STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHAKOPEE FRIENDSHIP MANOR	1340 THIRD AVENUE WEST SHAKOPEE, MN 55379

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** Based on document review and interview, the facility failed to re-assess a change in transfer ability for 1 of 8 residents (R1) reviewed who required a mechanical lift for transfer. R1 complained of weakness during the transfer, fell from a standing lift, sustained a [MEDICAL CONDITION] was hospitalized and subsequetly died . This resulted in actual harm for R1. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], included moderate cognitive impairment with a [DIAGNOSES REDACTED]. R1's ADL (activities of daily living) Care Area Assessment (CAA) dated [DATE], included the need for extensive assistance with all ADL's and mobility. R1's most recent Fall Evaluation dated [DATE], described R1 as alert and oriented, with no falls in the past three months, chair bound and non-ambulatory. Fall interventions included staff assisting with transfers. R1's ADL care plan dated [DATE], directed staff to assist with transfers using a mechanical lift, to use an EZ Way Smart Stand (a mechanical lift which requires the resident to hang onto handles and to stand up, bearing weight while being lifted) during the day shift, and an EZ Way Smart Lift (a mechanical lift which supports the entire body in a sling to transfer, no weight bearing is required) during the evening shift. Transfer with EZ Way Smart Lift and 2 assist on evening shift per family request to prevent falls out of EZ Way Smart Stand. Staff were also directed to use a seat strap (EZ Way Smart Stand accessory that attaches to the lift, and is placed loosely under the buttocks to support if resident were to try and sit during the transfer) and calf strap (strap that attaches to the Stand and goes behind the calves for support). R1's treatment administration record (TAR) dated [DATE], included to use EZ Stand with day shift and full body EZ Lift in evenings due to fatigue and decreased safety/weakness at night. R1's Daily Assignment Sheet dated [DATE], used by the nursing assistants to know how to provide care to each resident, directed staff to use the EZ Way Smart Stand during the day with the sit strap and calf strap accessories, and at 2:00 p.m. to switch to the full body lift, and assist of two staff. R1's nurse practitioner visit note dated [DATE], described R1 as having occasional back and knee pain, and a difficult time getting comfortable. R1 reported ongoing weakness and pain in her hands. R1's incident report dated [DATE], included, Aide was assisting resident from her w/c (wheel chair) to her bed with the ez stand lift when the resident raised her arms up and she slid from the ez stand lift. She did not hit her head. Resident c/o (complained of) right hip pain. Resident would not allow nurse to check range of motion and right leg appears shorter than left. Received orders to send to the ER (emergency room) to be evaluated. Sent out at 3pm. R1's investigative report dated [DATE], included, Resident was okay to use ezstand for transfers during the dayshift and then switch over to hoyer (full body lift) lift starting at 2pm. Aide was using the ezstand but did not use the sit strap which is an added strap to the ez stand to have if the resident would try to sit down too soon to give a bit of extra support. In talking with the aide she described that when she had the resident in the ez stand and was in the middle of the transfer, she realized when she brought resident close to the bed, the bed was up a bit too high and the resident would not be able to sit on the bed. So the aide went to lower the ht (height) of the bed but then the resident stated she was feeling weak, the aide started to move the resident (while in the ez stand lift) back towards the w/c to sit her back down. But the resident let go of the hand grips and raised her arms, so she slid under the harness and landed on the floor. The aide and the nurse stated the harness strap and the behind the calf strap was buckled. The extra sit strap was not in place to help support her if her legs would bend to try to sit. The resident had severe pain in her right hip. The nurse stated resident's right leg was shorter than the left and she was not able to do range of motion to the right leg. Nurse got an order from the doctor to send to the ER to be evaluated. She was sent to the ER at 3pm and has since been transferred from SFRMC (St. Francis Regional Medical Center) to Abbott Hospital. In questioning the aide further, it was determined that the aide felt the resident wasn't transferring very well earlier in the day when she was using the EZ stand for toileting resident. When this writer asked her if she informed the nurse at that time about the transfer she stated no she did not. When it was time to lay resident down for a nap at 1:30 pm the aide stated she asked another aide if she should use the hoyer to transfer the resident to bed. That aide said no because it isn't 2pm yet so you can use the ezstand. Again this writer told the aide that she should have told the nurse and asked for assistance if she felt unsure of the transfer being safe. The instance of the aide not using the sit strap, although it was wrong of her not to follow the care plan, it was likely that would not have prevented the fall, the ER diagnosed her with Right hip fx (fracture) and pneumonia too. Which she had no symptoms of pneumonia leading up to the fall. She had not been running a temp, O2 sats (oxygen level) were good, no cough. The pneumonia caused her weakness to not tolerate holding onto the hand grips and when she let go of the lift and raised her arms she slid down through the bottom of the harness. The report indicated the nursing assistant was re-educated on transferring with the lifts and reporting condition changes. R1's nursing progress note dated [DATE], at 2:25 p.m. included a nursing assistant used the EZ Stand to transfer R1 from the wheelchair to bed. Staff used the EZ Stand waist strap (harness used for all EZ Stand transfers that connects around the torso) and calf strap. During the transfer, R1 raised arms and legs, and fell to the floor. Upon inspection, the right leg appeared to be, slightly shorter than left leg. Family was contacted. The on-call provider gave an order to send R1 to the emergency room for evaluation. R1's progress note on [DATE], at 9:38 p.m. noted hospital staff later called to inform that R1 was admitted for a, [MEDICAL CONDITION] and uncontrolled pain level. Per R1's progress note dated [DATE], at 11:17 a.m. included, Received call from (R1's family) (R1) is in a lot of pain and also has pneumonia. This writer explained what happened during the transfer with the ez stand and that (R1) stated she was feeling weak and then let go of the hand grips and raised her arms up and slid out of harness. The pneumonia could have contributed to her weakness and unable to stand as long as she usually does. The pneumonia was (diagnosed) at the hospital as (R1) did not have any symptoms while at this facility. R1's progress note dated [DATE], at 9:09 a.m. Spoke with (R1's family) via telephone .the cardiologist states (R1) can't have surgery as she needs heart valve replaced, they will probably not do surgery for [REDACTED].'family is working at finding a hopsice' (sic) .(R1) 'is in so much pain', the family plans to 'vigil her end of life care' When interviewed on [DATE], at 12:11 p.m. family member (FM)-B stated the full body lift is what facility staff used whenever FM-B visited and was not aware they were still using the standing lift for any transfers. FM-B stated R1 was not doing well at the hospital and felt the fall could have been prevented if they had used the full body lift all the time, or at least when R1 felt weak. When interviewed on [DATE], at 12:53 p.m. registered nurse (RN)-A stated she was working at the time of R1's fall on [DATE], and found out sometime after the fall, that the nursing assistant working with R1 that day thought R1 seemed weak during an earlier EZ Stand transfer. RN-A stated her expectation was for staff to notify her when concerns about R1's weakness with transfer arose. RN-A stated if she had known about the weakness, she would have changed the daily assignment sheet right away to stop using the EZ Stand and start using the full body EZ Lift. RN-A assessed R1 after the fall, one leg was shorter than the other and was in significant pain. RN-A stated this fall could have been prevented if she had known about the concern of weakness during the earlier EZ Stand

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHAKOPEE FRIENDSHIP MANOR	**1340 THIRD AVENUE WEST SHAKOPEE, MN 55379**

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	(continued... from page 1) transfer. RN-A stated R1 did not like the full body EZ Lift, so they used the EZ Stand during the day as a compromise to accommodate R1's preferences. RN-A had spoken to family, who felt the fall was preventable, and planned to take R1 home from the hospital so family could be with her until she died . When interviewed on [DATE], at 2:45 p.m. the director of nursing (DON) stated the nurse aide (NA)-A who transferred R1 was new and did not know R1's normal condition as well as other staff, did not report the weakness to the nurse and should have, should have checked with the nurse about transfer concerns and should have used the buttocks strap on the lift. R1 needed assist of one staff for the EZ Stand during the day, but always assist of 2 staff with the full body EZ Lift. Staff can switch to the full body lift if the resident is weaker and should notify the nurse with any change in condition. Family had been part of the discussion and in agreement about using the EZ stand during the day and full body lift in the afternoon as R1 did not like the full body lift, and wanted to maintain some independence. When interviewed on [DATE], at 9:20 a.m. the DON stated R1 had died in the hospital. When interviewed on [DATE], at 9:59 a.m. NA-A stated [DATE], was the first day they had worked with R1 and knew R1 needed the standing lift during the day and the full body lift after 2:00 p.m. NA-A had transferred R1 after breakfast, to the toilet, and it did not go well, her buttocks hung down and didn't actually stand up like is needed, so when R1 needed to lie down again it was before 2:00 p.m. so she asked NA-B if she should use the EZ lift instead, and was told since it was before 2:00 p.m. to go ahead and use the standing lift. NA-B had not reported the difficult earlier transfer to a nurse. NA-A attached the main harness around R1's torso, and the calf strap around R1's legs, and lifted R1 out of the wheelchair. NA-A moved R1 to the bed, and then realized the bed was too tall for R1 to sit down on. NA-A went to the bed controls to lower the bed, but then R1 stated she was getting tired. NA-A tried to get R1 back to her wheelchair, but before R1's buttocks was over the chair, R1 let go of the EZ Stand handles, and fell right through the harness that was around her torso. NA-A did not realize R1 required the use of the seat strap while using the standing lift until afterwards. When interviewed on [DATE], at 10:27 a.m. NA-B stated R1 was often difficult to transfer using the EZ Stand, R1 needed reminders to bend her knees and sometimes had difficulty standing up in the lift. Nursing was aware of this, but compromised with R1 as she did not like to use the full body lift, so used the stand during the day and switched to the lift after 2:00 p.m. On [DATE], NA-A had asked her if she should use the full body lift versus the stand and NA-B told her no, use the stand lift as it was before 1:30 p.m. NA-B was not aware R1 had difficulty with the standing lift earlier in the day. If she had known, she would have told the nurse and she would have directed NA-A to use the full body lift. A Communication With Staff training document, provided during orientation, undated, required nursing assistants to communicate with the nurse about resident care related to changes in mobility, such as the ability to sit, stand or move. The training required nursing assistants to communicate with the nurse for continuity of care. Sit/Stand Mechanical Lift Policy reviewed [DATE], described the transfer as being safe when the resident was able to bear weight on both legs and hold on to the handles with at least one hand securely, or with two hands securely. The procedure described needing to apply the harness around the chest/waist, and the strap around the lower legs, and then apply the seat strap for residents who did not stand straight or had upper arm weakness.