STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47638 Based on interview and document review, the facility failed to ensure a full body mechanical lift was used per manufacturers recommendations for 1 of 3 residents (R1) reviewed for mechanical lift use. This resulted in actual harm for R1 when staff failed to ensure the lift sling was secured prior to transfer causing R1 to fall from the lift causing pain and a fractured clavicle. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition and required assistance with all activities of daily living (ADL)'s. R1's diagnoses included history of glioblastoma multiforme of brain, seizure disorder, hemiplegia of left nondominant side and type II diabetes. R1's care plan dated 6/4/24, directed staff to transfer R1 with a Hoyer lift (a brand name full body mechanical lift) with two staff. R1's progress note dated 7/22/24 at 12:40 p.m., indicated that R1 had a witnessed fall in his room from a mechanical lift at 11:28 a.m., nursing assistant (NA)-A and NA-B were transferring R1 from his bed to his wheelchair when R1 fell out of the sling when the right bottom strap came undone from the lift. R1 had complaints of pain in his left hip and head. R1's progress note dated 7/22/24 at 12:25 p.m., indicated R1 left the facility at 12:25 p.m. via ambulance. R1's emergency department (ED) record dated 7/22/24 identified R1 presented to the ED for evaluation of fall injury after sustaining a fall from a full body mechanical lift earlier that day. R1 injured his left shoulder and had pain with any movement of left shoulder. No history of left shoulder injuries. Imaging identified moderately displaced clavicle fracture. R1 was discharged back to the facility with orders for acetaminophen, ice, and sling. R1's progress note dated 7/22/24 at 6:29 p.m., indicated R1 returned to the facility at 5:00 p.m. via Medicab (medical transportation service). (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 7/28/24 at 2:22 a.m., indicated R1 vocalized a pain rating of 5/10 during transfers and repositioning and 2/10 while at rest. R1 also vocalized that current treatment was minimally effective. R1's progress note dated 7/28/24 at 9:01 a.m., indicated RN-A obtained a new order from the on-call physician for hydrocodone-acetaminophen (Norco) 5-325 milligrams (mg), a narcotic, to be taken twice daily and every 8 hours as needed for pain for 10 days. R1's July 2024 medication administration record (MAR) began monitor pain rating 0-10 every four hours on 7/22/24 after R1 returned from the hospital. R1 first vocalized a pain rating of 2 at 10:00 p.m. There were 67 additional entries ranging from 0-8, with the average being 3/10. From 7/22/24 to 7/31/24 (10 days) there were 7 doses of as needed (PRN) Tylenol (acetaminophen) documented as administered for pain. In addition, there were 7 doses of scheduled Norco administered and 7 PRN doses, for a total of 14 doses. R1's August 2024 MAR indicated pain monitoring with 50 entries of pain rating ranging from 0-8, with the average being 3.5/10. From 8/1/24 to 8/13/24 (12 days) there were 25 scheduled doses of Norco administer (twice daily). No PRN Norco was administered. In addition, there were 2 doses of PRN Tylenol administered for pain. Review of the facility's maintenance logs for the Hoyer mechanical lift A Model #PC450S, Serial #A5955 was inspected bi-annually with the last inspection date of 7/10/2024. The checklist indicated the actuator was greased, castors cleaned and oiled, two back leg bumpers were replaced, battery load test finding was 12.9 with evening spare noted, touch up paint was applied to needed areas, and noted lift is in good condition. Lift A had also been inspected earlier in the year (1/10/24) with similar findings. On 8/13/24 at 3:35 p.m., R1 stated his lack of acceptance of his position here may have led to the fall. R1 stated his feet may have slipped out. R1 denied any concerns about safety, the care that he received, or the staff that provided care to him. R1 no longer had pain from the clavicle fracture. On 8/13/24 at 4:27 p.m., NA-A indicated on 7/22/24 her and NA-B were involved with the transfer that led to R1's fall from the mechanical lift. NA-A stated that she was the initial staff in the room and had placed the sling under R1 while he was lying in bed before NA-B entered room to assist with lift and transfer. NA-A stated it was the right bottom strap that came undone. NA-A stated she can't remember which straps she connected to the lift. NA-A stated that she was the one that was using the controls of the lift. NA-A stated that it happened so fast and that both her and NA-B attempted to protect the resident from hitting his head from the fall. NA-A stated she was not sure of what happened or what could have been avoided. On 8/13/24 at 4:18 p.m., NA-B stated she was called into room to assist with a transfer and when she entered room sling was already in place under R1. NA-B stated she attached and secured the straps on the left side of lift and that NA-A had attached and secured the straps on the right side of lift. NA-B confirmed NA-A was using the lift controls. NA-B stated when R1 was up in the air, the right bottom strap came undone and R1 fell out of sling. NA-B stated that she immediately went to protect R1's head. NA-B stated licensed practical nurse (LPN)-A came in and assessed R1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/13/24 at 4:31 p.m., registered nurse (RN)-A stated that he was called into R1's room following the fall. RN-A stated the lift was found on the right side of R1's bed and the top two straps were still secured and that one of the bottom straps was undone. RN-A stated initially R1 had complaints of hip pain. RN-A stated the strap that came undone must not have been secured under the retainer clip on lift. RN-A stated lift was immediately taken off the floor to be inspected and it was verified that lift was functioning properly, and that sling was also assessed with no defects noted. On 8/14/24 at 9:54 a.m. lift representative (LR)-C stated there are sling retainer clips on each of the hangers to secure the straps of the sling. LR-C stated the only way for the strap to become unsecured is that the strap was not all the way on the hoop as it may have gotten hooked on the top of the hook but not under the retainer clip. LR-C indicated causes for loop to come off included operator error. On 8/14/24 at 11:09 a.m. LPN-A stated the aides notified her of R1's fall, she went and got the RN before entering room to assist with assessment. They entered R1's room and found the sling up in the air with one strap hanging. LPN-A could not recall which strap. LPN-A stated assistant director of nursing (ADON) entered room and instructed LPN-A to go and notify family. LPN-A confirmed that if strap was under retainer clip strap should not have come loose. On 8/14/24 at 11:11 a.m., ADON stated she received call from RN-A to come to R1 room. ADON stated when she entered R1's room, R1 was laying on the floor with the mechanical lift in between bed and R1. ADON stated sling was no longer attached to the lift and/or underneath R1. ADON assessed R1 for injuries and instructed LPN-A to notify doctor and family. ADON stated that they initially thought injury had occurred to left hip as it was longer in length and rotated outward. ADON stated R1 had complaints of hip and head pain at that time. ADON stated she notified the director of nursing (DON) and executive director of fall. ADON stated that maintenance was notified immediately to assess lift prior to it being used again. ADON stated that DON compiled all investigation information to submit a vulnerable adult report and she reviewed prior to submission. ADON stated DON also initiated the retraining material and delegated re-training of staff to RN-B. ADON confirmed that re-training forms that were received were the only training completed. On 8/14/24 at 11:36 a.m., DON stated she immediately spoke with NA-A and NA-B who were involved in the incident and had them complete written statements of the incident. DON stated she completed on the spot retraining with NA-A and NA-B that included verification that straps are secure under the retainer clip prior to transfer of resident. DON stated that maintenance assessed lift to ensure proper functioning and sling was also removed for assessment with no defects noted. DON stated that she had RN-B do random audits of floor staffing performing Hoyer lift transfers to ensure proper technique was being completed. DON stated she placed education sheet in the stand-up binder in each unit to have staff read and sign that they understood. Education sheet included reminder to ensure bed was at the appropriate height when transferring and that staff need to verbalize confirmation of secure connection on straps on their side of lift. DON confirmed that not all staff had been re-trained. DON confirmed that incident was operator error. Volaro Series 4 Lift PC450-HD450 Operator's Manual included the following: Safety Notes: Make sure all four loops from the slip are properly nested in the bottom of the hooks before lifting or transferring a patient or resident. Also make sure all four retainer springs are functioning correctly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Lifting from bed to chair using the divided leg sling: Note: Raise until these is tension on the straps and then double-check to make sure the loops are nested in the bottom of the hooks. The facility policy safe patient/resident handling and movement policy, dated 4/1/2005, indicated employees shall use proper techniques, mechanical lifting devices, and other approved equipment/aids during performance of high-risk patient handling tasks per facility policy and manufacturer's guidelines. This is being issued at Past noncompliance (PNC) after it was verified the facility put the following corrective action in place. -On 7/23/24 education was placed in a binder on each unit that identified When utilizing the full mechanical lift please ensure that you have the bed at the appropriate height so that the lift does not have to raise all the way up. Please ensure that you are pausing to double check loops are attached appropriately as well prior to lifting the resident up. Please verbalize double checks when utilizing lifts. Make sure we are double checking our partners work to make sure slings are clipped in all the way. All staff interviewed confirmed that they had seen this training. -Management conducted 16 random audits to confirm staff were utilizing the lifts properly. -On 7/22/24 maintenance inspected the lift for function and safety. Additionally checked the sling for any issues. -On 7/22/24 the executive director (ED)-A emailed requesting bids for all new mechanical Hoyer lifts through a different vendor. On 8/1/24 ED-A received approval to purchase all new EZ-way mechanical lifts.