

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Mennonite Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5353 Columbus Street SE Albany, OR 97321	

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 - Actual harm</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>42271</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure an environment free from accident hazards for 1 of 3 (#10) sampled residents reviewed for accidents. The facility failed to properly attach the sling with the lower leg straps to the Hoyer (a mechanical lift device used to transfer residents) during a transfer. As a result, Resident 10 sustained a left leg femoral (largest leg bone) fracture and an avulsion injury to the left foot (occurs when an injury causes a ligament or tendon to break off a small piece of a bone that is attached to it). Findings include:</p> <p>Resident 10 was admitted to the facility in 8/2015, with diagnoses including Alzheimer's and restless leg syndrome. The resident was not able to be observed or interviewed as she/he had passed away.</p> <p>The 1/1998 Mennonite Village Policy and Procedure on Mechanical Lifts stated to follow the manufacturer's instructions when using any type of mechanical lift.</p> <p>The undated Invacare Owner's Operator and Maintenance Manual for Electric Portable Patient Lift included the following instructions: When the sling is elevated a few inches off the surface of the bed/chair and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar (Hoyer). Adjustments for safety and comfort should be made before moving the patient.</p> <p>Resident 10's 12/18/24 Care Plan revealed the resident had cognitive deficits related to advanced Alzheimer's/Dementia. Resident 10's care plan revealed she/he was non ambulatory and a fall risk. Interventions included Resident 10 was kept in a high traffic area, sat in the reclining chair off the dining area and was a two person assist with a Hoyer lift.</p> <p>On 2/24/25 the facility submitted a report to the State Survey Agency (SSA) which revealed Resident 10 was transferred via Hoyer lift from the recliner to the wheelchair with two CNAs (using the U-shaped sling) as care planned. During the transfer Resident 10 slid from the sling and fell to the floor. Resident 10 had a blanket covering her/him during the transfer. Resident 10 was immediately assessed by Staff 4 (LPN) and transferred to the hospital. Staff 1 (Administrator), Staff 2 (DNS) and Staff 8 (COO) reviewed the facility's video footage of the incident. The video revealed a blanket was covering up the view of the placement of the leg straps (sling). It was determined the straps were not attached properly.</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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(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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/4/25 at 10:36 AM, Staff 4 (LPN) stated she was called to assess Resident 10 who fell on the floor. Staff 4 stated the sling was not hooked up correctly on the legs. Staff 4 stated the sling normally was placed between the legs, crisscrossed in front, then hooked to the Hoyer lift.</p> <p>On 3/4/25 at 10:51 AM, Staff 7 (CNA) stated she finished up in a resident's room around 1:30 PM on 2/24/25 and then assisted Staff 6 with the transfer of Resident 10. Staff 7 stated she was not sure about the placement of the sling, there was a blanket over Resident 10's legs and she did not verify the placement of the straps.</p> <p>On 3/4/25 at 11:11 AM, Staff 6 (CNA) stated she was assigned to Resident 10 on 2/24/25. Staff 6 stated Resident 10 was seated in a recliner in the alcove area outside of the dining room. Staff 6 stated she hooked Resident 10's straps from the sling up to the Hoyer lift, made sure everything was ok, then placed a blanket over the resident and stepped away to assist another resident. Staff 6 returned to Resident 10 and stated she did not double check the straps on the Hoyer lift, but stated she was sure it was the right way between the legs and she hooked it up the way she was trained. Staff 6 stated she was not gone long, and Resident 10 was in the same position when she had left.</p> <p>On 3/4/25 at 2:06 PM, Staff 5 (Light duty CNA) stated she was not present when Staff 6 (CNA) hooked Resident 10 up to the Hoyer lift. Staff 5 stated she was standing behind Resident 10 and did not physically have hands on Resident 10 while Staff 6 lifted Resident 10 with the Hoyer. Resident 10 suddenly slid out of the front of the sling on to the floor. Staff 5 stated after Resident 10 fell she noticed the sling was still hooked up and it made her think it was not crisscrossed through Resident 10's legs because she/he would not have been able to slide out.</p> <p>On 3/4/25 at 11:31 AM, two angles of the video footage of the incident were reviewed with Staff 8 (COO). The video revealed: Staff 6 (CNA) with Resident 10 hooking up four straps to the Hoyer lift, then placing a blanket over the resident's lap. Staff 6 left Resident 10 hooked up to the Hoyer lift seated in the recliner and left to attend to another resident. Moments later, Staff 6 returned to Resident 10, did not verify strap placement or remove the blanket, and started to lift Resident 10 up out of the recliner. Staff 6 swung Resident 10 around to the reclining wheelchair which was approximately six to ten feet away. Staff 5 (CNA) was visualized standing on the back side of Resident 10 and Staff 7 (CNA) was standing in front of Resident 10 next to Staff 6. Staff 8 stated it looked like Resident 10 was moving her/his left foot and then swung both her/his legs and the movement of the Hoyer and the swinging of the legs caused Resident 10 to slip out of the sling on to the floor, feet first and her/his legs buckled underneath her/him.</p> <p>On 3/4/25 at 3:39 PM, Staff 9 (CNA) and Staff 13 (CNA) were observed to transfer a resident using the Hoyer lift. Staff used the full body sling with no concerns identified. Staff 9 demonstrated how the U-shape sling was to be used. Staff 9 stated it was not possible for a resident to slip out of the U-sling if it was hooked up correctly under the thighs and crisscrossed in front and loops attached to the Hoyer.</p> <p>On 3/4/25 at 4:33 PM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 8 (COO) acknowledged the sling was not set up properly and contributed to Resident 10's fall and leg fracture.</p>		