

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2025
NAME OF PROVIDER OR SUPPLIER  Avera Granite Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  250 Jordan Drive Granite Falls, MN 56241	

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 - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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(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 - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure a mechanical lift sling was properly secured and free from entanglement hazards following transfer and/or prior to wheelchair transport for 1 of 3 residents (R1) which resulted in harm when R1's left leg became entangled in the strap which caused a traumatic hematoma on the leg that required hospitalization, surgical intervention, and blood transfusion. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance (PNC). Findings include:R1's quarterly [NAME] Data Set (MDS) dated [DATE] indicated R1 had moderately impaired cognition, required maximum assistance with mobility, and was dependent on staff for transfers using a wheelchair. Diagnoses included heart failure, peripheral vascular disease, neuropathy, arthritis, osteopenia, and chronic pain syndrome.R1's activities of daily living (ADL) care plan dated 9/27/22 identified her as at risk for ADL decline, with interventions that included the use of a full-body mechanical lift for all transfers (initiated on 4/19/23). Staff to use purple sling with green trim lift sling and to ensure straps are secured in wheelchair per residents' preference.The facility reported incident dated 9/11/25, identified R1 was being returned to her room by Activity Director (AD)-A following an outing when a lower sling strap became caught in the front wheel of her wheelchair, pulling R1's left lower leg backward and tightly against the chair. Nursing assistant (NA-J) was sitting at the nurses' station, heard R1 say Ow and observed the entanglement. NA-J immediately intervened, stopped the wheelchair and loosened the strap. At the time, no visible injury was noted by NA-J or licensed practical nurse (LPN)-A.R1's hospital Discharge summary dated [DATE], indicated R1 experienced increased, uncontrolled pain, and was transferred to the emergency department. She was diagnosed with a traumatic hematoma, requiring incision and drainage. R1 also required a blood transfusion of 2 units, due to a hemoglobin dropping from 14 to 7.3 grams per deciliter (Normal range is 12.0 to 13.5g/dl). R1 was admitted to acute care, discharged back to the facility on 9/15/25. Hospice consult was ordered. and placed on hospice care the same day. She required ongoing daily dressing changes to the hematoma site.The facility's internal investigation dated 9/11/25, revealed the leg strap of the lift sling that had been left underneath R1 after she was transferred to the wheelchair had not been properly secured or tucked away. Interviews with AD-A and NA-J confirmed that the sling strap had fallen and became wrapped around the front wheelchair wheel, pulling R1's leg backwards.AD-A's typed statement dated 9/11/25, identified that AD-A was returning R1 to her room after an outing at approximately 2:00 p.m., when her straps from her sling dropped down and got caught in R1's front wheelchair wheel. This strap pulled R1's leg back. R1 yelled out and they stopped abruptly. NA-J was sitting at the nurses' station and assisted to get the strap out of the wheel. NA-J returned R1 to her room while AD-A informed licensed practical nurse (LPN)-A of incident.NA-J's Granite Falls Health Vulnerable Adult Witness/Report Form dated 9/12/25 was handwritten by NA-J, identified on 9/11/25 at approximately 2:40 p.m., R1 was being brought back to her room by AD-A. When they were passing the nurses' station on B wing NA-J heard R1 say Ow. He looked over and immediately saw the left leg sling strap had fallen and was wrapped around the front wheel of R1's wheelchair. Trapping R1's left leg backwards against the wheelchair. NA-J had AD-A stop immediately and knelt in front of R1 to loosen the leg strap and re-tuck the leg strap beside R1. NA-J then took R1 back to her room and laid her down in bed. NA-J did not see any bruising, redness or swelling to site. LPN-A's Vulnerable Adult Witness/Report form dated 9/12/25, identified LPN-A was made aware of incident on 9/11/25, by activity staff that R1's sling strap got ran over and caught R1's left leg with it. LPN-A indicated she did not see redness or bruising on R1's leg.During an interview on 9/18/25 at 2:05 p.m., AD-A stated she was the staff person pushing R1 back to her room when the lower strap became entwined in the from wheel of R1's wheelchair. AD-A let NA-J take R1 back to her room while she went to LPN-A to report the incident. AD-A stated she could not remember if when unloading R1 from bus if the sling straps were hanging down but thought had she been aware she would have tucked them in. During an interview on 9/18/25 at 2:16 p.m. , NA-J stated he was sitting at Nurses' station B when AD-A was pushing R1 in her wheelchair back to her room. R1' stated Ow. NA-J looked over and saw that the lower strap of the full body lift sheet had fallen and pulled R1's left lower leg back against the chair tightly. NA-J stopped AD-A and assisted with getting the strap loosened and tucked back into the chair. NA-J took R1 back to her room and assisted her to bed. He examined the lower left leg and did not see any redness or bruising. Na-J further stated that when he had gotten R1 up for the outing, he had tucked her straps back and under R1 so they would not be hanging</p>		