Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 31, 2021

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

RE: CCN: 245090
Cycle Start Date: July 15, 2021

Dear Administrator:

On August 5, 2021, we notified you a remedy was imposed. On August 23, 2021 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 July 16, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 20, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 5, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 31, 2021

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Re: Reinspection Results
Event ID: CEBV12

Dear Administrator:

On August 23, 2021 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 15, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 Submitted
August 5, 2021

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

RE: CCN: 245090
Cycle Start Date: July 15, 2021

Dear Administrator:

On July 15, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 15, 2021, 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 G.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 20, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 20, 2021, (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 20, 2021, (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.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pleasant Manor LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2021. 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" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 15, 2022 (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:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245090	A. BUILDING ______ B. WING ______	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(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	F 000		

On 7/14/21 to 7/15/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities

The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to follow manufacturer's guidelines to ensure safety measures where implemented for the use of a mechanical lift for 2 of 2 resident (R2 and R4) who utilized a full body lift. This deficient practice resulted in an immediate jeopardy (IJ) for R2, who fell from the mechanical lift and sustained a fracture to left tibia (a long bone in the lower leg). The IJ began on 6/12/21, and the immediacy was removed on 7/15/21.

The above findings constituted substandard quality of care, and an extended survey was conducted on 7/15/21.

The following complaints was found to be SUBSTANTIATED:
H5090089C (MN00074516), with a deficiency cited at F689.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/06/2021

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

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's guidelines to ensure safety measures were implemented for the use of a mechanical lift for 2 of 2 resident (R2 and R4) who utilized a full body lift. This deficient practice resulted in an immediate jeopardy (IJ) for R2, who fell from the mechanical lift and sustained a fracture to left tibia (a long bone in the lower leg). The IJ began on 6/12/21, at 6:45 p.m. when nursing assistants (NA)-A and (NA)-B were transferring R2 with a mechanical lift and failed to follow manufacturer safety guidelines, causing R2 to fall out of the sling to the floor. The administrator and director of nursing (DON) were notified of the IJ on 7/14/21, at 5:56 p.m. The IJ was removed on 7/15/21, at 3:47 p.m. however, non-compliance remained at the lower scope and severity level G, isolated, scope and severity, which indicate actual harm that is not immediate jeopardy.	F 689	Residents R2 and R4's slings were reviewed and replaced with proper slings that are of correct size and follow manufacturer guidelines. All like residents that utilize mechanical lifts with slings were reviewed to ensure the proper size and manufacturer guidelines are being met. Facility Mechanical Lift Policy and Safe Resident Handling Policy were reviewed and remain current. All facility Nursing, Therapy and Agency staff were re-educated on the proper use of mechanical lift slings including proper sizing, proper brand of sling, location of lift slings within the facility, and proper sling information for each resident on facility group sheets. Administrator or designee will complete	8/6/21

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F 689

Continued From page 2

Findings include:

R2's facesheet printed on 7/14/21, indicated diagnoses of fracture of the upper end of left tibia, multiple sclerosis (MS) (a disease of the brain and spinal cord) and paraplegia (paralysis of the legs and lower body).

R2's quarterly Minimum Data Set (MDS) assessment dated 7/7/21, indicated R2 was cognitively intact, with adequate hearing and vision, clear speech, she understood others and was able to understand. R2 had total dependence on two staff for transfers from bed to wheelchair and wheelchair to bed, and assistance of one staff for bed mobility, dressing, toileting and personal hygiene.

R2's plan of care, with date range of 4/8/20, to 10/10/21, indicated the following:
---On 4/8/20, R2 was identified as a fall risk related to inability to transfer without assistance. Intervention dated 6/21/21, included: hoyer (a brand name of a mechanical lift) with two staff; physical therapy/occupational therapy to establish a program with regard to preferences and MS.
---On 4/8/20, the care plan identified that R2 had alteration in mobility related to MS and paraplegia. Interventions dated 4/8/20, included: assist with movement in bed and in/out of bed via hoyer. Assist with transfers with two staff and hoyer lift. R2 checks straps; wishes straps to be crossed under legs and not crossed between legs.
--The care plan did not indicate that R2 used her own lift sling from home.

Progress note dated 6/12/21, at 7:45 p.m.

F 689

audits of correct sling usage, including size, manufacturer and group sheets to ensure that the correct sling size is listed. These audits will be completed on five residents five times per week for four weeks, weekly for three months, and follow-up with QAPI committee.

Date certain for deficiency correction is 7/16/2021.

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F 689	Continued From page 3	F 689		

indicated registered nurse (RN)-A was called to R2's room at 6:45 p.m. and observed R2 laying on the floor with NA-B holding her head on a pillow. R2 was on her back with legs out in front of her. R2 was alert and orientated, and denied pain. NA-A stated R2 was being transferred by two staff and fell out of the sling. One staff caught R2's head and it did not hit the floor. There was no bruising noted to back or buttocks. R2 was assisted to bed via mechanical lift and four staff.

Progress note dated 6/13/21, at 2:43 p.m. indicated R2 could not be awakened for morning medications, morning vital signs or noon lunch and therefore was transferred by ambulance to the local hospital at 1:35 p.m. As R2 was transferred onto the ambulance stretcher, she complained of leg and buttock pain (left or right leg was not specified in progress note). R2 was subsequently transferred from the local hospital to a metro hospital.

Admission note from metro hospital dated 6/13/21, indicated R2 was transferred due to altered mental status, fever and low blood pressure. R2 was diagnosed with severe sepsis (when the body's response to an infection damages it's own tissue). Notes further indicated R2 fell out of hoyer on 6/12, and subsequently developed left lower extremity pain with any range of motion. Due to R2's left leg being very sensitive with all movement, an xray was obtained which revealed a tibia fracture of the left leg. Non-operative management was recommended and a brace was placed on R2's left knee/leg.

During an interview on 7/14/21, at 10:35 a.m., observed R2 in her room, seated in her

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F 689		F 689		

Continued From page 4
wheelchair, wearing a left leg brace. When asked about her fall last month, R2 stated "they dropped me out of the hoyer; hence I broke my leg, my tibia," but did not know why or how it happened. R2 went on to say that the straps looked right to her when she was being lifted out of her wheelchair in her sling." As far as I can tell, they did everything right. It scared the ... [profanity used] out of me." R2 added she was told a week ago the facility was going to order a new sling for her. R2 stated the hoyer was used on her twice a day, once to get her up in the morning and once to put her to bed in the evening and had not had any problems prior to this.

During an interview on 7/14/21, at 11:17 a.m. (NA)-C stated R2 had her own sling. When asked if any other residents had their own sling, NA-C pointed out R4's sling which was a "Med Care" brand sling; white cloth with gold trim. R4 was observed sitting on the sling in her wheelchair in the common area at the entrance of the facility.

During an interview on 7/14/21, at 12:05 p.m., (NA)-A stated she had been helping (NA)-B with R2's transfer on 6/12/21; she was guiding R2 in her sling from wheelchair to bed with her hands when R2 fell out of the sling, falling about three feet to the floor. NA-A stated R2 wanted her sling a particular way and described R2's nuances: she wanted the straps under her legs and not crisscrossed between them, and wanted to hold onto some of the straps that did not hook to the hoyer. NA-A stated R2's sling was her own sling from home and did not know the brand of the sling. NA-A did not know why R2 fell out of the sling, adding "I was just worried about catching her head." NA-A stated R2 had this sling for the two years she had worked at the facility, and had

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F 689	Continued From page 5	F 689		

helped lift R2 three or four times prior to this. NA-A stated she had training for the mechanical lift when she started working at the facility but could not recall who trained her.

During a telephone interview on 7/14/21, at 12:32 p.m., RN-A stated she was called to R2's room right after the fall. When she entered the room, R2 was sitting on the floor with a pillow behind her back and her legs out in front of her. NA's told her that the strap on the lift came loose and R2 fell out of the sling. RN-A stated she had the two NA's reenact what they did and didn't see any problem with it. RN-A inspected the straps on the sling and they were intact. RN-A stated R2 used her own sling and didn't know the brand name, adding "R2 is very particular about how she wants them (staff) to use the sling." "She's hooked in there pretty well...I've watched them do this before." When asked if there were any written instructions for R2's particular lift/sling preferences, RN-A stated not that she knew of. RN-A reported the fall to the administrator and DON.

During an interview and observation on 7/14/21, at 12:40 p.m., R2 and family member (FM)-A were playing cards in R2's room. FM-A stated she used to be a personal care attendant (PCA) for R2 when R2 lived at home. FM-A stated R2 ordered the sling online and that it was for her mechanical lift at home. According to FM-A, R2's sling had eight straps; four on each side but only six of the eight straps were used with the facility lift. R2 liked to hold onto the two straps that weren't used. R2 stated the staff crisscrossed two straps under her legs, but not in-between and over her legs because that caused pain. R2 stated, "I have no idea why I fell." FM-A stated "I

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	245090	A. BUILDING ______ B. WING ______	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(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		

don't think they crisscrossed the straps under her legs - that gets her butt up. If they did not do that, she would fall right out of the sling." Neither R2 or FM-A knew the brand name of R2's sling from home, adding there was no identifying information on it anymore.

During an interview on 7/14/21, a 1:45 p.m., physical therapy assistant (PTA)-D was asked about R2's physical therapy (PT) Evaluation & Plan of Treatment report dated 6/24/21. According to the report, a referral was made to PT by nursing following R2's fall. PT was to: evaluate patient bed mobility without overhead trapeze and safety of "basket style hoyer lift." Following the evaluation, the clinical impression by the physical therapist indicated "...basket sling was being used prior to the fall, and remains safe after fall if implemented by qualified individuals." The PT description of the sling was incongruous with the actual sling utilized by R2 which was a split leg sling and not a basket style sling. PTA-D stated she had never seen the sling or observed R2 being moved with the lift/sling. Since another therapist had written the note and was unavailable, she could not offer more information.

During observation, the facility had three Volaro brand mechanical lifts available for resident use; one on each unit. Each lift had four hooks. The manufacturer of the Volaro lift was SMT Health Systems and a section of the operators manual dated 3/2019, titled "safety notes" indicated: use only Volaro slings and accessories designed for use with the Volaro lift models.

During an interview on 7/14/21, at 3:20 p.m. the DON stated after R2's fall, PT verified that the staff performed R2's transfer correctly using the

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Volaro mechanical lift and R2's personal sling, and PT said it was okay to continue to use R2's own sling; "we wanted to make sure the sling was the right one based on information we had at the time." The DON stated after the fall, they continued with the same lift process and the use of R2's personal sling because PT evaluated R2 using the lift and sling and said it was okay. When asked if there had been new training for the staff following the incident, the DON stated PT was supposed to verify training for two staff on each shift, but didn't know for certain if that had been done.

During same interview, the DON stated she felt there was no proof, nor did she believe R2 broke her leg during the fall on 6/12/21, adding R2 had been out of the facility all day on 6/12/21 and "could have hit her leg on a door frame and broke it." The DON stated the fracture could have occurred during the transfer from the facility to the local hospital, or from the local hospital to the metro hospital. When asked if it was acceptable practice to use any manufacturers sling with the Volaro lift, the DON stated she was not aware of a potential safety risk with a resident using their personal sling with the facility lift until after R1 fell from the lift. She indicated the facility ordered new slings from the Volaro company on 7/7/21, and this was verified by reviewing the packing slip. However, slings not specified by the manufacturer continued to be used for R2 and R4 until Volaro brand slings arrived to the facility on 7/14/21. The DON confirmed the sling for R4 had been switched out, but the sling for R2 would not be switched out until the morning of 7/15/21, at R2's request. R2 informed staff she did not want her sling replaced until her regular lift transfer in the morning.

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During a telephone interview on 7/14/21, at 4:04 p.m., Volaro representative (VR)-F stated in March 2020, she went through each of the facility mechanical lifts with maintenance staff. When asked if she looked at the slings also, VR-F stated she looked at the slings that were brought to her in the chapel that day and did not recall if she saw any non-Volaro slings. VR-F stated "whatever the manufacturer says for slings are what should be used. If you receive a Volaro lift you use Volaro-manufactured sling." According to VR-F, the rationale being the company could not ensure the safety of a sling made by another manufacturer. Safety notes in the Manufacturer Operator's Manual for Volaro Mechanical Lift, dated 3/2019, indicated to use only Volaro slings and accessories designed for use with the Volaro lift models.

During an interview on 7/14/21, at 4:11 p.m., PTA-D stated when physical therapy staff do training for the nursing staff after an incident like R2's, they usually trained two staff on the day and evening shifts and those staff trained other staff. However according to another therapists notes, that had not been done after R2's fall. PTA-D acknowledged she was not aware of the manufacturer specification that only their slings be used with their lifts. Additionally, PTA-D did not know that R2's sling was not one recommended by the Volaro manufacturer.

During an interview on 7/14/21, at 4:38 p.m., NA-B who was the second staff member involved in R2's fall, stated he did not know how R2 fell; "she fell out of the left side, but the straps were still on the hooks." NA-B acknowledged there were more straps on R2's sling than there were

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hooks on the Volaro lift, adding that R2 held onto the extra ones with her hands. After R2 fell, NA-B stated she was placed in bed for the night by staff and the mechanical lift. NA-B did not recall if R2 had pain when she was returned to bed. NA-B did not recall if he received training on the use of the Volaro lift when he started employment at the facility.

During an observation on 7/15/21, at 10:04 a.m. in R2's room, R2 was lying in bed on the new SMT sling. NA-C and NA-D hooked up the four straps on the sling to the four hooks on the Volaro mechanical lift. NA-C operated the mechanical lift and NA-D guided R2 to the wheelchair.

During an interview on 7/15/21, at 10:21 a.m. the administrator stated it was following a different incident that occurred on 7/5/21, with another resident that she became aware of Volaro's specification to utilize only slings designed for use with the Volaro lifts. It was at that time she was informed by the facility regional nurse consultant there was a potential safety risk if slings not specified by the manufacturer were used. Once that was identified, the facility did an audit of all 14 residents who used the mechanical lift and discovered R2 and R4 did not have the correct slings. New slings were ordered for R2 and R4 from the Volaro mechanical lift company which arrived to the facility on 7/14/21. The administrator admitted that from 7/5/21, to 7/14/21, the facility continued to use slings not specified by the manufacturer for R2 and R4, resulting in the potential for harm.

During interviews on 7/15/21, at 3:20 p.m., training was verified as having occurred for evening shift staff on duty prior to the start of their

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Continued From page 10

shift. Evening staff interviewed included (RN)-B, (LPN)-B, (LPN)-C, (NA)-E, (NA)-F, (NA)-G, and (NA)-H; all articulated the training as described in the training plan (e.g., only manufacturer recommended slings can be used, cannot use a sling from another hospital or ambulance service and correct size was to be utilized). Staff stated they went into R2's room for demonstration as part of the training.

R4

R4's facesheet printed on 7/15/21, indicated diagnoses of chronic pain, heart disease and diabetes.

R4's quarterly Minimum Data Set (MDS) assessment dated 5/6/21, indicated R4 was cognitively intact, with adequate hearing and vision, and clear speech. R4 required extensive assistance of two staff for moving in bed and transfers from bed to wheelchair and wheelchair to bed; extensive assistance of one or two staff for dressing, toileting and personal hygiene.

R4's plan of care dated 1/13/21, indicated R4 was a fall risk related to impaired mobility and R4 would be safe and free from falls. R4 was identified as having an alteration in mobility related to obesity. Two staff were to assist with transfers using the hoyer lift. The care plan did not indicate the type of sling utilized for R4.

During an interview on 7/14/21, at 11:17 a.m. (NA)-C stated R4 had her own sling which was a "Med Care" brand sling; white cloth with gold trim that she was using since returning from a recent hospitalization. R4 was observed sitting on the sling in her wheelchair in the common area at the

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F 689	Continued From page 11 entrance of the facility. During an interview on 7/14/21, at 4:15 p.m., the DON stated R4 had been using a sling from a metro hospital where she had recently been hospitalized. The DON stated a new sling had been ordered from the Volaro manufacturer for R4 and it arrived 7/14/21, and R4 would be utilizing the new one. During an interview on 7/15/21, at 10:21 a.m. the administrator stated it was following a different incident that occurred on 7/5/21, with another resident that she became aware of Volaro's recommendation to utilize only slings designed for use with the Volaro lifts. It was at that time she was informed by the facility regional nurse consultant there was a potential safety risk if slings not recommended by the manufacturer were used. Once that was identified, the facility did an audit of all 14 residents who used the mechanical lift and discovered R4 did not have the correct sling. A new sling was ordered for R4 from the Volaro mechanical lift company which arrived to the facility on 7/14/21, and was stated to be utilized for R4. The immediate jeopardy that began on 6/12/21, was removed on 7/15/21, when the facility audited the 14 residents who used mechanical lifts for the correct sling brand and size and removed all non-SMT brand slings from circulation. All other slings were gathered and inventoried, and additional back-up slings were ordered from the manufacturer. All 14 residents had a "lift mobility status" assessment completed. NA care sheets were updated with the sling size, and care plans were audited for correct transfer status. Education was initiated and remained	F 689		

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F 689	Continued From page 12 on-going for all nursing and physical/occupational therapy staff regarding correct sling brand, size, location and color coding system. The education included how a staff member can find the correct sling size to use per the group sheet. All nursing and PT/OT staff completed this education prior to next shift worked. Administrator or designee completed a knowledge quiz with all educated staff to ensure the education was sustained for the next shift worked. Administrator or designee completed a physical audit of correct sling usage on five residents, five times per week for four weeks and then weekly thereafter for three months with follow-up or needed education. Administrator or designee completed an audit of group sheets being up-to-date with correct sling size five times per week for four weeks and then weekly thereafter for three months with follow-up or needed education. The safety committee would review the resident safe handling policy at their next meeting. Audits would be reviewed at the next QAPI (quality assurance performance improvement) meeting. Correct sling size education would be put in agency training binder for all new agency staff and would be incorporated into orientation for new nursing hires. However, the noncompliance remained at the lower scope and severity level G, isolated, scope and severity, which indicate actual harm that is not IJ.	F 689		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 5, 2021

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Re: State Nursing Home Licensing Orders
Event ID: CEBV11

Dear Administrator:

The above facility was surveyed on July 14, 2021 through July 15, 2021 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: ________ B. WING ________	C **07/15/2021**

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2 000	Initial Comments	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 7/14//21-7/15/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5090089C (MN74516) with a licensing order issued at 4658.0520. 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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2 830	Continued From page 2	2 830		
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.	2 830		8/6/21
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's guidelines to ensure safety measures were implemented for the use of a mechanical lift for 2 of 2 resident (R2 and R4) who utilized a full body lift. This deficient practice resulted in an immediate jeopardy (IJ) for R2, who fell from the mechanical lift and sustained a fracture to left tibia (a long bone in the lower leg). The IJ began on 6/12/21, at 6:45 p.m. when nursing assistants (NA)-A and (NA)-B were transferring R2 with a mechanical lift and failed to follow manufacturer safety guidelines, causing R2 to fall out of the sling to the floor. The administrator and director of nursing (DON) were notified of the IJ on 7/14/21, at 5:56 p.m. The IJ was removed on 7/15/21, at 3:47 p.m. however, non-compliance remained at the lower scope and		Residents R2 and R4's slings were reviewed and replaced with proper slings that are of correct size and follow manufacturer guidelines. All like residents that utilize mechanical lifts with slings were reviewed to ensure the proper size and manufacturer guidelines are being met. Facility Mechanical Lift Policy and Safe Resident Handling Policy were reviewed and remain current. All facility Nursing, Therapy and Agency staff were re-educated on the proper use of mechanical lift slings including proper sizing, proper brand of sling, location of lift slings within the facility, and proper sling information for each resident on facility	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 severity level G, isolated, scope and severity, which indicate actual harm that is not immediate jeopardy. Findings include: R2's facesheet printed on 7/14/21, indicated diagnoses of fracture of the upper end of left tibia, multiple sclerosis (MS) (a disease of the brain and spinal cord) and paraplegia (paralysis of the legs and lower body). R2's quarterly Minimum Data Set (MDS) assessment dated 7/7/21, indicated R2 was cognitively intact, with adequate hearing and vision, clear speech, she understood others and was able to understand. R2 had total dependence on two staff for transfers from bed to wheelchair and wheelchair to bed, and assistance of one staff for bed mobility, dressing, toileting and personal hygiene. R2's plan of care, with date range of 4/8/20, to 10/10/21, indicated the following: ---On 4/8/20, R2 was identified as a fall risk related to inability to transfer without assistance. Intervention dated 6/21/21, included: hoyer (a brand name of a mechanical lift) with two staff; physical therapy/occupational therapy to establish a program with regard to preferences and MS. ---On 4/8/20, the care plan identified that R2 had alteration in mobility related to MS and paraplegia. Interventions dated 4/8/20, included: assist with movement in bed and in/out of bed via hoyer. Assist with transfers with two staff and hoyer lift. R2 checks straps; wishes straps to be crossed under legs and not crossed between legs. --The care plan did not indicate that R2 used her own lift sling from home.	2 830	group sheets. Administrator or designee will complete audits of correct sling usage, including size, manufacturer and group sheets to ensure that the correct sling size is listed. These audits will be completed on five residents five times per week for four weeks, weekly for three months, and follow-up with QAPI committee. Date certain for deficiency correction is 7/15/2021.	

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	00568	A. BUILDING: ___ B. WING ___	C 07/15/2021

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2 830	Continued From page 4	2 830		

Progress note dated 6/12/21, at 7:45 p.m. indicated registered nurse (RN)-A was called to R2's room at 6:45 p.m. and observed R2 laying on the floor with NA-B holding her head on a pillow. R2 was on her back with legs out in front of her. R2 was alert and orientated, and denied pain. NA-A stated R2 was being transferred by two staff and fell out of the sling. One staff caught R2's head and it did not hit the floor. There was no bruising noted to back or buttocks. R2 was assisted to bed via mechanical lift and four staff.

Progress note dated 6/13/21, at 2:43 p.m. indicated R2 could not be awakened for morning medications, morning vital signs or noon lunch and therefore was transferred by ambulance to the local hospital at 1:35 p.m. As R2 was transferred onto the ambulance stretcher, she complained of leg and buttock pain (left or right leg was not specified in progress note). R2 was subsequently transferred from the local hospital to a metro hospital.

Admission note from metro hospital dated 6/13/21, indicated R2 was transferred due to altered mental status, fever and low blood pressure. R2 was diagnosed with severe sepsis (when the body's response to an infection damages it's own tissue). Notes further indicated R2 fell out of hoyer on 6/12, and subsequently developed left lower extremity pain with any range of motion. Due to R2's left leg being very sensitive with all movement, an xray was obtained which revealed a tibia fracture of the left leg. Non-operative management was recommended and a brace was placed on R2's left knee/leg.

During an interview on 7/14/21, at 10:35 a.m.,

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observed R2 in her room, seated in her wheelchair, wearing a left leg brace. When asked about her fall last month, R2 stated "they dropped me out of the hoyer; hence I broke my leg, my tibia," but did not know why or how it happened. R2 went on to say that the straps looked right to her when she was being lifted out of her wheelchair in her sling." As far as I can tell, they did everything right. It scared the ... [profanity used] out of me." R2 added she was told a week ago the facility was going to order a new sling for her. R2 stated the hoyer was used on her twice a day, once to get her up in the morning and once to put her to bed in the evening and had not had any problems prior to this.

During an interview on 7/14/21, at 11:17 a.m. (NA)-C stated R2 had her own sling. When asked if any other residents had their own sling, NA-C pointed out R4's sling which was a "Med Care" brand sling; white cloth with gold trim. R4 was observed sitting on the sling in her wheelchair in the common area at the entrance of the facility.

During an interview on 7/14/21, at 12:05 p.m., (NA)-A stated she had been helping (NA)-B with R2's transfer on 6/12/21; she was guiding R2 in her sling from wheelchair to bed with her hands when R2 fell out of the sling, falling about three feet to the floor. NA-A stated R2 wanted her sling a particular way and described R2's nuances: she wanted the straps under her legs and not crisscrossed between them, and wanted to hold onto some of the straps that did not hook to the hoyer. NA-A stated R2's sling was her own sling from home and did not know the brand of the sling. NA-A did not know why R2 fell out of the sling, adding "I was just worried about catching her head." NA-A stated R2 had this sling for the two years she had worked at the facility, and had

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2 830	Continued From page 6 helped lift R2 three or four times prior to this. NA-A stated she had training for the mechanical lift when she started working at the facility but could not recall who trained her. During a telephone interview on 7/14/21, at 12:32 p.m., RN-A stated she was called to R2's room right after the fall. When she entered the room, R2 was sitting on the floor with a pillow behind her back and her legs out in front of her. NA's told her that the strap on the lift came loose and R2 fell out of the sling. RN-A stated she had the two NA's reenact what they did and didn't see any problem with it. RN-A inspected the straps on the sling and they were intact. RN-A stated R2 used her own sling and didn't know the brand name, adding "R2 is very particular about how she wants them (staff) to use the sling." "She's hooked in there pretty well...I've watched them do this before." When asked if there were any written instructions for R2's particular lift/sling preferences, RN-A stated not that she knew of. RN-A reported the fall to the administrator and DON. During an interview and observation on 7/14/21, at 12:40 p.m., R2 and family member (FM)-A were playing cards in R2's room. FM-A stated she used to be a personal care attendant (PCA) for R2 when R2 lived at home. FM-A stated R2 ordered the sling online and that it was for her mechanical lift at home. According to FM-A, R2's sling had eight straps; four on each side but only six of the eight straps were used with the facility lift. R2 liked to hold onto the two straps that weren't used. R2 stated the staff crisscrossed two straps under her legs, but not in-between and over her legs because that caused pain. R2 stated, "I have no idea why I fell." FM-A stated "I don't think they crisscrossed the straps under her	2 830		

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legs - that gets her butt up. If they did not do that, she would fall right out of the sling." Neither R2 or FM-A knew the brand name of R2's sling from home, adding there was no identifying information on it anymore.

During an interview on 7/14/21, a 1:45 p.m., physical therapy assistant (PTA)-D was asked about R2's physical therapy (PT) Evaluation & Plan of Treatment report dated 6/24/21. According to the report, a referral was made to PT by nursing following R2's fall. PT was to: evaluate patient bed mobility without overhead trapeze and safety of "basket style hoyer lift." Following the evaluation, the clinical impression by the physical therapist indicated "...basket sling was being used prior to the fall, and remains safe after fall if implemented by qualified individuals." The PT description of the sling was incongruous with the actual sling utilized by R2 which was a split leg sling and not a basket style sling. PTA-D stated she had never seen the sling or observed R2 being moved with the lift/sling. Since another therapist had written the note and was unavailable, she could not offer more information.

During observation, the facility had three Volaro brand mechanical lifts available for resident use; one on each unit. Each lift had four hooks. The manufacturer of the Volaro lift was SMT Health Systems and a section of the operators manual dated 3/2019, titled "safety notes" indicated: use only Volaro slings and accessories designed for use with the Volaro lift models.

During an interview on 7/14/21, at 3:20 p.m. the DON stated after R2's fall, PT verified that the staff performed R2's transfer correctly using the Volaro mechanical lift and R2's personal sling, and PT said it was okay to continue to use R2's

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own sling; "we wanted to make sure the sling was the right one based on information we had at the time." The DON stated after the fall, they continued with the same lift process and the use of R2's personal sling because PT evaluated R2 using the lift and sling and said it was okay. When asked if there had been new training for the staff following the incident, the DON stated PT was supposed to verify training for two staff on each shift, but didn't know for certain if that had been done.

During same interview, the DON stated she felt there was no proof, nor did she believe R2 broke her leg during the fall on 6/12/21, adding R2 had been out of the facility all day on 6/12/21 and "could have hit her leg on a door frame and broke it." The DON stated the fracture could have occurred during the transfer from the facility to the local hospital, or from the local hospital to the metro hospital. When asked if it was acceptable practice to use any manufacturers sling with the Volaro lift, the DON stated she was not aware of a potential safety risk with a resident using their personal sling with the facility lift until after R1 fell from the lift. She indicated the facility ordered new slings from the Volaro company on 7/7/21, and this was verified by reviewing the packing slip. However, slings not specified by the manufacturer continued to be used for R2 and R4 until Volaro brand slings arrived to the facility on 7/14/21. The DON confirmed the sling for R4 had been switched out, but the sling for R2 would not be switched out until the morning of 7/15/21, at R2's request. R2 informed staff she did not want her sling replaced until her regular lift transfer in the morning.

During a telephone interview on 7/14/21, at 4:04 p.m., Volaro representative (VR)-F stated in

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March 2020, she went through each of the facility mechanical lifts with maintenance staff. When asked if she looked at the slings also, VR-F stated she looked at the slings that were brought to her in the chapel that day and did not recall if she saw any non-Volaro slings. VR-F stated "whatever the manufacturer says for slings are what should be used. If you receive a Volaro lift you use Volaro-manufactured sling." According to VR-F, the rationale being the company could not ensure the safety of a sling made by another manufacturer. Safety notes in the Manufacturer Operator's Manual for Volaro Mechanical Lift, dated 3/2019, indicated to use only Volaro slings and accessories designed for use with the Volaro lift models.

During an interview on 7/14/21, at 4:11 p.m., PTA-D stated when physical therapy staff do training for the nursing staff after an incident like R2's, they usually trained two staff on the day and evening shifts and those staff trained other staff. However according to another therapists notes, that had not been done after R2's fall. PTA-D acknowledged she was not aware of the manufacturer specification that only their slings be used with their lifts. Additionally, PTA-D did not know that R2's sling was not one recommended by the Volaro manufacturer.

During an interview on 7/14/21, at 4:38 p.m., NA-B who was the second staff member involved in R2's fall, stated he did not know how R2 fell; "she fell out of the left side, but the straps were still on the hooks." NA-B acknowledged there were more straps on R2's sling than there were hooks on the Volaro lift, adding that R2 held onto the extra ones with her hands. After R2 fell, NA-B stated she was placed in bed for the night by staff and the mechanical lift. NA-B did not recall if R2

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2 830	Continued From page 10 had pain when she was returned to bed. NA-B did not recall if he received training on the use of the Volaro lift when he started employment at the facility. During an observation on 7/15/21, at 10:04 a.m. in R2's room, R2 was lying in bed on the new SMT sling. NA-C and NA-D hooked up the four straps on the sling to the four hooks on the Volaro mechanical lift. NA-C operated the mechanical lift and NA-D guided R2 to the wheelchair. During an interview on 7/15/21, at 10:21 a.m. the administrator stated it was following a different incident that occurred on 7/5/21, with another resident that she became aware of Volaro's specification to utilize only slings designed for use with the Volaro lifts. It was at that time she was informed by the facility regional nurse consultant there was a potential safety risk if slings not specified by the manufacturer were used. Once that was identified, the facility did an audit of all 14 residents who used the mechanical lift and discovered R2 and R4 did not have the correct slings. New slings were ordered for R2 and R4 from the Volaro mechanical lift company which arrived to the facility on 7/14/21. The administrator admitted that from 7/5/21, to 7/14/21, the facility continued to use slings not specified by the manufacturer for R2 and R4, resulting in the potential for harm. During interviews on 7/15/21, at 3:20 p.m., training was verified as having occurred for evening shift staff on duty prior to the start of their shift. Evening staff interviewed included (RN)-B, (LPN)-B, (LPN)-C, (NA)-E, (NA)-F, (NA)-G, and (NA)-H; all articulated the training as described in the training plan (e.g., only manufacturer recommended slings can be used, cannot use a	2 830		

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2 830	Continued From page 11 sling from another hospital or ambulance service and correct size was to be utilized). Staff stated they went into R2's room for demonstration as part of the training. R4 R4's facesheet printed on 7/15/21, indicated diagnoses of chronic pain, heart disease and diabetes. R4's quarterly Minimum Data Set (MDS) assessment dated 5/6/21, indicated R4 was cognitively intact, with adequate hearing and vision, and clear speech. R4 required extensive assistance of two staff for moving in bed and transfers from bed to wheelchair and wheelchair to bed; extensive assistance of one or two staff for dressing, toileting and personal hygiene. R4's plan of care dated 1/13/21, indicated R4 was a fall risk related to impaired mobility and R4 would be safe and free from falls. R4 was identified as having an alteration in mobility related to obesity. Two staff were to assist with transfers using the hoyer lift. The care plan did not indicate the type of sling utilized for R4. During an interview on 7/14/21, at 11:17 a.m. (NA)-C stated R4 had her own sling which was a "Med Care" brand sling; white cloth with gold trim that she was using since returning from a recent hospitalization. R4 was observed sitting on the sling in her wheelchair in the common area at the entrance of the facility. During an interview on 7/14/21, at 4:15 p.m., the DON stated R4 had been using a sling from a metro hospital where she had recently been hospitalized. The DON stated a new sling had	2 830		

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2 830	Continued From page 12 been ordered from the Volaro manufacturer for R4 and it arrived 7/14/21, and R4 would be utilizing the new one. During an interview on 7/15/21, at 10:21 a.m. the administrator stated it was following a different incident that occurred on 7/5/21, with another resident that she became aware of Volaro's recommendation to utilize only slings designed for use with the Volaro lifts. It was at that time she was informed by the facility regional nurse consultant there was a potential safety risk if slings not recommended by the manufacturer were used. Once that was identified, the facility did an audit of all 14 residents who used the mechanical lift and discovered R4 did not have the correct sling. A new sling was ordered for R4 from the Volaro mechanical lift company which arrived to the facility on 7/14/21, and was stated to be utilized for R4. The immediate jeopardy that began on 6/12/21, was removed on 7/15/21, when the facility audited the 14 residents who used mechanical lifts for the correct sling brand and size and removed all non-SMT brand slings from circulation. All other slings were gathered and inventoried, and additional back-up slings were ordered from the manufacturer. All 14 residents had a "lift mobility status" assessment completed. NA care sheets were updated with the sling size, and care plans were audited for correct transfer status. Education was initiated and remained on-going for all nursing and physical/occupational therapy staff regarding correct sling brand, size, location and color coding system. The education included how a staff member can find the correct sling size to use per the group sheet. All nursing and PT/OT staff completed this education prior to next shift worked. Administrator or designee	2 830		

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2 830	Continued From page 13 completed a knowledge quiz with all educated staff to ensure the education was sustained for the next shift worked. Administrator or designee completed a physical audit of correct sling usage on five residents, five times per week for four weeks and then weekly thereafter for three months with follow-up or needed education. Administrator or designee completed an audit of group sheets being up-to-date with correct sling size five times per week for four weeks and then weekly thereafter for three months with follow-up or needed education. The safety committee would review the resident safe handling policy at their next meeting. Audits would be reviewed at the next QAPI (quality assurance performance improvement) meeting. Correct sling size education would be put in agency training binder for all new agency staff and would be incorporated into orientation for new nursing hires. However, the noncompliance remained at the lower scope and severity level G, isolated, scope and severity, which indicate actual harm that is not IJ. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident equipment is utilized following manufactures guidelines. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. The DON or designee could provide Quality Assurance (QA) committee audit findings to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		