Electronically delivered
February 2, 2021

Administrator
Augustana HCC Of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

RE: CCN: 245264
Cycle Start Date: January 19, 2021

Dear Administrator:

On January 19, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On January 5, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 forimposition: 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, Augustana Hcc Of Apple Valley is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effectiveJanuary 19, 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.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/07/21- 1/19/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be UNSUBSTANTIATED: MN68747/H5264127C.	2 000	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.	

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2 000	Continued From page 1 The following complaint MN68768/MN68778/H5264126C was substantiated. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
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	2 830		3/4/21

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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the sling was properly applied to the full body mechanical lift for 1 of 3 residents (R1) who used a mechanical lift. R1 suffered a fractured knee and subdural hemorrhage requiring hospitalization when the loop of the sling come out of the mechanical lift causing R1 to fall to the ground. The facility immediately implemented interventions and corrected the deficient practice on 1/5/21. As a result of the immediate interventions this is being issued as past noncompliance at Immediate Jeopardy (IJ). The immediate jeopardy began on 1/4/21, when R1 fell out of the sling during a transfer from bed to wheelchair was corrected on 1/5/21, when the facility implemented interventions to prevent reoccurrence. The administrator and director of nursing (DON) were notified of the past noncompliance immediate jeopardy at 5:30 p.m. on 1/7/21, as a result of the immediate corrective action taken by the facility. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 10/20/20, indicated R1 was cognitively intact and required two plus person physical assist for transfers.	2 830	No POC required	

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2 830	Continued From page 3 R1's care plan dated 10/28/20, indicated R1's ambulation and transfers were impaired due to obesity, weakness, depression and required a mechanical lift with transfers. The care plan directed staff to "provide total assist of two for transfers using Hoyer." R1's progress note dated 1/4/21, at 8:30 a.m. indicated, "Resident called daughter to update on resident's change in condition and laceration on back of head. Facility to send to emergency room [ER] to have laceration looked at due to increased bleeding." R1's progress noted dated 1/4/21, at 10:25 a.m. indicated, "Resident laying on flour [sic] on her back side. Aid [sic] reported resident fell from the lift while the aid [sic] was transferring her from the bed to wheelchair, hit her head on the dresser and landed on her back." When interviewed on 1/7/21, at 11:00 a.m. nursing assistant (NA)-C stated staff were supposed to attach the sling loop to the lift bar and always double check to ensure everything was properly in place prior to moving the resident. When interviewed on 1/7/21, at 11:24 a.m. NA-B stated he and another aide (NA-A) were in the room when R1 fell from the lift. NA-B stated R1 was an assist of two for transfers and required a large sling. NA-B stated he placed the sling under R1, brought the lift into the room and attached the sling loops to the lift bar. NA-B stated NA-A was in the room when he started to move the resident. NA-B stated, "I started lifting the lift using the remote control and then looked to make sure the sling was secure." NA-B further stated he started moving the resident off the bed while NA-A assisted with R1's legs. NA-A then turned to	2 830		

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2 830	Continued From page 4	2 830		

position by the wheelchair. "Just before [R1] fell it sounded like something snapped off. The clasps were both still on. The loops on the sling were not torn or anything." NA-B further stated his process was to hook the loops on and then pull down and shake them to make sure they were hooked up correctly. NA-B further stated he did that this time and every time and that both staff were supposed to verify the sling was secure.

When interviewed on 1/7/21, at 12:03 p.m. DON stated the director of environmental services inspected the lift following the accident on 1/4/21, and did not find anything wrong with the lift. DON further stated, "If there was a part of the sling caught in the clasp [safety clip] it could pull out." DON further stated it was okay for one NA to set up the sling and connect it to the lift alone as long as the second NA was in the room for the transfer and had verified everything was hooked up correctly.

When interviewed on 1/7/21, at 12:26 p.m. NA-A stated she was assisting with R1's roommate on 1/4/21, when NA-B requested assistance to transfer R1 from the bed to the wheelchair. "[NA-B] got R1 ready for transfer and got her all hooked up while I was emptying the trash." NA-A stated she was directing R1's feet but as she turned to position herself by the wheelchair she heard a pop, turned back around and R1 was falling to the ground. NA-A stated the process was that one staff would move the lift while the other staff would direct the resident's feet. NA-A further stated that she worked with NA-B a lot and he would normally pull on the sling [loops] prior to lifting to make sure they are secure, but could not recall seeing him do that this time. "Honestly, I should have walked over and looked closer, but I trust [NA-B]. I did visualize the loops; I am 98

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2 830	Continued From page 5	2 830		

percent sure they were in there correctly." NA-A further stated the silver [safety] clips were in place and both secure after the incident and the sling was not ripped. NA-A further stated, "It is possible the sling was under the clasp [safety clip]. It is possible it was under the clasp and I just did not see it. I should have gone over physically myself to make sure, but knowing [NA-B], I had no doubt he did anything wrong. It [double checking] is something that should absolutely be done." NA-A further stated they were short staffed that day with only five NAs when they normally have eight. "When we are short staffed, we hurry." NA-A further stated she had a competency on the lifts at her prior facility and transferred to this facility December of 2019. NA-A further stated she did not receive another competency on this lift at this facility and did not receive a normal orientation due to being a transfer. NA-A stated, "The machines here [this facility] are different than the ones there [previous facility]."

When interviewed on 1/7/21, at 1:37 p.m. in-service educator (ISE) stated NAs were trained on the lifts during orientation which included a video and return demonstration and then received a yearly skill check off competency. ISE could not confirm NA-A completed a competency during orientation or prior to her first shift at this facility and that lift competencies were supposed to be done every year per policy. ISE further stated, the second staff present during transfers did not have to be present while the sling was being attached to the lift, but the second person still had full responsibility to ensure everything was properly connected.

When interviewed on 1/7/21, at 1:54 p.m. maintenance director (MD) stated there was a

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2 830	Continued From page 6 work order on 1/4/21, following the accident requesting him to inspect the lift. MD confirmed the lift involved was Viking M Liko lift number three. "The lift was clearly marked out of service. I looked it over completely did not find any flaws with it." M-A further stated he did not consider it [the accident] a lift malfunction. When interviewed on 1/7/21, at 2:55 p.m. maintenance technician (M)-A stated the lifts were inspected monthly. M-B stated most common issue found on monthly inspection was missing safety clips. When interviewed on 1/7/21, at 3:10 p.m. MD stated the lifts were inspected monthly and it was rare to find a mechanical problem with the lifts. MD stated the most common issue was missing the safety clip. When interviewed on 1/7/21, at 3:28 p.m. tech support specialist from the mechanical lift company (TSS)-A stated the recommended maintenance schedule for the Liko Viking M lift was yearly and could be done by a Liko representative or the facility. TSS-A further stated to operate the lift properly "they are supposed to inspect the lift and all clips prior to raising." TSS-A further stated under normal use the safety clips should not come off. "I have noticed when staff are in a hurry staff yank it [the sling] off and not slide it off the way it should." TSS-A further stated, "The only way it [sling loop coming out of the sling bar] could happen if the sling loop was not on properly. It would have to go past that [safety] clip. It would have to go past that [safety clip] it will not come out once you put weight in the sling and properly lift. It will not come off."	2 830		

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2 830	Continued From page 7 Review of the facility investigation file indicated an email from MD to DON on 1/5/21, indicating "Monday morning I was informed through our maintenance program that I needed to repair a lift. There were no specifics as to what was wrong with it so I looked it over the best I could and found nothing wrong that would cause an accident." Review of the facility Event Report dated 1/4/21, at 1:36 p.m. indicated R1 experienced a witnessed fall during a transfer from bed to wheelchair using a mechanical lift, resulting in a "major injury" requiring R1 to be sent to the ER. The report further indicated factors leading to fall included "machine malfunction" and that the Hoyer machine was taken away to be inspected by maintenance. Review of NA-A's education transcript indicated NA-A completed and met expectation on the EZ Lift on 6/19/19. The transcript further indicated NA-A completed the LIKO mechanical lift competency skills checklist on 1/5/21, after the incident occurred. Review of the undated Viking M Mobile Lift instructions for use indicated, "The equipment should only be used by trained personnel. Exercise care and caution during use. As a caregiver, you are always responsible for the patient's safety." The instructions direct users to always make sure that before lifting, the sling's strap loops are correctly connected to the sling bar hooks when the sling straps are stretched up but before the patient is lifted from the underlying surface." Review of the facility policy Floor-Based, Full Body Sling Lift Use dated 1/14/19, indicated full	2 830		

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2 830	Continued From page 8 body lifts were to be used for the transfer of resident per resident's care plan. The use of a full body lift required two staff members present to assist in the transfer. The policy further indicated the lift and sling must be checked to ensure all parts were in place prior to using. The policy directed staff to ensure all clips or loops were secure then lift resident until there is slight tension on the sling loops. "Perform safety check: Once there is tension on the loops, double check each loop to be sure each is securely in the hook. Double-check the position and stability of all straps and other equipment. Ensure clips, latches, and bars are securely fastened and structurally sound. Lift resident about 2 inches off the surface and verify that weight is evenly spread between the straps of the sling." The past noncompliance immediate jeopardy began on 1/4/21. The immediate jeopardy was removed, and the deficient practice corrected by 1/5/21, after the facility implemented a systemic plan that included the following actions: The facility immediately decommissioned the lift on 1/4/21, and sent it to maintenance for inspection. On 1/4/21, the facility initiated an investigation to include a step-by-step reenactment with the staff members (NA-A and NA-B) involved as well as lift competency testing for both the NA's and return lift demonstration. On 1/5/21 and 1/6/21, the facility provided in-service lift review and re-education training to all staff who assist with lift transfers. Also, NA-A and NA-B were retrained and required to demonstrate competency on mechanical lift transfers on 1/5/21 and 1/7/21 respectively. Staff interviews confirmed the facility implemented corrective action and therefore this will be cited at past noncompliance. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 9 The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 1/07/21-1/19/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 1/7/21-1/19/21, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to be in compliance. The following complaint was found to be unsubstantiated: MN68747/H5264127C. On 1/7/21- 1/19/21, an abbreviated standard survey also was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The abbreviated standard survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 1/4/21, when the facility failed to ensure the sling loops were	F 000		

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

Electronically Signed | 03/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 01/19/2021

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F 000	Continued From page 1 secured correctly on the Hoyer lift prior the initiation of a transfer for R1 which resulted in the sling loop to come out of the lift and R1 fell to the ground. As a result, R1 suffered a fractured femur above the knee and subdural hemorrhage and was hospitalized. The administrator and director of nursing (DON) were notified of the IJ for R1 on 1/7/21, at 5:30 p.m.. The facility immediately implemented correction action on 1/5/21, and F689 is being issued at past non-compliance. The above findings constituted substandard quality of care, and an extended survey was conducted on 1/19/21. Complaint MN68768/MN68778/H5264126C was substantiated at F689, for past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	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	F 689		3/4/21

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F 689	Continued From page 2 by: Based on interview and document review, the facility failed to ensure the sling was properly applied to the full body mechanical lift for 1 of 3 residents (R1) who used a mechanical lift. R1 suffered a fractured knee and subdural hemorrhage requiring hospitalization when the loop of the sling come out of the mechanical lift causing R1 to fall to the ground. The facility immediately implemented interventions and corrected the deficient practice on 1/5/21. As a result of the immediate interventions this is being issued as past noncompliance at Immediate Jeopardy (IJ). The immediate jeopardy began on 1/4/21, when R1 fell out of the sling during a transfer from bed to wheelchair was corrected on 1/5/21, when the facility implemented interventions to prevent reoccurrence. The administrator and director of nursing (DON) were notified of the past noncompliance immediate jeopardy at 5:30 p.m. on 1/7/21, as a result of the immediate corrective action taken by the facility. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 10/20/20, indicated R1 was cognitively intact and required two plus person physical assist for transfers. R1's care plan dated 10/28/20, indicated R1's ambulation and transfers were impaired due to obesity, weakness, depression and required a mechanical lift with transfers. The care plan directed staff to "provide total assist of two for transfers using Hoyer."	F 689	Past noncompliance: no plan of correction required.	

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R1's progress note dated 1/4/21, at 8:30 a.m. indicated, "Resident called daughter to update on resident's change in condition and laceration on back of head. Facility to send to emergency room [ER] to have laceration looked at due to increased bleeding."

R1's progress noted dated 1/4/21, at 10:25 a.m. indicated, "Resident laying on flour [sic] on her back side. Aid [sic] reported resident fell from the lift while the aid [sic] was transferring her from the bed to wheelchair, hit her head on the dresser and landed on her back."

When interviewed on 1/7/21, at 11:00 a.m. nursing assistant (NA)-C stated staff were supposed to attach the sling loop to the lift bar and always double check to ensure everything was properly in place prior to moving the resident.

When interviewed on 1/7/21, at 11:24 a.m. NA-B stated he and another aide (NA-A) were in the room when R1 fell from the lift. NA-B stated R1 was an assist of two for transfers and required a large sling. NA-B stated he placed the sling under R1, brought the lift into the room and attached the sling loops to the lift bar. NA-B stated NA-A was in the room when he started to move the resident. NA-B stated, "I started lifting the lift using the remote control and then looked to make sure the sling was secure." NA-B further stated he started moving the resident off the bed while NA-A assisted with R1's legs. NA-A then turned to position by the wheelchair. "Just before [R1] fell it sounded like something snapped off. The clasps were both still on. The loops on the sling were not torn or anything." NA-B further stated his process was to hook the loops on and then pull down and shake them to make sure they were hooked up

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correctly. NA-B further stated he did that this time and every time and that both staff were supposed to verify the sling was secure.

When interviewed on 1/7/21, at 12:03 p.m. DON stated the director of environmental services inspected the lift following the accident on 1/4/21, and did not find anything wrong with the lift. DON further stated, "If there was a part of the sling caught in the clasp [safety clip] it could pull out." DON further stated it was okay for one NA to set up the sling and connect it to the lift alone as long as the second NA was in the room for the transfer and had verified everything was hooked up correctly.

When interviewed on 1/7/21, at 12:26 p.m. NA-A stated she was assisting with R1's roommate on 1/4/21, when NA-B requested assistance to transfer R1 from the bed to the wheelchair. "[NA-B] got R1 ready for transfer and got her all hooked up while I was emptying the trash." NA-A stated she was directing R1's feet but as she turned to position herself by the wheelchair she heard a pop, turned back around and R1 was falling to the ground. NA-A stated the process was that one staff would move the lift while the other staff would direct the resident's feet. NA-A further stated that she worked with NA-B a lot and he would normally pull on the sling [loops] prior to lifting to make sure they are secure, but could not recall seeing him do that this time. "Honestly, I should have walked over and looked closer, but I trust [NA-B]. I did visualize the loops; I am 98 percent sure they were in there correctly." NA-A further stated the silver [safety] clips were in place and both secure after the incident and the sling was not ripped. NA-A further stated, "It is possible the sling was under the clasp [safety

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clip]. It is possible it was under the clasp and I just did not see it. I should have gone over physically myself to make sure, but knowing [NA-B], I had no doubt he did anything wrong. It [double checking] is something that should absolutely be done." NA-A further stated they were short staffed that day with only five NAs when they normally have eight. "When we are short staffed, we hurry." NA-A further stated she had a competency on the lifts at her prior facility and transferred to this facility December of 2019. NA-A further stated she did not receive another competency on this lift at this facility and did not receive a normal orientation due to being a transfer. NA-A stated, "The machines here [this facility] are different than the ones there [previous facility]."

When interviewed on 1/7/21, at 1:37 p.m. in-service educator (ISE) stated NAs were trained on the lifts during orientation which included a video and return demonstration and then received a yearly skill check off competency. ISE could not confirm NA-A completed a competency during orientation or prior to her first shift at this facility and that lift competencies were supposed to be done every year per policy. ISE further stated, the second staff present during transfers did not have to be present while the sling was being attached to the lift, but the second person still had full responsibility to ensure everything was properly connected.

When interviewed on 1/7/21, at 1:54 p.m. maintenance director (MD) stated there was a work order on 1/4/21, following the accident requesting him to inspect the lift. MD confirmed the lift involved was Viking M Liko lift number three. "The lift was clearly marked out of service.

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I looked it over completely did not find any flaws with it." M-A further stated he did not consider it [the accident] a lift malfunction.

When interviewed on 1/7/21, at 2:55 p.m. maintenance technician (M)-A stated the lifts were inspected monthly. M-B stated most common issue found on monthly inspection was missing safety clips.

When interviewed on 1/7/21, at 3:10 p.m. MD stated the lifts were inspected monthly and it was rare to find a mechanical problem with the lifts. MD stated the most common issue was missing the safety clip.

When interviewed on 1/7/21, at 3:28 p.m. tech support specialist from the mechanical lift company (TSS)-A stated the recommended maintenance schedule for the Liko Viking M lift was yearly and could be done by a Liko representative or the facility. TSS-A further stated to operate the lift properly "they are supposed to inspect the lift and all clips prior to raising." TSS-A further stated under normal use the safety clips should not come off. "I have noticed when staff are in a hurry staff yank it [the sling] off and not slide it off the way it should." TSS-A further stated, "The only way it [sling loop coming out of the sling bar] could happen if the sling loop was not on properly. It would have to go past that [safety] clip. It would have to go past that [safety clip] it will not come out once you put weight in the sling and properly lift. It will not come off."

Review of the facility investigation file indicated an email from MD to DON on 1/5/21, indicating "Monday morning I was informed through our

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maintenance program that I needed to repair a lift. There were no specifics as to what was wrong with it so I looked it over the best I could and found nothing wrong that would cause an accident."

Review of the facility Event Report dated 1/4/21, at 1:36 p.m. indicated R1 experienced a witnessed fall during a transfer from bed to wheelchair using a mechanical lift, resulting in a "major injury" requiring R1 to be sent to the ER. The report further indicated factors leading to fall included "machine malfunction" and that the Hoyer machine was taken away to be inspected by maintenance.

Review of NA-A's education transcript indicated NA-A completed and met expectation on the EZ Lift on 6/19/19. The transcript further indicated NA-A completed the LIKO mechanical lift competency skills checklist on 1/5/21, after the incident occurred.

Review of the undated Viking M Mobile Lift instructions for use indicated, "The equipment should only be used by trained personnel. Exercise care and caution during use. As a caregiver, you are always responsible for the patient's safety." The instructions direct users to always make sure that before lifting, the sling's strap loops are correctly connected to the sling bar hooks when the sling straps are stretched up but before the patient is lifted from the underlying surface."

Review of the facility policy Floor-Based, Full Body Sling Lift Use dated 1/14/19, indicated full body lifts were to be used for the transfer of resident per resident's care plan. The use of a full

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body lift required two staff members present to assist in the transfer. The policy further indicated the lift and sling must be checked to ensure all parts were in place prior to using. The policy directed staff to ensure all clips or loops were secure then lift resident until there is slight tension on the sling loops. "Perform safety check: Once there is tension on the loops, double check each loop to be sure each is securely in the hook. Double-check the position and stability of all straps and other equipment. Ensure clips, latches, and bars are securely fastened and structurally sound. Lift resident about 2 inches off the surface and verify that weight is evenly spread between the straps of the sling."

The past noncompliance immediate jeopardy began on 1/4/21. The immediate jeopardy was removed, and the deficient practice corrected by 1/5/21, after the facility implemented a systemic plan that included the following actions: The facility immediately decommissioned the lift on 1/4/21, and sent it to maintenance for inspection. On 1/4/21, the facility initiated an investigation to include a step-by-step reenactment with the staff members (NA-A and NA-B) involved as well as lift competency testing for both the NA's and return lift demonstration. On 1/5/21 and 1/6/21, the facility provided in-service lift review and re-education training to all staff who assist with lift transfers. Also, NA-A and NA-B were retrained and required to demonstrate competency on mechanical lift transfers on 1/5/21 and 1/7/21 respectively. Staff interviews confirmed the facility implemented corrective action and therefore this will be cited at past noncompliance.