Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 21, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: July 26, 2024

Dear Administrator:

On August 13, 2024, we notified you a remedy was imposed. On August 15, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 3, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 28, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 28, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 3, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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 Location 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 21, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: Reinspection Results
Event ID: 4HRW12

Dear Administrator:

On August 15, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 26, 2024. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

REVISED LETTER DUE TO SCOPE AND SEVERITY REVISION. THIS LETTER IS TO REPLACE THE LETTER PREVIOUSLY RECEIVED ON 8/13/24.

Electronically delivered
August 16, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: July 26, 2024

Dear Administrator:

On July 26, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 28, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 28, 2024.

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.

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

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 $12,924; 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.

If you have not achieved substantial compliance by August 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Johns On Fountain Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 28, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 26, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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
202-795-7490

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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,

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
	245635	A. BUILDING ______ B. WING ______	C 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

(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 7/25/24 and 7/26/24, 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 following complaints were reviewed: H56355427C (MN00104666) 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 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 by:	F 689		8/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 08/14/2024

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

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F 689	Continued From page 1	F 689		

Summary Statement of Deficiencies (F 689):

Based on interview and document review the facility failed to safely use a full body mechanical lift per manufacturer's recommendations for 1 of 3 residents (R1) reviewed who used a mechanical lift. This resulted in harm when R1 fell from a full body mechanical lift causing ongoing pain in shoulders and neck region. In addition the facility failed to ensure comprehensive assessments were completed to determine proper sling size for 3 of 3 residents (R1, R2, and R3) who required transfers with a mechanical lift.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R1 was alert and with diagnosis of quadriplegia, bilateral range of motion impairment to both upper and lower extremities. R1 was dependent with all activities of daily living (ADLs) except for eating, which required set up only and used a electric wheelchair independently.

R1's Nursing Assessment for Total Mechanical lift dated 4/13/24 indicated R1 was deemed unsafe to use standing lift. The assessment directed staff to use the Hoyer lift (brand of full body mechanical lift) with two staff assist. The assessment did not address sling size and type.

R1's care plan dated 7/10/24, directed staff to transfer R1 with a Hoyer lift with two staff, but did not identify size or type of sling to use during transfers.

R1's progress notes dated 7/5/24 at 11:45 p.m., indicated at 11:10 p.m. R1 fell from Hoyer sling during transfer. R1 reported he had hit his head and his upper back. R1 rated his pain at 7/10 and

Provider's Plan of Correction (F 689):

F000
Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.

F689
Accident Hazards/Supervision/Devices

All residents have the potential to be impacted by the facility□s failure to follow manufacturer□s guidelines for safe lift transfers.

R1-R10 were immediately corrected per the IJ Removal Plan on 7/26/2024.

All residents that use an EZ Stand were reviewed for harness sizing and added to Kardex and care plans on or before 8/2/2024 if not already noted.

The policy and procedure for Using a Mechanical Lifting Machine was reviewed for accuracy, updated with the following language Nursing to complete assessment upon start of use, change of condition, return from hospital, and annually. Nursing will review resident□s weight weekly to ensure sling size remains appropriate, if there is a change in sling size, care plan will be updated, and put in place effective 7/25/2024.

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ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE** **ALBERT LEA, MN 56007**

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F 689	Continued From page 2 was given Tylenol. Nurse discussed with R1 option of going into the emergency room (ER) to be further evaluated for any injuries, R1 declined further ER evaluation multiple times. No visible injuries noted. No swelling, redness or bruising noted anywhere at this time. Director of nursing (DON) notified by phone. Fall protocol worksheet initiated and continue to monitor. R1's Post Fall Evaluation dated 7/6/24 at 7:46 a.m., indicated R1 vocalized a pain rating of 7/10 and was a new issue. No further documentation noted. R1's situation background assessment, and recommendation (SBAR) progress note dated 7/9/24 at 10:44 a.m. identified R1 had a fall on 7/5/24, within the last week has had an increase in pain in the back and neck, recommendation to be seen at the clinic and have a CT scan completed to rule out fractures. R1's progress note dated 7/9/24 at 11:47 a.m., indicated R1 left the facility at 11:00 a.m. and returned at 2:45 p.m. R1's hospital After Visit Summary dated 7/9/24 indicated R1 was seen in the emergency room for back pain. R1 was administered an injection of Ketoralac 15 milligrams (mg) (non-steroidal anti-inflammatory medication to relieve pain). Imagining tests were completed with no new findings or fractures. New orders included: Tylenol 1000 milligrams (mg) every 6 hours for pain, could also take 600 mg of ibuprofen every 6 hours, and use topical over the counter patches such as lidocaine or Salonpas and over the counter ointments/creams Voltaren gel or Asper to assist with pain control. Apply ice and/or heat	F 689	All new admissions that receive therapy services are reviewed for transfer and mobility status by nursing until therapy can evaluate them within 24 hours. This includes mechanical lifts and ensuring appropriate sling sizing effective 7/26/2024 and forward. All other new admissions are reviewed for transfer and mobility status by nursing to include mechanical lifts and ensuring appropriate sling sizing effective 7/26/2024 and forward. To communicate this, therapy completes a Resident Status Communication Form that gets sent/given to the nursing department to inform staff of transfer status. All newly hired nurses, and agency staff, will receive training on using a mechanical lift, sling sizing, and complete a return demonstration. All newly hired C.N.A□s and T.M.A.□s will receive training on using a mechanical lift, sling sizing, and complete a return demonstration starting 7/26/2024 and moving forward. Resident sling size is located on the Kardex in the resident□s cubby□s and care plan for C.N.A□s and T.M.A□s to access. An audit has been initiated on 8/2/2024 by DON or designee daily (M-F) for 1 month, 1x weekly for 1 month and monthly for 3 months to ensure compliance with sling sizing standards and how to complete a	

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F 689	Continued From page 3 for 20 minutes at a time multiple times per day and can alternate ice and heat. R1's medication administration record (MAR) was reviewed for June and July 2024. The June MAR included a physician order for Acetaminophen (Tylenol) hydrocodone (narcotic pain medication) 325/5 milligrams (mg) three times a day; R1's average pain rating was marked 4 and 5 out of 10 scale (10 being the most severe). June's MAR also identified an order for as needed (PRN) Tylenol 1000 mg every two hours; MAR identified one administration on 6/22/24 for pain level of 8 out of 10. July's MAR identified the aforementioned orders. The pain rating for the scheduled Acetaminophen/hydrocodone identified increased pain ratings between 7/5/24 and 7/11/24 after the fall. R1 reported pain 6/10 on five occasions and 7/10 pain on 4 occasions. July's MAR also identified R1 was administered PRN Tylenol on 10 occasions between 7/5/25 through 7/11/24; R1 reported pain rated 6/10 prior to one administration, pain rated 7/10 prior to eight administrations, and pain rated 8/10 prior to one administration. R1's Nursing Assessment for Total Mechanical lift dated 7/25/24 indicated R1 was deemed unsafe to use standing lift; R1 could follow commands but not always cooperative. The summary included: Hoyer lift was appropriate and effective in transfers using two assist due to medical diagnoses. The assessment did not address the sling size or type. During an interview on 7/25/24 at 11:22, R1 recalled his fall from the lift on 7/5/24. R1 stated nursing assistant (NA)-B and NA-H were transferring him from his wheelchair to his bed	F 689	transfer with the mechanical lift. An additional audit, initiated on 8/3/2024, for sling sizing is being completed weekly. Results will be reported to QAPI.	

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F 689	Continued From page 4	F 689		

with a mechanical lift when the right shoulder sling loop/strap came off the lift causing him to fall to the floor. R1's voice became rigid and abrasive as he explained his frustration that he had to go the hospital several days later on 7/9/24 to make sure "nothing was broke" even though he continued to have pain currently from this fall.

During an interview on 7/25/24 at 4:00 p.m., NA-B indicated on 7/5/24 at approximately 11:00 p.m. NA-H was helping him transfer R1 from his wheelchair to his bed. NA-B explained R1 was raised into the air and while the lift was pushed toward the bed, the right upper lift strap came off the lift hook causing R1 to fall approximately 3 feet to the floor. NA-B indicated they connected the sling to the lift "the normal way", NA-B connected his side and NA-H connected her side. NA-B was not able to articulate why the strap came off of the lift and did not identify tension was checked prior to moving the lift away from the wheelchair. The NA's called for the nurse over the radio. RN-H arrived to the room and they used the same lift to get R1 off the floor and into bed after RN-H did an assessment. NA-B stated R1 was complaining of pain in his neck and back. NA-B indicated staff used whatever sling was in the room and was not able to articulate how sling sizes were determined. NA-B indicated the lift was not removed from operation per for a safety inspection immediately following the fall.

During an interview on 7/25/24 at 4:07 p.m., NA-H indicated on 7/5/24 she was assisting NA-B with R1's bedtime cares. We (NA-H and NA-B) were transferring R1 from his chair to his bed. They moved the lift away from the chair and that is when the right upper sling strap, which was on NA-B's side of the lift, came off causing R1 to fall

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F 689	Continued From page 5	F 689		

backwards to the floor. Initially NA-H thought the sling broke, but everything was fine. NA-H indicated the loop must not have been all the way around the hook and more resting on top of the hook, indicating they had not checked for the tension prior to moving. NA-H stated they called for the nurse immediately. RN-H responded, she checked R1 for injury and checked the lift to make sure it worked. After that was done, a different sling was used to get R1 off the floor into bed. R1 was complaining of pain in his upper back and shoulder area. NA-H indicated staff used whatever sling was in the room and was not able to articulate how sling sizes was determined. NA-H further stated the lift was not removed from the floor for inspection after the incident.

The facility's fall investigation was reviewed; the investigation did not address and/or identify if the appropriate sling size and type that was used at the time of R1's transfer. The facility's Vulnerable Adult Investigation Form for NA-H dated 7/6/24 at 10:30 a.m. signed by DON indicated NA-H, reported "We were putting resident to bed and hook up sling to the hoyer, we made sure the sling was attached. We lifted resident up and one of the straps snapped off, and resident rolled out the right side onto the floor" The investigation form for NA-B dated 7/6/24 at 9:00 signed by DON indicated NA-B reported "We were putting [resident room number] to bed like we always do. We made sure all the straps were hooked up. Resident [was] also checking to make sure he wasn't caught on anything and we started to lift him up and the strap on the right back snapped off and resident rolled out the right side onto his back...He was 2-3 feet up and it happened so fast there was nothing we could do." Both NA-H and NA-B's forms included "Re-Education: discussed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

(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 6 F 689

and educated CNA on the importance of checking and double checking the straps are properly hooked to hoyer. NOC [night] nurse on duty at the time of the fall educated staff on importance of checking straps during transfer. Nurse also observed res [resident] transfer in the a.m. with staff and hoyer."

During an interview on 7/25/24 at 2:27 p.m., RN-H stated she was called to R1's room around 11:00 p.m. on 7/5/24, because R1 had fallen from a mechanical lift. RN-H entered the room, R1 was on the floor beside the bed on his back. R1 was alert and oriented, she did not observe any obvious injuries, however, R1 complained of pain in his upper back and neck area but refused to go the ED. RN-H inspected both the lift and the sling. She did not see anything wrong with either but used a different sling to get R1 off the floor. RN-H stated she thought a large size sling was used for both transfers however could not say for sure. RN-H indicated the facility did not have an assessment or system for determining sling sizes however she would make sure the sling "covered the shoulders to upper thighs". RN-H indicated the lift was not removed from the floor because she had found it was in working order. RN-H had not asked maintenance to inspect the lift, nor was the transfer sling inspected. RN-H further indicated that R1 was continuing to have on going pain and had gone to the emergency room on 7/9/24 and was found to not have any injuries.

Review of the facility's maintenance logs for the Hoyer mechanical lifts for the months of June and July indicated all lifts were checked on 6/5/24, one lift was checked on 7/8/24, three days after R1's fall. The records indicated the remaining lifts were inspected on 7/25/24. The facility was using

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING ______ B. WING ______	C 07/26/2024

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F 689	Continued From page 7	F 689		

EZ-Way brand lifts rather than Hoyer brand lifts.

R3's quarterly MDS dated 7/17/24, indicated R3 did not have cognitive impairment. R3 had no impairment of upper or lower extremities. R3 was dependent with all transfers and did not walk.

R3's Nursing Assessment for Total Mechanical lift dated 6/21/22, indicated R3 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling.

R3's ADL care plan 6/21/24 directed staff to transfer R3 with Hoyer lift with two staff. The care plan did not include the sling size and type that R3 required.

R3's Nursing Assessment for Total Mechanical dated 7/25/24, indicated R3 required a Hoyer lift with two staff assistance. The summary included: Hoyer lift is appropriate and effective for transfers and two assist due to resident's decline in mobility. This assessment also did not address sling size and type.

During an observation on 7/25/24 at 12:56 p.m., R3 sat in her recliner with a green sling underneath her. This sling size was extra-large per manufactures sizing guide on mechanical lift outside of room.

During an observation on 7/25/24 at 1:11 p.m., nurse manager (NM)-A entered R3's room and verified that the sling R3 was sitting on was extra large in size. NM-A was not aware of how to measure for the appropriate sling size and type and indicated there was no process in place for completing sling assessments.

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F 689	Continued From page 8	F 689		

Continued From page 8

During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)- A stated the sling R3 was sitting on, was not the correct sling size. LR-A stated R3 should be a large sling size and not extra large.

R2's quarterly MDS dated 7/17/24, R2 had severe cognitive impairment. R2's diagnoses included hip fracture, Alzheimer's disease, and dementia. R2 was dependent for ADLs except required moderate assistance with eating. R2 had impairment on one side of her lower extremities and used a manual wheelchair.

R2's Nursing Assessment for Total Mechanical lift dated 6/20/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling.

R2's ADL care plan 6/20/24, for transfers directed staff to use a Hoyer lift with two staff. The care plan did not identify sling size and type that R2 required.

R2's Nursing Assessment for Total Mechanical lift dated 7/25/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment continued to lack mention of size and type of sling.

During an interview on 7/25/24 at 10:25 a.m., NA-A stated an unawareness of how to properly determine sling size and would use the sling that was in the resident's rooms. NA-A thought nursing or therapy decided the sling size.

During an interview on 7/25/24 at 10:51 a.m., NA-M indicated the sling size was dependent on the size and weight of the person. NA-M would

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F 689	Continued From page 9	F 689		

check the sling size chart on the lift against the resident's weight. She would use whatever sling was in the room unless she questioned the fit.

During an interview on 7/25/24 at 5:50 p.m., Administrator and DON both indicated if there was not anything wrong with the lift and the sling the cause of the fall would be operator error. DON and Administrator expected staff to follow the manufacturers recommendations for safety. Stated there had not previously been a process in place to determine proper sling size and staff were expected to follow the manufacturer's instructions.

During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they were secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of. LR-A stated the correct sling sizes were important to prevent falls and injuries to both residents and staff. Additionally, with the correct sling size, the staff can obtain better resident placement in chair and bed without pushing or pulling on resident.

EZ-Way Smart Lift Operator Manual included the following:
WARNING: For safe operation of the EZ Way Lifts, the lift must be used by trained personnel in accordance with operators manual, video, and training checklist to avoid injury to patient.
-do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation,

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F 689	Continued From page 10 -the sling size is calculated using the resident weight, height, and girth, a proper fir will involve judgement of the caregiver, - proper sling placement include top of sling at the shoulder level and the base of the sling two inches below the tail bone, -while lifting the patient upward, continue until there is tension on the sling legs, making sure all the loops on the sling are securely hooked on the hanger bars before moving resident from over the surface transferring from, -all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 13, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: July 26, 2024

Dear Administrator:

On July 26, 2024, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 26, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 28, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 28, 2024 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 28, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy

must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 26, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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, St Johns On Fountain Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 26, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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 January 26, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Steven.Delich@cms.hhs.gov

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

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

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

emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution

policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

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F 000	INITIAL COMMENTS On 7/25/24 and 7/26/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 7/5/24, when R1 fell from a mechanical lift to the floor resultiong in continued pain in R1's upper back. The administrator and director of nursing (DON) were notified of the IJ on 7/25/24 at 5:40 p.m. The IJ was removed on 7/26/24 after it was verified corrective action was implemented. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 7/26/24. The following complaints were reviewed: H56355427C (MN00104666) 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2024

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

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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 interview and document review the facility failed to safely use a full body mechanical lift per manufacturer's recommendations for 1 of 3 residents (R1) reviewed who used a mechanical lift. This resulted in an immediate jeopardy (IJ) for R1 when they fell from a full body mechanical lift causing R1 ongoing pain in shoulders and neck region. In addition to the residents in the IJ, the facility failed to ensure comprehensive assessments were completed to determine proper sling size for 3 of 3 residents (R1, R2, and R3) who required transfers with a mechanical lift. The IJ began on 7/5/24 at 11:10 p.m., when staff failed to ensure lift sling was secured prior to the transfer, causing R1 to fall from the mechanical lift. The administrator and director of nursing (DON) were notified of the IJ on 7/25/24 at 5:40 p.m. The IJ was removed on 7/26/24 at 2:45 p.m., but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include:	F 689	F000 Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. F689 Accident Hazards/Supervision/Devices All residents have the potential to be impacted by the facility's failure to follow manufacturer's guidelines for safe lift transfers. R1-R10 were immediately corrected per the IJ Removal Plan on 7/26/2024. All residents that use an EZ Stand were reviewed for harness sizing and added to Kardex and care plans on or before 8/2/2024 if not already noted.	8/3/24

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F 689

Continued From page 2

R1's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R1 was alert and with diagnosis of quadriplegia, bilateral range of motion impairment to both upper and lower extremities. R1 was dependent with all activities of daily living (ADLs) except for eating, which required set up only and used a electric wheelchair independently.

R1's Nursing Assessment for Total Mechanical lift dated 4/13/24 indicated R1 was deemed unsafe to use standing lift. The assessment directed staff to use the Hoyer lift (brand of full body mechanical lift) with two staff assist. The assessment did not address sling size and type.

R1's care plan dated 7/10/24, directed staff to transfer R1 with a Hoyer lift with two staff, but did not identify size or type of sling to use during transfers.

R1's progress notes dated 7/5/24 at 11:45 p.m., indicated at 11:10 p.m. R1 fell from Hoyer sling during transfer. R1 reported he had hit his head and his upper back. R1 rated his pain at 7/10 and was given Tylenol. Nurse discussed with R1 option of going into the emergency room (ER) to be further evaluated for any injuries, R1 declined further ER evaluation multiple times. No visible injuries noted. No swelling, redness or bruising noted anywhere at this time. Director of nursing (DON) notified by phone. Fall protocol worksheet initiated and continue to monitor.

R1's Post Fall Evaluation dated 7/6/24 at 7:46 a.m., indicated R1 vocalized a pain rating of 7/10 and was a new issue. No further documentation noted.

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The policy and procedure for Using a Mechanical Lifting Machine was reviewed for accuracy, updated with the following language “Nursing to complete assessment upon start of use, change of condition, return from hospital, and annually. Nursing will review resident’s weight weekly to ensure sling size remains appropriate, if there is a change in sling size, care plan will be updated”, and put in place effective 7/25/2024.

All new admissions that receive therapy services are reviewed for transfer and mobility status by nursing until therapy can evaluate them within 24 hours. This includes mechanical lifts and ensuring appropriate sling sizing effective 7/26/2024 and forward.

All other new admissions are reviewed for transfer and mobility status by nursing to include mechanical lifts and ensuring appropriate sling sizing effective 7/26/2024 and forward.

To communicate this, therapy completes a “Resident Status Communication Form” that gets sent/given to the nursing department to inform staff of transfer status.

All newly hired nurses, and agency staff, will receive training on using a mechanical lift, sling sizing, and complete a return demonstration. All newly hired C.N.A’s and T.M.A.’s will receive training on using a mechanical lift, sling sizing, and complete a return demonstration starting

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	245635	A. BUILDING ______ B. WING ______	C 07/26/2024

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ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 689	Continued From page 3 R1's situation background assessment, and recommendation (SBAR) progress note dated 7/9/24 at 10:44 a.m. identified R1 had a fall on 7/5/24, within the last week has had an increase in pain in the back and neck, recommendation to be seen at the clinic and have a CT scan completed to rule out fractures. R1's progress note dated 7/9/24 at 11:47 a.m., indicated R1 left the facility at 11:00 a.m. and returned at 2:45 p.m. R1's hospital After Visit Summary dated 7/9/24 indicated R1 was seen in the emergency room for back pain. R1 was administered an injection of Ketoralac 15 milligrams (mg) (non-steroidal anti-inflammatory medication to relieve pain). Imagining tests were completed with no new findings or fractures. New orders included: Tylenol 1000 milligrams (mg) every 6 hours for pain, could also take 600 mg of ibuprofen every 6 hours, and use topical over the counter patches such as lidocaine or Salonpas and over the counter ointments/creams Voltaren gel or Asper to assist with pain control. Apply ice and/or heat for 20 minutes at a time multiple times per day and can alternate ice and heat. R1's medication administration record (MAR) was reviewed for June and July 2024. The June MAR included a physician order for Acetaminophen (Tylenol) hydrocodone (narcotic pain medication) 325/5 milligrams (mg) three times a day; R1's average pain rating was marked 4 and 5 out of 10 scale (10 being the most severe). June's MAR also identified an order for as needed (PRN) Tylenol 1000 mg every two hours; MAR identified one administration on 6/22/24 for pain level of 8 out of 10. July's MAR identified the	F 689	7/26/2024 and moving forward. Resident sling size is located on the Kardex in the resident's cubby's and care plan for C.N.A's and T.M.A's to access. An audit has been initiated on 8/2/2024 by DON or designee daily (M-F) for 1 month, 1x weekly for 1 month and monthly for 3 months to ensure compliance with sling sizing standards and how to complete a transfer with the mechanical lift. An additional audit, initiated on 8/3/2024, for sling sizing is being completed weekly. Results will be reported to QAPI.	

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aforementioned orders. The pain rating for the scheduled Acetaminophen/hydrocodone identified increased pain ratings between 7/5/24 and 7/11/24; R1 reported pain 6/10 on five occasions and 7/10 pain on 4 occasions. July's MAR also identified R1 was administered PRN Tylenol on 10 occasions between 7/5/25 through 7/11/24; R1 reported pain rated 6/10 prior to one administration, pain rated 7/10 prior to eight administrations, and pain rated 8/10 prior to one administration.

R1's Nursing Assessment for Total Mechanical lift dated 7/25/24 indicated R1 was deemed unsafe to use standing lift; R1 could follow commands but not always cooperative. The summary included: Hoyer lift was appropriate and effective in transfers using two assist due to medical diagnoses. The assessment did not address the sling size or type.

During an interview on 7/25/24 at 11:22, R1 recalled his fall from the lift on 7/5/24. R1 stated nursing assistant (NA)-B and NA-H were transferring him from his wheelchair to his bed with a mechanical lift when the right shoulder sling loop/strap came off the lift causing him to fall to the floor. R1's voice became rigid and abrasive as he explained his frustration that he had to go the hospital several days later on 7/9/24 to make sure "nothing was broke" even though he continued to have pain currently from this fall.

During an interview on 7/25/24 at 4:00 p.m., NA-B indicated on 7/5/24 at approximately 11:00 p.m. NA-H was helping him transfer R1 from his wheelchair to his bed. NA-B explained R1 was raised into the air and while the lift was pushed toward the bed, the right upper lift strap came off

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the lift hook causing R1 to fall approximately 3 feet to the floor. NA-B indicated they connected the sling to the lift "the normal way", NA-B connected his side and NA-H connected her side. NA-B was not able to articulate why the strap came off of the lift and did not identify tension was checked prior to moving the lift away from the wheelchair. The NA's called for the nurse over the radio. RN-H arrived to the room and they used the same lift to get R1 off the floor and into bed after RN-H did an assessment. NA-B stated R1 was complaining of pain in his neck and back. NA-B indicated staff used whatever sling was in the room and was not able to articulate how sling sizes were determined. NA-B indicated the lift was not removed from operation per for a safety inspection immediately following the fall.

During an interview on 7/25/24 at 4:07 p.m., NA-H indicated on 7/5/24 she was assisting NA-B with R1's bedtime cares. We (NA-H and NA-B) were transferring R1 from his chair to his bed. They moved the lift away from the chair and that is when the right upper sling strap, which was on NA-B's side of the lift, came off causing R1 to fall backwards to the floor. Initially NA-H thought the sling broke, but everything was fine. NA-H indicated the loop must not have been all the way around the hook and more resting on top of the hook, indicating they had not checked for the tension prior to moving. NA-H stated they called for the nurse immediately. RN-H responded, she checked R1 for injury and checked the lift to make sure it worked. After that was done, a different sling was used to get R1 off the floor into bed. R1 was complaining of pain in his upper back and shoulder area. NA-H indicated staff used whatever sling was in the room and was not able to articulate how sling sizes was determined.

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NA-H further stated the lift was not removed from the floor for inspection after the incident.

The facility's fall investigation was reviewed; the investigation did not address and/or identify if the appropriate sling size and type that was used at the time of R1's transfer. The facility's Vulnerable Adult Investigation Form for NA-H dated 7/6/24 at 10:30 a.m. signed by DON indicated NA-H, reported "We were putting resident to bed and hook up sling to the hoyer, we made sure the sling was attached. We lifted resident up and one of the straps snapped off, and resident rolled out the right side onto the floor" The investigation form for NA-B dated 7/6/24 at 9:00 signed by DON indicated NA-B reported "We were putting [resident room number] to bed like we always do. We made sure all the straps were hooked up. Resident [was] also checking to make sure he wasn't caught on anything and we started to lift him up and the strap on the right back snapped off and resident rolled out the right side onto his back...He was 2-3 feet up and it happened so fast there was nothing we could do." Both NA-H and NA-B's forms included "Re-Education: discussed and educated CNA on the importance of checking and double checking the straps are properly hooked to hoyer. NOC [night] nurse on duty at the time of the fall educated staff on importance of checking straps during transfer. Nurse also observed res [resident] transfer in the a.m. with staff and hoyer."

During an interview on 7/25/24 at 2:27 p.m., RN-H stated she was called to R1's room around 11:00 p.m. on 7/5/24, because R1 had fallen from a mechanical lift. RN-H entered the room, R1 was on the floor beside the bed on his back. R1 was alert and oriented, she did not observe any

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obvious injuries, however, R1 complained of pain in his upper back and neck area but refused to go the ED. RN-H inspected both the lift and the sling. She did not see anything wrong with either but used a different sling to get R1 off the floor. RN-H stated she thought a large size sling was used for both transfers however could not say for sure. RN-H indicated the facility did not have an assessment or system for determining sling sizes however she would make sure the sling "covered the shoulders to upper thighs". RN-H indicated the lift was not removed from the floor because she had found it was in working order. RN-H had not asked maintenance to inspect the lift, nor was the transfer sling inspected. RN-H further indicated that R1 was continuing to have on going pain and had gone to the emergency room on 7/9/24 and was found to not have any injuries.

Review of the facility's maintenance logs for the Hoyer mechanical lifts for the months of June and July indicated all lifts were checked on 6/5/24, one lift was checked on 7/8/24, three days after R1's fall. The records indicated the remaining lifts were inspected on 7/25/24. The facility was using EZ-Way brand lifts rather than Hoyer brand lifts.

R3's quarterly MDS dated 7/17/24, indicated R3 did not have cognitive impairment. R3 had no impairment of upper or lower extremities. R3 was dependent with all transfers and did not walk.

R3's Nursing Assessment for Total Mechanical lift dated 6/21/22, indicated R3 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling.

R3's ADL care plan 6/21/24 directed staff to transfer R3 with Hoyer lift with two staff. The care

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plan did not include the sling size and type that R3 required.

R3's Nursing Assessment for Total Mechanical dated 7/25/24, indicated R3 required a Hoyer lift with two staff assistance. The summary included: Hoyer lift is appropriate and effective for transfers and two assist due to resident's decline in mobility. This assessment also did not address sling size and type.

During an observation on 7/25/24 at 12:56 p.m., R3 sat in her recliner with a green sling underneath her. This sling size was extra-large per manufactures sizing guide on mechanical lift outside of room.

During an observation on 7/25/24 at 1:11 p.m., nurse manager (NM)-A entered R3's room and verified that the sling R3 was sitting on was extra large in size. NM-A was not aware of how to measure for the appropriate sling size and type and indicated there was no process in place for completing sling assessments.

During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)- A stated the sling R3 was sitting on, was not the correct sling size. LR-A stated R3 should be a large sling size and not extra large.

R2's quarterly MDS dated 7/17/24, R2 had severe cognitive impairment. R2's diagnoses included hip fracture, Alzheimer's disease, and dementia. R2 was dependent for ADLs except required moderate assistance with eating. R2 had impairment on one side of her lower extremities and used a manual wheelchair.

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F 689	Continued From page 9 R2's Nursing Assessment for Total Mechanical lift dated 6/20/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling. R2's ADL care plan 6/20/24, for transfers directed staff to use a Hoyer lift with two staff. The care plan did not identify sling size and type that R2 required. R2's Nursing Assessment for Total Mechanical lift dated 7/25/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment continued to lack mention of size and type of sling. During an interview on 7/25/24 at 10:25 a.m., NA-A stated an unawareness of how to properly determine sling size and would use the sling that was in the resident's rooms. NA-A thought nursing or therapy decided the sling size. During an interview on 7/25/24 at 10:51 a.m., NA-M indicated the sling size was dependent on the size and weight of the person. NA-M would check the sling size chart on the lift against the resident's weight. She would use whatever sling was in the room unless she questioned the fit. During an interview on 7/25/24 at 5:50 p.m., Administrator and DON both indicated if there was not anything wrong with the lift and the sling the cause of the fall would be operator error. DON and Administrator expected staff to follow the manufacturers recommendations for safety. Stated there had not previously been a process in place to determine proper sling size and staff were expected to follow the manufacturer's instructions.	F 689		

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During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they were secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of. LR-A stated the correct sling sizes were important to prevent falls and serious injuries to both residents and staff. Additionally, with the correct sling size, the staff can obtain better resident placement in chair and bed without pushing or pulling on resident.

EZ-Way Smart Lift Operator Manual included the following:
WARNING: For safe operation of the EZ Way Lifts, the lift must be used by trained personnel in accordance with operators manual, video, and training checklist to avoid injury to patient.
-do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation,
-the sling size is calculated using the resident weight, height, and girth, a proper fir will involve judgement of the caregiver,
- proper sling placement include top of sling at the shoulder level and the base of the sling two inches below the tail bone,
-while lifting the patient upward, continue until there is tension on the sling legs, making sure all the loops on the sling are securely hooked on the hanger bars before moving resident from over the surface transferring from,
-all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided.

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F 689	Continued From page 11 The IJ was removed on 7/26/24 at 2:45 p.m., when it was verified the facility had completed the following: -The policy and procedure for using a mechanical lifting machine was reviewed for accuracy, updated, and put in place effective 7/25/24, -Nursing assessments were verified and completed for all 10 residents that used a mechanical lift, -All 10 residents that used a mechanical lift were reviewed for sling size and their care plans were updated to reflect these changes, -All nursing staff were re-educated, with return demonstration, prior to working their next shift, on manufactures recommendations of using the full body mechanical lift, to include checking the straps for tension and using the proper sling size according to the resident's care plan.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders
Event ID: 4HRW11

Dear Administrator:

The above facility was surveyed on July 25, 2024 through July 26, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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

Minnesota Department of Health

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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 7/25/24 NS 7/26/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H56355427 (MN00104666) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to safely use a full body mechanical lift per manufacturer's recommendations for 1 of 3 residents (R1) reviewed who used a mechanical lift. This resulted in an immediate jeopardy (IJ) for R1 when they fell from a full body mechanical lift causing R1 ongoing pain in shoulders and neck region. In addition to the residents in the IJ, the facility failed to ensure comprehensive assessments were completed to determine proper sling size for 3 of 3 residents (R1, R2, and R3) who required transfers with a	2 830	F000 Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. F689	8/3/24

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2 830	Continued From page 3 mechanical lift. The IJ began on 7/5/24 at 11:10 p.m., when staff failed to ensure lift sling was secured prior to the transfer, causing R1 to fall from the mechanical lift. The administrator and director of nursing (DON) were notified of the IJ on 7/25/24 at 5:40 p.m. The IJ was removed on 7/26/24 at 2:45 p.m., but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/10/24, indicated R1 was alert and with diagnosis of quadriplegia, bilateral range of motion impairment to both upper and lower extremities. R1 was dependent with all activities of daily living (ADLs) except for eating, which required set up only and used a electric wheelchair independently. R1's Nursing Assessment for Total Mechanical lift dated 4/13/24 indicated R1 was deemed unsafe to use standing lift. The assessment directed staff to use the Hoyer lift (brand of full body mechanical lift) with two staff assist. The assessment did not address sling size and type. R1's care plan dated 7/10/24, directed staff to transfer R1 with a Hoyer lift with two staff, but did not identify size or type of sling to use during transfers. R1's progress notes dated 7/5/24 at 11:45 p.m., indicated at 11:10 p.m. R1 fell from Hoyer sling during transfer. R1 reported he had hit his head and his upper back. R1 rated his pain at 7/10 and	2 830	Accident Hazards/Supervision/Devices All residents have the potential to be impacted by the facility's failure to follow manufacturer's guidelines for safe lift transfers. R1-R10 were immediately corrected per the IJ Removal Plan on 7/26/2024. All residents that use an EZ Stand were reviewed for harness sizing and added to Kardex and care plans on or before 8/2/2024 if not already noted. The policy and procedure for Using a Mechanical Lifting Machine was reviewed for accuracy, updated with the following language "Nursing to complete assessment upon start of use, change of condition, return from hospital, and annually. Nursing will review resident's weight weekly to ensure sling size remains appropriate, if there is a change in sling size, care plan will be updated", and put in place effective 7/25/2024. All new admissions that receive therapy services are reviewed for transfer and mobility status by nursing until therapy can evaluate them within 24 hours. This includes mechanical lifts and ensuring appropriate sling sizing effective 7/26/2024 and forward. All other new admissions are reviewed for transfer and mobility status by nursing to include mechanical lifts and ensuring appropriate sling sizing effective 7/26/2024 and forward.	

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2 830	Continued From page 4 was given Tylenol. Nurse discussed with R1 option of going into the emergency room (ER) to be further evaluated for any injuries, R1 declined further ER evaluation multiple times. No visible injuries noted. No swelling, redness or bruising noted anywhere at this time. Director of nursing (DON) notified by phone. Fall protocol worksheet initiated and continue to monitor. R1's Post Fall Evaluation dated 7/6/24 at 7:46 a.m., indicated R1 vocalized a pain rating of 7/10 and was a new issue. No further documentation noted. R1's situation background assessment, and recommendation (SBAR) progress note dated 7/9/24 at 10:44 a.m. identified R1 had a fall on 7/5/24, within the last week has had an increase in pain in the back and neck, recommendation to be seen at the clinic and have a CT scan completed to rule out fractures. R1's progress note dated 7/9/24 at 11:47 a.m., indicated R1 left the facility at 11:00 a.m. and returned at 2:45 p.m. R1's hospital After Visit Summary dated 7/9/24 indicated R1 was seen in the emergency room for back pain. R1 was administered an injection of Ketoralac 15 milligrams (mg) (non-steroidal anti-inflammatory medication to relieve pain). Imagining tests were completed with no new findings or fractures. New orders included: Tylenol 1000 milligrams (mg) every 6 hours for pain, could also take 600 mg of ibuprofen every 6 hours, and use topical over the counter patches such as lidocaine or Salonpas and over the counter ointments/creams Voltaren gel or Asper to assist with pain control. Apply ice and/or heat for 20 minutes at a time multiple times per day	2 830	To communicate this, therapy completes a "Resident Status Communication Form" that gets sent/given to the nursing department to inform staff of transfer status. All newly hired nurses, and agency staff, will receive training on using a mechanical lift, sling sizing, and complete a return demonstration. All newly hired C.N.A's and T.M.A.'s will receive training on using a mechanical lift, sling sizing, and complete a return demonstration starting 7/26/2024 and moving forward. Resident sling size is located on the Kardex in the resident's cubby's and care plan for C.N.A's and T.M.A's to access. An audit has been initiated on 8/2/2024 by DON or designee daily (M-F) for 1 month, 1x weekly for 1 month and monthly for 3 months to ensure compliance with sling sizing standards and how to complete a transfer with the mechanical lift. An additional audit, initiated on 8/3/2024, for sling sizing is being completed weekly. Results will be reported to QAPI.	

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2 830	Continued From page 5	2 830		

and can alternate ice and heat.

R1's medication administration record (MAR) was reviewed for June and July 2024. The June MAR included a physician order for Acetaminophen (Tylenol) hydrocodone (narcotic pain medication) 325/5 milligrams (mg) three times a day; R1's average pain rating was marked 4 and 5 out of 10 scale (10 being the most severe). June's MAR also identified an order for as needed (PRN) Tylenol 1000 mg every two hours; MAR identified one administration on 6/22/24 for pain level of 8 out of 10. July's MAR identified the aforementioned orders. The pain rating for the scheduled Acetaminophen/hydrocodone identified increased pain ratings between 7/5/24 and 7/11/24; R1 reported pain 6/10 on five occasions and 7/10 pain on 4 occasions. July's MAR also identified R1 was administered PRN Tylenol on 10 occasions between 7/5/25 through 7/11/24; R1 reported pain rated 6/10 prior to one administration, pain rated 7/10 prior to eight administrations, and pain rated 8/10 prior to one administration.

R1's Nursing Assessment for Total Mechanical lift dated 7/25/24 indicated R1 was deemed unsafe to use standing lift; R1 could follow commands but not always cooperative. The summary included: Hoyer lift was appropriate and effective in transfers using two assist due to medical diagnoses. The assessment did not address the sling size or type.

During an interview on 7/25/24 at 11:22, R1 recalled his fall from the lift on 7/5/24. R1 stated nursing assistant (NA)-B and NA-H were transferring him from his wheelchair to his bed with a mechanical lift when the right shoulder sling loop/strap came off the lift causing him to

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fall to the floor. R1's voice became rigid and abrasive as he explained his frustration that he had to go the hospital several days later on 7/9/24 to make sure "nothing was broke" even though he continued to have pain currently from this fall.

During an interview on 7/25/24 at 4:00 p.m., NA-B indicated on 7/5/24 at approximately 11:00 p.m. NA-H was helping him transfer R1 from his wheelchair to his bed. NA-B explained R1 was raised into the air and while the lift was pushed toward the bed, the right upper lift strap came off the lift hook causing R1 to fall approximately 3 feet to the floor. NA-B indicated they connected the sling to the lift "the normal way", NA-B connected his side and NA-H connected her side. NA-B was not able to articulate why the strap came off of the lift and did not identify tension was checked prior to moving the lift away from the wheelchair. The NA's called for the nurse over the radio. RN-H arrived to the room and they used the same lift to get R1 off the floor and into bed after RN-H did an assessment. NA-B stated R1 was complaining of pain in his neck and back. NA-B indicated staff used whatever sling was in the room and was not able to articulate how sling sizes were determined. NA-B indicated the lift was not removed from operation per for a safety inspection immediately following the fall.

During an interview on 7/25/24 at 4:07 p.m., NA-H indicated on 7/5/24 she was assisting NA-B with R1's bedtime cares. We (NA-H and NA-B) were transferring R1 from his chair to his bed. They moved the lift away from the chair and that is when the right upper sling strap, which was on NA-B's side of the lift, came off causing R1 to fall backwards to the floor. Initially NA-H thought the sling broke, but everything was fine. NA-H indicated the loop must not have been all the way

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2 830	Continued From page 7 around the hook and more resting on top of the hook, indicating they had not checked for the tension prior to moving. NA-H stated they called for the nurse immediately. RN-H responded, she checked R1 for injury and checked the lift to make sure it worked. After that was done, a different sling was used to get R1 off the floor into bed. R1 was complaining of pain in his upper back and shoulder area. NA-H indicated staff used whatever sling was in the room and was not able to articulate how sling sizes was determined. NA-H further stated the lift was not removed from the floor for inspection after the incident. The facility's fall investigation was reviewed; the investigation did not address and/or identify if the appropriate sling size and type that was used at the time of R1's transfer. The facility's Vulnerable Adult Investigation Form for NA-H dated 7/6/24 at 10:30 a.m. signed by DON indicated NA-H, reported "We were putting resident to bed and hook up sling to the hoyer, we made sure the sling was attached. We lifted resident up and one of the straps snapped off, and resident rolled out the right side onto the floor" The investigation form for NA-B dated 7/6/24 at 9:00 signed by DON indicated NA-B reported "We were putting [resident room number] to bed like we always do. We made sure all the straps were hooked up. Resident [was] also checking to make sure he wasn't caught on anything and we started to lift him up and the strap on the right back snapped off and resident rolled out the right side onto his back...He was 2-3 feet up and it happened so fast there was nothing we could do." Both NA-H and NA-B's forms included "Re-Education: discussed and educated CNA on the importance of checking and double checking the straps are properly hooked to hoyer. NOC [night] nurse on duty at the time of the fall educated staff on importance of	2 830		

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checking straps during transfer. Nurse also observed res [resident] transfer in the a.m. with staff and hoyer."

During an interview on 7/25/24 at 2:27 p.m., RN-H stated she was called to R1's room around 11:00 p.m. on 7/5/24, because R1 had fallen from a mechanical lift. RN-H entered the room, R1 was on the floor beside the bed on his back. R1 was alert and oriented, she did not observe any obvious injuries, however, R1 complained of pain in his upper back and neck area but refused to go the ED. RN-H inspected both the lift and the sling. She did not see anything wrong with either but used a different sling to get R1 off the floor. RN-H stated she thought a large size sling was used for both transfers however could not say for sure. RN-H indicated the facility did not have an assessment or system for determining sling sizes however she would make sure the sling "covered the shoulders to upper thighs". RN-H indicated the lift was not removed from the floor because she had found it was in working order. RN-H had not asked maintenance to inspect the lift, nor was the transfer sling inspected. RN-H further indicated that R1 was continuing to have on going pain and had gone to the emergency room on 7/9/24 and was found to not have any injuries.

Review of the facility's maintenance logs for the Hoyer mechanical lifts for the months of June and July indicated all lifts were checked on 6/5/24, one lift was checked on 7/8/24, three days after R1's fall. The records indicated the remaining lifts were inspected on 7/25/24. The facility was using EZ-Way brand lifts rather than Hoyer brand lifts.

R3's quarterly MDS dated 7/17/24, indicated R3 did not have cognitive impairment. R3 had no impairment of upper or lower extremities. R3 was

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2 830	Continued From page 9 dependent with all transfers and did not walk. R3's Nursing Assessment for Total Mechanical lift dated 6/21/22, indicated R3 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling. R3's ADL care plan 6/21/24 directed staff to transfer R3 with Hoyer lift with two staff. The care plan did not include the sling size and type that R3 required. R3's Nursing Assessment for Total Mechanical dated 7/25/24, indicated R3 required a Hoyer lift with two staff assistance. The summary included: Hoyer lift is appropriate and effective for transfers and two assist due to resident's decline in mobility. This assessment also did not address sling size and type. During an observation on 7/25/24 at 12:56 p.m., R3 sat in her recliner with a green sling underneath her. This sling size was extra-large per manufactures sizing guide on mechanical lift outside of room. During an observation on 7/25/24 at 1:11 p.m., nurse manager (NM)-A entered R3's room and verified that the sling R3 was sitting on was extra large in size. NM-A was not aware of how to measure for the appropriate sling size and type and indicated there was no process in place for completing sling assessments. During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)- A stated the sling R3 was sitting on, was not the correct sling size. LR-A stated R3 should be a large sling size and not extra large.	2 830		

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R2's quarterly MDS dated 7/17/24, R2 had severe cognitive impairment. R2's diagnoses included hip fracture, Alzheimer's disease, and dementia. R2 was dependent for ADLs except required moderate assistance with eating. R2 had impairment on one side of her lower extremities and used a manual wheelchair.

R2's Nursing Assessment for Total Mechanical lift dated 6/20/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling.

R2's ADL care plan 6/20/24, for transfers directed staff to use a Hoyer lift with two staff. The care plan did not identify sling size and type that R2 required.

R2's Nursing Assessment for Total Mechanical lift dated 7/25/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment continued to lack mention of size and type of sling.

During an interview on 7/25/24 at 10:25 a.m., NA-A stated an unawareness of how to properly determine sling size and would use the sling that was in the resident's rooms. NA-A thought nursing or therapy decided the sling size.

During an interview on 7/25/24 at 10:51 a.m., NA-M indicated the sling size was dependent on the size and weight of the person. NA-M would check the sling size chart on the lift against the resident's weight. She would use whatever sling was in the room unless she questioned the fit.

During an interview on 7/25/24 at 5:50 p.m., Administrator and DON both indicated if there was not anything wrong with the lift and the sling

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2 830	Continued From page 11 the cause of the fall would be operator error. DON and Administrator expected staff to follow the manufacturers recommendations for safety. Stated there had not previously been a process in place to determine proper sling size and staff were expected to follow the manufacturer's instructions. During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they were secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of. LR-A stated the correct sling sizes were important to prevent falls and serious injuries to both residents and staff. Additionally, with the correct sling size, the staff can obtain better resident placement in chair and bed without pushing or pulling on resident. EZ-Way Smart Lift Operator Manual included the following: WARNING: For safe operation of the EZ Way Lifts, the lift must be used by trained personnel in accordance with operators manual, video, and training checklist to avoid injury to patient. -do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation, -the sling size is calculated using the resident weight, height, and girth, a proper fir will involve judgement of the caregiver, - proper sling placement include top of sling at the shoulder level and the base of the sling two inches below the tail bone, -while lifting the patient upward, continue until there is tension on the sling legs, making sure all	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31639	A. BUILDING: ___ B. WING ___	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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2 830	Continued From page 12 the loops on the sling are securely hooked on the hanger bars before moving resident from over the surface transferring from, -all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. The IJ was removed on 7/26/24 at 2:45 p.m., when it was verified the facility had completed the following: -The policy and procedure for using a mechanical lifting machine was reviewed for accuracy, updated, and put in place effective 7/25/24, -Nursing assessments were verified and completed for all 10 residents that used a mechanical lift, -All 10 residents that used a mechanical lift were reviewed for sling size and their care plans were updated to reflect these changes, -All nursing staff were re-educated, with return demonstration, prior to working their next shift, on manufactures recommendations of using the full body mechanical lift, to include checking the straps for tension and using the proper sling size according to the resident's care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or designee, should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be	2 830		

Minnesota Department of Health

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2 830	Continued From page 13 taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		