| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245239 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Guardian Angels Health & Rehab Center | 1500 East Third Avenue<br>Hibbing, MN 55746 |

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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790<br><br>Based on interview and document review, the facility failed to safely use a toileting sling per manufacture's recommendations to transfer 1 of 3 residents (R1) reviewed for accidents. This resulted in immediate jeopardy (IJ) when R1 fell from a mechanical lift, sustaining subarachnoid and subdural bleeds (brain bleeds) that required a hospital admission.<br><br>The IJ began on 7/25/24 at 4:10 p.m., when R1 fell from a mechanical lift. The administrator and director of nursing (DON) were informed of the IJ on 7/31/24 at 4:27 p.m. The facility had implemented corrective action on 7/26/24, prior to the start of the survey, and was therefore past noncompliance.<br><br>Findings include:<br><br>R1's Face Sheet, undated, indicated R1 had diagnoses of hemiplegia affecting right dominant side, abnormal involuntary movements, epilepsy, and malignant neoplasm of frontal lobe.<br><br>R1's care plan reviewed 7/24/24, indicated R1 needed total assist of two staff with a mechanical lift for transfers using a medium toileting sling.<br><br>On 7/25/24 at 7:30 p.m. a progress note indicated R1 was sent to the emergency room (ER) and a call was made there to follow up on her. resident. R1 had a subarachnoid bleed and a subdural bleed, and was being transported to a larger hospital.<br><br>On 7/26/24 at 1:28 a.m., a progress note indicated on 7/25/24 at 4:10 a.m., R1 was found on the floor, lying on her right side between the legs of the lift, and her head was on the left leg of the lift and her arms were in the air. R1 had an approx. 5 centimeter (cm) lump on the back of her head, and was complaining of increased lower back pain and dizziness. Due to her injury, R1 was sent to the emergency department (ED).<br><br>On 7/30/24 at 2:07 p.m., nursing assistant (NA)-C and another NA entered room [ROOM NUMBER] to assist a female resident with a mechanical lift transfer from bed to her wheelchair. A size small toileting sling was placed under the resident, which was the correct size, and the legs straps were crossed in between the resident's legs. The belt was clipped around the resident's chest, her arms were outside of the sling, and the straps were attached to the mechanical lift. The resident was transferred into her wheelchair with no signs of distress.<br><br>(continued on next page) |



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

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| | 245239 | A. Building<br>B. Wing | 07/31/2024 |

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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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 7/30/24 at 2:39 p.m., NA-C stated on 7/25/24 around dinner time, nursing assistant (NA)-D asked her to come help transfer R1 to the bathroom. NA-D told R1 to put her arms inside the toileting sling. She knew that was wrong, but did not want to argue with NA-D, so she did not say anything. The buckle to the sling was not buckled around R1's waist either. NA-D pressed the button to lift the machine, NA-C moved the wheelchair, and R1 fell out of the sling backwards hitting her head on the left leg of the mechanical lift and then on the floor. She then went and got the nurse, and R1 was sent to the hospital. Prior to this incident, she had never been trained on these types of mechanical lifts and sling placements, and she only watched others when she was being trained. NA-C stated she is now aware after training that the resident needs to be buckled into the sling and if the residents arms are inside of the sling to say something and make sure they are moved to the outside.<br><br>On 7/30/24 at 3:17 p.m., NA-D stated when she was getting ready to toilet R1, the sling buckle that should have gone around R1's waist was not buckled, and R1's arms were inside the toileting sling. She pushed the button to lift the R1, and R1 fell out the back of the sling and hit her head on the ground. She had not had training on how to use the mechanical lifts or sling placement prior to the incident. NA-D stated she is now aware after training that R1 should have had her arms outside of the sling and that she should have been buckled into the sling.<br><br>On 7/31/24 at 10:18 a.m., the mechanical lift company representative (CR)-A stated if a resident was not buckled into the toileting sling, or if their arms were not on the outside of the toileting sling, they would be at an increased risk of falling out of the sling.<br><br>On 7/31/24 at 11:58 a.m., the facility medical director stated the toileting sling being put on R1 incorrectly was the cause of her injuries.<br><br>On 7/31/24 at 12:26 p.m., the director of nursing (DON) stated staff were expected to ensure the resident was buckled into the toileting sling, and their arms were placed outside of the sling. She stated all staff have been re-educated on the use of the mechanical lifts and the slings.<br><br>On 7/31/24 at 12:39 p.m., the administrator stated the staff were expected to use the toileting sling per the manufacturing instructions.<br><br>SMT Health Systems Volaro Toileting Sling user guide dated 5/11/16 directed to use the sling on residents with some upper-body strength, and make sure the persons arms are on the outside of the sling.<br><br>The past noncompliance immediate jeopardy began on 7/25/24. The immediate jeopardy was removed, and the deficient practice was corrected by 7/26/24, after the facility implemented a systemic plan that included the following actions: Reviewed their policies on use of mechanical lifts, including the proper placement and size of the slings. The facility has re-assessed all residents who utilize a mechanical lift to ensure they have the proper size sling. The facility has re-educated all staff who use the mechanical lift on the policy and procedure and did competency testing. The facility completed audits three times weekly observing staff transferring residents with mechanical lifts results will then be brought to QAPI committee. Verification of corrective action was confirmed by observation, interview, and document review on 7/30/24 and 7/31/24. |