Electronically delivered
June 12, 2020

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

SUBJECT: SURVEY RESULTS
CCN: 245461
Cycle Start Date: April 10, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 27, 2020, the Minnesota Department of Health completed a complaint investigation at Eventide Lutheran Home to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 27, 2020 survey. Eventide Lutheran Home may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 27, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Eventide Lutheran Home may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

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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 5/21/20, to 5/27/20, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5461039C 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		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 5 of 6 nursing assistants (NA-B, NA-D, NA-F, NA-G, and NA-H), and 1 of 2 licensed practical nurses (LPN-B) from a staffing agency were competent in the use of a mechanical (Hoyer) lift per resident specific care plan guidelines, which resulted in a resident fall from a Hoyer lift. Findings include: R1's annual Minimum Data Set (MDS) dated 4/19/20, identified R1 had severe cognitive impairment, and diagnoses included dementia, and hemiplegia/hemiparesis (weakness or paralysis on one side of the body). The MDS identified R1 required total assistance from staff with transfers. The MDS indicated R1 had one fall	2 300	All travel nurses and travel CNA's have completed competency training on Hoyer lifts. All residents who utilize a Hoyer lift for transfers and are assisted by travel staff have the potential to be affected. Re-education was provided to the Director of Clinical Education and Human Resources Assistant regarding orientation and competency testing for travel staff. The DON is no longer employed with Eventide. An Agency Staff Orientation policy has been created. Nurse leadership and Human Resources will be educated on the policy.	7/2/20

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2 300	Continued From page 2 with minor injury since her last assessment. R1's Fall Care Area Assessment (CAA) dated 5/4/20, identified R1 had a fall in January 2020, when a Hoyer (mechanical lift) tipped over while R1 was being transferred. The CAA further indicated R1 required assist of three staff when using the Hoyer lift for transfers following the fall from the Hoyer lift. R1's care plan revised 5/7/20, identified R1 had a potential for falls related to impaired mobility, and required assist of three staff with Hoyer lift for all transfers. The care plan directed all staff to ensure the legs of the Hoyer lift were extended all the way out during the entire transfer, and two staff were to be present when hooking/unhooking the Hoyer sling. A review of the facility form titled "Scandia Care Plan" dated 5/11/20, identified R1 required assist of three staff with all Hoyer lift transfers. The care plan directed staff to ensure the Hoyer lift legs were extended all the way out during the entire transfer, and two staff should be present when hooking/unhooking the Hoyer sling. The facility incident initial report dated 5/20/20, which identified that during a transfer with the Hoyer lift, the lift began to tip to the side, and R1 was supported by staff and lowered to the floor via the Hoyer lift. R1 was then assisted off the floor into bed with three staff and the Hoyer lift. The Hoyer lift was inspected by the maintenance department, and found to be in safe working order. The nursing assistants involved were suspended pending the investigation. R1's Resident Incident Report Form dated 5/20/20, indicated an ongoing investigation which	2 300	The DON or designee will audit all travel staff human resource files for the next year to ensure that mechanical lift competencies have been completed. Findings of noncompliance with the competency resting will be reported to the DON and follow-up action will be taken as needed. The trends and action taken as a result of this audit will be reported to the QAPI Committee. The committee's recommendations will be followed for further actions. The DON or designee is responsible for compliance.	

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2 300	Continued From page 3	2 300		

indicated at 9:45 a.m. two employees transferred R1 from her wheelchair to her bed with a Hoyer lift, when the lift tipped to the side. The staff involved were able to keep the resident from hitting her head on the floor. Contributing factors identified by the facility included the root cause of the fall was due to R1's care plan not being followed.

R1's progress note dated 5/20/20, at 9:45 a.m. indicated R1 had a fall during a transfer with a Hoyer lift and two staff, when the lift tipped over sideways. R1 was assisted to the floor by two staff. R1 sustained no injuries, and education had been provided on the "proper use" of the Hoyer lift. R1's progress note did not identify whether R1's care plan had been followed at the time of the fall.

On 5/21/20, at 12:52 p.m. the DON was interviewed and stated the facility was currently in the process of completing an investigation following R1's fall. The DON confirmed both NA-A and NA-B had not followed R1's care plan which instructed them to have three staff during Hoyer lift transfers. The DON confirmed NA-B was an agency staff, and had only received a partial shift of orientation with another nursing assistant. The DON stated the facility did not complete skills competency for mechanical lift transfers with agency staff, and had been under the impression the staffing agency completed skills assessments for their staff.

On 5/21/20, at 3:20 p.m. NA-B's employment records were reviewed with the DON. NA-B's employment record contained Clinical Assessments By Prophecy dated 4/8/20, which was a self assessment, and not competency testing. The DON confirmed the agency staff

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2 300	Continued From page 4 received no competency testing at the facility. The DON stated the facility had assumed the staffing agency had provided competency testing, so the facility had not provided it. The DON stated the facility had the agency staff fill out forms, and complete a partial shift on the floor as part of their orientation. On 5/21/2020, at 12:22 p.m. during a telephone interview NA-B stated she she had not received competency training to use the Hoyer lift at the facility or with the staffing agency. On 5/21/20, at 2:22 p.m. NA-D stated she worked with a staffing agency, and was new to the facility. NA-D stated the facility had not completed a skills competency assessment on the use of mechanical lifts since she started, from either the facility or the staffing agency. NA-D stated another NA had shown her how to use the mechanical lift when she received orientation. On 5/21/20, at 3:20 p.m. a review of NA-B's employment records with DON revealed a form titled "Clinical Assessments By Prophecy" dated 4/8/20, included a skill self assessment, but lacked documentation of competency testing. The DON confirmed the travel pool staff received no competency testing at the facility, and indicated she had assumed the travel pool staffing company had provided competency testing. Review of agency staff personnel records revealed the following; NA-B began work at the facility on 5/18/20. NA-B's employee record failed to include facility competency testing completed to assure resident care and safety.	2 300		

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2 300	Continued From page 5 NA-D began work at the facility on 5/18/20. NA-D's employee record failed to include facility competency testing completed to assure resident care and safety. NA-F began work at the facility on 5/13/20. NA-F's employee record failed to include facility competency testing completed to assure resident care and safety. NA-G began work at the facility on 4/30/20. NA-G's employee record failed to include facility competency testing completed to assure resident care and safety. NA-H began work at the facility on 5/13/20. NA-B's employee record failed to include facility competency testing completed to assure resident care and safety. LPN-B began work at the facility on 5/11/20. LPN-B's employee record failed to include facility competency testing completed to assure resident care and safety. On 5/26/20, at 9:51 a.m. a voice message requesting a call from clinical education director (CED)-A was left. No return call was received. On 5/27/20, at 1:12 p.m. during a telephone interview the DON again confirmed the facility practice of orientation for agency staff included following a nursing assistant the second half of the first day. The DON stated the facility had not provided competency testing. The DON stated the human resource department was under the impression all competencies were tested by the staffing agency, which the facility had though was sufficient. The DON confirmed the Clinical Assessments forms in the agency staff	2 300		

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2 300	Continued From page 6 employment files were self assessments. The DON stated R1's fall was a result of the care plan not being followed, and competency testing not completed. A policy on agency staff orientation was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to mechanical lift training and resident care plans. DON or designee could provid training to the travel pool staff and with completing competency skills in these areas. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 300		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		7/2/20

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2 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from accident hazards when a resident was transferred without following the plan of care and without utilizing a mechanical lift in a safe manner for 1 of 1 residents (R1) who had fallen while being transferred with a mechanical lift. Findings include: R1's annual Minimum Data Set (MDS) dated 4/19/20, identified R1 had severe cognitive impairment, and diagnoses included hemiplegia/hemiparesis (weakness or paralysis on one side of the body). The MDS identified R1 required total assistance from staff with transfers. The MDS indicated R1 had one fall with minor injury since her last assessment. R1's Fall Care Area Assessment (CAA) dated 5/4/20, identified R1 had a fall in January 2020, when a Hoyer (mechanical lift) tipped over while R1 was being transferred. The CAA further indicated R1 required assist of three staff when using the Hoyer lift for transfers following the fall from the Hoyer lift. R1's care plan revised 5/7/20, identified R1 had a potential for falls related to impaired mobility, and required assist of three staff with Hoyer lift for all transfers. The care plan directed all staff to ensure the legs of the Hoyer lift were extended all the way out during the entire transfer, and two staff were to be present when hooking/unhooking the Hoyer sling. A review of the facility form titled "Scandia Care Plan" dated 5/11/20, identified R1 required assist	2 830	The recent falls, fall risk assessments, and care plans for the resident identified were reviewed to ensure that appropriate interventions were present on the care plan. All residents who require assistance with transfers, but particulary those who utilize a Hoyer lift, have the potential to be affected. The care plans of residents who utilize a Hoyer lift for transfers have been reviewed for accuracy. The fall prevention and care plan policy and procedure were reviewed and are appropriate. The Hoyer Lift policies have been updated to reflect the need to refer to the care plan for additional information. Licensed nurses and NAR's will be re-educated on the policies and the importance of following the care plan. The DON or designee will audit 8 resident Hoyer lift transfers weekly x 3 months, then 4 resident Hoyer lift transfers weekly x 3 months, then 4 resident Hoyer lift transfers monthly x 6 months. Findings of noncompliance with the resident's care plan will be reported to the DON and follow-up action will be taken as needed. The trends and action taken as a result of this audit will be reported to the QAPI Committee. The committee's recommendations will be followed for further actions.	

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2 830	Continued From page 8	2 830		

of three staff with all Hoyer lift transfers. The care plan directed staff to ensure the Hoyer lift legs were extended all the way out during the entire transfer, and two staff should be present when hooking/unhooking the Hoyer sling.

The facility incident initial report dated 5/20/20, which identified that during a transfer with the Hoyer lift, the lift began to tip to the side, and R1 was supported by staff and lowered to the floor via the Hoyer lift. R1 was then assisted off the floor into bed with three staff and the Hoyer lift. The Hoyer lift was inspected by the maintenance department, and found to be in safe working order. The nursing assistants involved were suspended pending the investigation.

R1's Resident Incident Report Form dated 5/20/20, indicated an ongoing investigation which indicated at 9:45 a.m. two employees transferred R1 from her wheelchair to her bed with a Hoyer lift, when the lift tipped to the side. The staff involved were able to keep the resident from hitting her head on the floor. Contributing factors identified by the facility included the root cause of the fall was due to R1's care plan not being followed.

A review of R1's progress notes from 1/1/20, to 5/21/20, identified the following:

On 1/2/20, at 8:00 p.m. R1 had a fall during a transfer with a Hoyer lift and two staff when the lift tipped over towards a chair in R1's room. R1 had been lowered to the floor with the assistance of staff and had no injuries. The note indicated the facility had determined R1 had fallen as a result of the Hoyer lifts legs not being fully extended when she was transferred from her specialized wheelchair. R1's care plan had been updated with

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2 830	Continued From page 9 fall prevention interventions to include the use of three staff when transferring R1 with the Hoyer lift. The note indicated education had been provided to staff on how to position the Hoyer lift with R1's specialized wheelchair to ensure the legs of the Hoyer lift could be extended throughout R1's transfer. On 5/20/20, at 9:45 a.m. R1 had a fall during a transfer with a Hoyer lift and two staff, when the lift tipped over sideways, and she was assisted to the floor. R1 had sustained no injuries, and education had been provided on the "proper use" of the Hoyer lift. R1's progress note did not identify whether R1's care plan had been followed at the time of the fall. On 5/21/2020, at 1:55 p.m. R1 was observed during a Hoyer lift transfer from her wheelchair to bed with assistance of three staff. Nursing assistant (NA)-I was running the controls of the Hoyer lift, NA-C held R1's legs and feet while NA-D guided the back of the sling during the transfer. Registered nurse (RN)-A was also in the room with a clip board and indicated she was completing an audit of the Hoyer lift use. On 5/21/20, at 12:22 p.m. during a telephone interview, NA-B stated on 5/20/20, she and NA-A were transferring R1 with the Hoyer lift. NA-B stated R1 had been placed in a lift sling, was raised up in the Hoyer lift, NA-B pushed R1 ahead approximately 1 inch, then the lift tipped. NA-B stated she had not received competency training to use the Hoyer lift at the facility or with her agency staffing company. NA-B stated she had filled out a skills form which had indicated she had training on the Hoyer lift use. At 1:03 p.m. during a follow up telephone	2 830		

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2 830	Continued From page 10	2 830		

interview, NA-B stated she had not reviewed R1's care plan prior to assisting R1 to transfer with the Hoyer lift. NA-B stated she had a copy of R1's care plan, but had not "had a chance to read it" before assisting R1. NA-B stated the first day of her employment with the facility she had been told to read the resident care plans when she got a chance. NA-B stated she had been told to review resident care plans at the beginning of each shift, after R1's fall.

On 5/21/20, at 12:30 p.m. NA-A was interviewed and stated on 5/20/20, she and NA-B were assisting R1 to the bed from her wheelchair. NA-A stated she was aware that three staff were required to transfer R1 with the Hoyer lift. NA-A stated she had "made a bad decision, and should have waited for the third person to arrive" before they transferred R1 from her wheelchair.

On 5/21/20, at 12:52 p.m. the DON was interviewed and stated the facility was currently in the process of completing an investigation following R1's fall. The DON confirmed both NA-A and NA-B had not followed R1's care plan which instructed them to have three staff during Hoyer lift transfers. The DON confirmed NA-B was an agency staff, and had only received a partial shift of orientation with another nursing assistant. The DON stated the facility did not complete skills competency for mechanical lift transfers with agency staff, and had been under the impression the staffing agency completed skills assessments for their staff.

On 5/21/20, at 2:22 p.m. NA-D stated she worked with a staffing agency, and was new to the facility. NA-D stated the facility had not completed a skills competency assessment on the use of mechanical lifts since she started, from either the

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	00072	A. BUILDING: _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

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2 830	Continued From page 11 facility or the staffing agency. NA-D stated another NA had shown her how to use the mechanical lift when she received orientation. On 5/21/20, at 2:49 p.m. RN-A stated R1 was dependent on staff for transfers and required the use of a Hoyer lift. RN-A confirmed R1's care plan identified she required the assistance of three staff for all transfers, and had a previous fall from the lift when two staff assisted her. RN-A stated she had started audits of resident transfers with a Hoyer lift to ensure resident care plans were followed, and to ensure staff competency. RN-A confirmed she had begun audits of staff competency during Hoyer lift transfers, and R1 was the first transfer she had observed today. RN-A indicated the facility planned to continue the audits until all staff were signed off. RN-A indicated she had met with NA-A and NA-B with the DON and it was determined the NA's had not follow R1's care plan for Hoyer lift transfers. On 5/26/20, at 9:51 a.m. a voice message requesting a call from clinical education director was left. No return call was received. On 5/27/20, at 2:32 p.m. a during a phone interview with LPN-A confirmed on 5/20/20, she had been called to R1's room to assess R1 when she fell while in a Hoyer lift. LPN-A confirmed NA-A and NA-B had not followed R1's care plan to utilize 3 staff during the Hoyer lift transfer. LPN-A indicated NA-B had informed her she thought it would be alright to transfer R1 with only 2 staff, and had informed the DON she had not read R1's care plan. On 5/27/20, at 1:12 p.m. during a follow up telephone interview, the DON confirmed NA-A had completed mechanical lift competency	2 830		

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2 830	Continued From page 12	2 830		

testing, reviewed the vulnerable adult policy, standards of care policy and the use of resident care plans. The DON confirmed she had completed a coaching form with NA-A regarding safety rounds and care plan expectations. The DON indicated NA-B had been terminated and no longer worked at the facility. The DON confirmed the facility practice of orientation for travel pool staff did not include skills competency testing, such as use of a Hoyer lift. The DON indicated the human resource department was under the impression all competencies were tested by the company. The DON indicated the facility had not been aware the staffing company did not complete actual skills assessment and a skills checklist form was used. The DON indicated, at that time, the clinical education director (CED) had begun to complete competency testing for all pool staff. The DON stated her expectation was for the staff to follow resident care plans, and confirmed R1's fall was a result of the care plan not being followed and lack of staff competency with use of a Hoyer lift.

The facility policy titled Hoyer Lifts-Volaro revised 1/17, directed an electronic lift (Hoyer or standing) would be used to transfer a resident whenever it was unsafe to transfer that resident due to their weight, inability to stand, or inability to cooperate. The policy further directed the purpose was to provide a safe method of transfer. The policy failed to direct staff to follow specific resident individualized care plan interventions.

Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures and train staff to assure staff are following resident care plans and assure proper use of mechanical lifts. The director of nursing or designee, could conduct random audits of the

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2 830	Continued From page 13 delivery of care; to ensure appropriate care and services are implemented. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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F 000	INITIAL COMMENTS On 5/21/20, to 5/27/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5461039C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were	F 689	The recent falls, fall risk assessments, and care plans for the resident identified	7/2/20

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

Electronically Signed | 06/17/2020

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

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F 689	Continued From page 1 free from accident hazards when a resident was transferred without following the plan of care and without utilizing a mechanical lift in a safe manner for 1 of 1 residents (R1) who had fallen while being transferred with a mechanical lift. Findings include: R1's annual Minimum Data Set (MDS) dated 4/19/20, identified R1 had severe cognitive impairment, and diagnoses included hemiplegia/hemiparesis (weakness or paralysis on one side of the body). The MDS identified R1 required total assistance from staff with transfers. The MDS indicated R1 had one fall with minor injury since her last assessment. R1's Fall Care Area Assessment (CAA) dated 5/4/20, identified R1 had a fall in January 2020, when a Hoyer (mechanical lift) tipped over while R1 was being transferred. The CAA further indicated R1 required assist of three staff when using the Hoyer lift for transfers following the fall from the Hoyer lift. R1's care plan revised 5/7/20, identified R1 had a potential for falls related to impaired mobility, and required assist of three staff with Hoyer lift for all transfers. The care plan directed all staff to ensure the legs of the Hoyer lift were extended all the way out during the entire transfer, and two staff were to be present when hooking/unhooking the Hoyer sling. A review of the facility form titled "Scandia Care Plan" dated 5/11/20, identified R1 required assist of three staff with all Hoyer lift transfers. The care plan directed staff to ensure the Hoyer lift legs were extended all the way out during the entire	F 689	were reviewed to ensure that appropriate interventions were present on the care plan. All residents who require assistance with transfers, but particulary those who utilize a Hoyer lift, have the potential to be affected. The care plans of residents who utilize a Hoyer lift for transfers have been reviewed for accuracy. The fall prevention and care plan policy and procedure were reviewed and are appropriate. The Hoyer Lift policies have been updated to reflect the need to refer to the care plan for additional information. Licensed nurses and NAR□s will be re-educated on the policies and the importance of following the care plan. The DON or designee will audit 8 resident Hoyer lift transfers weekly x 3 months, then 4 resident Hoyer lift transfers weekly x 3 months, then 4 resident Hoyer lift transfers monthly x 6 months. Findings of noncompliance with the resident□s care plan will be reported to the DON and follow-up action will be taken as needed. The trends and action taken as a result of this audit will be reported to the QAPI Committee. The committee□s recommendations will be followed for further actions. The DON or designee is responsible for compliance.	

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F 689	Continued From page 2	F 689		

transfer, and two staff should be present when hooking/unhooking the Hoyer sling.

The facility incident initial report dated 5/20/20, which identified that during a transfer with the Hoyer lift, the lift began to tip to the side, and R1 was supported by staff and lowered to the floor via the Hoyer lift. R1 was then assisted off the floor into bed with three staff and the Hoyer lift. The Hoyer lift was inspected by the maintenance department, and found to be in safe working order. The nursing assistants involved were suspended pending the investigation.

R1's Resident Incident Report Form dated 5/20/20, indicated an ongoing investigation which indicated at 9:45 a.m. two employees transferred R1 from her wheelchair to her bed with a Hoyer lift, when the lift tipped to the side. The staff involved were able to keep the resident from hitting her head on the floor. Contributing factors identified by the facility included the root cause of the fall was due to R1's care plan not being followed.

A review of R1's progress notes from 1/1/20, to 5/21/20, identified the following:

On 1/2/20, at 8:00 p.m. R1 had a fall during a transfer with a Hoyer lift and two staff when the lift tipped over towards a chair in R1's room. R1 had been lowered to the floor with the assistance of staff and had no injuries. The note indicated the facility had determined R1 had fallen as a result of the Hoyer lifts legs not being fully extended when she was transferred from her specialized wheelchair. R1's care plan had been updated with fall prevention interventions to include the use of three staff when transferring R1 with the Hoyer

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F 689	Continued From page 3	F 689		

lift. The note indicated education had been provided to staff on how to position the Hoyer lift with R1's specialized wheelchair to ensure the legs of the Hoyer lift could be extended throughout R1's transfer.

On 5/20/20, at 9:45 a.m. R1 had a fall during a transfer with a Hoyer lift and two staff, when the lift tipped over sideways, and she was assisted to the floor. R1 had sustained no injuries, and education had been provided on the "proper use" of the Hoyer lift. R1's progress note did not identify whether R1's care plan had been followed at the time of the fall.

On 5/21/2020, at 1:55 p.m. R1 was observed during a Hoyer lift transfer from her wheelchair to bed with assistance of three staff. Nursing assistant (NA)-I was running the controls of the Hoyer lift, NA-C held R1's legs and feet while NA-D guided the back of the sling during the transfer. Registered nurse (RN)-A was also in the room with a clip board and indicated she was completing an audit of the Hoyer lift use.

On 5/21/20, at 12:22 p.m. during a telephone interview, NA-B stated on 5/20/20, she and NA-A were transferring R1 with the Hoyer lift. NA-B stated R1 had been placed in a lift sling, was raised up in the Hoyer lift, NA-B pushed R1 ahead approximately 1 inch, then the lift tipped. NA-B stated she had not received competency training to use the Hoyer lift at the facility or with her agency staffing company. NA-B stated she had filled out a skills form which had indicated she had training on the Hoyer lift use.

At 1:03 p.m. during a follow up telephone interview, NA-B stated she had not reviewed R1's

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F 689	Continued From page 4	F 689		

care plan prior to assisting R1 to transfer with the Hoyer lift. NA-B stated she had a copy of R1's care plan, but had not "had a chance to read it" before assisting R1. NA-B stated the first day of her employment with the facility she had been told to read the resident care plans when she got a chance. NA-B stated she had been told to review resident care plans at the beginning of each shift, after R1's fall.

On 5/21/20, at 12:30 p.m. NA-A was interviewed and stated on 5/20/20, she and NA-B were assisting R1 to the bed from her wheelchair. NA-A stated she was aware that three staff were required to transfer R1 with the Hoyer lift. NA-A stated she had "made a bad decision, and should have waited for the third person to arrive" before they transferred R1 from her wheelchair.

On 5/21/20, at 12:52 p.m. the DON was interviewed and stated the facility was currently in the process of completing an investigation following R1's fall. The DON confirmed both NA-A and NA-B had not followed R1's care plan which instructed them to have three staff during Hoyer lift transfers. The DON confirmed NA-B was an agency staff, and had only received a partial shift of orientation with another nursing assistant. The DON stated the facility did not complete skills competency for mechanical lift transfers with agency staff, and had been under the impression the staffing agency completed skills assessments for their staff.

On 5/21/20, at 2:22 p.m. NA-D stated she worked with a staffing agency, and was new to the facility. NA-D stated the facility had not completed a skills competency assessment on the use of mechanical lifts since she started, from either the

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F 689	Continued From page 5	F 689		

facility or the staffing agency. NA-D stated another NA had shown her how to use the mechanical lift when she received orientation.

On 5/21/20, at 2:49 p.m. RN-A stated R1 was dependent on staff for transfers and required the use of a Hoyer lift. RN-A confirmed R1's care plan identified she required the assistance of three staff for all transfers, and had a previous fall from the lift when two staff assisted her. RN-A stated she had started audits of resident transfers with a Hoyer lift to ensure resident care plans were followed, and to ensure staff competency. RN-A confirmed she had begun audits of staff competency during Hoyer lift transfers, and R1 was the first transfer she had observed today. RN-A indicated the facility planned to continue the audits until all staff were signed off. RN-A indicated she had met with NA-A and NA-B with the DON and it was determined the NA's had not follow R1's care plan for Hoyer lift transfers.

On 5/26/20, at 9:51 a.m. a voice message requesting a call from clinical education director was left. No return call was received.

On 5/27/20, at 2:32 p.m. a during a phone interview with LPN-A confirmed on 5/20/20, she had been called to R1's room to assess R1 when she fell while in a Hoyer lift. LPN-A confirmed NA-A and NA-B had not followed R1's care plan to utilize 3 staff during the Hoyer lift transfer. LPN-A indicated NA-B had informed her she thought it would be alright to transfer R1 with only 2 staff, and had informed the DON she had not read R1's care plan.

On 5/27/20, at 1:12 p.m. during a follow up telephone interview, the DON confirmed NA-A

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F 689	Continued From page 6 had completed mechanical lift competency testing, reviewed the vulnerable adult policy, standards of care policy and the use of resident care plans. The DON confirmed she had completed a coaching form with NA-A regarding safety rounds and care plan expectations. The DON indicated NA-B had been terminated and no longer worked at the facility. The DON confirmed the facility practice of orientation for travel pool staff did not include skills competency testing, such as use of a Hoyer lift. The DON indicated the human resource department was under the impression all competencies were tested by the company. The DON indicated the facility had not been aware the staffing company did not complete actual skills assessment and a skills checklist form was used. The DON indicated, at that time, the clinical education director (CED) had begun to complete competency testing for all pool staff. The DON stated her expectation was for the staff to follow resident care plans, and confirmed R1's fall was a result of the care plan not being followed and lack of staff competency with use of a Hoyer lift. The facility policy titled Hoyer Lifts-Volaro revised 1/17, directed an electronic lift (Hoyer or standing) would be used to transfer a resident whenever it was unsafe to transfer that resident due to their weight, inability to stand, or inability to cooperate. The policy further directed the purpose was to provide a safe method of transfer. The policy failed to direct staff to follow specific resident individualized care plan interventions.	F 689		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services	F 726		7/2/20

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F 726	Continued From page 7 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 5 of 6 nursing assistants (NA-B, NA-D, NA-F, NA-G, and NA-H), and 1 of 2 licensed practical nurses (LPN-B) from a staffing agency were competent in the use of a mechanical (Hoyer) lift per resident specific care plan guidelines, which resulted in a resident fall from a Hoyer lift.	F 726	All travel nurses and travel CNA□s have completed competency training on Hoyer lifts. All residents who utilize a Hoyer lift for transfers and are assisted by travel staff have the potential to be affected.	

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F 726	Continued From page 8 Findings include: R1's annual Minimum Data Set (MDS) dated 4/19/20, identified R1 had severe cognitive impairment, and diagnoses included dementia, and hemiplegia/hemiparesis (weakness or paralysis on one side of the body). The MDS identified R1 required total assistance from staff with transfers. The MDS indicated R1 had one fall with minor injury since her last assessment. R1's Fall Care Area Assessment (CAA) dated 5/4/20, identified R1 had a fall in January 2020, when a Hoyer (mechanical lift) tipped over while R1 was being transferred. The CAA further indicated R1 required assist of three staff when using the Hoyer lift for transfers following the fall from the Hoyer lift. R1's care plan revised 5/7/20, identified R1 had a potential for falls related to impaired mobility, and required assist of three staff with Hoyer lift for all transfers. The care plan directed all staff to ensure the legs of the Hoyer lift were extended all the way out during the entire transfer, and two staff were to be present when hooking/unhooking the Hoyer sling. A review of the facility form titled "Scandia Care Plan" dated 5/11/20, identified R1 required assist of three staff with all Hoyer lift transfers. The care plan directed staff to ensure the Hoyer lift legs were extended all the way out during the entire transfer, and two staff should be present when hooking/unhooking the Hoyer sling. The facility incident initial report dated 5/20/20, which identified that during a transfer with the	F 726	Re-education was provided to the Director of Clinical Education and Human Resources Assistant regarding orientation and competency testing for travel staff. The DON is no longer employed with Eventide. An Agency Staff Orientation policy has been created. Nurse leadership and Human Resources will be educated on the policy. The DON or designee will audit all travel staff human resource files for the next year to ensure that mechanical lift competencies have been completed. Findings of noncompliance with the competency resting will be reported to the DON and follow-up action will be taken as needed. The trends and action taken as a result of this audit will be reported to the QAPI Committee. The committee□s recommendations will be followed for further actions. The DON or designee is responsible for compliance.	

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	245461	A. BUILDING _____ B. WING _____	C 05/27/2020

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Hoyer lift, the lift began to tip to the side, and R1 was supported by staff and lowered to the floor via the Hoyer lift. R1 was then assisted off the floor into bed with three staff and the Hoyer lift. The Hoyer lift was inspected by the maintenance department, and found to be in safe working order. The nursing assistants involved were suspended pending the investigation.

R1's Resident Incident Report Form dated 5/20/20, indicated an ongoing investigation which indicated at 9:45 a.m. two employees transferred R1 from her wheelchair to her bed with a Hoyer lift, when the lift tipped to the side. The staff involved were able to keep the resident from hitting her head on the floor. Contributing factors identified by the facility included the root cause of the fall was due to R1's care plan not being followed.

R1's progress note dated 5/20/20, at 9:45 a.m. indicated R1 had a fall during a transfer with a Hoyer lift and two staff, when the lift tipped over sideways. R1 was assisted to the floor by two staff. R1 sustained no injuries, and education had been provided on the "proper use" of the Hoyer lift. R1's progress note did not identify whether R1's care plan had been followed at the time of the fall.

On 5/21/20, at 12:52 p.m. the DON was interviewed and stated the facility was currently in the process of completing an investigation following R1's fall. The DON confirmed both NA-A and NA-B had not followed R1's care plan which instructed them to have three staff during Hoyer lift transfers. The DON confirmed NA-B was an agency staff, and had only received a partial shift of orientation with another nursing assistant. The

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DON stated the facility did not complete skills competency for mechanical lift transfers with agency staff, and had been under the impression the staffing agency completed skills assessments for their staff.

On 5/21/20, at 3:20 p.m. NA-B's employment records were reviewed with the DON. NA-B's employment record contained Clinical Assessments By Prophecy dated 4/8/20, which was a self assessment, and not competency testing. The DON confirmed the agency staff received no competency testing at the facility. The DON stated the facility had assumed the staffing agency had provided competency testing, so the facility had not provided it. The DON stated the facility had the agency staff fill out forms, and complete a partial shift on the floor as part of their orientation.

On 5/21/2020, at 12:22 p.m. during a telephone interview NA-B stated she she had not received competency training to use the Hoyer lift at the facility or with the staffing agency.

On 5/21/20, at 2:22 p.m. NA-D stated she worked with a staffing agency, and was new to the facility. NA-D stated the facility had not completed a skills competency assessment on the use of mechanical lifts since she started, from either the facility or the staffing agency. NA-D stated another NA had shown her how to use the mechanical lift when she received orientation.

On 5/21/20, at 3:20 p.m. a review of NA-B's employment records with DON revealed a form titled "Clinical Assessments By Prophecy" dated 4/8/20, included a skill self assessment, but lacked documentation of competency testing. The

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F 726	Continued From page 11 DON confirmed the travel pool staff received no competency testing at the facility, and indicated she had assumed the travel pool staffing company had provided competency testing. Review of agency staff personnel records revealed the following; NA-B began work at the facility on 5/18/20. NA-B's employee record failed to include facility competency testing completed to assure resident care and safety. NA-D began work at the facility on 5/18/20. NA-D's employee record failed to include facility competency testing completed to assure resident care and safety. NA-F began work at the facility on 5/13/20. NA-F's employee record failed to include facility competency testing completed to assure resident care and safety. NA-G began work at the facility on 4/30/20. NA-G's employee record failed to include facility competency testing completed to assure resident care and safety. NA-H began work at the facility on 5/13/20. NA-B's employee record failed to include facility competency testing completed to assure resident care and safety. LPN-B began work at the facility on 5/11/20. LPN-B's employee record failed to include facility competency testing completed to assure resident care and safety. On 5/26/20, at 9:51 a.m. a voice message	F 726		

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F 726	Continued From page 12 requesting a call from clinical education director (CED)-A was left. No return call was received. On 5/27/20, at 1:12 p.m. during a telephone interview the DON again confirmed the facility practice of orientation for agency staff included following a nursing assistant the second half of the first day. The DON stated the facility had not provided competency testing. The DON stated the human resource department was under the impression all competencies were tested by the staffing agency, which the facility had though was sufficient. The DON confirmed the Clinical Assessments forms in the agency staff employment files were self assessments. The DON stated R1's fall was a result of the care plan not being followed, and competency testing not completed. A policy on agency staff orientation was requested, but not provided.	F 726		