DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 30, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: June 28, 2021

Dear Administrator:

On August 18, 2021, we notified you a remedy was imposed. On September 21, 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 September 8, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2021 be discontinued as of September 8, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 21, 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 28, 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 30, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Reinspection Results
Event ID: FPE412

Dear Administrator:

On September 21, 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 28, 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered

August 18, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: June 28, 2021

Dear Administrator:

On July 21, 2021, we informed you that we may impose enforcement remedies.

On July 28, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. 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. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 28, 2021, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 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 September 2, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2021.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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, Rochester East Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 28, 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 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 28, 2021 (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 § 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:

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.

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 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, 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
	245184	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 7/26/21 and 7/28/21, 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 for proper use of slings for eight residents (R2, R11, R18, R13, R8, R10, R12, R9) of 14 residents who utilized full body lifts. This deficient practice resulted in an immediate jeopardy (IJ) for R1, who fell from the full body lift and had the potential for injury for R2, R11, R18, R13, R8, R10, R12, R9 as a result of not following the manufacturer's guidance for proper use. Furthermore, the facility failed to assess and evaluate causal factors for falls, and failed to ensure adequate supervision and interventions were implemented to reduce falls for 2 of 2 resident (R3 and R4) reviewed who sustained multiple falls. The above findings constituted substandard quality of care, and an extended survey was conducted on 7/28/21. The following complaint was found to be SUBSTANTIATED: H5184140C (MN00074970 and MN00074948), 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	F 000		

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

Electronically Signed | 08/27/2021

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 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 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=K	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 for proper use of slings for eight residents (R2, R11, R18, R13, R8, R10, R12, R9) of 14 residents who utilized full body lifts. This deficient practice resulted in an immediate jeopardy (IJ) for R1, who fell from the full body lift and had the potential for injury for R2, R11, R18, R13, R8, R10, R12, R9 as a result of not following the manufacturer's guidance for proper use. Furthermore, the facility failed to assess and evaluate causal factors for falls, and failed to ensure adequate supervision and interventions were implemented to reduce falls for 2 of 2 resident (R3 and R4) reviewed who sustained multiple falls.	F 689	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope and severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied.	9/8/21

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F 689	Continued From page 2 The IJ began on 7/18/21, at 11:00 p.m. when licensed practical nurse (LPN)-A and nursing assistant (NA)-A were transferring R1 with a full body lift and R1 fell out of the sling to the floor. The administrator and director of nursing (DON) were notified of the IJ on 7/26/21, at 7:04 p.m. The IJ was removed on 7/28/21, at 3:30 p.m. however, noncompliance remained at the lower scope and severity level of E, pattern, no actual harm, but potential for more than minimal harm. Findings include: R1's facesheet printed on 7/19/21, listed diagnoses which included amyothrophic lateral sclerosis (ALS) (nerve cells break down, reducing functionality in the muscles they supply), dysphasia (language disorder that affects a person's ability to communicate), anxiety,and quadriplegia (paralysis of all four limbs). R1's admission Minimum Data Set (MDS) assessment dated 5/26/21, indicated R1 was cognitively intact, had adequate hearing and vision, unclear speech, was sometimes able to make self understood and could usually understand. R1 required extensive assistance or was dependent upon two staff and/or the use of a full body lift for bed mobility, transfers, dressing, toileting, and moving about in a wheelchair. R1's plan of care initiated on 5/14/21, indicated: a) self-care deficit as evidenced by increased dependence on others to complete activities of daily living related to disease progress and newly diagnosed ALS, and would require transfer with a mechanical lift and assistance of two. b) impaired functional mobility as evidenced by diagnosis of ALS. Nursing would provide assistance as	F 689	R 1 no longer resides at the facility. R3 and R4 falls were reviewed by the Director of Clinical Services and post fall assessment or falls risk assessment and summary completed with care plan updates as indicated. Residents who use the full body mechanical lift for transfers or who experience falls have the potential to be impacted by the alleged practice. Review of falls since June 1, 2021 was completed on July 30 by the Director of Clinical Services or designee. Falls since July 31 to 8/25 have been/will be audited by the Director of Clinical Services or designee and care plans and assessments have been/will be updated as indicated for those residents reviewed. Mechanical lift slings were ordered 7/23/2021 and received 7/27/2021 and put into use. Generic loop slings were removed from use on 7/27/2021. Lift assessments were completed for residents and sling type and size identified and care planned. Process for falls review during morning clinical meetings was updated and daily compliance will be monitored starting 8/25/2021. Director of Nursing or designee will review fall event and verify that all post fall assessments and documentation are completed, verify that an appropriate immediate care plan intervention to prevent further falls or injury was initiated, and review the root cause with interdisciplinary team at first morning	

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F 689	Continued From page 3 needed for transfers via total mechanical lift and two staff. R1's care plan did not indicate the type of sling nor size of sling to be used with the full body lift. R1's progress note dated 7/19/21, at 4:15 a.m. by LPN-A indicated: R1 fell from Hoyer (mechanical lift used for a full body lift) approximately three feet from floor while transferring to commode. R1 hit her head and back on the leg of hoyer. No apparent injury but R1 transferred to local hospital via ambulance. Unsure how fall from hoyer occurred. R1's progress note dated 7/19/21, at 4:30 a.m., by LPN-A indicated: R1 was admitted to the hospital with three rib fractures on the right side and would probably be in the hospital for two days. During a telephone interview on 7/26/21, at 10:02 a.m., family member (FM)-D stated he received a call on 7/18/21, that R1 was being sent to the hospital. FM-D was told R1 had been in the mechanical lift and something happened causing her to fall three feet hitting her head and lower back on the ground; but they didn't know how it happened. FM-D stated R1 did not like using the full body lift; it scared her and she didn't trust certain staff using it, but no one would listen to R1 and ask her why she was afraid. "If they did it the right way every time, she wouldn't be afraid." FM-D stated R1 was still in the hospital and was uncertain if R1 would return to facility due to her fear of being moved with the mechanical lift. During an interview on 7/26/21, at 11:10 a.m., (NA)-B stated there were three Invacare brand full body lifts -- one on each floor, and there were	F 689	clinical meeting after event. If a trend is identified, like residents will be assessed to determine if changes are needed to their plan of care. All fall incidents will be submitted monthly to the Quality Assurance/Performance Improvement committee for review and recommendations. Education was provided by the Director of Clinical Services or designee on the use of the mechanical lift, sling selection, and inspection of slings before use beginning 7/26/2021. Staff who have not received education will be educated prior to working their next shift. New hires are being trained on the use of mechanical lifts during the orientation process. Falls documentation requirements education for licensed nurses was initiated by the Director of Clinical Services or designee beginning August 19, 2021. Education on falls review was provided by the Director of Clinical Services to the Executive Director on 8/19/2021 and will be provided by the Executive Director to the interdisciplinary team on 08/25/2021. Audits of mechanical lift use were initiated the week of 7/26/2021 and three observations are completed weekly and will continue for eight weeks, then twice weekly for four weeks, then weekly for four weeks. Results of these audits will be submitted to the Quality Assurance/Performance Improvement committee for review and recommendations. Audits of compliance with falls guidelines will be completed five	

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F 689	Continued From page 4 two different manufacturer slings being used with the lifts: Invacare and MedCare, adding "MedCare slings were not made for the Invacare lifts but we use them." During document review, the Invacare User Manual dated 10/18/18, indicated the following warning: Invacare slings and patient lift accessories are specifically designed to be used in conjunction with Invacare patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of Invacare's patient lift system. During an interview and observation on 7/26/21, at 12:40 p.m. with NA-B, R2 was sitting in a wheelchair in the dining room on a MedCare sling, color navy with gold trim. Per NA-B, R2 was not on dialysis, "but she ended up on a MedCare sling." During an interview on 7/26/21, at 12:45 p.m., (NA)-C stated the facility used more than one brand of sling for the mechanical lift, but didn't know the brand names. Stated staff always crisscrossed the legs on the sling, adding that was how she was trained. NA-C was aware of R1's fall from a lift and stated she had recent retraining after the incident, and the training included to use an Invacare sling with an Invacare lift. Stated prior to recent training, did not know a sling specified by the lift manufacturer should be used. During a telephone interview on 7/26/21, at 1:10 p.m. LPN-A verified she was involved in the 7/18 incident in which R1 fell from the full body lift. LPN-A stated they were moving R1 from bed to the commode. LPN-A was guiding R1's feet and	F 689	times weekly until substantial compliance with guidelines is noted.	

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F 689	Continued From page 5	F 689		

looking at the commode to see how close they were when suddenly R1 fell out of the sling to the floor. LPN-A stated R1's head hit the ground and her back was over the leg of the lift. LPN-A recalled the sling being royal blue in color, but didn't remember the trim color or the brand name. LPN-A was certain the legs of the sling were crisscrossed around R1's legs. "I have no idea how she fell out; we have done this many times before and nothing was out of the ordinary."

During an interview on 7/26/21, at 1:14 p.m. corporate director of clinical services (DCS)-C stated she knew residents should be using slings specified by the mechanical lift manufacturer. It was not until the incident with R1 on 7/18, that she became aware the facility had been using more than one brand of sling. DCS-C stated once she became aware of this, more Invacare slings were ordered, but had not arrived yet. Of the 14 residents who used the full body lift, eight were still using MedCare brand slings: R2, R11, R18, R13, R8, R10, R12, R9. DCS-C stated the correct sling had been used for R1 at the time of her fall, a large Invacare sling. After the fall DCS-C inspected the sling and there were no abnormalities, tears or frays.

During an observation on 7/26/21, at 1:20 p.m. observed NA-B and (LPN)-B transfer R2 from wheelchair to bed using the Invacare lift with a MedCare sling.

During an interview on 7/26/21, at 1:46 p.m. the administrator acknowledged he was unaware until R1's incident that only slings specified by the lift manufacturer could be used with a lift. As a result of the facility investigation of the fall, he had approved the purchase of additional Invacare

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ROCHESTER EAST HEALTH SERVICES	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

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slings to ensure all residents who used the lift had the proper sling. Furthermore, the administrator was aware that non-Invacare slings continued to be used with the Invacare lift for R2, R11, R18, R13, R8, R10, R12, R9 until additional Invacare slings arrived.

During an interview on 7/26/21, at 2:55 p.m., the director of nursing (DON) stated the MedCare slings were acquired from the local hospital who wanted dialysis residents on this sling. Over time the facility acquired more of the slings and they were being used on non-dialysis residents and with the Invacare full body lift. The DON stated it was after R1's fall that she became aware of lift manufacturer specifications to use only slings designed for their mechanical lift. The DON was aware that non-Invacare slings continued to be used with the Invacare lift for R2, R11, R18, R13, R8, R10, R12, R9 until additional Invacare slings arrived.

During a telephone interview on 7/26/21, at 3:07 p.m. with the Invacare representative (IR)-E, was asked if it were possible when a split leg sling was crisscrossed under and over a person's leg, and if the legs were sticking out rigid, could a person fall out of the sling. IR-E stated if the sling was too big, it's plausible, but very unlikely. IR-E stated the most likely cause would be that it wasn't attached to the hanger bar properly. "One of two reasons a resident falls from a lift: usually not hooked up to lift properly -- the loop on the sling isn't secure in the hook on the lift and one end falls off the hook. Or they didn't crisscross the sling at the legs. Someone of that size wouldn't likely fall through the middle if the sling was attached properly." IR-E added, at 163 pounds (weight of R1), a person would use a

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large sling, adding even if an extra large sling were used, it would be highly unlikely a person would fall out. IR-E stated "we're very strict with use of our slings with our equipment. We can't test anyone else's slings. Our stance is clear: we can't guarantee someone else's sling will work properly in our lifts and vice versa." IR-E was unaware of this incident as the facility had not informed him.

During an interview on 7/28/21, at 10:10 a.m. the DON stated the Invacare representative had not been contacted to inform him of a fall from their company's lift, or to utilize his expertise for problem solving or for staff education; "we hadn't thought of that."

Training records were reviewed for the two staff involved in R1's fall from lift on 7/18. According to DCS-C, NA-A and LPN-A's training included a Relias online learning module titled: Safe Use of Mechanical Lifts. DCS-C provided a 19 page document dated 2017, which outlined the content of the training and listed "...the safe and proper use of mechanical lifts was illustrated with an emphasis on abiding by the manufacturer's guidelines for operation, and the most important part of an individual's responsibility in using mechanical lift devices was complying with both the manufacturers instructions and the organizations policies and procedures." And also included "You must abide by all of the manufacturer's specific instructions for the lift you are using. Never assume that because you used one practice or piece of equipment for one mechanical lift that you can use it for another type of lift. Doing so may result in equipment failure or even injury, or worse, death."

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F 689	Continued From page 8 - NA-A's training transcript listed the lift training had been completed on 7/14/19, and competency testing for mechanical lift was validated on 9/20/19. -LPN-A's transcript which included dates from 2018 to 2020, did not indicate completion of the Relias's online learning module titled Safe Use of Mechanical Lifts. The facility was not able to provide evidence that LPN-A completed training on safe use of mechanical lifts. Facility policy titled Safe Lifting and Movement of Residents with revised date of 8/19/2020, indicated: In order to protect staff and residents, the facility would use appropriate techniques and devices to lift and move residents. Staff would receive training and complete a competency for use of the mechanical lifts prior to providing direct care. Residents who required the use of a mechanical lift would be assessed for the appropriate lift type and size using the Lift Mobility Status UDA. Registered nursing staff would assess residents upon admission, with significant change, and on an ongoing basis for need for transfer assistance. This information would be documented in the care plan and kardexes. Sufficient slings in sizes required by residents would be available at all times, and maintenance would perform routine checks and maintenance of equipment used for lifting consistent with the manufacturers guidance. The immediate jeopardy that began on 7/18/21, was removed on 7/28/21, when the facility's DON reviewed the Lift Mobility Status Assessment for residents who utilized full body lifts, care plans and kardexes were updated with size and type of	F 689		

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F 689	Continued From page 9 sling for each resident. The facility initiated the use of the previously ordered Invacare slings for all residents on 7/27/21. The facility developed a color-coded list for sling sizes were laminated and attached to each Invacare Reliant 450 Lift as well as laminated instructions for each type of sling to provide a quick, easily accessible reference for staff who completed training. The DON educated staff on the Lift Mobility Assessment to ensure the assessment was completed in full and specified vendor specific lift sling for type of lift and proper style. The facility nursing staff were re-educated on the use of full body lift and specifically regarding the use of Invacare slings, selection and sizing and use of these slings was provided. The DON or designee performed audits to ensure staff demonstrated understanding of sling types, size and proper application for full body mechanical lifts However the noncompliance remained at the lower scope and severity level of E, pattern, no actual harm, but potential for more than minimal harm. Falls R3 R3's facesheet printed on 7/28/21, indicated diagnoses of orthopedic aftercare following surgical amputation of great toe, muscle weakness, chronic osteomyelitis (inflammation of bone caused by infection) of right foot and ankle, schizophrenia (serious mental disorder in which people interpret reality abnormally), and diabetes. R3's admission Minimum Data Set (MDS) assessment dated 5/24/21, indicated R3 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self	F 689		

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understood and could understand others. R3 required extensive assistance of two staff for bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and hygiene. R3 did not walk.

R3's care area assessment (CAA) for falls dated 5/24/21, indicated R3 would return to group home when he was back to his baseline, was working with therapy following amputation of right great toe. Used a wheelchair and walker. R3 had a fall prior to hospitalization due to weakness and illness.

R3's admission fall risk assessment, dated 5/19/21, and completed by licensed practical nurse (LPN)-D, indicated R3 was at risk for falls; had a history of one to two falls in the past 30 days, including a fracture related to falls in the past 6 month prior to admission. He had fall risk factors related to medications and exhibited gait or balance problems.

R3's plan of care initiated on 5/27/21, indicated R3 was at risk for falls due to recent amputation of right great toe and history of falls. Interventions included:
--Have commonly used articles within easy reach.
--Medications as ordered.
--Provide assistance to transfer and ambulate as needed.
--Reinforce need to call for assistance.
--Reinforce wheelchair safety as needed such as locking breaks.
--Therapy evaluation and treat as ordered.
All of the above interventions were initiated on 5/27/21. No new interventions were added to the care plan after falls on 6/2/21, 6/3/21, 7/17/21, and 7/18/21.

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Four fall incident reports for R3 indicated the following:
--6/2/21: At 2:50 a.m., R3 was found sitting on the floor next to the bed. According to an unnamed NA in the room, R3 had been sitting in his wheelchair while she changed his bedding. R3 leaned forward and the NA assisted him to slide from the wheelchair to the floor. No injury sustained.
--6/3/21: At 11:04 p.m., R3 was found sitting on the floor next to the bed with wheelchair behind his back. R3 told RN-C that he was trying to stand up and lost his balance. No injury sustained.
--7/17/21: At 5:57 p.m., R3 attempted to transfer self from bed to wheelchair. Staff were present and assisted him to the floor between the wheelchair and bed. R3 stated he was trying to get in the chair but slipped. No injury sustained.
--7/18/21: At 2:50 p.m., R3 was found in the hallway with his knees, hands and forehead on the floor and his wheelchair behind him. Another resident informed staff he saw R3 leaning forward in his wheelchair and assisted him to the floor. R3 was sent to the hospital for evaluation and returned to the facility on 7/27/21.

R4
R4's facesheet printed on 7/28/21, indicated diagnoses of traumatic subarachnoid (fluid filled space around the brain) hemorrhage with loss of consciousness, muscle weakness, abnormalities of gait and mobility, dementia, depression, age-related cognitive decline, and bilateral cataracts (clouding of the lens of the eye).

R4's admission Minimum Data Set (MDS) assessment dated 5/25/21, indicated R4 was cognitively intact, had moderate difficulty hearing,

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adequate vision, clear speech, was able to make self understood and could understand others. R3 required extensive assistance of one staff for bed mobility, transfers, walking in room, locomotion on and off the unit, dressing, toileting, and hygiene.

R4's admission fall risk assessment, dated 5/18/21, and completed by licensed practical nurse (LPN)-D, indicated R4 was at risk for falls; had a history of one to two falls in both the past 30 and 60 days. R4 had fall risk factors related to medications and exhibited gait or balance problems.

R4's plan of care initiated on 5/18/21, indicated R4 was at risk for falls/injury due to history of falls and cognitive impairment. Interventions included:
--Have commonly used articled within easy reach.
--Medications as ordered.
--Provide assistance to transfer and ambulate as needed.
--Reinforce need to call for assistance.
--Reinforce wheelchair safety as needed such as locking breaks.
--Therapy evaluation and treat as ordered.
All of the above interventions were initiated on 5/27/21. No new interventions were added to the care plan after falls on 5/19, 5/29 and 5/30/21. In addition, R4's fall interventions were identical to R3's fall interventions.

Three fall incident reports for R4 indicated the following:
--5/19/21: At 5:15 a.m., R4 was found sitting on the floor in his room. No injury. R4 stated he was going to the bathroom and didn't know what happened.
--5/29/21: At 4:15 p.m., R4 was found crawling on

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the floor by his bed, and told staff he slipped out of bed. No injury.
--5/30/21: At 4:26 a.m., R4 was found on floor in his room. No injury.

During an interview on 7/28/21, at 10:10 a.m., NA-F did not recall R4, however did recall R3, and that R3 was tall and a riser had been placed on his toilet to prevent him from having to get up and down from a low position. When asked what other kind of fall interventions were used for R3, NA-F stated they removed clutter from his room and floors, made sure his call light was within reach, and put signs in the room to remind him to use the call light. When asked how she was made aware of fall interventions for a resident, NA-F stated after a fall, management updated residents care plan with interventions. Use of a toilet riser was not an intervention on R3's care plan. NA-F confirmed recent training on slings and lifts, including brand of sling must match the lift manufacturer.

During an interview on 7/28/21, at 11:12 a.m., when the DON was asked how resident falls were addressed, specifically determining causal factors and adding or modifying existing fall risk interventions. The DON presented three documents titled "War Meeting Key Indicators" and stated falls were discussed at this meeting. The documents provided the following information:

One document dated 6/8/21, had two handwritten entries for R3 under a section titled "falls" which indicated:
a) Date 6/2, R3's name and the word "self." When asked what that meant, the DON stated R3 fell while self transferring. The DON admitted no new

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interventions had been identified or put into place after that fall.
b) Date 6/3, R3's name and "call don't fall" was written. When asked what that meant, the DON stated they added a sign to R3's room that read "call, don't fall."
c) There was no documentation for falls on 7/17 and 7/18.

One document dated 5/25/21, had an entry for R4 under a section titled "falls" which indicated:
a) Date 5/19, R4's name and "call don't fall." When asked what that meant, the DON stated they added a sign to R4's room that read "call don't fall." Asked if a sign was the most effective intervention for someone with a brain injury, the DON didn't reply.

Another documented dated 6/3/21, had an entry for R4 under a section titled "falls" which indicated:
a) Date 5/29, R4's name and "crawl on floor said slid from bed - mattress." When asked what that meant, the DON stated R4 slid off his bed and thought R4 was given a new mattress to prevent further falls, but did not know what kind of mattress, adding that the maintenance supervisor would know but he was on vacation.
b) Date 5/30, R4's name and "slid out of chair - therapy evaluate chair." Physical therapy notes from May through June were reviewed and did not include an evaluation of R4's wheelchair.

During the same interview, when asked how new fall interventions are communicated to the nursing staff, the DON stated it was done at shift report. When asked what new fall interventions were identified for R3 after his four falls, the DON admitted only the sign had been identified after

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the 6/3 fall, but had not been added to R3's care plan. The DON verified that no new interventions had been discussed or identified after R3's falls on 6/2, 7/17 and 7/18.

During the same interview, when asked what new fall interventions were discussed and identified for R4 after his three falls, the DON stated the sign had been identified, as well as new mattress. However the DON could not verify what type of mattress as the resident was no longer in the facility. In addition, therapy was to "evaluate chair," but unable to determine if that was done. The DON verified these interventions had not been added to R4's care plan after his falls. The DON admitted if the fall interventions were not on the care plan, nursing staff would not be aware of them.

During an interview on 7/28/21, at 1:42 p.m., when asked for post-fall assessments for R3 and R4, DCS-C stated "I wish I could give them to you, but they don't exist, they weren't done." When pointed out the facility fall prevention and management guidelines indicated they must be completed, DCS-C stated she was aware of that and could not explain why they were not done; the expectation was they were done after each fall.

During an interview on 7/28/21, at 2:10 p.m., when asked what occurred after a resident fall to prevent further falls, NA-G stated NA's inform a nurse that a resident fell and the nurse informs the DON, and the DON and therapy decided any new interventions. When asked how NA's learned about new fall interventions, NA-G stated "through the nursing channel." "Usually verbal; someone tells us." NA-G added that if the therapy

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department determined an intervention, staff were required to sign off on it. NA-G was aware of R1's fall and confirmed re-training on lifts and slings, including sling to match the lift manufacturer.

During an interview on 7/28/21, at 2:20 p.m. when asked what her responsibility was after a resident fell, RN-B stated she assessed the resident and obtained vital signs, notified the provider, completed a risk management report and informed the DON and family. RN-B stated she can recommend fall interventions, for example moving the bed against a wall or adding a fall mat. When asked how her recommendation would get passed onto other staff, RN-B stated it was passed on during the 24 hour report. RN-B stated there were no new fall interventions in R3's care plan that she was aware of and according to RN-B, "when we see R3 leaning forward in his wheelchair, we have to lay him down to prevent a fall." That had been passed on in report on 7/18/21. RN-B stated apparently R3 had been leaning forward for most of the day on 7/18/21, and fell out of his wheelchair at the beginning of her evening shift at 2:50 p.m. RN-B sent R3 to the hospital for evaluation (he returned on 7/26/21). RN-B did not recall R4 and his falls and/or fall interventions. RN-B verified recent training on slings and mechanical lift after a resident fell from the lift.

During an interview on 7/28/21, at 2:50 p.m., TMA-A stated after a resident fell, "they figured out a way so it doesn't happen again," adding that the nurse and the DON would get back to them and tell them what to do for fall interventions. If therapy was involved, they required nursing to sign off on any new interventions. "Sometimes new interventions get added to the care plan but

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not always." TMA-A was not able to state specific fall interventions for either R3 or R4, only general interventions such as call light within reach, a sign in the room reminding a resident to use call light and floor mats. TMA-A verified she had recent training on use of lifts and slings and specifically slings and lifts brands needed to match.

During an interview on 7/28/21, at 3:57 p.m. the administrator stated falls were discussed at the weekly WAR (weekly at risk) meeting where at-risk residents were discussed. The leadership team also reviewed the 24 hour report (generated by nursing staff on each shift) each morning and discussed everything from falls to behaviors, and from there nursing identified fall prevention tactics and communicated them to the staff. The administrator assumed interventions were being added to resident care plans, but could not speak to that. The administrator was aware the workload for nurse leaders had been challenging due to recent resignations of nurse managers.

The facility Fall Prevention and Management Guidelines with revised date of 3/10/21, defined a fall as an episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself.

Facility policy titled Fall Prevention and Management Guidelines with revised date of 3/10/21, indicated the facility would implement a fall program for residents determined to be at risk for falls. A fall referred to unintentionally coming to rest on the ground. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, was considered a fall. Specific interventions would be developed based

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F 689	Continued From page 18 on the results of the fall assessment. An individualized plan of care would be developed and communicated with staff. An investigation and comprehensive fall risk assessment would be completed. After review, investigation, and assessment, a nurse would update the care plan with new interventions and remove interventions no longer appropriate. Each fall was reviewed at the interdisciplinary team meeting (IDT), which may include the review of the investigation and potential root cause for the fall, review of updates and revisions to the plan of care, and education to the staff of any care plan revisions. If after IDT review, it was determined that existing interventions in the care plan were appropriate, the rationale was to be documented and any additional actions taken was to be included. All staff were to receive in-services on falls upon orientation, semiannually, and after a fall as necessary.	F 689		

Electronically delivered
August 18, 2021

Administrator
Rochester East Health Services
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: FPE411

Dear Administrator:

The above facility was surveyed on July 26, 2021 through July 28, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(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
2 000	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 7/26/21 and 7/28/21, 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.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5184140C (MN00074948 and MN00074970) 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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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's guidelines for proper use of slings for eight residents (R2, R11, R18, R13, R8, R10, R12, R9) of 14 residents who utilized full body lifts. This deficient practice resulted in an immediate jeopardy (IJ) for R1, who fell from the full body lift and had the potential for injury for R2, R11, R18, R13, R8, R10, R12, R9 as a result of not following the manufacturer's guidance for proper use. Furthermore, the facility failed to assess and evaluate causal factors for falls, and failed to	2 830	See above	9/8/21

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2 830	Continued From page 3 ensure adequate supervision and interventions were implemented to reduce falls for 2 of 2 resident (R3 and R4) reviewed who sustained multiple falls. The IJ began on 7/18/21, at 11:00 p.m. when licensed practical nurse (LPN)-A and nursing assistant (NA)-A were transferring R1 with a full body lift and R1 fell out of the sling to the floor. The administrator and director of nursing (DON) were notified of the IJ on 7/26/21, at 7:04 p.m. The IJ was removed on 7/28/21, at 3:30 p.m. however, noncompliance remained at the lower scope and severity level of E, pattern, no actual harm, but potential for more than minimal harm. Findings include: R1's facesheet printed on 7/19/21, listed diagnoses which included amyothrophic lateral sclerosis (ALS) (nerve cells break down, reducing functionality in the muscles they supply), dysphasia (language disorder that affects a person's ability to communicate), anxiety,and quadriplegia (paralysis of all four limbs). R1's admission Minimum Data Set (MDS) assessment dated 5/26/21, indicated R1 was cognitively intact, had adequate hearing and vision, unclear speech, was sometimes able to make self understood and could usually understand. R1 required extensive assistance or was dependent upon two staff and/or the use of a full body lift for bed mobility, transfers, dressing, toileting, and moving about in a wheelchair. R1's plan of care initiated on 5/14/21, indicated: a) self-care deficit as evidenced by increased dependence on others to complete activities of daily living related to disease progress and newly	2 830		

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2 830	Continued From page 4 diagnosed ALS, and would require transfer with a mechanical lift and assistance of two. b) impaired functional mobility as evidenced by diagnosis of ALS. Nursing would provide assistance as needed for transfers via total mechanical lift and two staff. R1's care plan did not indicate the type of sling nor size of sling to be used with the full body lift. R1's progress note dated 7/19/21, at 4:15 a.m. by LPN-A indicated: R1 fell from Hoyer (mechanical lift used for a full body lift) approximately three feet from floor while transferring to commode. R1 hit her head and back on the leg of hoyer. No apparent injury but R1 transferred to local hospital via ambulance. Unsure how fall from hoyer occurred. R1's progress note dated 7/19/21, at 4:30 a.m., by LPN-A indicated: R1 was admitted to the hospital with three rib fractures on the right side and would probably be in the hospital for two days. During a telephone interview on 7/26/21, at 10:02 a.m., family member (FM)-D stated he received a call on 7/18/21, that R1 was being sent to the hospital. FM-D was told R1 had been in the mechanical lift and something happened causing her to fall three feet hitting her head and lower back on the ground; but they didn't know how it happened. FM-D stated R1 did not like using the full body lift; it scared her and she didn't trust certain staff using it, but no one would listen to R1 and ask her why she was afraid. "If they did it the right way every time, she wouldn't be afraid." FM-D stated R1 was still in the hospital and was uncertain if R1 would return to facility due to her fear of being moved with the mechanical lift.	2 830		

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2 830	Continued From page 5 During an interview on 7/26/21, at 11:10 a.m., (NA)-B stated there were three Invacare brand full body lifts -- one on each floor, and there were two different manufacturer slings being used with the lifts: Invacare and MedCare, adding "MedCare slings were not made for the Invacare lifts but we use them." During document review, the Invacare User Manual dated 10/18/18, indicated the following warning: Invacare slings and patient lift accessories are specifically designed to be used in conjunction with Invacare patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of Invacare's patient lift system. During an interview and observation on 7/26/21, at 12:40 p.m. with NA-B, R2 was sitting in a wheelchair in the dining room on a MedCare sling, color navy with gold trim. Per NA-B, R2 was not on dialysis, "but she ended up on a MedCare sling." During an interview on 7/26/21, at 12:45 p.m., (NA)-C stated the facility used more than one brand of sling for the mechanical lift, but didn't know the brand names. Stated staff always crisscrossed the legs on the sling, adding that was how she was trained. NA-C was aware of R1's fall from a lift and stated she had recent retraining after the incident, and the training included to use an Invacare sling with an Invacare lift. Stated prior to recent training, did not know a sling specified by the lift manufacturer should be used. During a telephone interview on 7/26/21, at 1:10 p.m. LPN-A verified she was involved in the 7/18 incident in which R1 fell from the full body lift.	2 830		

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2 830	Continued From page 6 LPN-A stated they were moving R1 from bed to the commode. LPN-A was guiding R1's feet and looking at the commode to see how close they were when suddenly R1 fell out of the sling to the floor. LPN-A stated R1's head hit the ground and her back was over the leg of the lift. LPN-A recalled the sling being royal blue in color, but didn't remember the trim color or the brand name. LPN-A was certain the legs of the sling were crisscrossed around R1's legs. "I have no idea how she fell out; we have done this many times before and nothing was out of the ordinary." During an interview on 7/26/21, at 1:14 p.m. corporate director of clinical services (DCS)-C stated she knew residents should be using slings specified by the mechanical lift manufacturer. It was not until the incident with R1 on 7/18, that she became aware the facility had been using more than one brand of sling. DCS-C stated once she became aware of this, more Invacare slings were ordered, but had not arrived yet. Of the 14 residents who used the full body lift, eight were still using MedCare brand slings: R2, R11, R18, R13, R8, R10, R12, R9. DCS-C stated the correct sling had been used for R1 at the time of her fall, a large Invacare sling. After the fall DCS-C inspected the sling and there were no abnormalities, tears or frays. During an observation on 7/26/21, at 1:20 p.m. observed NA-B and (LPN)-B transfer R2 from wheelchair to bed using the Invacare lift with a MedCare sling. During an interview on 7/26/21, at 1:46 p.m. the administrator acknowledged he was unaware until R1's incident that only slings specified by the lift manufacturer could be used with a lift. As a result of the facility investigation of the fall, he had	2 830		

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2 830	Continued From page 7 approved the purchase of additional Invacare slings to ensure all residents who used the lift had the proper sling. Furthermore, the administrator was aware that non-Invacare slings continued to be used with the Invacare lift for R2, R11, R18, R13, R8, R10, R12, R9 until additional Invacare slings arrived. During an interview on 7/26/21, at 2:55 p.m., the director of nursing (DON) stated the MedCare slings were acquired from the local hospital who wanted dialysis residents on this sling. Over time the facility acquired more of the slings and they were being used on non-dialysis residents and with the Invacare full body lift. The DON stated it was after R1's fall that she became aware of lift manufacturer specifications to use only slings designed for their mechanical lift. The DON was aware that non-Invacare slings continued to be used with the Invacare lift for R2, R11, R18, R13, R8, R10, R12, R9 until additional Invacare slings arrived. During a telephone interview on 7/26/21, at 3:07 p.m. with the Invacare representative (IR)-E, was asked if it were possible when a split leg sling was crisscrossed under and over a person's leg, and if the legs were sticking out rigid, could a person fall out of the sling. IR-E stated if the sling was too big, it's plausible, but very unlikely. IR-E stated the most likely cause would be that it wasn't attached to the hanger bar properly. "One of two reasons a resident falls from a lift: usually not hooked up to lift properly -- the loop on the sling isn't secure in the hook on the lift and one end falls off the hook. Or they didn't crisscross the sling at the legs. Someone of that size wouldn't likely fall through the middle if the sling was attached properly." IR-E added, at 163 pounds (weight of R1), a person would use a	2 830		

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2 830	Continued From page 8 large sling, adding even if an extra large sling were used, it would be highly unlikely a person would fall out. IR-E stated "we're very strict with use of our slings with our equipment. We can't test anyone else's slings. Our stance is clear: we can't guarantee someone else's sling will work properly in our lifts and vice versa." IR-E was unaware of this incident as the facility had not informed him. During an interview on 7/28/21, at 10:10 a.m. the DON stated the Invacare representative had not been contacted to inform him of a fall from their company's lift, or to utilize his expertise for problem solving or for staff education; "we hadn't thought of that." Training records were reviewed for the two staff involved in R1's fall from lift on 7/18. According to DCS-C, NA-A and LPN-A's training included a Relias online learning module titled: Safe Use of Mechanical Lifts. DCS-C provided a 19 page document dated 2017, which outlined the content of the training and listed "...the safe and proper use of mechanical lifts was illustrated with an emphasis on abiding by the manufacturer's guidelines for operation, and the most important part of an individual's responsibility in using mechanical lift devices was complying with both the manufacturers instructions and the organizations policies and procedures." And also included "You must abide by all of the manufacturer's specific instructions for the lift you are using. Never assume that because you used one practice or piece of equipment for one mechanical lift that you can use it for another type of lift. Doing so may result in equipment failure or even injury, or worse, death." - NA-A's training transcript listed the lift training	2 830		

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2 830	Continued From page 9 had been completed on 7/14/19, and competency testing for mechanical lift was validated on 9/20/19. -LPN-A's transcript which included dates from 2018 to 2020, did not indicate completion of the Relias's online learning module titled Safe Use of Mechanical Lifts. The facility was not able to provide evidence that LPN-A completed training on safe use of mechanical lifts. Facility policy titled Safe Lifting and Movement of Residents with revised date of 8/19/2020, indicated: In order to protect staff and residents, the facility would use appropriate techniques and devices to lift and move residents. Staff would receive training and complete a competency for use of the mechanical lifts prior to providing direct care. Residents who required the use of a mechanical lift would be assessed for the appropriate lift type and size using the Lift Mobility Status UDA. Registered nursing staff would assess residents upon admission, with significant change, and on an ongoing basis for need for transfer assistance. This information would be documented in the care plan and kardexes. Sufficient slings in sizes required by residents would be available at all times, and maintenance would perform routine checks and maintenance of equipment used for lifting consistent with the manufacturers guidance. The immediate jeopardy that began on 7/18/21, was removed on 7/28/21, when the facility's DON reviewed the Lift Mobility Status Assessment for residents who utilized full body lifts, care plans and kardexes were updated with size and type of sling for each resident. The facility initiated the use of the previously ordered Invacare slings for	2 830		

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2 830	Continued From page 10 all residents on 7/27/21. The facility developed a color-coded list for sling sizes were laminated and attached to each Invacare Reliant 450 Lift as well as laminated instructions for each type of sling to provide a quick, easily accessible reference for staff who completed training. The DON educated staff on the Lift Mobility Assessment to ensure the assessment was completed in full and specified vendor specific lift sling for type of lift and proper style. The facility nursing staff were re-educated on the use of full body lift and specifically regarding the use of Invacare slings, selection and sizing and use of these slings was provided. The DON or designee performed audits to ensure staff demonstrated understanding of sling types, size and proper application for full body mechanical lifts However the noncompliance remained at the lower scope and severity level of E, pattern, no actual harm, but potential for more than minimal harm. Falls R3 R3's facesheet printed on 7/28/21, indicated diagnoses of orthopedic aftercare following surgical amputation of great toe, muscle weakness, chronic osteomyelitis (inflammation of bone caused by infection) of right foot and ankle, schizophrenia (serious mental disorder in which people interpret reality abnormally), and diabetes. R3's admission Minimum Data Set (MDS) assessment dated 5/24/21, indicated R3 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R3 required extensive assistance of two staff for bed mobility, transfers, locomotion on and off the unit,	2 830		

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ROCHESTER EAST HEALTH SERVICES	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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2 830	Continued From page 11 dressing, toileting, and hygiene. R3 did not walk. R3's care area assessment (CAA) for falls dated 5/24/21, indicated R3 would return to group home when he was back to his baseline, was working with therapy following amputation of right great toe. Used a wheelchair and walker. R3 had a fall prior to hospitalization due to weakness and illness. R3's admission fall risk assessment, dated 5/19/21, and completed by licensed practical nurse (LPN)-D, indicated R3 was at risk for falls; had a history of one to two falls in the past 30 days, including a fracture related to falls in the past 6 month prior to admission. He had fall risk factors related to medications and exhibited gait or balance problems. R3's plan of care initiated on 5/27/21, indicated R3 was at risk for falls due to recent amputation of right great toe and history of falls. Interventions included: --Have commonly used articles within easy reach. --Medications as ordered. --Provide assistance to transfer and ambulate as needed. --Reinforce need to call for assistance. --Reinforce wheelchair safety as needed such as locking breaks. --Therapy evaluation and treat as ordered. All of the above interventions were initiated on 5/27/21. No new interventions were added to the care plan after falls on 6/2/21, 6/3/21, 7/17/21, and 7/18/21. Four fall incident reports for R3 indicated the following: --6/2/21: At 2:50 a.m., R3 was found sitting on the floor next to the bed. According to an unnamed	2 830		

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2 830	Continued From page 12 NA in the room, R3 had been sitting in his wheelchair while she changed his bedding. R3 leaned forward and the NA assisted him to slide from the wheelchair to the floor. No injury sustained. --6/3/21: At 11:04 p.m., R3 was found sitting on the floor next to the bed with wheelchair behind his back. R3 told RN-C that he was trying to stand up and lost his balance. No injury sustained. --7/17/21: At 5:57 p.m., R3 attempted to transfer self from bed to wheelchair. Staff were present and assisted him to the floor between the wheelchair and bed. R3 stated he was trying to get in the chair but slipped. No injury sustained. --7/18/21: At 2:50 p.m., R3 was found in the hallway with his knees, hands and forehead on the floor and his wheelchair behind him. Another resident informed staff he saw R3 leaning forward in his wheelchair and assisted him to the floor. R3 was sent to the hospital for evaluation and returned to the facility on 7/27/21. R4 R4's facesheet printed on 7/28/21, indicated diagnoses of traumatic subarachnoid (fluid filled space around the brain) hemorrhage with loss of consciousness, muscle weakness, abnormalities of gait and mobility, dementia, depression, age-related cognitive decline, and bilateral cataracts (clouding of the lens of the eye). R4's admission Minimum Data Set (MDS) assessment dated 5/25/21, indicated R4 was cognitively intact, had moderate difficulty hearing, adequate vision, clear speech, was able to make self understood and could understand others. R3 required extensive assistance of one staff for bed mobility, transfers, walking in room, locomotion on and off the unit, dressing, toileting, and	2 830		

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2 830	Continued From page 13 hygiene. R4's admission fall risk assessment, dated 5/18/21, and completed by licensed practical nurse (LPN)-D, indicated R4 was at risk for falls; had a history of one to two falls in both the past 30 and 60 days. R4 had fall risk factors related to medications and exhibited gait or balance problems. R4's plan of care initiated on 5/18/21, indicated R4 was at risk for falls/injury due to history of falls and cognitive impairment. Interventions included: --Have commonly used articled within easy reach. --Medications as ordered. --Provide assistance to transfer and ambulate as needed. --Reinforce need to call for assistance. --Reinforce wheelchair safety as needed such as locking breaks. --Therapy evaluation and treat as ordered. All of the above interventions were initiated on 5/27/21. No new interventions were added to the care plan after falls on 5/19, 5/29 and 5/30/21. In addition, R4's fall interventions were identical to R3's fall interventions. Three fall incident reports for R4 indicated the following: --5/19/21: At 5:15 a.m., R4 was found sitting on the floor in his room. No injury. R4 stated he was going to the bathroom and didn't know what happened. --5/29/21: At 4:15 p.m., R4 was found crawling on the floor by his bed, and told staff he slipped out of bed. No injury. --5/30/21: At 4:26 a.m., R4 was found on floor in his room. No injury. During an interview on 7/28/21, at 10:10 a.m.,	2 830		

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2 830	Continued From page 14 NA-F did not recall R4, however did recall R3, and that R3 was tall and a riser had been placed on his toilet to prevent him from having to get up and down from a low position. When asked what other kind of fall interventions were used for R3, NA-F stated they removed clutter from his room and floors, made sure his call light was within reach, and put signs in the room to remind him to use the call light. When asked how she was made aware of fall interventions for a resident, NA-F stated after a fall, management updated residents care plan with interventions. Use of a toilet riser was not an intervention on R3's care plan. NA-F confirmed recent training on slings and lifts, including brand of sling must match the lift manufacturer. During an interview on 7/28/21, at 11:12 a.m., when the DON was asked how resident falls were addressed, specifically determining causal factors and adding or modifying existing fall risk interventions. The DON presented three documents titled "War Meeting Key Indicators" and stated falls were discussed at this meeting. The documents provided the following information: One document dated 6/8/21, had two handwritten entries for R3 under a section titled "falls" which indicated: a) Date 6/2, R3's name and the word "self." When asked what that meant, the DON stated R3 fell while self transferring. The DON admitted no new interventions had been identified or put into place after that fall. b) Date 6/3, R3's name and "call don't fall" was written. When asked what that meant, the DON stated they added a sign to R3's room that read "call, don't fall." c) There was no documentation for falls on 7/17	2 830		

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2 830	Continued From page 15 and 7/18. One document dated 5/25/21, had an entry for R4 under a section titled "falls" which indicated: a) Date 5/19, R4's name and "call don't fall." When asked what that meant, the DON stated they added a sign to R4's room that read "call don't fall." Asked if a sign was the most effective intervention for someone with a brain injury, the DON didn't reply. Another documented dated 6/3/21, had an entry for R4 under a section titled "falls" which indicated: a) Date 5/29, R4's name and "crawl on floor said slid from bed - mattress." When asked what that meant, the DON stated R4 slid off his bed and thought R4 was given a new mattress to prevent further falls, but did not know what kind of mattress, adding that the maintenance supervisor would know but he was on vacation. b) Date 5/30, R4's name and "slid out of chair - therapy evaluate chair." Physical therapy notes from May through June were reviewed and did not include an evaluation of R4's wheelchair. During the same interview, when asked how new fall interventions are communicated to the nursing staff, the DON stated it was done at shift report. When asked what new fall interventions were identified for R3 after his four falls, the DON admitted only the sign had been identified after the 6/3 fall, but had not been added to R3's care plan. The DON verified that no new interventions had been discussed or identified after R3's falls on 6/2, 7/17 and 7/18. During the same interview, when asked what new fall interventions were discussed and identified for R4 after his three falls, the DON stated the sign	2 830		

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2 830	Continued From page 16 had been identified, as well as new mattress. However the DON could not verify what type of mattress as the resident was no longer in the facility. In addition, therapy was to "evaluate chair," but unable to determine if that was done. The DON verified these interventions had not been added to R4's care plan after his falls. The DON admitted if the fall interventions were not on the care plan, nursing staff would not be aware of them. During an interview on 7/28/21, at 1:42 p.m., when asked for post-fall assessments for R3 and R4, DCS-C stated "I wish I could give them to you, but they don't exist, they weren't done." When pointed out the facility fall prevention and management guidelines indicated they must be completed, DCS-C stated she was aware of that and could not explain why they were not done; the expectation was they were done after each fall. During an interview on 7/28/21, at 2:10 p.m., when asked what occurred after a resident fall to prevent further falls, NA-G stated NA's inform a nurse that a resident fell and the nurse informs the DON, and the DON and therapy decided any new interventions. When asked how NA's learned about new fall interventions, NA-G stated "through the nursing channel." "Usually verbal; someone tells us." NA-G added that if the therapy department determined an intervention, staff were required to sign off on it. NA-G was aware of R1's fall and confirmed re-training on lifts and slings, including sling to match the lift manufacturer. During an interview on 7/28/21, at 2:20 p.m. when asked what her responsibility was after a resident fell, RN-B stated she assessed the resident and obtained vital signs, notified the provider,	2 830		

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2 830	Continued From page 17 completed a risk management report and informed the DON and family. RN-B stated she can recommend fall interventions, for example moving the bed against a wall or adding a fall mat. When asked how her recommendation would get passed onto other staff, RN-B stated it was passed on during the 24 hour report. RN-B stated there were no new fall interventions in R3's care plan that she was aware of and according to RN-B, "when we see R3 leaning forward in his wheelchair, we have to lay him down to prevent a fall." That had been passed on in report on 7/18/21. RN-B stated apparently R3 had been leaning forward for most of the day on 7/18/21, and fell out of his wheelchair at the beginning of her evening shift at 2:50 p.m. RN-B sent R3 to the hospital for evaluation (he returned on 7/26/21). RN-B did not recall R4 and his falls and/or fall interventions. RN-B verified recent training on slings and mechanical lift after a resident fell from the lift. During an interview on 7/28/21, at 2:50 p.m., TMA-A stated after a resident fell, "they figured out a way so it doesn't happen again," adding that the nurse and the DON would get back to them and tell them what to do for fall interventions. If therapy was involved, they required nursing to sign off on any new interventions. "Sometimes new interventions get added to the care plan but not always." TMA-A was not able to state specific fall interventions for either R3 or R4, only general interventions such as call light within reach, a sign in the room reminding a resident to use call light and floor mats. TMA-A verified she had recent training on use of lifts and slings and specifically slings and lifts brands needed to match. During an interview on 7/28/21, at 3:57 p.m. the administrator stated falls were discussed at the	2 830		

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2 830	Continued From page 18 weekly WAR (weekly at risk) meeting where at-risk residents were discussed. The leadership team also reviewed the 24 hour report (generated by nursing staff on each shift) each morning and discussed everything from falls to behaviors, and from there nursing identified fall prevention tactics and communicated them to the staff. The administrator assumed interventions were being added to resident care plans, but could not speak to that. The administrator was aware the workload for nurse leaders had been challenging due to recent resignations of nurse managers. The facility Fall Prevention and Management Guidelines with revised date of 3/10/21, defined a fall as an episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself. Facility policy titled Fall Prevention and Management Guidelines with revised date of 3/10/21, indicated the facility would implement a fall program for residents determined to be at risk for falls. A fall referred to unintentionally coming to rest on the ground. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, was considered a fall. Specific interventions would be developed based on the results of the fall assessment. An individualized plan of care would be developed and communicated with staff. An investigation and comprehensive fall risk assessment would be completed. After review, investigation, and assessment, a nurse would update the care plan with new interventions and remove interventions no longer appropriate. Each fall was reviewed at the interdisciplinary team meeting (IDT), which may include the review of the investigation and potential root cause for the fall, review of updates	2 830		

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2 830	Continued From page 19 and revisions to the plan of care, and education to the staff of any care plan revisions. If after IDT review, it was determined that existing interventions in the care plan were appropriate, the rationale was to be documented and any additional actions taken was to be included. All staff were to receive in-services on falls upon orientation, semiannually, and after a fall as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, and accidents to assure proper assessment and interventions are being implemented.. The DON or designee could re-educate staff on policies and procedures. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies. The results of the audits could be brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		