

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Viewcrest Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Church Street Duluth, MN 55811	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</p> <p>Based on interview and document review, the facility failed to follow manufacturer's recommendation on EZ Way sling usage, facility policy, and transfer care plan for 1 of 3 (R1) residents reviewed for mechanical lift transfers. Additionally, the facility lacked a system to assess and document appropriate resident sling size. R1 fell out of the sling, sustained a laceration to the back of her head and was sent to the Emergency Department (ED).</p> <p>The IJ began on 3/13/25 at 11:00 p.m., when R1 fell from a mechanical lift causing a laceration to her head and the likelihood for potential serious harm. The administrator and director of nursing (DON) were informed of the IJ on 3/21/25 at 10:30 a.m. The facility had implemented corrective action on 3/14/25, prior to the start of the survey, and was therefore past noncompliance.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 2/4/25, indicated R1 had cerebral palsy, abnormal posture, functional quadriplegia, and scoliosis.</p> <p>R1's annual minimum data set (MDS) dated [DATE], indicated R1 was cognitively intact, needed extensive assistance with two people for transfers.</p> <p>R1's care plan dated 2/26/25, indicated R1 needed a mechanical lift with two staff assistance for transfers. R1 used a size small sling.</p> <p>R1's weight on 3/12/25, was 115.5 lbs.</p> <p>R1's medical record did not have evidence that a sling assessment had been completed.</p> <p>R1's encounter summary dated 3/14/25, indicated R1 fell roughly 4-5 feet. R1 had a contusion noted to the lower back of head.</p> <p>R1's progress note dated 3/14/25 at 8:33 a.m., written by registered nurse (RN) -B indicated R1 was being transfers with an EZ Way smart lift from her wheelchair to her bed. R1 had an inappropriate sling on and was transferred with assist of one staff instead of two staff. R1 had laceration to the back of R1s head and was sent to the ED.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/20/25 at 9:35 a.m., R1 stated nursing assistant (NA)-A was transferring her with the EZ Way smart lift from her wheelchair to her bed and R1 slid out of the sling when it was in the air and hit her back and head on the floor. R1 stated NA-A was the only staff in the room.</p> <p>During an interview on 3/20/25 at 12:24 p.m., NA-A stated on 3/13/25 at around 11:00 p.m., NA-A transferred R1 by herself with a green sling. NA-A was not aware the sling was not appropriate or that two staff were needed to assist with an EZ Way smart lift. NA-A placed the sling on R1 correctly and attached the sling correctly to the lift. NA-A lifted R1 into the air and she started to move the EZ Way lift towards R1's bed when R1 started to slide out of the opening where R1's buttocks were. NA-A left R1 and ran to get help as R1 was falling out of the sling. When NA-A got back to the room R1 was on the floor bleeding from her head. NA-A stated she asked other nursing assistants how R1 transfers but did not look at the care plan. NA-A also indicated that she received safe-transfer training but denied knowing she should have transferred R1 with two people.</p> <p>During an interview on 3/20/25 at 12:42 p.m., RN- A stated on 3/13/25 around 11:40 p.m., NA-A came running down the hall stating R1 was falling out of her sling. RN-A stated she went to R1's room and found her on the floor bleeding for her head. RN-A stated the sling was green in color and straps were still attached to the lift correctly but R1 was no longer in the sling. RN-A indicated she was unsure if that's how the straps were attached at the time of the fall.</p> <p>During an interview on 3/20/25 at 1:14 p.m., EZ Way representative stated EZ Way had never made a completely green sling for any lifts. EZ Way lifts should have only been used with EZ Way brand slings as no other brand would have been safe to use.</p> <p>During an interview on 3/20/25 at 1:54 p.m., certified nurse practitioner (CNP)-A stated she would have expected the facility staff to have followed the policies and care plans put in place for R1.</p> <p>During an interview on 3/20/25 at 2:06 p.m., the director or nursing (DON) stated the green sling used on R1 was not an EZ Way brand and should not have been used and R1 should have been transferred per policy and care plan with two staff. DON further stated on 3/21/25 at 8:01 a.m., since her time at the facility, starting in May of 2023, the facility has not had a process for assessing appropriate sling type and size until following R1's incident on 3/13/25.</p> <p>During an interview on 3/21/25 at 8:36 a.m., RN-B stated a week and a half ago RN-B started overseeing R1's care at the facility. RN-B stated she was not sure why R1's sling was not an EZ Way brand and was unaware of the sling issue until R1 had fallen. The only slings that should've been used were EZ Way brand slings.</p> <p>During an interview on 3/21/25 at 9:14 a.m., medical director (MD)-A stated he would have expected the facility staff to follow facility policy and manufactures instructions for EZ Way products.</p> <p>EZ Way Smart Life Operator's Instructions revised 6/13/2011, indicated EZ Way slings were made specifically for EZ Way Smart Lifts. For the safety of the patient and the caregiver, only EZ Way slings should be used with EZ Way lifts.</p> <p>EZ Way Sling Sizing Chart undated, indicated a small sling should've been used for residents who weighed 70 to 100 pounds. Residents who weighed 90-220 pounds should've use a medium sling. R1's recorded weight at the time of the incident was 115.5lbs.</p> <p>(continued on next page)</p>		

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