STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility failed to follow manufacturer's guidelines for proper use of slings for eight residents (R2, R11, R18, R13, R8, R10, R12, R9) of 14 residents who utilized full body lifts. This deficient practice resulted in an immediate jeopardy (IJ) for R1, who fell from the full body lift and had the potential for injury for R2, R11, R18, R13, R8, R10, R12, R9 as a result of not following the manufacturer's guidance for proper use. Furthermore, the facility failed to assess and evaluate causal factors for falls, and failed to ensure adequate supervision and interventions were implemented to reduce falls for 2 of 2 resident (R3 and R4) reviewed who sustained multiple falls. The IJ began on 7/18/21, at 11:00 p.m. when licensed practical nurse (LPN)-A and nursing assistant (NA)-A were transferring R1 with a full body lift and R1 fell out of the sling to the floor. The administrator and director of nursing (DON) were notified of the IJ on 7/26/21, at 7:04 p.m. The IJ was removed on 7/28/21, at 3:30 p. m. however, noncompliance remained at the lower scope and severity level of E, pattern, no actual harm, but potential for more than minimal harm. Findings include: R1's facesheet printed on 7/19/21, listed diagnoses which included amyothrophic lateral sclerosis (ALS) (nerve cells break down, reducing functionality in the muscles they supply), dysphasia (language disorder that affects a person's ability to communicate), anxiety,and quadriplegia (paralysis of all four limbs). R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R1 was cognitively intact, had adequate hearing and vision, unclear speech, was sometimes able to make self understood and could usually understand. R1 required extensive assistance or was dependent upon two staff and/or the use of a full body lift for bed mobility, transfers, dressing, toileting, and moving about in a wheelchair. R1's plan of care initiated on 5/14/21, indicated: a) self-care deficit as evidenced by increased dependence on others to complete activities of daily living related to disease progress and newly diagnosed ALS, and would require transfer with a mechanical lift and assistance of two. b) impaired functional mobility as evidenced by diagnosis of ALS. Nursing would provide assistance as needed for transfers via total mechanical lift and two staff. R1's care plan did not indicate the type of sling nor size of sling to be used with the full body lift. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R1's progress note dated 7/19/21, at 4:15 a.m. by LPN-A indicated: R1 fell from Hoyer (mechanical lift used for a full body lift) approximately three feet from floor while transferring to commode. R1 hit her head and back on the leg of hoyer. No apparent injury but R1 transferred to local hospital via ambulance. Unsure how fall from hoyer occurred. R1's progress note dated 7/19/21, at 4:30 a.m., by LPN-A indicated: R1 was admitted to the hospital with three rib fractures on the right side and would probably be in the hospital for two days. During a telephone interview on 7/26/21, at 10:02 a.m., family member (FM)-D stated he received a call on 7/18/21, that R1 was being sent to the hospital. FM-D was told R1 had been in the mechanical lift and something happened causing her to fall three feet hitting her head and lower back on the ground; but they didn't know how it happened. FM-D stated R1 did not like using the full body lift; it scared her and she didn't trust certain staff using it, but no one would listen to R1 and ask her why she was afraid. If they did it the right way every time, she wouldn't be afraid. FM-D stated R1 was still in the hospital and was uncertain if R1 would return to facility due to her fear of being moved with the mechanical lift. During an interview on 7/26/21, at 11:10 a.m., (NA)-B stated there were three Invacare brand full body lifts -- one on each floor, and there were two different manufacturer slings being used with the lifts: Invacare and MedCare, adding MedCare slings were not made for the Invacare lifts but we use them. During document review, the Invacare User Manual dated 10/18/18, indicated the following warning: Invacare slings and patient lift accessories are specifically designed to be used in conjunction with Invacare patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of Invacare's patient lift system. During an interview and observation on 7/26/21, at 12:40 p.m. with NA-B, R2 was sitting in a wheelchair in the dining room on a MedCare sling, color navy with gold trim. Per NA-B, R2 was not on dialysis, but she ended up on a MedCare sling. During an interview on 7/26/21, at 12:45 p.m., (NA)-C stated the facility used more than one brand of sling for the mechanical lift, but didn't know the brand names. Stated staff always crisscrossed the legs on the sling, adding that was how she was trained. NA-C was aware of R1's fall from a lift and stated she had recent retraining after the incident, and the training included to use an Invacare sling with an Invacare lift. Stated prior to recent training, did not know a sling specified by the lift manufacturer should be used. During a telephone interview on 7/26/21, at 1:10 p.m. LPN-A verified she was involved in the 7/18 incident in which R1 fell from the full body lift. LPN-A stated they were moving R1 from bed to the commode. LPN-A was guiding R1's feet and looking at the commode to see how close they were when suddenly R1 fell out of the sling to the floor. LPN-A stated R1's head hit the ground and her back was over the leg of the lift. LPN-A recalled the sling being royal blue in color, but didn't remember the trim color or the brand name. LPN-A was certain the legs of the sling were crisscrossed around R1's legs. I have no idea how she fell out; we have done this many times before and nothing was out of the ordinary. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/26/21, at 1:14 p.m. corporate director of clinical services (DCS)-C stated she knew residents should be using slings specified by the mechanical lift manufacturer. It was not until the incident with R1 on 7/18, that she became aware the facility had been using more than one brand of sling. DCS-C stated once she became aware of this, more Invacare slings were ordered, but had not arrived yet. Of the 14 residents who used the full body lift, eight were still using MedCare brand slings: R2, R11, R18, R13, R8, R10, R12, R9. DCS-C stated the correct sling had been used for R1 at the time of her fall, a large Invacare sling. After the fall DCS-C inspected the sling and there were no abnormalities, tears or frays. During an observation on 7/26/21, at 1:20 p.m. observed NA-B and (LPN)-B transfer R2 from wheelchair to bed using the Invacare lift with a MedCare sling. During an interview on 7/26/21, at 1:46 p.m. the administrator acknowledged he was unaware until R1's incident that only slings specified by the lift manufacturer could be used with a lift. As a result of the facility investigation of the fall, he had approved the purchase of additional Invacare slings to ensure all residents who used the lift had the proper sling. Furthermore, the administrator was aware that non-Invacare slings continued to be used with the Invacare lift for R2, R11, R18, R13, R8, R10, R12, R9 until additional Invacare slings arrived. During an interview on 7/26/21, at 2:55 p.m., the director of nursing (DON) stated the MedCare slings were acquired from the local hospital who wanted dialysis residents on this sling. Over time the facility acquired more of the slings and they were being used on non-dialysis residents and with the Invacare full body lift. The DON stated it was after R1's fall that she became aware of lift manufacturer specifications to use only slings designed for their mechanical lift. The DON was aware that non-Invacare slings continued to be used with the Invacare lift for R2, R11, R18, R13, R8, R10, R12, R9 until additional Invacare slings arrived. During a telephone interview on 7/26/21, at 3:07 p.m. with the Invacare representative (IR)-E, was asked if it were possible when a split leg sling was crisscrossed under and over a person's leg, and if the legs were sticking out rigid, could a person fall out of the sling. IR-E stated if the sling was too big, it's plausible, but very unlikely. IR-E stated the most likely cause would be that it wasn't attached to the hanger bar properly. One of two reasons a resident falls from a lift: usually not hooked up to lift properly -- the loop on the sling isn't secure in the hook on the lift and one end falls off the hook. Or they didn't crisscross the sling at the legs. Someone of that size wouldn't likely fall through the middle if the sling was attached properly. IR-E added, at 163 pounds (weight of R1), a person would use a large sling, adding even if an extra large sling were used, it would be highly unlikely a person would fall out. IR-E stated we're very strict with use of our slings with our equipment. We can't test anyone else's slings. Our stance is clear: we can't guarantee someone else's sling will work properly in our lifts and vice versa. IR-E was unaware of this incident as the facility had not informed him. During an interview on 7/28/21, at 10:10 a.m. the DON stated the Invacare representative had not been contacted to inform him of a fall from their company's lift, or to utilize his expertise for problem solving or for staff education; we hadn't thought of that. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Training records were reviewed for the two staff involved in R1's fall from lift on 7/18. According to DCS-C, NA-A and LPN-A's training included a Relias online learning module titled: Safe Use of Mechanical Lifts. DCS-C provided a 19 page document dated 2017, which outlined the content of the training and listed .the safe and proper use of mechanical lifts was illustrated with an emphasis on abiding by the manufacturer's guidelines for operation, and the most important part of an individual's responsibility in using mechanical lift devices was complying with both the manufacturers instructions and the organizations policies and procedures. And also included You must abide by all of the manufacturer's specific instructions for the lift you are using. Never assume that because you used one practice or piece of equipment for one mechanical lift that you can use it for another type of lift. Doing so may result in equipment failure or even injury, or worse, death. - NA-A's training transcript listed the lift training had been completed on 7/14/19, and competency testing for mechanical lift was validated on 9/20/19. -LPN-A's transcript which included dates from 2018 to 2020, did not indicate completion of the Relias's online learning module titled Safe Use of Mechanical Lifts. The facility was not able to provide evidence that LPN-A completed training on safe use of mechanical lifts. Facility policy titled Safe Lifting and Movement of Residents with revised date of 8/19/2020, indicated: In order to protect staff and residents, the facility would use appropriate techniques and devices to lift and move residents. Staff would receive training and complete a competency for use of the mechanical lifts prior to providing direct care. Residents who required the use of a mechanical lift would be assessed for the appropriate lift type and size using the Lift Mobility Status UDA. Registered nursing staff would assess residents upon admission, with significant change, and on an ongoing basis for need for transfer assistance. This information would be documented in the care plan and kardexes. Sufficient slings in sizes required by residents would be available at all times, and maintenance would perform routine checks and maintenance of equipment used for lifting consistent with the manufacturers guidance. The immediate jeopardy that began on 7/18/21, was removed on 7/28/21, when the facility's DON reviewed the Lift Mobility Status Assessment for residents who utilized full body lifts, care plans and kardexes were updated with size and type of sling for each resident. The facility initiated the use of the previously ordered Invacare slings for all residents on 7/27/21. The facility developed a color-coded list for sling sizes were laminated and attached to each Invacare Reliant 450 Lift as well as laminated instructions for each type of sling to provide a quick, easily accessible reference for staff who completed training. The DON educated staff on the Lift Mobility Assessment to ensure the assessment was completed in full and specified vendor specific lift sling for type of lift and proper style. The facility nursing staff were re-educated on the use of full body lift and specifically regarding the use of Invacare slings, selection and sizing and use of these slings was provided. The DON or designee performed audits to ensure staff demonstrated understanding of sling types, size and proper application for full body mechanical lifts However the noncompliance remained at the lower scope and severity level of E, pattern, no actual harm, but potential for more than minimal harm. Falls (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R3 R3's facesheet printed on 7/28/21, indicated diagnoses of orthopedic aftercare following surgical amputation of great toe, muscle weakness, chronic osteomyelitis (inflammation of bone caused by infection) of right foot and ankle, schizophrenia (serious mental disorder in which people interpret reality abnormally), and diabetes. R3's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R3 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R3 required extensive assistance of two staff for bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and hygiene. R3 did not walk. R3's care area assessment (CAA) for falls dated 5/24/21, indicated R3 would return to group home when he was back to his baseline, was working with therapy following amputation of right great toe. Used a wheelchair and walker. R3 had a fall prior to hospitalization due to weakness and illness. R3's admission fall risk assessment, dated 5/19/21, and completed by licensed practical nurse (LPN)-D, indicated R3 was at risk for falls; had a history of one to two falls in the past 30 days, including a fracture related to falls in the past 6 month prior to admission. He had fall risk factors related to medications and exhibited gait or balance problems. R3's plan of care initiated on 5/27/21, indicated R3 was at risk for falls due to recent amputation of right great toe and history of falls. Interventions included: --Have commonly used articles within easy reach. --Medications as ordered. --Provide assistance to transfer and ambulate as needed. --Reinforce need to call for assistance. --Reinforce wheelchair safety as needed such as locking breaks. --Therapy evaluation and treat as ordered. All of the above interventions were initiated on 5/27/21. No new interventions were added to the care plan after falls on 6/2/21, 6/3/21, 7/17/21, and 7/18/21. Four fall incident reports for R3 indicated the following: --6/2/21: At 2:50 a.m., R3 was found sitting on the floor next to the bed. According to an unnamed NA in the room, R3 had been sitting in his wheelchair while she changed his bedding. R3 leaned forward and the NA assisted him to slide from the wheelchair to the floor. No injury sustained. --6/3/21: At 11:04 p.m., R3 was found sitting on the floor next to the bed with wheelchair behind his back. R3 told RN-C that he was trying to stand up and lost his balance. No injury sustained. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--7/17/21: At 5:57 p.m., R3 attempted to transfer self from bed to wheelchair. Staff were present and assisted him to the floor between the wheelchair and bed. R3 stated he was trying to get in the chair but slipped. No injury sustained. --7/18/21: At 2:50 p.m., R3 was found in the hallway with his knees, hands and forehead on the floor and his wheelchair behind him. Another resident informed staff he saw R3 leaning forward in his wheelchair and assisted him to the floor. R3 was sent to the hospital for evaluation and returned to the facility on [DATE]. R4 R4's facesheet printed on 7/28/21, indicated diagnoses of traumatic subarachnoid (fluid filled space around the brain) hemorrhage with loss of consciousness, muscle weakness, abnormalities of gait and mobility, dementia, depression, age-related cognitive decline, and bilateral cataracts (clouding of the lens of the eye). R4's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R4 was cognitively intact, had moderate difficulty hearing, adequate vision, clear speech, was able to make self understood and could understand others. R3 required extensive assistance of one staff for bed mobility, transfers, walking in room, locomotion on and off the unit, dressing, toileting, and hygiene. R4's admission fall risk assessment, dated 5/18/21, and completed by licensed practical nurse (LPN)-D, indicated R4 was at risk for falls; had a history of one to two falls in both the past 30 and 60 days. R4 had fall risk factors related to medications and exhibited gait or balance problems. R4's plan of care initiated on 5/18/21, indicated R4 was at risk for falls/injury due to history of falls and cognitive impairment. Interventions included: --Have commonly used articled within easy reach. --Medications as ordered. --Provide assistance to transfer and ambulate as needed. --Reinforce need to call for assistance. --Reinforce wheelchair safety as needed such as locking breaks. --Therapy evaluation and treat as ordered. All of the above interventions were initiated on 5/27/21. No new interventions were added to the care plan after falls on 5/19, 5/29 and 5/30/21. In addition, R4's fall interventions were identical to R3's fall interventions. Three fall incident reports for R4 indicated the following: --5/19/21: At 5:15 a.m., R4 was found sitting on the floor in his room. No injury. R4 stated he was going to the bathroom and didn't know what happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--5/29/21: At 4:15 p.m., R4 was found crawling on the floor by his bed, and told staff he slipped out of bed. No injury. --5/30/21: At 4:26 a.m., R4 was found on floor in his room. No injury. During an interview on 7/28/21, at 10:10 a.m., NA-F did not recall R4, however did recall R3, and that R3 was tall and a riser had been placed on his toilet to prevent him from having to get up and down from a low position. When asked what other kind of fall interventions were used for R3, NA-F stated they removed clutter from his room and floors, made sure his call light was within reach, and put signs in the room to remind him to use the call light. When asked how she was made aware of fall interventions for a resident, NA-F stated after a fall, management updated residents care plan with interventions. Use of a toilet riser was not an intervention on R3's care plan. NA-F confirmed recent training on slings and lifts, including brand of sling must match the lift manufacturer. During an interview on 7/28/21, at 11:12 a.m., when the DON was asked how resident falls were addressed, specifically determining causal factors and adding or modifying existing fall risk interventions. The DON presented three documents titled War Meeting Key Indicators and stated falls were discussed at this meeting. The documents provided the following information: One document dated 6/8/21, had two handwritten entries for R3 under a section titled falls which indicated: a) Date 6/2, R3's name and the word self. When asked what that meant, the DON stated R3 fell while self transferring. The DON admitted no new interventions had been identified or put into place after that fall. b) Date 6/3, R3's name and call don't fall was written. When asked what that meant, the DON stated they added a sign to R3's room that read call, don't fall. c) There was no documentation for falls on 7/17 and 7/18. One document dated 5/25/21, had an entry for R4 under a section titled falls which indicated: a) Date 5/19, R4's name and call don't fall. When asked what that meant, the DON stated they added a sign to R4's room that read call don't fall. Asked if a sign was the most effective intervention for someone with a brain injury, the DON didn't reply. Another documented dated 6/3/21, had an entry for R4 under a section titled falls which indicated: a) Date 5/29, R4's name and crawl on floor said slid from bed - mattress. When asked what that meant, the DON stated R4 slid off his bed and thought R4 was given a new mattress to prevent further falls, but did not know what kind of mattress, adding that the maintenance supervisor would know but he was on vacation. b) Date 5/30, R4's name and slid out of chair - therapy evaluate chair. Physical therapy notes from May through June were reviewed and did not include an evaluation of R4's wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During the same interview, when asked how new fall interventions are communicated to the nursing staff, the DON stated it was done at shift report. When asked what new fall interventions were identified for R3 after his four falls, the DON admitted on ly the sign had been identified after the 6/3 fall, but had not been added to R3's care plan. The DON verified that no new interventions had been discussed or identified after R3's falls on 6/2, 7/17 and 7/18. During the same interview, when asked what new fall interventions were discussed and identified for R4 after his three falls, the DON stated the sign had been identified, as well as new mattress. However the DON could not verify what type of mattress as the resident was no longer in the facility. In addition, therapy was to evaluate chair, but unable to determine if that was done. The DON verified these interventions had not been added to R4's care plan after his falls. The DON admitted if the fall interventions were not on the care plan, nursing staff would not be aware of them. During an interview on 7/28/21, at 1:42 p.m., when asked for post-fall assessments for R3 and R4, DCS-C stated I wish I could give them to you, but they don't exist, they weren't done. When pointed out the facility fall prevention and management guidelines indicated they must be completed, DCS-C stated she was aware of that and could not explain why they were not done; the expectation was they were done after each fall. During an interview on 7/28/21, at 2:10 p.m., when asked what occurred after a resident fall to prevent further falls, NA-G stated NA's inform a nurse that a resident fell and the nurse informs the DON, and the DON and therapy decided any new interventions. When asked how NA's learned about new fall interventions, NA-G stated through the nursing channel. Usually verbal; someone tells us. NA-G added that if the therapy department determined an intervention, staff were required to sign off on it. NA-G was aware of R1's fall and confirmed re-training on lifts and slings, including sling to match the lift manufacturer. During an interview on 7/28/21, at 2:20 p.m. when asked what her responsibility was after a resident fell , RN-B stated she assessed the resident and obtained vital signs, notified the provider, completed a risk management report and informed the DON and family. RN-B stated she can recommend fall interventions, for example moving the bed against a wall or adding a fall mat. When asked how her recommendation would get passed onto other staff, RN-B stated it was passed on during the 24 hour report. RN-B stated there were no new fall interventions in R3's care plan that she was aware of and according to RN-B, when we see R3 leaning forward in his wheelchair, we have to lay him down to prevent a fall. That had been passed on in report on 7/18/21. RN-B stated apparently R3 had been leaning forward for most of the day on 7/18/21, and fell out of his wheelchair at the beginning of her evening shift at 2:50 p.m. RN-B sent R3 to the hospital for evaluation (he returned on 7/26/21). RN-B did not recall R4 and his falls and/or fall interventions. RN-B verified recent training on slings and mechanical lift after a resident fell from the lift. During an interview on 7/28/21, at 2:50 p.m., TMA-A stated after a resident fell , they figured out a way so it doesn't happen again, adding that the nurse and the DON would get back to them and tell them what to do for fall interventions. If therapy was involved, they required nursing to sign off on any new interventions. Sometimes new interventions get added to the care plan but not always. TMA-A was not able to state specific fall interventions for either R3 or R4, only general interventions such as call light within reach, a sign in the room reminding a resident to use call light and floor mats. TMA-A verified she had recent training on use of lifts and slings and specifically slings and lifts brands needed to match. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/28/21, at 3:57 p.m. the administrator stated falls were discussed at the weekly WAR (weekly at risk) meeting where at-risk residents were discussed. The leadership team also reviewed the 24 hour report (generated by nursing staff on each shift) each morning and discussed everything from falls to behaviors, and from there nursing identified fall prevention tactics and communicated them to the staff. The administrator assumed interventions were being added to resident care plans, but could not speak to that. The administrator was aware the workload for nurse leaders had been challenging due to recent resignations of nurse managers. The facility Fall Prevention and Management Guidelines with revised date of 3/10/21, defined a fall as an episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself. Facility policy titled Fall Prevention and Management Guidelines with revised date of 3/10/21, indicated the facility would implement a fall program for residents determined to be at risk for falls. A fall referred to unintentionally coming to rest on the ground. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, was considered a fall. Specific interventions would be developed based on the results of the fall assessment. An individualized plan of care would be developed and communicated with staff. An investigation and comprehensive fall risk assessment would be completed. After review, investigation, and assessment, a nurse would update the care plan with new interventions and remove interventions no longer appropriate. Each fall was reviewed at the interdisciplinary team meeting (IDT), which may include the review of the investigation and potential root cause for the fall, review of updates and revisions to the plan of care, and education to the staff of any care plan revisions. If after IDT review, it was determined that existing interventions in the care plan were appropriate, the rationale was to be documented and any additional actions taken was to be included. All staff were to receive in-services on falls upon orientation, semiannually, and after a fall as necessary.