

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/26/2024
NAME OF PROVIDER OR SUPPLIER  First Care Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  900 Hilligoss Boulevard Southeast Fosston, MN 56542	

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>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35569</p> <p>Based on observation, interview and document review the facility failed to ensure safe transfer while utilizing a mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1.</p> <p>The immediate jeopardy began on [DATE], when R1 fell while being transferred in a full body mechanical lift that tipped over during provision of care. The facility failed to identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred. Additional transfer observations identified manufacturer's guidelines were not followed for safe use. The IJ was identified on [DATE]. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 5:05 p.m. on [DATE]. The IJ was removed on [DATE] at 3:22 p.m., but non-compliance remained at the lower scope and severity level 2, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>R1's Resident Face Sheet identified diagnosis that included chronic pain, depression, obesity and long term use of anticoagulants (blood thinners). R1's annual Minimum Data Set, dated dated dated [DATE], identified intact cognition and indicated he was dependent on staff for transfers.</p> <p>R1's care plan dated [DATE], identified the use of a full body mechanical lift for transfers and lift sling size 2 extra large (XL), updated [DATE]. The care plan identified a fall on [DATE], while in the mechanical lift involving two nursing assistants (NA)'s performing the transfer resulting in bruising and scrapes to the right side of R1's body. The care plan indicated staff were provided education on use of the full body lift and indicated a nurse was to be present in the room during transfers with two NA's performing the transfer to observe for safety and correct use of the lift. The care plan further indicated R1 had trauma induced signs and symptoms of nervousness and anxiety due to a previous fall from the lift.</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>Note: The nursing home is disputing this citation.</p>	<p>R1's Resident Progress Note dated [DATE], indicated two NA's were assisting R1 with transfer from bed to wheelchair using a full body mechanical lift. One NA was moving R1 from the bed to the chair and attempted to open the legs of the lift and the lift started to tip while R1 was in it. R1 fell with the lift and hit his head on the floor. [DATE], Resident Progress Note indicated the interdisciplinary team reviewed the fall and identified the contributing cause of the fall as; equipment tipped, staff reported R1 adjusted himself while in the lift when the lift was being moved out from under the bed to extend the legs. R1 reported the legs of the split leg sling were not crossed as recommended by the manufacturer because it caused him discomfort. Further root cause analysis indicated staff had used an XL sling and based on R1's current measurements the sling size should have been changed to a 2XL. Interventions to prevent recurrence included removing the lift from service.</p> <p>Facility document titled Mechanical Lift [DATE], Incident and OHFC (office of health facility complaints) Report indicated R1 fell while in full body mechanical lift sling during transfer from bed to his wheelchair. Lift tipped and R1 landed on the floor. Verified R1's weight was within range of the lift, R1's weight increased from 395 pounds to 413 pounds between [DATE], and [DATE], and sling size was updated to 2XL based on the weight gain. A nurse must be in the room for all transfers of R1 until further notice. Staff involved were interviewed. All transfers with the lift must be observed by a nurse to verify competency prior to using a lift without supervision. Lift involved was immediately removed from service and brought to maintenance, not to be used until cleared by maintenance. The incident occurred while staff were transferring R1. Staff were unable to extend the legs of the lift under R1's bed and as staff moved the lift clear of the bed to allow base to be extended, R1 adjusted himself in the lift causing the lift to tip over. R1 landed on his butt on the floor and hit his head on the floor. Staff reported R1 would not allow the straps on the sling to be criss crossed as recommended by the manufacturer. R1 also had an 18 pound weight gain over the past few months and XL sling was no longer appropriate. Reported indicated facility took the following action: Sling size was updated to 2XL based on the weight gain, staff were competency tested on full body mechanical lift and educated prior to working their next shift. Care plan was updated to include three staff present during R1's transfers to include a licensed staff member. Maintenance inspected the lift used during the transfer that resulted in the fall and removed some hair that had been hindering movement in the wheels.</p> <p>During interview on [DATE] at 1:36 p.m., R1 asked, Are you here about the ride I took? I hit my tailbone, it hurt so bad, but they did an X-ray and nothing was broken. R1 stated the staff had lifted him up off the bed and were going to swing the lift over and must have swung it a little too fast because it went over. R1 indicated the wheelchair was between the bed and the closet and said, I was in it [the lift] and when they started turning to put me in the chair, that's when it hit [tipped over]. R1 stated he was scared the last time the lift had tipped during a transfer but said, I'm getting used to it now. R1 stated he was scared it was going to happen again, and it did, indicated he was afraid and said, It will probably be more serious next time.</p> <p>During interview on [DATE] at 1:58 p.m., NA-A stated on [DATE], when the lift had tipped over during R1's transfer, she had been behind the wheelchair while NA-B was running the lift. NA-A said the legs on the lift were closed until it cleared the bed and when NA-B opened the legs the lift started tipping. NA-A stated she had not assisted with the transfer, only stood behind the chair. NA-A further stated the straps of the sling that go between R1's legs had not been crossed as recommended by the manufacturer and said staff had not been doing it for a long time because R1 did not like it that way. NA-A stated since the fall staff now crossed the sling between R1's legs and kept the legs of the lift open during the entire transfer.</p> <p>(continued on next page)</p>		

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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>Note: The nursing home is disputing this citation.</p>	<p>During interview on [DATE] at 2:06 p.m., registered nurse (RN)-A stated on [DATE], she had been called to R1's room and found him on the ground next to his wheelchair. RN-A said she was told staff had been transferring R1 from his bed to the wheelchair and the lift had tipped. RN-A said staff reported they could not open the legs of the lift while it was under the bed and when they pulled out the lift and tried to open the legs, the lift tipped over. RN-A stated one staff should have been operating the lift and the second staff should have been holding onto the handles of the sling to assist with guiding during the transfer. RN-A stated R1 had a trapeze to assist with movement in bed and the legs were under the bed and interfered with opening the legs of the lift. RN-A said since the incident occurred, staff had received more training and said everyone had been educated and said a nurse was observing transfers in R1's room. RN-A further stated R1 should have been assessed for a new sling during his assessment period in February 2024, and said at that time he may have needed a new sling size.</p> <p>During interview on [DATE] at 2:49 p.m., the lift company's representative stated other than a mechanical issue, the only way a lift could tip over was if the resident's weight was centered on the outside of one of the legs which would cause the lift to become unbalanced. The representative stated debris in the wheels may make the lift harder to push but would not cause it to tip over. The representative indicated using the incorrect sling would only affect comfort but would not affect the balance of the lift and said if the resident was attempting to re-adjust in the sling there was no way they could get enough leverage to get themselves outside the area where the legs are balanced. He added, they trained staff to make turns with the legs open but they should be able to safely turn the lift with the legs closed. The lift representative stated unless something on the lift failed, user error was usually the cause of a lift tipping over and if the lift tipped over it would have been during the maneuvering and a leg getting hung up on something.</p> <p>During interview on [DATE] at 3:37 p.m., NA-B stated she had been assisting with the transfer when the lift tipped over with R1 in it. NA-B stated she had been operating the lift and said as she pulled the lift back it tipped over. NA-B stated she could not fully extend the legs under the bed and when she tried to extend them they got stuck and the lift tipped.</p> <p>During interview on [DATE] at 3:50 p.m., the lift used during the transfer that resulted in R1's fall was observed with maintenance worker (MW)-A. The lift was a Volaro PC 450 Series. MW-A indicated there had been some hair stuck in the wheels and said he had removed some small strands. MW-A stated it had not been a significant amount of hair and said everything else had been in good working condition with no other mechanical concerns identified.</p> <p>During observation and interview on [DATE] at 11:25 a.m., NA-C and NA-D prepared to transfer R1 from his bed to wheelchair using the full body mechanical lift. NA-C moved the bed away from the wall so the legs of the trapeze would not interfere and they hooked the straps of the sling to the mechanical lift. When the lift was raised the battery was observed to be low powered and a sling strap came unhooked from the machine. NA-C stated he visualized the straps after hooking them up but did not pull on the straps to ensure they were secure. NA-C and NA-D secured the strap and completed the transfer. RN-B was present in the room to observe the transfer and did not intervene or question the low power warning or when the strap came undone from the lift.</p> <p>(continued on next page)</p>		

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