STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McIntosh Senior Living	600 Northeast Riverside Avenue McIntosh, MN 56556

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure residents were free from accidents for 1 of 3 residents (R1) when R1, who was care planned for the use of a mechanical lift, was transferred on multiple occasions using a pivot transfer by staff and the facility beautician. This resulted in actual harm for R1 who sustained a fracture related to improper transfers from staff. R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included Stroke, weakness and joint stiffness. Diagnosis added 8/15/25, included osteoporosis and fracture.R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. The MDS indicated R1 had not displayed rejection of care behaviors and was dependent on staff for transfers.R1's care plan dated 5/30/25, identified cognitive and communication impairments. The care plan identified impaired physical mobility related to a stroke with right sided hemiplegia (paralysis on one side of the body). The care plan directed staff to assist R1 to transfer using a mechanical stand device and two staff. The care plan was updated 8/12/25, to include a fracture of her left knee and directed staff to transfer using a mechanical stand and assist R1 with locomotion in wheelchair until she could use her left leg to self-propel again.R1's Progress Notes indicated the following:-8/8/25, R1 had been complaining of left knee pain since the previous evening. R1 had been guarding her knee, unable to manipulate it to a flat position and became upset when staff moved her leg. When asked if her pain was bad enough to make her cry, R1 shook her head yes. R1 had been moaning and grunting due to knee pain and shook her head yes when asked if it hurt when standing for transfer into bed the previous night.-8/9/25, R1 continued to have pain and swelling to her knee. -8/11/25, Physician updated due to continued knee pain. R1 had been tearful at times. Orders received for X-ray. Later in the shift, R1 left for CT (computed tomography) scan to knee. -8/11/25, R1 returned to the facility. Diagnosis of closed non-displaced fracture (a type of bone break where the bone cracks or breaks, but the pieces remain aligned and don't shift out of place) of condoyle (the two rounded prominences at the distal end of the thigh bone that articulate with the shin bone to form the knee joint) of left femur and had a splint in place. -8/12/25, Staff spoke with the physician who indicated R1 had severe osteoporosis that could have contributed to the fracture during the pivot transfers. R1 currently non-weight bearing and had a brace to be worn for six weeks. During interview on 8/19/25 at 12:02 p.m., the director of nursing (DON) stated their investigation identified five staff members identified to have transferred R1 without the use of the mechanical stand as care planned previous to her injury. During interview on 8/19/25 at 12:11 a.m., nursing assistant (NA)-A stated R1 needed to go to the beauty shop, and she and another staff member had performed a pivot transfer from R1's recliner to her wheelchair. NA-A said three total staff were in the room at the time. NA-A stated staff had a care sheet that identified how the residents were supposed to be transferred. During interview on 8/19/25 at 12:18 p.m., NA-B stated she had assisted NA-A to transfer R1 without following the care plan and stated it was not the first time she had performed a pivot transfer with R1. NA-B said R1's care plan indicated staff were to transfer using a mechanical stand. During interview on 8/19/25 at 12:30 p.m., NA-C stated staff, including herself, had been performing pivot transfers for R1 but not all the time. NA-C said she was not sure why but said they should not have. NA-C said R1's care plan directed staff to use a mechanical stand for transfers. During interview on 8/19/25, at 12:42 p.m., the facility beautician (B)-A stated R1 needed to get from her wheelchair to the salon chair and said NA-D came into the salon and attempted to transfer R1 by herself but said she was not strong enough. B-A stated she assisted NA-D to pivot transfer R1 to the chair. B-A said after she was finished with R1's hair, no staff were around so she placed her arms around R1, like a bear hug, under her arms and transferred her back into her wheelchair. B-A said after she got into the wheelchair R1 started to propel herself to the dining room but said another staff brought R1 back to use the bathroom before assisting her to the dining room. B-A said she thought since NA-D was going to transfer R1 by herself it was okay to assist with just one person.During interview on 8/19/25, at 3:02 p.m., the DON stated after they discovered staff had not been following the care plan for transfers with R1, they had immediately educated the NA's and B-A and initiated education with all staff that provide care and transfer residents. The DON stated they had also initiated audits of transfers and educated B-A she was not to perform any resident transfers. The DON said the physician said R1 had severe osteoporosis and felt the pivot transfers along with her diagnosis contributed to the fracture.Facility Policy Safet-patient-handling Program dated 3/19/23, indicated it was the policy of the facility that when residents required assistance to move residents, that assistance was provided