

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2025
NAME OF PROVIDER OR SUPPLIER  Sandstone Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  109 Court Avenue South Sandstone, MN 55072	

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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure safe transfer with a EZ Way smart lift, according to manufacturer's recommendations for 1 of 3 (R1) residents. This resulted in immediate jeopardy (IJ) when R1 fell out of the sling and sustained a contusion to the scalp, closed wedge compression fracture (front part of the vertebrae collapses) of T4 vertebra, and was sent to the Emergency Department (ED). The IJ began on 11/29/25 at 6:00 p.m., when staff, under the age of eighteen, used a full body mechanical lift to transfer R1 from her wheelchair to her bed, did not follow facility policy or manufacturer's instructions, and R1 fell out of the sling. The administrator, director of nursing, corporate nurse, and regional director of operations were notified of the IJ at 11:45 a.m. on 12/4/25. The facility implemented immediate corrective action on 11/30/25, prior to the survey, to prevent recurrence. Therefore, the IJ was issued at past noncompliance. Findings included: R1's care plan dated 3/13/25, indicated R1 needed an EZ Way smart lift with two staff assistance for transfers. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had diagnoses of intellectual disabilities and osteoporosis. R1 was fully dependent on staff for all transfers. R1's ED after visit summary dated 11/29/25, indicated R1 had a contusion to the scalp and a closed wedge compression fracture of T4 vertebra. R1's progress note dated 11/29/25 at 8:43 p.m., written by licensed practical nurse (LPN)-A indicated R1 was being transferred with an EZ Way smart lift by two nursing assistants (NA)s and one of the straps was not connected to the EZ Way smart lift when the nurse entered the room. R1 was sent to the ED. At 9:30 p.m., the ED called and stated R1 had a T4 fracture. During an interview on 12/3/25 at 1:39 p.m., nursing assistant (NA)-A stated on 11/29/25 at around 6:00 p.m., NA-A indicated both she and NA-B were [AGE] years old, and she knew one of them had to be at least 18 to complete a transfer using the lift but it slipped her mind at the time. NA-A stated she placed R1's right upper sling strap to the EZ Way smart lift and was going to place R1's bottom right sling strap to the lift but R1's neighbor needed assistance, NA-A went to the other side of the curtain to assist R1's roommate and NA-B started lifting R1 without NA-A being present. NA-A was not able to check the straps and did not place the right lower strap to the EZ Way smart lift. NA-A heard R1 fall to the floor and saw R1's right leg sling strap was not attached to the EZ Way smart lift. During an interview on 12/3/25 at 2:59 p.m., LPN-A stated on 11/29/25 around 6:00 p.m., unknown NA came to the nurse's office and stated LPN-A was needed in R1's room. LPN-A stated she went to R1's room and found two staff under the age of 18 in R1's room with R1 on the floor. R1's right leg strap was not attached to the EZ Way smart lift. During an interview on 12/3/25 at 3:12 p.m., EZ Way representative stated the EZ Way smart lift and sling used to transfer R1 at the time of the fall did not malfunction and was in working order. Staff under the age of 18 were not to operate the lift but can assist with the transfer. Both staff need to be present during the transfer and need to check all four straps to ensure they are all attached to the EZ Way smart lift correctly. During an interview on 12/4/25 at 7:19 a.m., NA-B confirmed she was [AGE] years old. NA-B indicated there should have been an adult present during the transfer but there was not because she forgot. NA-B stated she entered R1's room on 11/29/25 around 6:00 p.m., to assist NA-A transfer R1 with EZ Way smart lift. NA-B stated she attached both bottom straps then NA-A went to the other side of the curtain to help R1's roommate. NA-B indicated she checked all straps and then started lifting R1 while NA-A was helping R1's roommate behind the curtain. NA-B stated she should not have been running the machine as she is underage, and she should have waited for NA-A to be next to R1 before lifting her in the air. NA-B stated R1 leaned forward and fell out of the lift onto the ground. During an interview on 12/4/25 at 8:34 a.m., the facility medical director (MD)-A stated he looked at R1's imaging and R1's fracture was acute and occurred due to the fall on 11/29/25. MD-A indicated the fall has contributed to R1's decline and did harm R1. He would have expected two staff, one at least [AGE] years old, to be in the room during any full body mechanical lift transfer. During an interview on 12/4/25 at 9:29 a.m., the director or nursing (DON) stated both staff should have been next to R1 before the transfer started and two staff should have put eyes on the sling straps to ensure they were attached. One staff should have been over the age of 18 and that person should have been the one to manage the machine. EZ-Way Smart Life Operator's Instructions revised 5/9/2025, directed staff to do a final check of all four loop attachment points to ensure each loop was sufficiently attached to the respective hook of the hanger bars. Mechanical Lift Transfer Reminders undated, directed two staff to assist with EZ Way smart lift transfers, staff member operating the EZ Way smart lift must be [AGE] years of age. Both staff needed to check all four straps for correct placement on the EZ Way</p>		