STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Health and Rehabilitation Center LLC	200 South Dekalb Street Redwood Falls, MN 56283

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** 39998 Based on interview and document review the facility failed to comprehensively assess proper full body mechanical lift sling type and size according to manufacturer recommendations to ensure safety for 1 of 1 residents (R1). This resulted in immediate jeopardy (IJ) for R1 who had a history of behaviors during lift transfers, fell from the lift and suffered a shoulder fracture. The immediate jeopardy began on 1/19/25, when staff used a hygiene (toileting) sling that was too large causing R1 to experience pain resulted in behaviors and fell through the lift sling to the floor. The administrator, director of nursing, corporate nurse, and regional director of operations were notified of the IJ at 5:00 p.m. on 1/27/25. The facility implemented immediate corrective action on 1/19/25 to prevent recurrence, so the IJ was issued at past none compliance. Findings include: A facility Reported Incident (FRI) submitted to the state agency (SA) on 1/19/25 at 12:40 p.m., alleged potential caregiver neglect when R1 fell through the open area of the toileting (hygiene) sling and hit her head on the lift, sustained a shoulder fracture, had increased pain, and was evaluated at the emergency department (ED). R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had mild cognitive impairment, with fluctuating behaviors of inattention. R1 was dependent on staff for all transfers and toileting. R1 was frequently incontinent of urine but always continent of bowel. R1's diagnoses included heart failure, osteoporosis (condition that weakens the bones and make them more prone to fractures), and morbid obesity. R1's Lift/Mobility Status Form dated 6/26/24, indicated R1 had severe pain/discomfort which impacted transfers and repositioning. R1 required a full body lift with two staff assist. The form did not identify or assess for appropriate type of full body lift sling size or if R1 was safe to use the specialty sling or toileting sling. R1's care plan in place on 1/19/25, indicated R1 was to transfer with two staff assist using the full body lift. The care plan did not include the type or size of slings used for R1's transfers. (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 - Few	R1's progress notes on 1/19/25 at 9:54 a.m., indicated at 8:35 a.m., staff were transferring R1 from the bed to commode with the Hoyer (brand name of full body lift) and toileting sling when R1 complained of pain in her shoulder and began to lift her arm up causing her body to fold and slide out of the bottom of the toileting sling. R1 hit her head and complained of pain. R1 was transferred by emergency medical services (EMS) to the ED for evaluation and treatment. R1's progress noted on 1/19/25 at 2:45 p.m., indicated R1 had returned from the ED with a shoulder fracture and was requesting pain medication. The facility Incident Review and Analysis dated 1/21/25, identified the root cause of the fall from the lift was R1 lifted arms while in toileting sling and slid through lift sheet, falling to the floor, and hitting her head. Immediate Intervention identified was R1 would no longer use the toileting sling and will use the full body sling and the bedpan for toileting. During an interview on 1/27/25 at 11:35 a.m., licensed practical nurse (LPN)-A indicated R1 used the toileting sling, the straps go underneath the armpits, so arms are out of the sling. On 1/19/25, LPN-A assisted nursing assistant (NA)-A with transferring R1 when R1 fell from the lift. LPN-A explained R1 was in the toileting sling and the sling had been hooked up to the lift when she arrived in R1's room. When they began to lift R1 up in the sling, R1 complained of pain in her shoulder and shimmied her right arm around the strap, then got her left arm out, and fell out through the bottom hole with legs still in the sling. R1 always complained about being in the toileting sling, she had a habit of trying to pull that arm through, staff had to constantly remind her to keep her arm out. LPN-A further identified an extra-large sling was used to transfer R1 when she fell out of the lift. R1 should have used a large sling instead but they did not have the listing of the sling size to be used prior to that fall so did not know they were using the wrong size sling and stated, we basically went off [used] what wrapped around them. During an interview on 1/27/25 at 3:45 p.m., NA-A indicated she assisted R1 with the full lift transfer on 1/19/25 when R1 fell out of the lift. NA-A put the toileting sling on R1 and then called LPN-A for assistance to lift her to the commode. When they lifted R1 up into the sling, R1 complained her shoulder hurt, and they tried to put her back to bed but she fell out of the lift. NA-A was not sure what caused the fall because it happened so fast. NA-A stated R1 does not have assigned lift sheets [slings] so they would have use the biggest one for her The toileting sling that was used was hanging on the back of R1's door and was the one they always used to transfer R1. R1 always complained about her arms hurting when she was in the sling and had reported to the charge nurse, but they were already aware that R1 had pain. During an interview on 1/27/25 at 1:00 p.m., NA-B indicated R1 would always complain about her shoulders hurting and would try to lift the arms over the sling We would really have to watch her and tell her not to. NA-B had reported the pain and R1's attempts to lift her arms over the sling to the charge nurse but not sure what they did with that information. Prior to R1's fall, staff would have to know the resident's weight, look at the sizing chart in the utility room where the slings were stored, and pick out the sling that had the matching weight. After R1's fall, the residents name with the sling size was posted and there was a sticker on the resident's door with the color sling to use. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/27/25 at 1:25 p.m., NA-C indicated prior to R1's fall out of the full body lift, staff were directed to look at the resident's last weight and refer to the manufacturer's weight chart posted in the utility closet and decide what size sling to use. After R1's fall, the facility put list with the resident name, weight, size, and color of the sling as well as posting the color of the sling on the resident door with the sling hanging on the hook. NA-B further identified R1 always complained of pain in her shoulders when they used the toileting sling but did not use the toileting sling after the fall. During an interview on 1/27/25 at 11:00 a.m., registered nurse case manager (RNCM) was working the day R1 fell out of the lift and responded immediately after the fall. RNCM identified LPN-A and NA-A used an extra-large toileting sling to transfer R1, but it should have been a large sling used to transfer R1 according to her weight. RNCM immediately did re-education and took the toileting sling and full body lift out of use. During a follow up interview on 1/27/25 at 1:45 p.m., RNCM indicated prior to R1's fall out of the lift on 1/19/25, the facility assessed R1 for the use of the lift but did not assess for the sling size or appropriateness of use of the specialty slings. The RN also indicated the sling size was not listed on the care plan until after R1's fall. The RNCM identified she was aware of R1's chronic pain in her shoulders but not that R1 would try to get her arms out of the sling. During an interview on 1/27/25 at 2:10 p.m., the director of nursing identified after the facility investigation, it was determined the root cause of R1's fall from the lift was that the sling size used was an extra-large and should have been a large. R1 pulling her arms over the toileting sling contributed. R1 was assessed for the use of the lift but not assessed for the safety and appropriateness of the specialty (toileting) sling. Prior to R1's fall, the staff would determine the sling size by the resident weight alone and not by any other factors. After R1's fall from the lift, facility systems were changed, and education was provided to the facility staff. During an interview on 1/27/25 at 4:30 p.m., the administrator deferred to nursing but identified that facility wide changes had gone into effect on 1/19/25 after R1 fell out of the lift. During an interview on 1/27/25 at 10:15 a.m., an EZ Way representative indicated if a resident used a large full body sling to transfer, the toileting sling should also be a large. When using the toileting sling, the resident must be able to keep their arms outside of the sling. If the resident were to use a sling that was too large, it could result in a fall out of a lift and if a resident moved their arms to the inside of the sling that could also cause a fall from the lift. The EZ Way representative identified the facility contacted the company after the fall from the lift and would be going to the facility to do training on the lifts and the slings. EZ Way Sling Sizing Chart, Form #2-150 Revised 9/13/24, indicated it is important to evaluate the width of a patient in relation to the width of the sling; it is important that no portion of the patient overlap the sides of the sling; color coding is used on the binding of sling but not used for specialty slings; it is important that the base of the sling be positioned two inches below the tailbone and the top of the sling is parallel with the top of the shoulder line (base of the neck). Further identifies the size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of a patient. A proper fit will involve the judgement of the caregiver. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The EZ Way Belted Mesh Hygiene Sling Operating Instructions, Form #2-038 Reviewed 10/24/24, indicated to be eligible for the use of the sling, a resident must have adequate upper body strength and torso stability. If the patient has poor muscle tone and sinks down in the sling, the sling is not appropriate for the individual. When using the sling: The sling must be securely belted and tightened around the patient's torso. 2. The leg straps of the sling should be pulled tightly under the patient's legs close to the upper thigh area, and be crossed between the thighs, hooking the loops of the leg straps to the hanger bars hooks furthest from the patient. If a patient has sufficient muscle tone the straps can be placed closer to the knees, however this can result in a sunken position if a patient does not have adequate strength. You may use any of the three loops on each leg to attach to the hanger bar hooks but must always be consistent with using the same loop level on each leg strap. Example: If you use the longest loop on the right leg, you must use the longest loop on the left leg. 3. The shoulder strap loops should go under the patient's armpits, so their arms are on the outside of the sling. The patient can then place their hands along the sides of the sling. The loops should be hooked onto the sling hanger bars, again maintaining consistency with the identical length of loop used on each side. 4. Lift the patient and pull the patient's pants down as much as possible. 5. Lower the patient onto the toilet until they are in a seated position and unhook all loops of the sling from the hanger bars. Remove leg straps from under the patient's legs. You may now pull the patient's pants down further if necessary and remove or move the sling. When transferring the patient back to the bed or chair, follow the instructions above. The facility's Safe Resident Handling Program last reviewed 3/2020, indicates the facility interdisciplinary team will use the safe patient handling (SPH) program in determining and identifying the means for providing transfer and mobility assistance of residents. Each resident will be assessed for the safe patient handling needs during the admission process to the facility using the MHM Lift/Mobility Status Form and for each relevant activity in the care delivery process. The information from his assessment will be contained in the care plan for each resident and the care plan will identify the safe patient handling requirements for that individual. The immediate jeopardy was removed, and the deficient practice corrected by 1/19/25, after the facility implemented a systemic plan that included the following actions: R1 was assessed using manufacturer's guidelines, and care plan was updated to add the correct sling size and NOT to use a toileting sling; other residents that used full body lifts and slings were assessed, and care plans updated as appropriate for correct sling size and type; all staff education for sling sizing and where to find that information; mechanical lift competencies completed for all staff prior to next working shift; Safe Patient Handling policy was reviewed, and staff educated; the electronic record transferring tasks were updated to include sling size and color; and toileting slings were removed from service.