STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

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 -** Minimal harm or potential for 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 observation, interview, and document review, the facility failed to ensure residents were free from accident hazards when a resident was transferred without following the plan of care and without utilizing a mechanical lift in a safe manner for 1 of 1 residents (R1) who had fallen while being transferred with a mechanical lift. Findings include: R1's annual Minimum Data Set ((MDS) dated [DATE], identified R1 had severe cognitive impairment, and [DIAGNOSES REDACTED]. The MDS identified R1 required total assistance from staff with transfers. The MDS indicated R1 had one fall with minor injury since her last assessment. R1's Fall Care Area Assessment (CAA) dated 5/4/20, identified R1 had a fall in January 2020, when a Hoyer (mechanical lift) tipped over while R1 was being transferred. The CAA further indicated R1 required assist of three staff when using the Hoyer lift for transfers following the fall from the Hoyer lift. R1's care plan revised 5/7/20, identified R1 had a potential for falls related to impaired mobility, and required assist of three staff with Hoyer lift for all transfers. The care plan directed all staff to ensure the legs of the Hoyer lift were extended all the way out during the entire transfer, and two staff were to be present when hooking/unhooking the Hoyer sling. A review of the facility form titled Scandia Care Plan dated 5/11/20, identified R1 required assist of three staff with all Hoyer lift transfers. The care plan directed staff to ensure the Hoyer lift legs were extended all the way out during the entire transfer, and two staff should be present when hooking/unhooking the Hoyer sling. The facility incident initial report dated 5/20/20, which identified that during a transfer with the Hoyer lift, the lift began to tip to the side, and R1 was supported by staff and lowered to the floor via the Hoyer lift. R1 was then assisted off the floor into bed with three staff and the Hoyer lift. The Hoyer lift was inspected by the maintenance department, and found to be in safe working order. The nursing assistants involved were suspended pending the investigation. R1's Resident Incident Report Form dated 5/20/20, indicated an ongoing investigation which indicated at 9:45 a.m. two employees transferred R1 from her wheelchair to her bed with a Hoyer lift, when the lift tipped to the side. The staff involved were able to keep the resident from hitting her head on the floor. Contributing factors identified by the facility included the root cause of the fall was due to R1's care plan not being followed. A review of R1's progress notes from 1/1/20, to 5/21/20, identified the following: On 1/2/20, at 8:00 p.m. R1 had a fall during a transfer with a Hoyer lift and two staff when the lift tipped over towards a chair in R1's room. R1 had been lowered to the floor with the assistance of staff and had no injuries. The note indicated the facility had determined R1 had fallen as a result of the Hoyer lifts legs not being fully extended when she was transferred from her specialized wheelchair. R1's care plan had been updated with fall prevention interventions to include the use of three staff when transferring R1 with the Hoyer lift. The note indicated education had been provided to staff on how to position the Hoyer lift with R1's specialized wheelchair to ensure the legs of the Hoyer lift could be extended throughout R1's transfer. On 5/20/20, at 9:45 a.m. R1 had a fall during a transfer with a Hoyer lift and two staff, when the lift tipped over sideways, and she was assisted to the floor. R1 had sustained no injuries, and education had been provided on the proper use of the Hoyer lift. R1's progress note did not identify whether R1's care plan had been followed at the time of the fall. On 5/21/2020, at 1:55 p.m. R1 was observed during a Hoyer lift transfer from her wheelchair to bed with assistance of three staff. Nursing assistant (NA)-I was running the controls of the Hoyer lift, NA-C held R1's legs and feet while NA-D guided the back of the sling during the transfer. Registered nurse (RN)-A was also in the room with a clip board and indicated she was completing an audit of the Hoyer lift use. On 5/21/20, at 12:22 p.m. during a telephone interview, NA-B stated on 5/20/20, she and NA-A were transferring R1 with the Hoyer lift. NA-B stated R1 had been placed in a lift sling, was raised up in the Hoyer lift, NA-B pushed R1 ahead approximately 1 inch, then the lift tipped. NA-B stated she had not received competency training to use the Hoyer lift at the facility or with her agency staffing company. NA-B stated she had filled out a skills form which had indicated she had training on the Hoyer lift use. At 1:03 p.m. during a follow up telephone interview, NA-B stated she had not reviewed R1's care plan prior to assisting R1 to transfer with the Hoyer lift. NA-B stated she had a copy of R1's care plan, but had not had a chance to read it before assisting R1. NA-B stated the first day of her employment with the facility she had been told to read the resident care plans when she got a chance. NA-B stated she had been told to review resident care plans at the beginning of each shift, after R1's fall. On 5/21/20, at 12:30 p.m. NA-A was interviewed and stated on 5/20/20, she and NA-B were assisting R1 to the bed from her wheelchair. NA-A stated she was aware that three staff were required to transfer R1 with the Hoyer lift. NA-A stated she had made a bad decision, and should have waited for the third person to arrive before they transferred R1 from her wheelchair. On 5/21/20, at 12:52 p.m. the DON was interviewed and stated the facility was currently in the process of completing an investigation following R1's fall. The DON confirmed both NA-A and NA-B had not followed R1's care plan which instructed them to have three staff during Hoyer lift transfers. The DON confirmed NA-B was an agency staff, and had only received a partial shift of orientation with another nursing assistant. The DON stated the facility did not complete skills competency for mechanical lift transfers with agency staff, and had been under the impression the staffing agency completed skills assessments for their staff. On 5/21/20, at 2:22 p.m. NA-D stated she worked with a staffing agency, and was new to the facility. NA-D stated the facility had not completed a skills competency assessment on the use of mechanical lifts since she started, from either the facility or the staffing agency. NA-D stated another NA had shown her how to use the mechanical lift when she received orientation. On 5/21/20, at 2:49 p.m. RN-A stated R1 was dependent on staff for transfers and required the use of a Hoyer lift. RN-A confirmed R1's care plan identified she required the assistance of three staff for all transfers, and had a previous fall from the lift when two staff assisted her. RN-A stated she had started audits of resident transfers with a Hoyer lift to ensure resident care plans were followed, and to ensure staff competency. RN-A confirmed she had begun audits of staff competency during Hoyer lift transfers, and R1 was the first transfer she had observed today. RN-A indicated the facility planned to continue the audits until all staff were signed off. RN-A indicated she had met with NA-A and NA-B with the DON and it was determined the NA's had not follow R1's care plan for Hoyer lift transfers. On 5/26/20, at 9:51 a.m. a voice message requesting a call from clinical education director was left. No return call was received. On 5/27/20, at 2:32 p.m. a during a phone interview with LPN-A confirmed on 5/20/20, she had been called to R1's room to assess R1 when she fell while in a Hoyer lift. LPN-A confirmed NA-A and NA-B had not followed R1's care plan to utilize 3 staff during the Hoyer lift transfer. LPN-A indicated NA-B had informed her she thought it would be alright to transfer R1 with only 2 staff, and had informed the DON she had not read R1's care plan. On 5/27/20, at 1:12 p.m. during a follow up telephone interview, the DON confirmed NA-A had completed mechanical lift competency testing, reviewed the vulnerable adult policy, standards of care policy and the use of resident care plans. The DON confirmed she had completed a coaching form with NA-A regarding safety rounds and care plan expectations. The DON indicated NA-B had been terminated and no longer worked at the facility. The DON confirmed the facility practice of orientation for travel pool

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) staff did not include skills competency testing, such as use of a Hoyer lift. The DON indicated the human resource department was under the impression all competencies were tested by the company. The DON indicated the facility had not been aware the staffing company did not complete actual skills assessment and a skills checklist form was used. The DON indicated, at that time, the clinical education director (CED) had begun to complete competency testing for all pool staff. The DON stated her expectation was for the staff to follow resident care plans, and confirmed R1's fall was a result of the care plan not being followed and lack of staff competency with use of a Hoyer lift. The facility policy titled Hoyer Lifts-Volaro revised 1/17, directed an electronic lift (Hoyer or standing) would be used to transfer a resident whenever it was unsafe to transfer that resident due to their weight, inability to stand, or inability to cooperate. The policy further directed the purpose was to provide a safe method of transfer. The policy failed to direct staff to follow specific resident individualized care plan interventions.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 5 of 6 nursing assistants (NA-B, NA-D, NA-F, NA-G, and NA-H), and 1 of 2 licensed practical nurses (LPN-B) from a staffing agency were competent in the use of a mechanical (Hoyer) lift per resident specific care plan guidelines, which resulted in a resident fall from a Hoyer lift. Findings include: R1's annual Minimum Data Set ((MDS) dated [DATE], identified R1 had severe cognitive impairment, and [DIAGNOSES REDACTED]. The MDS identified R1 required total assistance from staff with transfers. The MDS indicated R1 had one fall with minor injury since her last assessment. R1's Fall Care Area Assessment (CAA) dated 5/4/20, identified R1 had a fall in January 2020, when a Hoyer (mechanical lift) tipped over while R1 was being transferred. The CAA further indicated R1 required assist of three staff when using the Hoyer lift for transfers following the fall from the Hoyer lift. R1's care plan revised 5/7/20, identified R1 had a potential for falls related to impaired mobility, and required assist of three staff with Hoyer lift for all transfers. The care plan directed all staff to ensure the legs of the Hoyer lift were extended all the way out during the entire transfer, and two staff were to be present when hooking/unhooking the Hoyer sling. A review of the facility form titled Scandia Care Plan dated 5/11/20, identified R1 required assist of three staff with all Hoyer lift transfers. The care plan directed staff to ensure the Hoyer lift legs were extended all the way out during the entire transfer, and two staff should be present when hooking/unhooking the Hoyer sling. The facility incident initial report dated 5/20/20, which identified that during a transfer with the Hoyer lift, the lift began to tip to the side, and R1 was supported by staff and lowered to the floor via the Hoyer lift. R1 was then assisted off the floor into bed with three staff and the Hoyer lift. The Hoyer lift was inspected by the maintenance department, and found to be in safe working order. The nursing assistants involved were suspended pending the investigation. R1's Resident Incident Report Form dated 5/20/20, indicated an ongoing investigation which indicated at 9:45 a.m. two employees transferred R1 from her wheelchair to her bed with a Hoyer lift, when the lift tipped to the side. The staff involved were able to keep the resident from hitting her head on the floor. Contributing factors identified by the facility included the root cause of the fall was due to R1's care plan not being followed. R1's progress note dated 5/20/20, at 9:45 a.m. indicated R1 had a fall during a transfer with a Hoyer lift and two staff, when the lift tipped over sideways. R1 was assisted to the floor by two staff. R1 sustained no injuries, and education had been provided on the proper use of the Hoyer lift. R1's progress note did not identify whether R1's care plan had been followed at the time of the fall. On 5/21/20, at 12:52 p.m. the DON was interviewed and stated the facility was currently in the process of completing an investigation following R1's fall. The DON confirmed both NA-A and NA-B had not followed R1's care plan which instructed them to have three staff during Hoyer lift transfers. The DON confirmed NA-B was an agency staff, and had only received a partial shift of orientation with another nursing assistant. The DON stated the facility did not complete skills competency for mechanical lift transfers with agency staff, and had been under the impression the staffing agency completed skills assessments for their staff. On 5/21/20, at 3:20 p.m. NA-B's employment records were reviewed with the DON. NA-B's employment record contained Clinical Assessments By Prophecy dated 4/8/20, which was a self assessment, and not competency testing. The DON confirmed the agency staff received no competency testing at the facility. The DON stated the facility had assumed the staffing agency had provided competency testing, so the facility had not provided it. The DON stated the facility had the agency staff fill out forms, and complete a partial shift on the floor as part of their orientation. On 5/21/2020, at 12:22 p.m. during a telephone interview NA-B stated she she had not received competency training to use the Hoyer lift at the facility or with the staffing agency. On 5/21/20, at 2:22 p.m. NA-D stated she worked with a staffing agency, and was new to the facility. NA-D stated the facility had not completed a skills competency assessment on the use of mechanical lifts since she started, from either the facility or the staffing agency. NA-D stated another NA had shown her how to use the mechanical lift when she received orientation. On 5/21/20, at 3:20 p.m. a review of NA-B's employment records with DON revealed a form titled Clinical Assessments By Prophecy dated 4/8/20, included a skill self assessment, but lacked documentation of competency testing. The DON confirmed the travel pool staff received no competency testing at the facility, and indicated she had assumed the travel pool staffing company had provided competency testing. Review of agency staff personnel records revealed the following; NA-B began work at the facility on 5/18/20. NA-B's employee record failed to include facility competency testing completed to assure resident care and safety. NA-D began work at the facility on 5/18/20. NA-D's employee record failed to include facility competency testing completed to assure resident care and safety. NA-F began work at the facility on 5/13/20. NA-F's employee record failed to include facility competency testing completed to assure resident care and safety. NA-G began work at the facility on 4/30/20. NA-G's employee record failed to include facility competency testing completed to assure resident care and safety. NA-H began work at the facility on 5/13/20. NA-B's employee record failed to include facility competency testing completed to assure resident care and safety. LPN-B began work at the facility on 5/11/20. LPN-B's employee record failed to include facility competency testing completed to assure resident care and safety. On 5/26/20, at 9:51 a.m. a voice message requesting a call from clinical education director (CED)-A was left. No return call was received. On 5/27/20, at 1:12 p.m. during a telephone interview the DON again confirmed the facility practice of orientation for agency staff included following a nursing assistant the second half of the first day. The DON stated the facility had not provided competency testing. The DON stated the human resource department was under the impression all competencies were tested by the staffing agency, which the facility had though was sufficient. The DON confirmed the Clinical Assessments forms in the agency staff employment files were self assessments. The DON stated R1's fall was a result of the care plan not being followed, and competency testing not completed. A policy on agency staff orientation was requested, but not provided.