a.m. LR-A stated, when moving the full body lift around, this could cause the sling to go back and forth with or without someone in the lift. It's best practice and has always been the company's expectation to have two people when transferring with a full body mechanical lift. One person acts	2 830		

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2 830	Continued From page 8 as the operator and the other as the spotter. The spotter would be observing the situation including the loop latch and providing protection and compensation to the patient. To ensure safety during the transfer, it is too much for one person to do alone. LR-A stated R1's fall could have been prevented had a second person or spotter been there to lead the lift and the movement of the sling. During an interview on 4/6/23, at 12:16 p.m. DON stated that NA-A and NA-B did not follow the facility policy when both aides were not in visual line of site during the full body lift transfer with R1. Additionally, R1's wheelchair the shortest distance possible from the transfer (R1 would have had to pushed in the lift while suspended to the transfer surface versus turning the lift to the transfer surface). DON expected staff to follow manufacturer's recommendations and facility policy when transferring residents with mechanical lifts. R2 R2's face sheet indicated diagnoses of dementia with other behavioral disturbance, Alzheimer's disease, delusional disorder, and anxiety disorder. R2's quarterly MDS assessment dated 1/20/23, indicated R2 has severe cognitive impairment and was dependent on two or more staff with transfers. R2's quarterly Resident Transfer Assessment, dated 1/14/23, indicated R2 weighed 104.4 lbs. The assessment indicated R1 incorrectly identified R2 required a medium universal sling (132 to 198 lbs.); according to R2's weight the R2	2 830		

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2 830	Continued From page 9 required the universal medium slim sling (99-154 lbs.) Assessment further identified R2 required a medium full back sling (88-176 lbs). The assessment did not specifically identify which sling was appropriate for R2. R2's care plan revision date 11/23/22, indicated R2 was transferred with a full body mechanical lift with two staff and directed to use medium slim sling. R2's undated care guide directed staff to use a yellow medium slim sling (however indicated the wrong color of yellow, the corresponding sling was gray). During an observation on 4/4/23, at 12:29 p.m., R2 was transferred via full body mechanical lift with a medium yellow high back sling from the chair to the bed. This was completed by NA-C and NA-D. The sling used was not in accordance with the care plan. During an interview on 4/5/23, at 9:33 a.m. clinical coordinator (CC)-A indicated the DON completed all of the Resident Transfer Assessments (that were not referred to therapy). The care plan and care guide were then updated to reflect the size sling; care guides were updated daily with any changes. CC-A reviewed R2's record, CC-A stated R2's assessment identified all three sling styles (universal, high back, and amputee sling) for R2, but did not specifically identify which sling R2 required and/or appropriate for transfers. CC-A was unable to articulate which sling should be used for any residents when all three slings were identified on the assessment. During an interview on 4/6/23, at 12:16 p.m. DON stated that R2 was transferred on 4/4/23, with the	2 830		

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2 830	Continued From page 10 wrong size sling. R2 should have been transferred with the high back medium slim gray sling. During interview on 4/4/23 at 12:18 p.m. occupational therapist (OT-A) indicated sling sizes were determined by weight and sometimes physical attributes such as being an amputee. OT-A stated there were not any other contributing factors when choosing universal sling versus high back. During interview on 4/4/23 on 2:58 physical therapist (PT-A) indicated the therapy staff is at times involved in sling determination. When therapy completed the lift assessments they would determine sling sized based on resident weights. Therapy would then fill out an interdisciplinary team communication sheet, the clinical coordinator would put it in the care plan. Facility used small, medium, and large size slings. PT-A stated that the facility had only been using universal slings and not high back or amputee slings. During interview on 4/4/23 at 3:05 Director of Therapy (DOT-A) indicated an unawareness of the facility's sling inventory and would need to verify what size and style slings were on hand. DOT-A was unable to articulate an indication for a high back sling. DOT-A indicated staff need to reference the color coded chart on the lift for what sling to use. DOT-A explained if a resident's weight was not accurate to the size or if manufactures recommendations were not followed then serious risks can occur. During an interview on 4/5/23, at 9:56 a.m. DON could not articulate the difference between the styles of the slings and indication of use. Further	2 830		

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2 830	Continued From page 11 indicated that the facility was not completing individualized comprehensive assessments for the appropriate lift sling size and style and confirmed all residents care plans and care guides were not accurate for identification of sling style and size. Facility policy Resident Transfer Assessment Policy dated April 2018 indicates that the assessment is to be completed by a licensed nurse or therapist. Licensed nurse or therapist will review documentation, interview direct caregivers, and observe a transfer of the resident. If the resident requires a mechanical lift the resident will be assessed for proper sling or harness using the manufactures guidelines. This will be noted in the assessment. The policy indicates that assist of two staff are required for all residents requiring a full mechanical lift. Facility "Mechanical Lift Transfer Policy" dated November 2018 directed the following: staff to always follow manufacturer's recommendation for the proper use of the equipment and slings. Two staff must remain present through the process of the transfer until the lift is no longer engaged and sling straps are unhooked. Staff are not to leave the resident out of visual line of site while the resident is attached to the lift. Further directs staff to place a wheelchair or other equipment, which the resident is to be transferred to, within the shortest distance possible from the bed, facing the head of the bed. Residents cannot be left hooked to the mechanical lift unless staff are present or directly visualizing. Manufacturer's recommendations for Universal and high-backed slings, dated 2020, indicated, "It is important to choose the correct size in order to achieve the highest level of comfort and safety. A	2 830		

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2 830	Continued From page 12 sling which is too large increases the risk of the patient sliding out of it, while one which is too small can cut into the groin and cause discomfort." Manufacturer instructions for the Liko Golvo lift dated 2017 included Before lifting always make certain that: -the lift strap is not twisted or worn and that it can move freely in and out of the lift unit; · the lifting accessories is selected appropriately in terms of type, size, material and design with regard to the patient's needs; ·the lifting accessory is correctly applied to the lifting equipment; ·the lifting accessory is correctly and securely applied to the patient, so that no personal injury can occur; ·the sling's strap loops are correctly fastened to the slingbar hooks when the sling strap is extended, but before the patient is lifted from the underlying surface. Never leave a patient unattended in a lifting situation! The immediate jeopardy that began on 3/29/23, was removed on 4/7/23, when it was verified the facility implemented the following: -The facility reviewed and revised the full body mechanical lift policy to include directives on completing the comprehensive assessment for sling sizes and styles. -The facility comprehensively assessed all residents who utilized full body lifts in accordance with the manufacturers recommendations. -The facility revised care plans and care guides based on the comprehensive assessment for all residents who utilized full body lifts. -The facility educated all nursing staff on required two staff assist for full body transfers, double	2 830		

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2 830	Continued From page 13 checking the position of the loops, completing comprehensive assessments for sling style and size, and on the types of slings and sizes. In addition, staff completed competency tested. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		