STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. Building B. Wing	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of St Cloud	1717 University Drive Southeast Saint Cloud, MN 56304

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082 Based on interview and document review the facility failed to report a resident fall from a Hoyer lift during provisions of care to the state agency (SA) for 1 of 2 residents (R1) reviewed. Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE] indicated no cognitive impairments and required assistance of staff with transfers. R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of 2 staff with Hoyer transfers and was non-ambulatory. On 12/13/21 a common entry point (CEP) was submitted to SA which indicated on 11/17/21, R1 was going to take a shower. Only one nursing assistance was using the Hoyer lift. R1 was up five feet, cleared bed and straps broke. R1 dropped five feet. On 11/17/21, at 9:00 p.m. a progress notes indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on [DATE]. DON stated the incident was not reported to the SA as R1 did not suffer any injuries. A facility policy Vulnerable Adult Abuse and Neglect Prevention dated 11/17/20, indicated if injury is unexplainable, or an allegation of abuse is reported or witnessed, if there is caregiver neglect, or if therapeutic error resulted in injury, a report must be made to the state health department immediately with initial findings.

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.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082 Based on interview and document review, the facility failed to thoroughly investigate a resident fall from a Hoyer lift and sling malfunction which resulted in a fall. for 1 of 2 residents (R1) reviewed for falls. Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE] indicated no cognitive impairments and required assistance of staff with transfers. R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of 2 staff with Hoyer transfers and was non-ambulatory. On 11/17/21, at 9:00 p.m. a progress notes indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. On 11/17/21. At 8:48 p.m. a facility risk assessment indicated an incident description from registered nurse (RN)-A was called to R1 rooms where R1 was on floor. Aide stated that the sling had ripped and R1 fell to floor. R1 voiced pain in left should, neck and right hip. R1 was alert and oriented. R1 was interviewed and agreed with aide description. R1 was immediately assess for bruises, RN-A did a neuro exam, and checked vitals. No bruises noted, nothing appeared to be broken. Sling replaced. No injuries were observed at time of incident. When interview on 12/15/21, at 11:50 a.m. R1 stated he was being transferred from his bed as he was getting a bath. R1 stated he was not interviewed about how the fall occurred. R1 stated he did not suffer any major injuries, only a sore shoulder. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on [DATE]. DON stated it was unknown who was assisting R1 with the transfer. DON stated she did interview staff but did not document the interviews and did not recall who was interviewed. DON stated she did assess R1 pain the next day after the fall but did not interview on the incident. DON stated there is camera footage, but it was not reviewed as part of the investigation. DON stated the sling manufacturer was not consulted during the investigation. When interviewed on 12/16/21, at 11:19 a.m. assistance director of nursing (ADON) stated when she arrived after the fall there were three staff present but she was not sure who performed the transfer or how many were present during the actual fall adding she interviewed two of the three staff that were present after the fall. ADON did not document interviews, it was all verbal. ADON stated she did not interview R1. The facility investigation lacked evidence of interviews with the resident, staff and witnesses, review of care plan and/or steps the facility took to investigate possible causes for the resident fall, including contacting the manufacturer.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 43082 Based on observation, interview and document review, the facility failed to have a preventative maintenance plan for resident Hoyer slings to ensure the integrity of the slings for safe resident use for 1 of 2 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1 when the sling split open while R1 was being transferred in the Hoyer lift and he fell , sustaining minor injuries. The IJ began on 11/17/21, when R1 fell while being transferred in the Hoyer lift when the sling split open and R1 fell to the floor, sustaining minor injuries. The administrator and director of nursing (DON) were informed of the IJ on 12/16/21, at 5:53 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 11/18/21, prior to the start of the survey and was therefore Past Noncompliance Findings include: R1's Diagnosis Information, undated, indicated R1's diagnoses included diabetes, unsteadiness on feet, other abnormalities of gait and mobility and morbid obesity. R1's significant change Minimum Data Set (MDS) dated [DATE] indicated no cognitive impairments and required assistance of staff with transfers. R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of two staff with Hoyer transfers and was non-ambulatory. On 12/13/21, a common entry point (CEP) was submitted to state agency (SA) which indicated on 11/17/21, R1 was going to take a shower. Only one nursing assistant was using the Hoyer lift during the transfer. R1 was up five feet, cleared bed and straps broke. R1 dropped five feet. On 11/17/21, at 9:00 p.m. a progress note indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. On 11/17/21, at 8:48 p.m. a facility risk assessment indicated an incident description from registered nurse (RN)-A was called to R1's room where R1 was on floor. Aide stated that the sling had ripped and R1 fell to floor. R1 voiced pain in left shoulder, neck, and right hip. R1 was alert and oriented. R1 was interviewed and agreed with aide description. R1 was immediately assessed for bruises, RN-A did a neuro exam, and checked vitals. No bruises noted, nothing appeared to be broken. Sling replaced. No injuries were observed at time of incident. During observation and interview on 12/15/21, at 11:50 a.m. R1 was sitting in his wheelchair in his bedroom. R1 stated he was being transferred from his bed as he was getting ready for a bath. R1 stated only one nursing assistant was performing the transfer with the Hoyer lift. R1 stated he fell while in the sling and believed one of the loops ripped. R1 stated he was not interviewed about how the fall occurred. R1 stated he did not suffer any major injuries, only a sore shoulder. During observation R1's Hoyer sling was not observed in his room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on 12/15/21, at 4:28 p.m. RN-A stated she completed the assessment after R1 fell , she was not a witness. RN-A stated the nurse aide came to her and stated R1 had fallen from the Hoyer and believed she was alone but did not remember which aide it was. RN-A stated the sling was removed by assistant director of nursing (ADON) and given a new sling to use. RN-A stated she did not make a report to the State Agency. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on [DATE]. DON stated it was unknown who was assisting R1 with the transfer. At request of survey staff, DON reviewed camera footage and it was identified at that time, only one aide preformed the Hoyer lift transfer resulting in a fall. DON stated it is policy to have a minimum of two staff assisting in a Hoyer transfer. DON stated the sling had been removed when it ripped during the transfer. DON stated after the incident the sling was thrown away and added they did not contact the manufacturer to report the malfunction of the sling. DON stated the sling was ripped on a loop and noted the rip was not at the seam but rather in the center of the fold of the loop. DON stated staff were re-educated on checking slings integrity before use, reviewed importance of following R1's care plan and reviewed facility policy. DON stated an audit was developed and completed for all slings which resulted in no concerns with the integrity of other slings in the facility. DON stated there was no audits performed on slings prior to this incident. DON stated the incident was not reported to the SA as R1 did not suffer any injuries. When interviewed on 12/16/21, at 11:19 a.m. assistance director of nursing (ADON) stated she worked the day of R1's fall on 11/17/21. ADON stated she was called to R1's room after the fall occurred and assisted getting R1 off the floor. ADON stated when she arrived after the fall there were three staff present but was not sure who performed the transfer or how many were present, ADON did not investigate with staff interviews. Phone call interview on 12/16/21, at 1: 25 p.m. with sling manufacturer INVOCARE representative who stated when a facility had an incident with a sling, they would want all incidents reported and would want the sling sent back so they could complete their own investigation to determine the cause of the fall/rip. During observations on 12/16/21, starting at 3:25 p.m. two separate resident Hoyer lift transfers were observed with no concerns regarding sling integrity or care plan implementation noted. Nursing assistant (NA)-A was attempted to be interviewed for this survey; calls were not returned. On 11/18/21, facility provided education on sling integrity with all floor staff. On 11/18/21, facility administered a Hoyer sling integrity audit resulting in no other issues with the slings in the facility. R1's sling was removed and provided a new sling. Facility's Policy and Procedure Using a Mechanical Lift dated 8/1/15, indicated the portable lift should be used by two nursing assistants to perform the procedure. Facility's Policy and Procedures Post Fall Policy dated 3/23/20, indicated to complete a Risk Management incident. The report should include but is not limited to the following information: residents account of the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The past non-compliance immediate jeopardy began on 11/17/21. The immediate jeopardy was removed, and the deficient practice corrected by 11/18/21, after the facility implemented education with all staff concerning implementation of care plan needs of residents, integrity of slings, removal of the malfunctioned sling and current and ongoing audits of all the slings in use at the facility. Audits concluded no other slings were malfunctioning. Verification was identified onsite through interview, observation, and record review.