STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augustana Care Hastings Health and Rehabilitation	930 West 16th Street Hastings, MN 55033

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 - 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** Based on interview and document review, the facility failed to ensure a safe transfer with a mechanical lift was performed to reduce the risk of serious harm, injury, impairment, or death for 1 of 3 residents (R1) reviewed for mechanical lifts. This resulted in immediate jeopardy for R1. The immediate jeopardy (IJ) began on 3/16/26 when nursing assistant (NA)-A and NA-B did not check to ensure all four straps of the sling were attached to the lift, resulting in a fall, fractured ribs and hospitalization for R1 and was identified on 3/19/26. The regional nursing consultant, the assistant director of nursing, the administrator, medical records, the director of nursing, and the nurse manager were notified of the IJ on 3/19/26 at 3:45 p.m. The IJ was removed on 3/17/26 and the deficient practice corrected 3/17/26 prior to the start of survey and was therefore past noncompliance. Findings include: R1's care plan dated 1/5/26 indicated R1 required a mechanical lift for transfer with assistance of two staff. R1's undated care sheet indicated R1 used a medium sized sling. R1's progress note dated 3/16/25 at 10:26 a.m. indicated two staff nursing assistants (NA)-A and NA-B were using the mechanical lift with the appropriately sized sling when the top left strap of the sling came loose from the mechanical lift. R1 fell from the lift and injured her left shoulder. Emergency Services were contacted and R1 was sent to the hospital for further evaluation and care. R1's incident report dated 3/17/26, indicated an interdisciplinary team meeting (IDT) meeting was held regarding R1's fall on 3/16/17. R1 had suffered acute displaced fractures of 2nd and 3rd left ribs. R1's face sheet dated 3/18/26 indicated R1 was an [AGE] year-old female who admitted to the facility on [DATE]. R1's relevant diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the left side, osteoarthritis, and fibromyalgia. During an interview on 3/18/26 at 1:35 p.m., NA-F stated staff know a resident's transfer status via the care sheets provided at the nursing station. If a resident transfers using a mechanical lift, they always use two staff at a minimum. Before moving the resident, they ensure the sling is securely connected to the mechanical lift. NA-F stated the nurse educator had come and spoken with staff that morning with reeducation about using mechanical lift. The mechanical lift education provided was the same information provided to staff upon hire. During an interview on 3/18/26 at 1:51 p.m., NA-G stated to transfer a resident they will use at least two staff. One staff member will manage the resident's legs, and the other staff will control the machine. NA-G stated before they move the residents, they ensure the lift sling loops are all attached completely. During an interview on 3/18/26 at 2:05 p.m., NA-E stated to move a patient with a mechanical lift, they use two staff members. One staff member should be positioning the resident's legs, and the other person will be operating the lift. NA-E stated they should raise the residents by approximately six inches and then check for safe sling contact before moving the residents to the new surface. After the incident on 3/16/26, she completed retraining and signed a paper stating she had done the education. She reported this did not change her practice when transferring residents because she goes by the book. During an interview on 3/18/26 at 4:04 p.m., the director of nursing (DON) stated after the incident on 3/16/26, the mechanical lift and the sling involved in the incident were removed from the floor. The staff involved were interviewed and reenactments were completed to determine what had happened. (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON stated they compared this situation to their current process for using mechanical lifts and found a discrepancy when the NA did not check to ensure all sling straps were secured to the mechanical lift. The DON stated they immediately reeducated all staff on shift with the existing mechanical lift reeducation used for staff onboarding. They continued with retraining staff for all morning, evening, and night shifts since 3/16/26. During an interview on 3/18/26 at 4:15 p.m., NA-A stated she was R1's aide the morning R1 fell from the lift. She requested help from NA-B to transfer R1 from her wheelchair to her bed. They used the medium sized sling that R1 was already underneath her. Because NA-A was on R1's right side, she attached the right upper and lower loops of the sling to the mechanical lift. NA-A controlled R1's feet as NA-B lifted her into the air and moved the lift backwards. They paused between the wheelchair and the bed to obtain R1's weight using the mechanical lift's weighing feature. While they were weighing R1, the top left strap of the sling came off the mechanical lift and R1 fell onto her left shoulder. NA-A stated she stayed with R1 while NA-B ran to get more staff members. NA-A stated if she could do anything differently, she should have checked all four points of sling to the lift and checked the other NA's work. During an interview on 3/18/26 at 4:39 p.m., the nurse manager stated when using a mechanical lift to transfer a patient, staff need to ensure all four loops of the sling are attached properly. Staff should check for this by lifting the residents slightly into the air and observing the sling loops are tight and completely attached to the machine. Only after this check should staff continue with the resident transfer. The nurse manager stated she was one of the nurses who responded to the incident on 3/16/26 and assessed R1. Staff called for an ambulance while she provided care until the emergency services arrived. Immediately after the fall, the staff development nurse began reeducating all staff on shift. The reeducation consisted of their preexisting checklist used to determine lift competency upon hire. If the staff development nurse is not available, the nurse manager and the DON have been coming in early or staying late to provide education to staff outside of business hours. During an interview on 3/19/26 at 8:38 a.m., NA-C stated to transfer a resident with the mechanical lift, she would ensure the sling was attached to the mechanical lift. To do this, she would place the loops on the machine and slightly lift the patient while over a stable surface to visualize the tension and attachment. Once she verified this, she would have another aide direct the resident's legs while she controlled the lift and completed the resident's transfer. Prior to the beginning of her shift this morning, NA-C stated the staff development nurse did 1:1 reeducation with her. During an interview on 3/19/26 at 8:47 a.m., NA-D stated before transferring a resident with a mechanical lift, staff should lift the resident halfway into the air. While above the surface, check all four points of contact of the sling to the machine. If there was an issue with the sling connection, staff should lower the resident back onto the original surface and adjust the sling prior to continuing. Once the sling is properly attached to the lift, they can complete the transfer. NA-D stated he received reeducation on 3/16/26 because he was working at the time of the incident. The re-education was not new materials and was a reminder of staff expectations. During an interview on 3/19/26 at 11:14 a.m., NA-B stated she assisted with transferring R1 from her wheelchair to her bed. NA-B stated she lowered the mechanical lift over R1 and secured the sling's lower loop to the mechanical lift. NA-B stated she waited for NA-A to secure the other loops before raising R1 into the air then moved R1 away from the wheelchair when she began to use the weighing feature of the mechanical lift to obtain R1's weight. NA-B stated the upper left sling loop then disconnected from the mechanical lift and R1 fell backwards, hitting her shoulder. NA-B stated she then ran from the room to get help. NA-B stated she should have double checked and tugged on the sling loops to make sure they were in the lift. During an interview on 3/19/26 at 12:45 p.m., NA-H stated if he was using a mechanical lift to transfer a resident, he would ensure the machine is working first. After securing the resident into the sling and attaching it to the mechanical lift, he would start to lift the resident and then observe the loops to ensure they are attached. NA-H stated they do not move the resident away from the bed or chair before they verify the sling is completely and securely attached to the mechanical lift. During an interview on 3/19/26 at 12:53 p.m., (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN-A stated to transfer a resident using the mechanical lift, they have to check the sling is properly attached. To ensure attachment, they will lift the residents into the air a little and visualize tension on all sling loop points. They must complete this check prior to continuing with the transfer. During an interview on 3/19/26 at 2:30 p.m., the staff development nurse stated all nursing and aide staff are educated about how to use a mechanical lift upon hire and annually. This training consists of a video, a competency checklist, and representatives from the lift company providing in-person training. Since the incident on 3/16/26, herself and other leadership staff have been using the competency checklist to provide reeducation with the staff. They conduct this education through a combination of shift huddle announcements and 1:1 with staff. During an interview on 3/19/26 at 2:50 p.m., the DON stated directly after she responded to the incident on 3/16/26, she began an investigation. She had NA-A and NA-B complete written statements and went through a demonstration with NA-A. Based on the information gathered, they believe NA-B did not attach or did not properly attach the upper left loop of R1's sling to the mechanical lift. Then, NA-A and NA-B failed to complete the pause and safety check prior to completing the transfer. Because of these preliminary findings, they suspended both NA-A and NA-B. To prevent any further incidents from occurring, they immediately began education staff with their existing competency checklist. Educational materials were discussed in shift huddles and on a 1:1 basis by herself, the nurse manager, and the staff development nurse. They also completed audits of like-residents and observed staff complete transfers using the mechanical lift. These audits were completed with the lift competency checklist. In an email sent on 3/19/26 at 10:51 a.m., the DON indicated 58 staff have been retrained on proper mechanical lift usage. All remaining staff were part-time employees, or on leave of absence. The past noncompliance immediate jeopardy began on 3/16/26. The immediate jeopardy was removed and the deficient practice corrected by 3/17/26, after the facility implemented a systemic plan that included the following actions: An observation of a mechanical lift transfer on 3/19/26 at 1:06 p.m. showed NA-C and NA-D entered R3's room and discussed transferring her from her wheelchair to her bed. NA-C brought the mechanical lift into the room and then lowered the arm directly over R1's head and lap. Using the sling R3 was already sitting on, NA-C attached the bottom loops to the mechanical lift and NA-D attached the top loops. NA-D directed NA-C to control the machine while he guided R3's legs. NA-C then lifted R3 slightly into the air and said Check while visually verifying all four sling loops were attached to the mechanical lift. NA-D also looked at the sling loops and said Okay, indicating he agreed with the check. NA-C then continued raising R1 into the air. NA-C and NA-D then successfully transferred R3 into her bed. An observation of a mechanical lift transfer was completed on 3/19/26 at 1:22 p.m. for R4. NA-C brought the mechanical lift into R4's room and discussed the plan to transfer from her wheelchair into her bed. When NA-E arrived, NA-C positioned the mechanical lift directly over R4's head and lap. Using the sling already in R4's wheelchair, NA-C attached the two left-side loops while NA-E attached the two right-sided loops. NA-C then raised R4 slightly into the air, then paused and said Check. Both NA-C and NA-E looked at the loops and verified there was tension in the loops. NA-C then continued raising R4 into the air. NA-C and NA-E then successfully transferred R4 into her bed. The facility policy and procedure titled Floor-Based Full Body Sling Lift Use, dated 2/1/26, indicated:1.Push the UP button on the hand control for the lift until there is slight tension on the sling loops. PERFORM SAFETY CHECKa. Once there is tension on the loops, double check each loop to be sure each is securely in the hook.b. Double-check the position and stability of all straps and other equipment. c. Ensure clips, latches, and bars are securely fastened and structurally sound.d. As needed, lift the resident's knee(s) and smooth out the sling under the thigh(s).e. Lift resident about 2 inches off the surface and verify that weight is evenly spread between the straps of the sling.f. Verify that residents will not slide out of the sling or tip backward or forward.