STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 Southbend Avenue Mankato, MN 56001

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** 49616 Based on observation, interview, and document review the facility failed to follow the care plan for safe transfers for a full body mechanical lift for 1 of 3 residents (R1) who required lifts for transfers. The facility's failures resulted in harm when R1 fell out of the lift and sustained subgaleal hematoma (bleeding between the skull and the scalp) and head laceration that required three staples. The facility implemented immediate corrective actions prior to survey and is issued at past non-compliance. Findings include: R1's face sheet dated 10/16/24, identified R1 had diagnoses that included traumatic brain injury (head injury causing damage to the brain by external force or mechanism), dementia (deterioration of memory, language, and other thinking abilities), bipolar disorder (serious mental illness characterized by extreme mood swings), and presence of cerebrospinal fluid drainage device (used when the normal flow of cerebrospinal fluid in the brain is obstructed). R1's quarterly (MDS) dated [DATE], identified R1 did not have cognitive impairment. R1 was dependent for transfers, required maximum assist with cares, and R1 did not have behaviors. R1's care plan dated 7/22/22, identified R1 required the full body mechanical lift with assistance from two staff for transfers. R1's care plan dated 11/16/18, identified R1 had issues with mood and behavior that included name calling, yelling, calling out, using profanities, and refusing to allow staff to complete tasks. Interventions included encouraging resident to call family, monitoring target behaviors, putting on favorite radio station, word searches, reading car/tractor magazines, offered a warm blanket, being alert to mood, and behavior changes, using a kind, and firm approach, approach in a calm voice making eye contact and using therapeutic touch, validate feelings, provide emotional support. R1's progress note dated 10/13/24 at 8:30 p.m., identified R1 was on the floor and bumped his head. R1 had a 1-centimeter (cm) x 2.0 cm gash like area. Nurse applied dressing to site and R1 was resistive to cares. The note did not identify why R1 was on the floor. (continued on next page)

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 emergency department after visit summary dated 10/14/24, identified the reason for the visit was fall, and laceration to head. R1 had a computed tomography (CT) completed on his head. The results identified a posterior vertex scalp [area between mid-scalp and crow] and subgaleal hematoma that required three staples to the site. R1's progress note dated 10/14/24 at 9:26 a.m., identified R1 returned from the emergency department with three staples to the back of his head. R1's Incident Review and Analysis report dated 10/14/24, identified the causal factor for the fall was R1 was agitated and moving around when nursing assistant (NA)-A attempted to transfer R1 off the commode (portable toilet). Interventions included all staff education related to lifts and safe transfers. The incident report identified R1 was transferred with one assist and R1 was to have two assist for all transfers. During an observation and interview on 10/16/24 at 10:36 a.m., R1 was sitting in his wheelchair looking out the window. R1 had 3 staples in the back of his head with dried red substance surrounding staples. R1 stated that transfer was poor operation, it was just one person and I damn near got killed in this room. R1 stated NA-A put the sling around him and transferred him without help. R1 stated this was the only time he was ever transferred with only one staff member. R1 could not recollect how far into the transfer they were when the fall occurred or what had happened that caused him to fall out of the sling. During a phone interview on 10/16/24 at 2:59 p.m., NA-A explained she was a contracted staff member and could not recall what date her first shift was, but that it was recent. On her first shift, NA-C had showed her around one of the units, how residents transferred on that unit, and where supplies were kept. NA-A indicated the orientation at this facility did not include compentency for lifts, however has used that brand of lifts at other facilities. On 10/13/24 she had been covering NA-B's hallway while she was on break but NA-B had not told her how resident's transferred on that hallway. NA-A stated when NA-B was on break R1 turned on his call light and went to answer it. When NA-A entered R1's room he was sitting on the commode yelling his back hurt and wanted to get off the commode. NA-A asked R1 if he could wait but he continued to yell that he wanted to go to his bed. Because R1 was yelling she decided she would transfer him. NA-A placed the full body mechanical lift sling underneath R1, attached the sling to the lift, and began lifting R1 even though R1 continued to display behaviors. While R1 was suspended in the air, R1 continued to yell and move his body around while in the sling. NA-A asked R1 to calm down, to stop yelling, and stop moving around but R1 did not listen. He slipped out of the sling and fell to the floor. NA-A stated she was unaware that R1 required two people to transfer and thought R1 was assist of one because NA-B said R1 could go to bed prior to going on her break. NA-A did not ask the nurse or other staff for help with the transfer. During an interview on 10/16/24 at 4:01 p.m., NA-C stated she worked with NA-A on her first day at facility but could not recall the date. NA-C explained she had been in a hurry that evening because she was leaving early so she only orientated NA-A to the building and where to find supplies. NA-C showed NA-A how to use a full body mechanical lift because she had never used one before at the facility and thought she had told NA-A she had to always use two staff to transfer residents with those lifts. NA-C stated most of the residents down the hall they were working on the evening of NA-A's first day required full body mechanical lifts however, NA-A had not assisted with a lot of those transfers. NA-A assisted the residents who only required one assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 10/16/24 at 1:30 p.m., NA-B stated NA-A came from a different hall to relieve her while she took her break on 10/13/24. R1 had his fall while she was on her break. There were two other NA's working on the other halls that were supposed to be called for transfers and/or licensed practical nurse (LPN)-A who was passing medications. During a phone interview on 10/16/24 at 1:14 p.m., LPN-A stated the evening of 10/13/24, NA-A asked her to go to R1's room. R1 was on the floor and the mechanical lift sling was attached to the machine, not on R1. NA-A told LPN-A R1 was wiggling and yelling and fell to the floor. LPN-A stated it took a long time to get R1 off the floor because he continued to yell and make demands do this, do that, give me this. LPN-A told NA-A that two people were required for full body mechanical lift transfers. NA-A had told LPN-A she was unaware of that. LPN-A stated it was very well known that full body mechanical lifts always required two staff to transfer. During a record review on 10/16/24 at 12:16 p.m., administrator sent an email identifying that the facility was unable to locate NA-A's orientation packet. Administrator provided a blank copy of what the orientation packet was, which included a competency for mechanical lifts. In a follow-up email dated 10/22/24, NA-A's first day of work at the facility on the floor was 9/29/24. During an interview on 10/17/24 at 9:16 a.m., director of nursing (DON) stated she had reviewed NA-A's completed orientation packet but was not aware of the date she had reviewed, and was not sure where the completed packet was. DON explained R1 had not had behaviors while utilizing the mechanical lift prior to the incident on 10/13/24. DON questioned if R1's diagnosis of pneumonia contributed to the behavior exhibited on 10/13/24. During an interview on 10/17/24 at 11:48 a.m., with administrator and DON, DON indicated NA-A should have called for assistance and waited for assistance prior to transferring R1 by herself on 10/13/24. The staff were expected to use two staff with full body mechanical lifts transfers. DON expected all orientation packets to be completed prior to working on the floor independently. Administrator and DON indicated the following had been implemented as a result of R1's fall prior to the survey: -NA-A was suspended pending investigation on 10/13/24, -Facility-wide education with competencies on mechanical lifts began 10/14/24. -Machine used for the transfer was locked out on 10/13/24 and inspected by facility maintenance department between 10/14/24-10/15/24, along with manufacturer inspection of all mechanical lifts at the facility the week of 10/20/24. -Identification of the system breakdown for orientation of new hires and agency staff on 10/14/24 with an ad hoc meeting attended by DON, Administrator, and nurse scheduler. -R1's care plan was updated to reflect trauma/risk of trauma from the fall from the lift. -R1's orders were updated to include treatment to head wound, monitoring of site for infection, monitoring for signs and symptoms of emotional distress, skin assessment, cognition, depression screening, and trauma questionnaires completed on 10/14/24, and on-going as needed. -Social services followed-up with R1 daily 10/14-10/16/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	EZ-Way Smart Lift Operators Instructions included: -For safe operation of the EZ Way Smart Lift, operators should watch the training video, read through this manual, complete competency checklist, and practice on fell ow staff members before use with patients. -The EZ Way Smart Lift was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patients condition, two caregivers maybe necessary. The food and drug administration (FDA) patient lifts safety guide identifies the use of a lift should be avoided if a patient is agitated, resistive, or combative, determine how many caregivers are required to safely lift the patient. Ensure patient is able to understand and follow directions. The facility Safe Resident Handling Program dated 3/20, identified training will be provided to direct care staff to demonstrate proper application and use of available safe patient handling equipment. Training records will be maintained and include dates of training, name and title of person conducting the training, name, and job title of employee. The records will be maintained in the employee's file. The facility Care Planning policy dated 1/6/22, identified the care plan will identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident.