September 29, 2017

George Berens
Voigt, Rode & Boxeth, LLC
1000 University Avenue West
Suite 250
St. Paul, MN 55104

Dear Mr. Berens:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by St. Benedict's Senior Community, St. Cloud, MN regarding two federal deficiencies issued as a result of a recertification and complaint investigation survey, exit date March 31, 2017. The IIDR was held before Administrative Law Judge Barbara Neilson. The Department received Judge Neilson's recommended decision on September 18, 2017.

Decision

After careful review of Judge Neilson's recommendation and the material submitted to the Judge in support of each party's position, I concur with Judge Neilson's recommendation that F tag 323 is affirmed as written, with a revised immediate jeopardy date of March 9, 2017. F323 was written at a scope and severity of Level J, actual harm that is immediate jeopardy on February 7, 2017. The immediacy was removed on March 31, 2017, however, noncompliance remained at Level E, no actual harm with potential for more than minimal harm that is not immediate jeopardy. F tag 456 is also affirmed as written. My decision is based on the following rationale.

Rationale

Tag F323 requires that the resident environment remains as free from accident hazards as is possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. The intent of the regulation is to ensure that the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Per the Centers for Medicare and Medicaid Services (CMS) interpretive guidance on this tag the facility is to identify hazard(s) and risk(s); evaluate and analyze hazard(s) and risk(s); implement interventions to reduce hazard(s) and risk(s); and monitor for effectiveness and modify interventions when necessary.

Resident 7 (R7) is an 88 years old man with diagnoses of dementia and Parkinson's disease. He generally needs the assistance of two staff and a standing lift to transfer and the assistance of one for bathing. On March 9, 2017 R7 was transferred into an Apollo Bathing System 6000 Series bath chair with the assistance of NA-H and another staff person. At the completion of R7's bath, when

NA-H was taking R7 out of the tub, she pulled the bath chair forward on the track, and heard a click, stepped on the pedal to release the track from the tub and the chair tipped backwards and fell off the track. NA-H lowered R7 and the bath chair to the ground and reported that R7 did not hit his head. NA-H immediately called an RN and R7 was examined, he had sustained a small skin tear to his right hip and right shoulder and denied any pain. Staff immediately contacted the Facility's Maintenance Department by telephone and posted a sign and directed staff not to use the tub. No written work order was submitted or completed regarding the incident with R7. The Assistant Director of Nursing (ADON) and RN who assessed R7 spoke with NA-H about the incident and concluded that NA-H had followed R7's care plan and had done everything she should have done and no human error was involved in the incident.

On March 9, 2017 the Director of Maintenance and another Maintenance Department employee inspected the tub and found issues with the secondary safety system on the bath chair. An email dated April 25, 2017 summarized the findings. The tub was back in operation by March 10, 2017, when a maintenance work order was received concerning the scale not weighing properly. After the work was completed on the tub the ADON assumed that the problem had been found and fixed and did not ask why the primary locking mechanism had failed. No formal system of preventative maintenance was implemented after the March 9 incident.

The initial fall report, dated March 19, 2017, mentioned tub mechanical failure occurred and resident was lowered to the ground as the tub chair separated from the base; a revised fall report, dated March 17, 2017, indicated that no predisposing environment, physiological, or situational factors were indicated and that the tub chair had a "possible mechanical issue." A post follow up report relating to R7 was prepared by an RN on March 17, 2017 identifying "mechanical failure of equipment" as the relevant factor in the fall and also noted that an interdisciplinary team (IDT) reviewed the incident on March 14, 2017, but did not include the IDT notes, a description of the mechanical failure that occurred, or what was done to prevent an incident from occurring again.

MDH surveyors requested that the Facility provide a tub system training curriculum and a preventative maintenance program policy. Neither was provided. The Facility's Safety and Health Committee met several times during 2016 and on the afternoon of March 9, 2017. Meeting minutes from 2016 and March 9, 2017 contain no discussion of any safety concerns with the transfer of residents into the tub systems. The Facility did not notify Apollo Company of the March 9, 2017 incident, or contact Apollo to request assistance or discuss possible reasons for the failure of the locking systems until late March 2017 when the surveyors were present at the Facility.

At the time of the survey, the Director of Maintenance stated that "the facility had no preventative maintenance schedule to inspect the tubs and tub chairs prior to the incident on 3/9/17, and the facility had not implemented a system for preventative maintenance following the incident." "Only when the maintenance department was alerted to a potential issue with the tubs or chairs, do they get looked at." The ADON "thought it was a mechanical error as soon as she entered the tub room", "she did not think human error was involved by the look of the chair, and NA-H's explanation of what happened."

During the survey, surveyors spoke to several other Facility staff about the bathing chairs and how the bathing system functioned. Staff responses indicated that there is a stopper to prevent the chair from going further if the rails are not lined up, that a second person is needed at times to hold the base in place when the rails did not line up so the base did not separate from the tub, and if the bath chair is not pulled far enough forward onto the base that it could by-pass the secondary locking system and fall off the base backwards. Surveyors also contacted a technical representative for Apollo Bathing Systems (TR-A) and, as reflected on the Statement of Deficiencies, TR-A stated, among other things, that it is recommended the Facility perform routine inspections on the tub system per the manufacturer's recommendations, that during normal operation of the chair the U-shaped metal brackets on the rail system would not bend on their own and if the secondary system had been maintained properly it should have prevented the resident from falling; the Facility is responsible for checking the rails, and primary and secondary locking systems monthly; the Facility needed to contact Apollo in the event of a fall; that Apollo could help investigate what had occurred and if a tub chair was repaired without following manufacturer's recommendations, it would not be safe to continue using.

The Facility failed to conduct a comprehensive investigation of R7's fall from the bath chair. The Facility concluded, from the onset, that human error was not involved and the incident was due to mechanical error. Both the primary and secondary locking mechanisms failed, yet the Facility did not comprehensively investigate why this occurred. It did not contact Apollo to report the incident and consult for assistance in determining the cause of the suspected mechanical failure. This left the potential for the mechanisms to fail again, placing residents at risk for injury.

The Facility failed to put preventative measures such as NA re-education into place following R7's fall. Surveyors were told by NA-H and other nursing assistants that they "listened for a click" when moving a resident in and out of the tub and carrier and relied on that click to mean the bath chair was properly secured to the carrier. The Apollo sales representative informed surveyors on March 31, 2017 "that a click can be heard without the chair fully locking into place" and "listening for the click was not a substitution for a visual verification that the chair was locked into place." The Facility also failed to provide a preventative maintenance program for the bathing tubs and chairs according to the manufacturer's recommendations.

Based on the Facility's failures to comprehensively investigate R7's fall from the chair and put into place sufficient/appropriate corrective and preventive measures, F Tag 323 was appropriately cited at Level J, Immediate Jeopardy, actual harm. The start date of the IJ is revised to March 9, 2017, the date the incident occurred and whereby the Facility was fully aware of the potential for more incidents involving the tub chairs.

Tag F456 requires that the facility be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. This includes maintaining patient care equipment in safe operating condition.

Facility staff stated that it had no preventative maintenance schedule to inspect the tubs and tub chairs prior to the March 9, 2017 incident and had not implemented a system for preventive maintenance following the incident. The Facility failed to implement a preventive maintenance program for its bathtubs and tub chairs according to the manufacturer's recommendation. Tag F456 is properly cited at Level E, a potential for harm that could affect 104 of 155 residents in the Facility who used the bathtubs.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department of Health is not binding on the Centers for Medicare and Medicaid Services.

Sincerely,

For

Edward P. Ehlinger, M.D., MSPH
Commissioner
P.O. Box 64975
Saint Paul, Minnesota 55164-0975

cc: Judge Barbara Neilson
Tamika Brown, CMS Region V
Cheryl Hennen
Susan Winkelmann
Holly Kranz
Becky Wong
Cynthia Olson

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September 18, 2017

VIA E-FILING ONLY
Edward Ehlinger
Commissioner
Minnesota Department of Health
PO Box 64975
Saint Paul, MN 55164
mary.cahill@state.mn.us

Re: ***In the Matter of the IIDR of St. Benedict's Senior Community***
OAH 72-0900-34437

Dear Commissioner Ehlinger:

Enclosed and served upon you is the Administrative Law Judge's **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED DECISION** in the above-entitled matter. The official record, along with a copy of the recording of the hearing, is also enclosed. The Office of Administrative Hearings' file in this matter is now closed.

If you have any questions, please contact my legal assistant Sheena Denny at (651) 361-7881 or Sheena.Denny@state.mn.us, or facsimile at (651) 539-0310.

Sincerely,

Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

BLN:sd
Enclosure
cc: Holly Kranz
George J. Berens

THIS DOCUMENT CONTAINS NOT PUBLIC DATA

OAH 72-0900-34437

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of St. Benedict's Senior Community (IIDR); Survey Exit Date: March 31, 2017

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED DECISION

This matter was the subject of an independent informal dispute resolution (IIDR) meeting convened by Administrative Law Judge Barbara L. Neilson on August 30, 2017. The record of the Office of Administrative Hearings (OAH) relating to this matter closed upon the receipt of the parties' supplemental submissions on September 1, 2017.[1]

Becky Wong, Nurse Surveyor, appeared on behalf of the Minnesota Department of Health (MDH or Department). Jennifer Bahr, Nurse Evaluator; Kathy Lucas, Supervisor; Pam Kerssen, Assistant Program Manager; Holly Kranz, Nurse Evaluator; and Mary Cahill, Planner Principal, also participated in the conference on behalf of the Department.

George J. Berens, Voigt, Rodè & Boxeth, LLC, appeared on behalf of St. Benedict's Senior Community (SBSC or Facility). Brandon Piestch, Interim Administrator; Diane Andersen-Sibley, Director of Education; Kathryn Hendrickson, Assistant Director of Nursing; Amran Abdullahi, Residential Care Aide; John Crane, Director of Maintenance; and William "Willie" Gerards, Maintenance Worker, also participated in the conference on behalf of the Facility.

[1] During the IIDR proceeding, the Administrative Law Judge requested that the parties provide more legible copies of Department Exhibit G (Apollo Bathing System Series 600 Manual) and Facility Exhibit 11 (Maintenance Work Orders). On September 1, 2017, the Facility filed an electronic version of the Apollo 6000 Manual and a transcription of the work orders set forth in Exhibit 11. In its filing on September 1, 2017, the Department objected to pages 37 and 38 of the electronic version of the manual provided by the Facility (part 2 of the submission, pdf 11 MB) because those pages were not included in the previous materials supplied to the survey team and do not relate to the model 6000 which is involved in the present proceeding. The Department's objection is well founded. Those pages will be disregarded, but the Facility's submission of the electronic version of the manual will otherwise be received into the record as Exhibit G (Electronic Version). The Department did not object to the transcription of the work orders submitted by the Facility, and that document will be received into the record as Exhibit 11A. Finally, both parties agreed that the video set forth at https://youtu.be/5tZgtTQwrbQ could be reviewed by the Judge to facilitate an understanding of the Apollo Bathing System involved in this proceeding.

DISPUTED DEFICIENCY CITATIONS (TAGS)

The following deficiency citations were submitted to the Administrative Law Judge for consideration in this matter:

(1) Tag F323, scope and severity level K; and

(2) Tag F456, scope and severity level E.

SUMMARY OF RECOMMENDATION

Tag F323 is **AFFIRMED** at scope and severity level K, but the immediate jeopardy is found to have begun on March 9, 2017, rather than February 7, 2017.

Tag F456 is **AFFIRMED** at scope and severity level E.

Based upon the arguments and submissions of the parties and the record in this matter, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Regulatory Framework

1. The Social Security Act mandates the establishment of minimum health and safety standards that must be met by providers and suppliers participating in the Medicare and Medicaid Programs.[2] Participation requirements for skilled nursing and long-term care facilities are set forth in 42 C.F.R. Part 483, Subpart B (2016).

2. The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.[3]

3. CMS assures compliance with the participation requirements through surveys conducted by state agencies, which have been delegated the responsibility for such action.[4] In Minnesota, the state survey agency is the Department. The state survey agency reports any deficiencies to the CMS on a standard form called a Statement of Deficiencies, Form CMS-2567.[5]

4. A deficiency is defined as a facility's failure to meet a participation requirement set forth in the Social Security Act or in the implementing rules, 42 C.F.R. Part 483.[6] Deficiencies are cited as alpha-numeric tags, which correspond to a

[2] 42 U.S.C. §§ 1302, 1320a-7(j), 1395hh (2012); *see also* 42 C.F.R. Part 483.
[3] MDH's Initial Statement at 4 (April 17, 2017).
[4] *See, e.g.,* 42 U.S.C. § 1864(a) (2012); 42 C.F.R. § 488.11 (2016).
[5] *See, e.g.,* Exhibit (Ex.) E (Statement of Deficiencies).
[6] 42 C.F.R. § 488.301 (2016).

regulatory requirement in 42 C.F.R. Part 483.[7] The citations are commonly referred to as F-Tags because they relate to the survey enforcement provisions set forth in 42 C.F.R. Part 488, Subpart F (2016).

5. To assist state agencies in conducting surveys, CMS publishes a State Operations Manual (SOM).[8] The SOM provides guidance to state survey agencies, as well as regulated facilities, as to how the CMS interprets the various rules and regulations.[9]

6. When a violation of a rule or a deficiency is identified, the state survey agency must then make a determination as to the seriousness of that deficiency. The seriousness of the deficiency determines the remedy or the sanction imposed. The seriousness of the deficiency depends upon its scope and its severity.[10]

7. Guidance on scope and severity is set forth in the SOM at Appendix P, Deficiency Categorization.[11] Pursuant to 42 C.F.R. § 488.404 and the SOM, there are four levels of severity (Levels 1 through 4), with Level 1 being the lowest level of severity and Level 4 the highest.[12]

8. A Level 1 deficiency involves no actual harm to any resident in the care of a facility, but has the potential to cause minimal harm. A Level 2 deficiency involves no actual harm to any resident, but has the potential to cause more than minimal harm but does not indicate a situation of immediate jeopardy. A Level 3 deficiency involves actual harm, but does not pose an immediate jeopardy. A Level 4 deficiency involves an immediate jeopardy to a resident's health or safety.[13]

9. Scope has three levels: isolated; pattern; and widespread.[14] Scope is considered to be isolated "when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations." Scope is considered to be a pattern "when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice" and "[t]he effect of the deficient practice is not found to be pervasive throughout the facility." Scope is considered to be widespread "when the problems causing the deficiencies are

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[7] *See* Ex. E.
[8] *See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.*
[9] MDH's Initial Statement at 3-4.
[10] 42 C.F.R. § 488.404 (2016).
[11] Ex. D (SOM Appendix P).
[12] *Id.*; 42 C.F.R. § 488.404(b)(1).
[13] *Id.*
[14] Ex. D; 42 C.F.R. § 488.404(b)(2).

pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents."[15]

10. Other factors may be considered in choosing a remedy within a remedy category, such as "the relationship of the one deficiency to other deficiencies resulting in noncompliance" and the facility's "prior history of noncompliance in general and specifically with reference to the cited deficiencies."[16]

11. Scope and severity are represented by a Scope and Severity Grid in the SOM (Grid). The Grid is a three-column, four-row grid table with the scope indicated by the column and the severity by the row. The left-most column is for deficiencies that are isolated while the right-most indicates a widespread deficiency and the middle column indicates the deficiency is observed in a pattern. The bottom-most row of the Grid indicates a Level 1 or least severe deficiency, and the severity of a deficiency increases through Level 4, the top row of the Grid.[17]

12. Each cell of the Grid is given a letter, starting at the bottom left-most corner of the Grid with "A," and continuing across the row with the next cells being labelled "B," and "C." The second row of the Grid is assigned "D," "E," and "F;" the third row "G," "H," and "I;" and the fourth row "J," "K," and "L." Thus "A" represents an isolated deficiency that did not cause any actual harm and has a potential to cause only minimal harm while "L" indicates a deficiency that is widespread and poses an immediate jeopardy to a resident's safety or health. Levels "F" through "L" are considered to represent a substandard quality of care. Below is a copy of the Grid.[18]

[15] *Id.*
[16] 42 C.F.R. § 488.404(c).
[17] Ex. C.
[18] *Id.*

	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2
Actual harm that is not immediate jeopardy	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1	I PoC Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F PoC Required* Cat. 2 Optional: Cat. 1
No actual harm with potential for minimal harm	A No PoC No Remedies Commitment to Correct Not on HCFA-2567	B PoC	C PoC

■ Substandard quality of care in any deficiency in 42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care that constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

☐ Substantial compliance

Factual Background

13. This matter arises from a recertification survey conducted by the Department at the Facility on March 27-31, 2017. The extended survey was completed on March 31, 2017.[19]

14. SBSC is a long-term care facility located in St. Cloud, Minnesota, that provides skilled nursing to its residents, as well as other services. There were approximately 155 residents at the Facility at the time the survey was conducted.[20] The Facility has a Maintenance Department composed of a Director and five employees.[21]

[19] Ex. E at 1; MDH's Initial Statement at 4.
[20] Ex. E at 1, 40; Comments of Becky Wong.
[21] Comments of Director of Maintenance and Maintenance Worker.

15. As part of the survey, a random sample of residents in the Facility was generated from a larger group of residents who had experienced falls and sustained injuries during the thirty days prior to the survey. The sample that was examined by the surveyors included Resident 7 (R7), who had experienced a fall with minor injuries on March 9, 2017, while being removed from one of the Facility's bathing systems.[22]

16. The Department found deficiencies during its survey and issued a Statement of Deficiencies to SBSC.[23] The Facility disputes deficiencies F323 and F456 and sought an independent review through the IIDR process.[24] Both of the disputed deficiencies relate to certain bathing systems used by the Facility.

Relevant Facility Policies

17. The Facility's Fall Risk Evaluation policy requires that all residents be evaluated on admission for fall risks related to potential alteration in safety. Residents are also evaluated for fall risks annually and whenever a resident has a significant change in condition, a pattern of falls, or as necessary at the discretion of the nurse.[25]

18. The Facility's Fall Management Policy directs staff to identify and implement interventions related to the resident's specific risks to try to prevent the resident from falling and to try to minimize complications from falling. Under the policy, a Post Fall Analysis – Resident Worksheet is to be completed on all residents who have sustained a fall. The Clinical Nurse Manager or designee is responsible for ensuring that this worksheet is completed with input from the unit's fall team.[26]

19. The Facility's Incident Reports Policy requires that all persons providing services at the Facility immediately complete a detailed incident report regarding an accident or injury and the action taken after learning of the accident or injury. Under the policy, staff is to render immediate assistance and report the situation to his or her supervisor for further action. The resident is not to be moved until a licensed nurse has evaluated the condition. The resident's physician is to be notified immediately when there is evidence of injury, and the resident's family or primary contact is also to be notified. Vital signs should be taken each shift during the next 24 hours, and the resident's plan of care is to be updated as needed. Complete, concise, and factual information concerning the incident is to be documented, and the clinical nurse manager or designee is to review the incident report and initiate any necessary additional assessments. The Director of Nursing and Director of Resident Support Services are responsible for ensuring compliance with the policy.[27]

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[22] Comments of Jennifer Bahr.
[23] *See* Ex. E.
[24] SBSC's Initial Statement at 1 (August 24, 2017). The Facility withdrew its initial appeal of F225 and F226 prior to the commencement of the IIDR proceeding.
[25] Ex. G.c.
[26] Ex. 16; Ex. G.b.; Ex. E at 38.
[27] Ex. 9.

Apollo Bathing System

20. SBSC has used six Apollo Bathing System 6000 Series tubs in the Facility since 2003 or 2005. These systems use a "level glide" feature that is designed to allow Facility staff to move residents who are seated in a special bath chair into the bath tub without any need for lifts or additional transfers. The bath chair is secured to a detachable carrier, or base, that has rails that align with rails mounted on each side of the tub. The carrier also has a digital scale that can be used for weighing the resident.[28]

21. Typically, when a SBSC resident is scheduled for a bath, a Nursing Assistant (NA)[29] takes the bath chair (which has been secured to the carrier) to the resident's room. The resident is then transferred to the bath chair and wheeled to the room where the tub is located. The Resident Care Assistant (RCA) thereafter latches the carrier to the tub by lining up a pin located on the bottom of the carrier with a docking port located at the bottom of the tub; tugs or pulls back on the chair to check that the carrier is securely attached to the tub and the pin is engaged; locks the wheels on the carrier; lifts the knob on a "gravity lock," which is located on the left side of the carrier just below the seat of the chair to allow the chair to move into the bath tub; and pushes the resident's bath chair backwards into place in the tub using the rails on the carrier and the tub. The carrier is then moved out of the way, the tub door is closed, and the tub is filled with water so that the resident can be bathed.[30]

22. The gravity lock is the primary locking mechanism for securing the bath chair to the carrier. The U-shaped metal brackets attached to the base of the chair on the rail assembly system are the secondary locking mechanism for securing the bath chair to the carrier.[31] If the primary locking mechanism fails, or if the user makes an error and does not engage it, the secondary locking mechanism is in place to prevent the resident's chair from falling off of the base.[32]

23. The 2005 operation manual for the use of the Apollo Bathing System Series 6000 describes the following steps to follow in using the system:

- Before the bathing session, check that the carrier latches securely to the tub; the chair locks to the carrier; the rails are tight and aligned; the seat belts are attached; the chair transfers smoothly and the wheels do not bind on rails; and the door gaskets are in place.[33]

[28] Comments of: George Berens; B. Wong; Director of Maintenance; Maintenance Worker; and Director of Education.
[29] The Facility's NAs are given the job title of Residential Care Aide. Comments of NA-H.
[30] *See* Ex. G at 1-19; *https://youtu.be/5tZgtTQwrbQ;* Comments of B. Wong, J. Bahr, Director of Maintenance, and Maintenance Worker.
[31] Comments of J. Bahr; Comments of Director of Maintenance; Ex. E at 29-30, 35; *see also* Ex. G at 82, 107.
[32] Comments of J. Bahr; Ex. E at 35.
[33] Ex. G at 9.

- Before using the Resident Transfer System, the manual warns that the user should be sure:
    1. Carrier rails are aligned with tub rails.
    2. Carrier will securely latch to tub.
    3. Chair will lock to the carrier.
    4. Seat belts are properly installed.[34]

- Before helping residents into or out of the chair, the wheels on the chair are to be locked and the chair is to be locked to the carrier.[35]

- Before transferring residents in or out of the tub, the user must fasten seat belts and verify that the chair is locked to the carrier.[36]

- Before residents are moved into the tub, the user is to latch the carrier to the tub, check that the carrier is secure by giving a tug on the carrier, lock the wheels, lift the gravity lock, and glide the chair into place.[37]

- While the resident is in the tub, the user is to attach the chair safety strap, move the carrier safely out of the way, and close the door at the end of the tub.[38]

24. The operation manual does not include a step-by-step description of how the resident should be removed from the tub once the bath is complete. Based upon the discussions during the IIDR meeting, the following steps should be followed to remove the resident after the bath is concluded:

- Drain the bath water from the tub.

- Open the door at the foot of the tub.

- Line up the rails on the carrier and tub, attach the carrier to the docking port located near the bottom of the tub, and give the carrier a tug to ensure that it is securely attached to the tub.

- Lock the carrier's wheels.

- Unfasten the safety strap securing the bath chair in the tub.

- Slide the bath chair forward over the rails and ensure that it is securely attached to the carrier. As the seat of the chair slides over

[34] *Id*. at 10-12.
[35] *Id*.
[36] *Id*.
[37] *Id*.
[38] *Id*. at 13.

to the carrier, the gravity lock should automatically engage and lock the chair to the carrier.

- Depress the foot pedal to release the carrier (and attached chair) from the docking port.[39]

25. The System Operating Guide for the Apollo Bathing System Model 6000 Series includes the following language:

> Improper adjustment of the Patient Transfer System or failure to lock patient chair onto carrier could allow patients to drop to the floor resulting in severe injury.
>
> - **Before transferring patients between carrier and tub:**
>   1. Be sure patient carrier rails are aligned with tub rails.
>   2. Be sure patient carrier is securely latched to tub.
> - **Before moving carrier,** check to be sure patient chair is locked to carrier and will not accidentally roll off carrier.[40]

Similarly, the Installation Instructions for the Model 6000 Series state:

> **Improper Resident Transfer System adjustment could allow residents to drop to the floor resulting in severe injury.**
>
> - Be sure resident carrier rails are aligned with tub rails.
> - Be sure resident carrier is securely latched to tub with wheels locked while transferring residents.[41]

In addition, the Operation Remedy portion of the Apollo Bathing System manual includes the following language:

> **!WARNING!**
>
> Patient carrier could drop if rails are loose or transfer chair wheels are not aligned with rails.
>
> - Be sure all fasteners and adjusting nuts are tight before using transfer system.
> - Inspect chair fastener screws periodically to insure [sic] they remain tight during use (Refer to **Maintenance Schedule**).[42]

26. The Facility provided surveyors with a Recommended Maintenance Schedule for Carriers and Scales pertaining to its Apollo tubs, which was dated March

[39] Comments of J. Bahr; Director of Maintenance; and G. Berens; Ex. E at 28.
[40] Ex. G at 5 (undated).
[41] *Id*. at 33 (2005) (emphasis in original).
[42] *Id*. at 84 (2003) (emphasis in original).

2003. According to the schedule, maintenance was to be provided to the following items at the intervals specified:

Docking Pin Setting to Receiver:	Every 3 Months
Carrier Locks (Should Work Freely)	Monthly
Carrier Rail Alignment (Align to Tub Rails)	Monthly
Chair Release Lever	Monthly
Castor Locks	Every 3 Months
Safety Sraps [sic] and Buckles	Monthly
Chair Mounting Bolts (Wheels, Arms Ect. [sic])	Every 6 Months
Bottom Chair Retaining Tabs (All Fasteners Tight)	Monthly
Chair Wheel Bearings	Every 12 Months[43]

27. The Trouble Shooting Guide included in Section 5 of the manual indicates that, if the "[g]ravity locks [are] not falling back into place," the possible cause is that the "[p]ivot bolt [is] too tight or locks are sticky from dried bathing products accumulating on or around lock area." The Guide indicates that the possible solution for this problem is to "[l]oosen pivot bolt just enough to allow lock to drop into place, and clean and rinse lock area until lock operates freely."[44]

28. Instructions for moving residents to and from the Apollo Bathing System are posted in each of the Facility's tub rooms. Among other things, the instructions state:

Before transferring resident IN or OUT of the bathing system . . .

1. Latch carrier to the bathing system.
2. Check that carrier is secure by giving a tug on the carrier.
3. Lock wheels.
4. Release primary lock and glide chair into place.

[43] *Id*. at 86.
[44] *Id*. at 88.

The instruction sheet also includes the following warning:

> Warning
>
> Before using Resident Transfer System be sure:
>
> 1. Carrier rails are aligned with tub rails.
> 2. Carrier will securely latch to tub.
> 3. Chair will lock to carrier.
> 4. Seat belts are properly installed.[45]

29. The Apollo manual includes photographs of the gravity lock next to statements that the user should verify that the bath chair is locked to the carrier.[46] Although the manual does not expressly state that persons operating the tub system should "visually confirm" that the gravity lock is in proper position to lock the chair to the carrier, it clearly implies that is the case.[47]

30. The Apollo manual does not include any mention of a "click" or other sound that will be heard when the chair has been securely attached to the carrier.

31. Between April 17, 2016, and April 9, 2017, the Facility's Maintenance Department received 26 written requests for maintenance work to be done on tubs in the Facility. Eight related to the scale; seven involved the operation of the whirlpool jets in the tubs; three involved the cleaning solutions used in the tubs; three involved issues with various parts (the fill tub level, the sprayer, and the pull-out knob); two involved the water reservoir; one involved a water leak; one involved a slow drain; and one involved the alignment of the rails on the carrier and tub.[48] The written work orders do not accurately reflect the number of maintenance issues relating to the bathing systems that are addressed in the Facility, since the Maintenance Department frequently receives telephone calls relating to water leaks and other more urgent issues associated with the tub systems and does not keep a written record of those calls or the work completed in response.[49]

32. On February 7, 2017, a Maintenance Work Order form was submitted for the Second Floor North tub. The form reflected staff's concern that "[t]ub chair does not

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[45] Ex. 6; Comments of NA-H.
[46] Ex. G at 9, 11.
[47] The Director of Education and the Director of Maintenance asserted during the IIDR proceeding that it is unlikely that visual confirmation would be possible with the Apollo 6000 model because the seat of the chair hides the locking mechanism as it pulls over it. However, based upon the Apollo video set forth at https://youtu.be/5tZgtTQwrbQ and the video provided by the Facility as Ex. 17, it appears that those claims are not accurate, and that it would be a fairly simple matter for staff removing a resident from the tub to visually check whether the end of the locking mechanism had properly popped up to block the chair from sliding backwards. In addition, an Apollo sales representative informed Facility staff and the surveyors on March 31, 2017, that "listening for the click was not a substitution for a visual verification that the chair was locked into place." Ex. E at 36.
[48] Exs. 11 and 11A.
[49] Comments of Director of Maintenance and Maintenance Worker.

go on correctly. Off track?"[50] A Maintenance Department employee responded to this work order on February 8, 2017. He moved the carrier in front of the tub, locked the carrier into position, and locked the front castors. He found that the latch was working correctly. When he checked the rail alignment, he found it was about 1/8 inch off to the right side. He also found the load cell screws were slightly loose. He retightened the screws, readjusted the rail, and found that the chair was working properly.[51]

33. The February 7, 2017, work order relating to the Second Floor North tub did not involve a situation in which a resident experienced a fall or was injured because the tub chair separated from the carrier. It only involved a slight misalignment of the rails on the carrier with the rails on the tub. A misalignment of that type would, at most, cause a resident being transferred into the tub to experience a somewhat "bumpy" transfer to the tub, and would not present a risk that the bath chair would disconnect from the carrier causing the resident to fall.[52]

34. Nursing assistants and licensed staff employed by the Facility are given training about disinfecting the tubs upon hire, while in the classroom setting. Once NAs are registered and have completed classroom orientation with the Facility's RNs (Registered Nurses), they go through clinical training with an RN that includes how to give a resident a bath. The RAs are then assigned to a preceptor (a more experienced NA) in the Facility. The preceptors do not go through any special orientation or preceptor program. The preceptors provide additional training to the NAs on a number of items, including how to operate and disinfect the tub systems in the unit to which they are assigned. The NAs are expected to follow the manufacturer's instructions for the tub systems that are posted in each tub room. If NAs float to a different unit, they are expected to have someone show them how to use the tub system if it is different from those they have been trained to use. The Facility also conducts annual skills fairs during which the NAs receive additional training on tubs, mechanical lifts, and other areas.[53]

March 9, 2017 Incident and Subsequent Facility Actions

35. R7 is an 88-year-old man who has resided in the Facility since 2010.[54] R7's diagnoses include dementia and Parkinson's disease.[55] His care plan dated January 25, 2017, notes that he "is alert and oriented at times" and "has increased confusion at times."[56] He has short-term memory impairment but intact long-term memory.[57] R7 has a self-care deficit related to Parkinson's disease with fluctuations in participation ability and resting tremors, decreased hearing. He generally needs the assistance of two staff and a standing lift to transfer[58] and the assistance of one for

[50] *See* Ex. E at 30; Ex G.a at 2; Ex. 11 at 9; Ex. 11A.
[51] Exs. 8 and E at 29; Comments of Maintenance Worker.
[52] Comments of Director of Maintenance and Maintenance Worker.
[53] Exs. 13 and E at 35; Comments of Director of Education.
[54] Ex. 2; *see also* Ex. J at 1, 10.
[55] Ex. 3 at 3; Ex. 4 at 22-23.
[56] Ex. 3 at 3.
[57] Ex. 4 at 8; Ex. E at 25.
[58] Ex. 3 at 7; *see also* Exs. E at 25 and J at 34.

bathing.[59] If R7 is transferred into the bath chair in his room with the assistance of two staff, he needs the assistance of only one staff person to be taken to the tub room for use of the Apollo Bathing System.[60]

36. During the morning of March 9, 2017, NA-H was assigned to assist R7 with bathing. NA-H has been employed by the Facility for approximately eight months. She works approximately six days each pay period and gives at least three residents baths each working day. All of the units where she provides baths in the Facility have the same type of Apollo tub. Prior to her employment with the Facility, NA-H attended NA training at Anoka Ramsey Community College, taught by the Facility's Director of Education. NA-H's clinical training included having an RN show her how to use the tub chair and receiving additional training from a preceptor at the Facility.[61]

37. Prior to 6:15 a.m. on March 9, 2017, NA-H went to R7's room with the bath chair from the Apollo Bathing System and transferred R7 into the bath chair with the assistance of another staff person. She fastened R7's safety belts and then wheeled R7 to the tub room located on the Second Floor North of the Facility. She then moved R7 into the tub using the "level glide" system, and proceeded to give him a bath. When NA-H was taking R7 out of the tub, she pulled the bath chair forward on the track and "heard the click." She then stepped on the pedal to release the track from the tub and the chair tipped backwards and fell off the track. RA-H lowered R7 and the bath chair to the ground the best she could. She reported that R7 did not hit his head.[62]

38. After the fall, NA-H immediately called an RN (believed to be RN-E) for assistance. When RN-E arrived, R7 was sitting on the tub chair lying on the floor on his back in a seated position. RN-E did a head-to-toe assessment of R7 while he was in that position, checked his pupils, and took his vital signs. R7 was transferred to his wheelchair using a full mechanical lift. Staff found that he had sustained a skin tear to his right hip and right shoulder, each of which measured 0.2 x 0.2 cm. R7 denied having any pain at the time.[63] At 11:23 a.m. the same morning, R7 told the Facility social worker that he was "doing okay" and expressed interest in going to the gift shop to purchase a greeting card. Additional progress notes relating to R7 for March 10, 2017, do not show that he expressed any concerns or complaints of pain relating to the accident.[64]

39. Immediately following the incident, Facility staff contacted the Facility's Maintenance Department by telephone and posted a sign and directed staff not to use

[59] Exs. 3 at 5 and J at 32.
[60] Comments of NA-H; *see also* Ex. E at 25.
[61] Comments of NA-H and Director of Education; Exs. 13, 15.
[62] Comments of NA-H; Exs. E at 26, J at 5.
[63] Exs. E at 25 and J at 2, 3; Comments of: G. Berens; NA-H; and Assistant Director of Nursing (ADON).
[64] Ex. 2.

the tub.[65] No written work order was submitted or completed regarding the incident with R7.[66]

40. The incident was reported to the ADON immediately after it occurred. Because the Facility's Director of Nursing (DON) was out on medical leave at the time the incident occurred, the ADON stepped in to handle the investigation. She and the Facility's Director of Social Services went to the tub room and saw the disconnected bath chair and carrier in the corner of the room. The ADON spoke with the RN who had assessed R7, who told her that R7 had denied having any pain, and that R7's responsible person and physician had been notified. The ADON also spoke with NA-H about the incident. After hearing NA-H's explanation, both the ADON and the RN concluded that NA-H had followed R7's care plan and had done everything she should have done, and no human error was involved in the incident.[67]

41. Shortly after the incident, RN-E notified the Unit Manager RN (RN-C) by telephone of the incident in the tub room. RN-E told RN-C that NA-H had demonstrated the steps she had taken during the incident. RN-C also believed that NA-H "did everything right, and there was no indication of possible human error."[68]

42. After receiving the call about the March 9, 2017, incident, the Facility's Director of Maintenance and another Maintenance Department employee went to inspect the tub equipment and found issues with the secondary safety system on the bath chair. In an e-mail message dated April 25, 2017 (approximately six weeks after the incident), the Maintenance Director summarized their findings as follows:

> [T]he carrier docked properly to the tub. The docking pin was at the correct height. The release functioned properly. The Primary Latch functioned properly when the empty chair was docked and undocked. The secondary carrier stops on the carrier rail functioned properly and kept the chair on the undocked carrier. We did bend the metal stops on the chair back to their factory position . . . .[69]

The record in this matter does not reflect the exact time or date that the tub was approved by the Maintenance Department to be used again, but it was ultimately returned to service after the metal stops were bent back to factory position. The tub was clearly back in use by March 19, 2017, when a maintenance work order was received asserting that the scale on the carrier was not weighing correctly.[70]

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[65] Exs. E at 29, 31-32 and J at 1.
[66] Ex. E at 29; Comments of Director of Maintenance and Maintenance Worker.
[67] Ex. E at 31-32; Comments of ADON.
[68] Ex. E at 31.
[69] Ex.7; *see also* Ex. 8; Comments of Director of Maintenance and Maintenance Worker.
[70] See Exs. 11 at 3 and 11A. In response to the March 19, 2017, work order, a maintenance worker noted only that he had "recalibrated [the] scale" on March 20, 2017. According to statements made by the Director of Maintenance to surveyors, the maintenance worker also "ensured the chair was in working order" on that date. Ex. E at 29.

43. After the Maintenance Department completed their work on the bath system, the ADON assumed that they had found the problem and it was fixed. She did not ask the Director of Maintenance why the primary locking mechanism had failed to keep the bath chair in place on the carrier.[71]

44. Following the incident, the Maintenance Department checked on all of the facility's tubs and tub chairs.[72]

45. The Maintenance Department did not implement a formal system of preventative maintenance for the tub systems following the March 9, 2017, incident, but continued to rely on Facility staff to bring issues to their attention by calling or submitting written work orders.[73]

46. At some point on March 9, 2017, RN-E and a maintenance employee went into the Second Floor North tub room and tried to reenact the accident by sitting in the bath chair. Nothing seemed to be wrong with the operation of the tub system. They later realized that the Director of Maintenance had already made repairs to the bath chair.[74]

47. Notations made by Facility RNs in R7's Progress Notes on March 9, 2017, indicate that the fall occurred due to "mechanical failure."[75] A Progress Note entered at 9:25 a.m. further stated, "This incident is not suspicious in nature. Resident's POC [Plan of Care] was being followed at time of fall. . . . After review, this incident is not deemed a VA [vulnerable adult] reportable event."[76]

48. The initial fall report relating to the incident included a notation by a Facility RN dated March 10, 2017, stating that "Resident received tub bath. When RCA was using tub chair to remove resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair separated from the base."[77] A Revised Fall Report prepared by another Facility RN on March 17, 2017, indicated that, when R7 was taken out of the tub, "an unknown issue occurred with equipment and the tub chair tilted backwards off of the track and resident fell backwards to floor . . ."[78] The report mentioned the abrasions to R7's right shoulder blade and right hip, indicated that R7 was alert following the incident, and stated that no predisposing environmental, physiological, or situational factors were indicated. The report noted that the tub chair had a "possible mechanical issue."[79]

49. A Facility RN prepared a post fall follow up report relating to R7 on March 17, 2017. The report again identified "mechanical failure of equipment" as the

[71] Comments of J. Bahr and ADON.
[72] Ex. E at 29; Ex. 7; Comments of Director of Maintenance.
[73] Comments of Director of Maintenance.
[74] Comments of ADON.
[75] Ex. J at 1, 2.
[76] Exs. E at 26 and J at 1.
[77] Exs. E at 26-27 and J at 5.
[78] Ex. J at 3.
[79] Exs. E at 26 and J at 3-5.

relevant factor in the fall. The report did not identify any new interventions for R7 and stated that the "[t]ub chair [was] out of order until maintenance assessed." The follow up report noted that an interdisciplinary team (IDT) reviewed the incident on March 14, 2017, but did not include the IDT notes, a description of the mechanical failure that occurred, or what was done to prevent an incident from occurring again.[80]

50. The Facility's Education Department was not contacted after the incident involving R7 on March 9, 2017. No further education was given to NAs after the incident to ensure that they were using the tub systems correctly until late March 2017, when the surveyors were present in the Facility.[81]

51. The MDH surveyors requested that the Facility provide a tub system training curriculum and a preventative maintenance program policy. Neither was provided by the Facility.[82]

52. The Facility's Safety and Health Committee met on January 14, 2016; February 11, 2016; March 10, 2016; April 14, 2016; June 9, 2016; August 11, 2016; September 8, 2016; October 13, 2016; January 12, 2017; February 9, 2017; and also on March 9, 2017 (the day that the incident occurred). Based on the meeting minutes, there was no discussion of any safety concerns with the transfer of residents into the tub systems at any of those meetings. In addition, there was no discussion of R7's fall during the meeting held during the afternoon of March 9, 2017.[83]

53. The Facility did not notify Apollo Company of the March 9, 2017, incident, or contact Apollo to request assistance or discuss possible reasons for the failure of the locking systems until late March 2017, when the surveyors were present in the Facility.[84]

54. At 5:42 p.m. on March 30, 2017, the Department notified the Facility's Administrator, the ADON, and the unit manager RN (RN-C) of its immediate jeopardy determination.[85] On March 31, 2017, an IDT including the ADON, Clinical Nurse Manager, Safety Officer, Social Services, LNHA, and maintenance staff, met to review the incident. They spoke with RN-E by telephone, who reiterated the steps she took after R7's fall on March 9, 2017, to put the tub out of order and notify maintenance. RN-E told the IDT that maintenance responded immediately and determined the chair and track required adjustments. She also said that, during the investigation by nursing, she "attempted to recreate the situation however the tub had already been repaired." The IDT determined that the RCA "repeatedly stated in multiple interviews that she heard the chair "click or lock," and "conclude[d] that the cause of the incident was related to the chair & rail needing to be adjusted." The Facility notes indicated that staff on all floors had been interviewed related to any issues or potential malfunctioning of the tubs,

[80] Exs. E at 27; Ex. 5; Ex. J at 6-8.
[81] Ex. E at 28, 35-36; Comments of J. Bahr and NA-H.
[82] Ex. E at 37.
[83] Exs. 12, G.f., and E at 31.
[84] Comments of J. Bahr and Director of Maintenance.
[85] Ex. E at 24; Comments of J. Bahr.

and that "[t]ubs on 2nd & 3rd Floor were identified as having issues and have been temporarily closed until the manufacturer is able to verfy [sic] safe working condition."[86]

MDH Survey

55. The MDH surveyors arrived at the Facility on March 27, 2017. After R7's fall was identified in the sample for a focused investigation, the surveyors interviewed several individuals, including R7, NA-H, the ADON, the Education Director, the Maintenance Director, several RNs and NAs, and representatives of the Apollo Company. They also visited the tub room involved in the incident on several occasions and received explanations and demonstrations from Facility staff about the operation of the Apollo Bathing System.[87]

56. On March 29, 2017, the Department's surveyors interviewed R7. He said that he fell from the tub chair when the track or connection was not tight and came apart. R7 told the surveyors that he did not receive any serious injury, but his bottom hurt that day. R7 indicated that he had continued to use the tub for bathing, without fear. He said that he did not know exactly what happened, or what the Facility did to fix the situation.[88]

57. On March 29, 2017, NA-F spoke with surveyors and demonstrated how the Apollo 6000 system worked in the tub room located on the Second Floor North of the Facility. NA-F had heard about R7's fall from the bath chair but was not sure what had happened. She said that there had not been any education about the tub system following the incident. She described the steps to remove a resident by the bath system as follows:

> NA-F stated after the bath was finished, the tub was drained, and the door at the end of the tub was opened. Once the rails were lined up, the base was locked into placed [sic], the security buckle on the back of the chair was released. The chair would then slide into place over the base, and it would click into place. The base was then released from the tub. NA-F stated the chair could fall if it was not completely on top of the base before releasing the base from the tub, or if the rails were not lined up properly. NA-F stated she had heard R7 had a fall from the bath chair, but was not sure what had happened. NA-F stated there had not been any education about the tub system following R7's fall.[89]

58. On March 29, 2017, the MDH surveyors interviewed another nursing assistant, NA-G. She said that she had heard about R7's fall in the tub room a few days after the fall occurred. She heard that the chair had malfunctioned and R7 fell backwards from the tub chair. NA-G told surveyors that it was important to hear a click before removing the base from the tub. She said she had been trained how to use the

[86] Ex. 1; Comments of K. Hendrickson.
[87] Comments of J. Bahr; *see generally* Ex. E at 23-41.
[88] Ex. E at 27.
[89] *Id*. at 27-28.

tub when she was hired, and indicated that there had not been any follow up or education following the incident involving R7.[90]

59. On March 30, 2017, the surveyors interviewed NA-H by telephone about the incident involving R7. NA-H told interviewers that, when she slid the bath chair out of the tub onto the chair base on March 9, 2017, she was "99 percent sure" that she heard "the click," which she indicated meant that "the chair was in position over the base." She then used the foot pedal to release the base from the tub and, when she started to move the base with the chair on it, R7 started falling backwards towards the floor.[91]

60. The surveyors had a series of conversations with the Maintenance Director on March 30, 2017. He indicated that, after the March 9, 2017, incident, the "secondary safety" (i.e., the U-shaped metal brackets attached to the base of the chair on the rail assembly system) was bent on both sides of the bath chair. If the primary locking lever was not engaged, and the chair was sliding back off, he stated that the base would come in contact with metal pieces that hung off the end of the rails on both sides of the chair, preventing the chair from falling off the base.[92] The Maintenance Director said that he had made the needed adjustments to the secondary safety on the chair and "was confident that that was the solution." He indicated that no new parts were ordered when the Second Floor North tub chair was fixed. He told the surveyors that, "along with mechanical errors, human error could have occurred, but it was hard to tell."[93]

61. The Director of Maintenance told the surveyors that there was nothing wrong with the primary lever when it was inspected on March 9, 2017, and that it should have locked the chair in place. He reiterated that the secondary safety was there in case the primary locking lever failed. After discussing various potential scenarios of how the chair could have fallen off the base, the Director of Maintenance told the surveyors that "the base had to have been released from the chair, the primary safety lever was not engaged, and secondary U-shaped brackets were bent causing the chair to fall backwards off the base." He told the surveyors that he "did not walk through any possible scenarios with the nursing staff" and he "just assumed the secondary safety failed." He said, "[n]o thought was put into the primary locking lever," and said, "if it was human error by not engaging the lock, or if it was engaged, then how did the primary locking lever fail?" The Director of Maintenance further stated "the incident was not thoroughly investigated."[94]

62. The Maintenance Director told the surveyors that no follow-up inspections had been made to the tub chair system on Second Floor North after the incident, and noted that the Facility relied on maintenance slips or phone calls if there were issues with the tubs or the bath chairs. He noted that a work order was submitted on

[90] *Id*. at 28.
[91] *Id*. at 33.
[92] *Id*. at 29-30.
[93] *Id*. at 28-29, 33.
[94] *Id*. at 29-30.

March 19, 2017, regarding the tub chair scale in the Second Floor North tub room, and said that a maintenance worker fixed the scale on March 20, 2017, and also ensured the chair was in working order.[95]

63. The Director of Maintenance also stated "there had never been preventative maintenance preformed [sic] on the tubs by the maintenance department" since they were installed in 2003. He said that the Facility did not contract with any other company to do routine inspection or maintenance on the tubs or tub chairs.[96] Upon further questioning by surveyors, the Maintenance Director said that "the facility had no preventative maintenance schedule to inspect the tubs and tub chairs prior to the incident on 3/9/17, and the facility had not implemented a system for preventative maintenance following the incident." He said that, "only when the maintenance department was alerted to a potential issue with the tubs or tub chairs, do they get looked at."[97]

64. The Director of Maintenance told the surveyors that, if staff put too much pressure on the front of the tub chair when moving it, the back of the chair could come off the rails and bypass the secondary locking system. He indicated that it should never take two people to move a resident from the base to the tub and vice versa, and staff should stop immediately if they were having issues and contact the Maintenance Department.[98] The Director of Maintenance said that he had been called a few times during the past year about the tub rails not lining up, and the rails were adjusted. He said the Department does not keep any written record of maintenance phone calls that were received or steps taken to follow up.[99]

65. The MDH surveyors also interviewed the ADON on March 30, 2017. The ADON said that she "thought it was a mechanical error as soon as she entered the tub room" after the fall occurred. She said that "she did not think human error was involved by the look of the chair, and [NA-H's] explanation of what happened." The Statement of Deficiencies includes the following additional description of the interview with the ADON:

> The ADON stated no further investigation was completed to determine if the fall was a result of human error or if the primary locking system failed. The ADON stated there should have been further investigation into the cause of the fall. The ADON further stated she thought mechanical issues were the reason for the fall. . . . The ADON stated there was no conversation with the DM [Director of Maintenance] after his review of the chair [to] see why the primary lock did not keep the chair in place over the base. The ADON stated she was not sure what was reviewed in the IDT [interdisciplinary team] review, and she was unaware if all possible

[95] The Maintenance Work Order form for the March 19, 2017, repair reflects staff's concern that "[t]ub chair scale [was] not weighing correctly." *See* Ex. E at 30-31; Ex. G.a. at 1; Ex. 11; Ex. 11A.
[96] Ex. E at 33.
[97] *Id*. at 28-29.
[98] *Id*. at 34.
[99] *Id*.

> sceneries [sic] had been covered to implement interventions to prevent another incident. . . . The ADON stated in hindsight a more complete investigation should have been completed . . . . [100]

66. The surveyors spoke with several other NAs and Facility staff while they were present at the Facility on March 30, 2017. One nursing assistant (NA-L) informed surveyors that "some staff do not get the base lined up with the track correctly, and they would call for assistance to push the chair off the base into the tub." NA-L noted that the chairs have "stoppers" (the secondary locking system) that prevent the chair from going any further if the rails are not lined up.[101] A licensed practical nurse (LPN-B) at the Facility also told surveyors that the third floor nursing assistants often needed to get help from a second person when putting a resident into and out of the tub. LPN-B said that the second person was needed to hold the base in place when the rails did not line up so the base did not separate from the tub.[102] Another nursing assistant (NA-I) told MDH surveyors that, if the bath chair is not pulled far enough forward onto the base, it could by-pass the secondary locking system and fall off the base backwards.[103]

67. The Director of Education was interviewed on March 31, 2017. The Director of Education told the MDH surveyors that the tub system should be treated like a mechanical lift. She indicated that, since being alerted to potential education issues regarding the tub systems, the Facility was working on a new process of using the manufacturer's checklist for training, with a return demonstration, and that the ADON and nurse unit managers had starting doing training in the tub rooms that morning.[104]

68. MDH surveyors conducted a telephone interview on March 31, 2017, of a technical representative for Apollo Bathing Systems (TR-A) who was familiar with the Apollo 6000 system. According to the Statement of Deficiencies:

> TR-A stated it is recommended the facility perform routine inspections on the tub system per the manufacturer's recommendations at intervals of monthly, quarterly and yearly. TR-A stated each facility is given a checklist on what needed to be inspected and when. TR-A further stated routine maintenance was essential to prevent part failure, and a facility not performing maintenance per manufacturer's recommendation was "running a high risk" of a resident falling and possibly sustaining "serious injury." TR-A stated in the event the primary locking lever failed, or if by user error it was not engaged, the secondary locking system was in place to prevent a resident from falling. TR-A stated during normal operation of the chair, the U-shaped metal brackets on the rail system would not bend on their own. If the secondary system had been maintained properly, it should have prevented a resident from falling. TR-A stated the facility was responsible for checking the rails, and primary and secondary locking

[100] *Id*. at 31-32.
[101] *Id*. at 31.
[102] *Id*. at 33.
[103] *Id*. at 34.
[104] *Id*. at 35-36.

> systems monthly, along with the pin that locks the base to the tub. TR-A stated the facility needed to contact Apollo in the event of a resident fall from an Apollo Bathing System, that "[i]t was extremely important," as the company tracks adverse events. TR-A further stated the company could help the facility investigate what had occurred. TR-A stated the facility had not reported the incident to Apollo, and if a tub chair was repaired without following manufacturer's recommendations, the chair would not be safe to continue using.[105]

69. At the recommendation of MDH and the Facility's Interim Administrator, the Facility asked Apollo's Regional Sales Manager (TR-B) to come to the Facility to ensure that the Apollo Bathing Systems were in safe working order. TR-B arrived at the Facility during the afternoon of March 31, 2017, and met with the Director of Maintenance and MDH surveyors. TR-B told the surveyors that he would conduct a thorough inspection of all of the Facility's tubs and fix or replace what was needed. He said that the Facility's maintenance staff was responsible for maintaining the bathing systems. He asserted that, when one nursing assistant trains another on how to use the tub system, they may miss details. He also contended that the "click" Facility staff indicated they listen for (so they know the chair is locked over the base) can be heard without the chair fully locking into place, and demonstrated that for the surveyors. TR-B also said that listening for the click was not a substitution for a visual verification that the chair was locked into place. After inspecting the bath chair, TR-B said that it was okay that the maintenance department had bent the U-shaped metal bracket of the secondary locking mechanism into place and that would not alter its strength. The Director of Maintenance said that "human error should be negated because there were a few missing screws on the chair at the time of the incident on 3/9/17." After a brief overview, TR-B said he thought the chair was safe to use, but recommended some upgraded safety enhancements to the primary lock lever.[106]

70. In an e-mail message dated April 25, 2017, the Maintenance Director noted that TR-B "stated that the bent part likely occurred during the fall and that bending the part back was the proper remedy." He stated that TR-B examined the tub carrier and the bath chair, and found them to be in working order when operated without weight in the chair. He told the surveyors that the tub could be put back into service."[107]

71. Approximately one hour later, as the MDH surveyors were leaving the Facility, the Facility's Interim Administrator informed the surveyors that TR-B and the Director of Maintenance "actually sat on the tub chair and noted the primary locking lever was not in working condition, and was not safe for use." The Administrator assured the surveyors that all defects found on all bathing systems would be fixed before use.[108] The Facility notes state:

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[105] *Id*. at 34-35.
[106] *Id*. at 36-37; Ex. 1; Comments of Director of Maintenance and ADON.
[107] Ex. 7 at 2; Comments of Director of Maintenance and Maintenance Worker.
[108] Comments of J. Bahr; Ex. E at 37; *see also* Ex. 17 (video demonstration of issue with primary lock).

> On 03/31/17, at approximately 2:40 p.m., the Apollo Tub Representative came to facility. Upon further review and investigation, it was identified that the latching mechanism consistently failed with weight in the chair. The mechanism was replaced and tested. The tubs were put back in service. All other tub chairs were inspected.[109]

72. The Interim Administrator invited the surveyors to return to the Second Floor North tub room to observe the operation of the tub system. The surveyors declined to do so. They were not surprised that the primary locking system was not working and that information did not change their minds about the deficiencies or their decision to lift the Immediate Jeopardy.[110] The Facility subsequently provided the Department with a short video showing TR-B in the tub chair.[111]

Tag F323

73. According to the Statement of Deficiencies, Tag F323 is based on 42 C.F.R. § 483.25(d)(1)-(2) and (n)(1)-(3) (2016),[112] which relates to the quality of care and services to be provided to residents. Section 483.25 sets forth the following general and specific requirements relating to this proceeding:

> *Quality of care.* Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:
>
> * * *
>
> (d) *Accidents.* The facility must ensure that –
>
> (1) The resident environment remains as free from accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

74. The SOM indicates that this requirement is intended "to ensure that the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent

[109] Ex. 1.
[110] Comments of J. Bahr and K. Lucas.
[111] Ex. 17; Comments of J. Bahr.
[112] Ex. E at 23. It appears that the citation to 42 C.F.R. § 483.25(n) was erroneously included in the Statement of Deficiencies as a basis for F323. That regulation relates solely to bed rails. Because the Department's allegations in support of F323 pertain solely to the Facility's bathing tubs and chairs and make no mention of any issue involving bed rails, the Administrative Law Judge recommends that the citation to 42 C.F.R. §483.25(n) be deleted from the Statement of Deficiencies.

avoidable accidents."[113] The term "assistance device" or "assistive device" is defined in the SOM to mean "any item (e.g., fixtures such as handrails, grab bars, and devices/equipment such as transfer lifts, canes, and wheelchairs, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety."[114] The term "accident" is generally defined to include "any unexpected or unintentional incident, which may result in injury or illness to a resident."[115] The SOM describes an "avoidable accident" as follows:

> "Avoidable Accident" means that an accident occurred because the facility failed to:
>
> - Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or
>
> - Evaluate/analyze the hazards and risks; and/or
>
> - Implement interventions, including adequate supervision, consistent with the resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or
>
> - Monitor the effectiveness of the interventions and modify interventions as necessary, in accordance with current standards of practice.[116]

75. Facilities are advised by the SOM to take a systematic approach to resident safety in order to comply with this regulation:

> A key element of a systemic approach is the consistent application of a process to consistently address identified hazards and/or risks. Risks may pertain to individual residents, groups of residents, or the entire facility. Hazards may include, but are not limited to, aspects of the physical plant, equipment, and devices that are defective or are not used properly (per manufacturer's specifications), are disabled/removed, or are not individually adapted or fitted to the resident's needs. An effective system not only identifies environmental hazards and the resident's risk for an avoidable accident, but also the resident's need for supervision.[117]

The SOM further notes that "[d]evices for resident care, such as pumps, ventilators, and assistive devices, may be hazardous when they are defective, disabled, or improperly

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[113] Ex. F at 1.
[114] *Id*. at 2.
[115] *Id*. at 1. The definition of "accident" set forth in the SOM excludes "adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction)."
[116] *Id*. at 1-2.
[117] *Id*. at 4-5.

used (i.e., used in a manner that is not per manufacturer's recommendations or current standards of practice.)"[118]

76. The Department determined, based on observation, interviews, and document review, that SBSC failed to provide a preventative maintenance program for the bathing tubs and chairs according to the manufacturer's recommendations; failed to comprehensively investigate R7's fall from the bath chair; and failed to put into place preventative measures following the fall. The Department found that this practice resulted in a risk for serious harm, injury, or death to 104 out of 155 residents who received baths in the facility.[119]

77. The survey team went through the Guidelines for Determining Immediate Jeopardy set forth in Appendix Q to the SOM to determine whether the immediate jeopardy factors were met. Because the tub system is patient care equipment, the surveyors expected the Facility to comply with manufacturer maintenance requirements. The manufacturer of the Apollo Bathing System had designed it with two locking systems in place, and the surveyors did not find it acceptable for the Facility to continue using the Bathing System with only one locking system in place. The team found it to be of particular importance that the Facility still had not determined why the primary locking system failed on March 9, 2017, and still had not initiated preventative maintenance to ensure that the secondary locking system did not get bent again.[120] Prior to issuing the deficiency and immediate jeopardy determination, the survey team also engaged in discussion and consultation with superiors and colleagues in the Department in order to ensure that there was a proper basis for the determination.[121]

78. The Department determined that the immediate jeopardy began on February 7, 2017, when the Facility's maintenance department received a written notice that the bathroom tub rails on the Facility's Second Floor North unit were not aligned correctly, and the Facility did not implement preventative maintenance to the bathing tubs and chairs according to the manufacturer's recommendations. The Department also found that the Facility failed to comprehensively assess R7's fall on March 9, 2017; failed to implement interventions to include nursing assistant re-education; and failed to implement a preventative maintenance program for the tubs in accordance with manufacturer's recommendations.[122]

79. The Department notified the Facility's Administrator, Assistant Director of Nursing, and Unit Manager Registered Nurse of the immediate jeopardy at 5:42 p.m. on March 30, 2017.[123] The Facility submitted an Immediate Jeopardy Removal Plan to the Department on March 31, 2017.[124] The immediate jeopardy was removed on March 31, 2017, at 3:38 p.m., but the Department found that noncompliance remained at the lower

[118] *Id*. at 9-10.
[119] Exs. E at 24 and H; Comments of J. Bahr; Comments of K. Lucas.
[120] Comments of J. Bahr; Comments of K. Lucas; Ex. H.
[121] Comments of K. Lucas; Comments of B. Wong.
[122] Ex. E at 24.
[123] *Id*. at 24, 38.
[124] Ex. G.h.

scope and severity level of a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E).[125] This determination was made because all staff training had not been completed and the Apollo representative had not inspected all the Apollo tubs for safety or completed any repairs that may have been needed for safe functioning.[126]

Tag F456

80. According to the Statement of Deficiencies, Tag F456 is based on 42 C.F.R. § 483.90(d)(2) and (e), which relates to the Facility's duty to maintain essential equipment in safe operating condition.[127] Section 483.90 sets forth the following general and specific requirements relating to this proceeding:

> *Physical environment.* The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.
>
> (d) *Space and equipment.* The facility must –
>
> * * *
>
> (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.
>
> (e) *Resident rooms.* Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.

81. The Department determined, based on interviews and review of documents, that SBSC failed to implement a preventative maintenance program for its bathtubs and tub chairs according to the manufacturer's recommendation, and that this had the potential to affect 104 of 155 residents in the Facility who used the bathtubs. This deficiency was cited at scope and severity level E.[128]

Additional Findings

82. On April 6, 2017, the Facility submitted a report to MedWatch, the FDA Safety Information and Adverse Event Reporting Program, regarding the March 9, 2017, incident. The report indicated that:

> Safety latch on Apollo Bathing System failed causing resident to be lowered to the floor. Resident sustained minor injury of two small skin tears. Manufacturer representative witnessed latch failure on recreating incident. Latch was replaced with newer model. Concern is that older

[125] Ex. E at 25, 38-39.
[126] *Id*. at 39; Ex. G.h.
[127] Ex. E at 39-40.
[128] *Id*.

style Apollo Bathing Systems may fail causing potential injury or death to a patient or resident.[129]

83. After the survey was concluded, the Facility learned that newer models of the Apollo Bathing System use weighted or spring-loaded primary latches rather than the gravity primary latch in place at the time of the March 9, 2017 accident. The Facility has replaced the gravity latches in the Facility with spring-loaded latches.[130]

84. The Facility has never received any notice of a recall or other possible defect involving the gravity locks used in the Apollo Bathing System Series 6000. In addition, the Facility was not aware prior to late March 2017 that newer models of the Apollo tub system incorporate significant changes in the design of the tub system's primary locking system.[131]

85. Prior to March 9, 2017, there had never been any incident in the Facility in which a bath chair used in the Apollo Bathing System became disconnected from the carrier during the transfer of a resident. There have not been any additional incidents since March 9, 2017.[132]

Based upon the Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. SBSC is a long-term care and skilled nursing facility subject to the federal Social Security Act and 42 C.F.R. Parts 483 and 488.

2. The Commissioner and the Administrative Law Judge have jurisdiction to hear this matter pursuant to Minn. Stat. § 144A.10 (2016).

3. All long-term care and skilled nursing home facilities regulated under the Social Security Act must comply with the obligations to ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents, as set forth in 42 C.F.R. § 483.25(d); and that all mechanical, electrical, and patient care equipment is maintained in safe operating condition; and resident rooms are designed and equipped for adequate nursing care, comfort, and privacy of residents, as set forth in 42 C.F.R. §§ 483.90(d) and (e).

4. The exhibits submitted and the arguments made in this matter support the Department's determination that SBSC failed to meet the above obligations and violated 42 C.F.R. §§ 483.25(d) and 482.90(d) and (e) (2016).

[129] Ex. 10; Comments of Director of Maintenance.
[130] Comments of Director of Maintenance.
[131] Comments of G. Berens; Comments of Director of Maintenance.
[132] Comments of Director of Maintenance and Maintenance Worker.

5. A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.[133] A facility is not in substantial compliance if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.[134]

6. Because SBSC has not shown that it was in substantial compliance with the regulatory standards cited by the Department, it is subject to remedial action by the Department, consistent with the CMS Remedy Matrix.

7. The Department's determination of the scope and severity of the above deficiencies was appropriate.

8. The Statement of Deficiencies should be revised as follows: (1) the citation to 42 C.F.R. §483.25(n) should be deleted from the description of the basis for Tag F323 since it is not relevant to the facts involved in this case; and (2) the date on which the Immediate Jeopardy under Tag F323 began should be changed to March 9, 2017, since the February 7, 2017, date is not supported by the evidence.

9. The attached Memorandum further explains the reasons for the Administrative Law Judge's recommendations and is incorporated in these Conclusions of Law.

Based upon the Findings of Fact and Conclusions of Law, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The citations issued by the Department with respect to Tags F323 and F456 are supported by the facts and should be **AFFIRMED** as to scope and severity. The Statement of Deficiencies should be **REVISED** as set forth in Conclusion 8.

Dated: September 18, 2017

Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

Reported: Digitally Recorded; No Transcript Prepared

[133] 42 C.F.R. § 488.400.
[134] 42 C.F.R. § 488.301.

NOTICE

In accordance with Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within ten calendar days of receipt of this recommended decision.

MEMORANDUM

In this proceeding, the Facility has appealed the MDH's deficiency findings under Tags F323 and 456. These deficiencies stemmed from the surveyors' review of a March 9, 2017, incident in which a resident's bath chair tipped backwards as a Nursing Assistant attempted to remove him from a bath tub.

First, the Department alleges that the Facility violated F323 by failing to ensure that the resident environment remained as free from accident hazards as is possible and that each resident received adequate supervision and assistance devices to prevent accidents. In particular, the Department asserts that the Facility failed to implement a preventative maintenance program for the bathing tubs and chairs according to manufacturer's recommendations; failed to comprehensively investigate R7's fall from the bath chair; and failed to put into place preventative measures such as nursing assistant re-education following the fall. The Department contends that this practice resulted in a risk for serious harm, injury, or death to 104 out of 155 residents who received baths in the Facility. The MDH cited this deficiency at a scope and severity level of K (immediate jeopardy to resident health or safety which is a pattern). The Department contends that the immediate jeopardy began on February 7, 2017, when the Facility's Maintenance Department was notified in writing that the chair and tub rails in the bathroom on Second Floor North were not aligned correctly, and the Facility did not implement preventative maintenance for the bathing tubs and chairs. The immediate jeopardy was removed on March 31, 2017, but the MDH asserts that noncompliance remained at the lower scope and severity level of E (still a pattern, but no actual harm with potential for more than minimal harm that is not immediate jeopardy).

Second, the Department asserts that the Facility violated F456 by failing to maintain all mechanical, electrical, and patient care equipment in safe operating equipment. The Department bases this allegation on the Facility's failure to implement a preventative maintenance program for the bathtubs and tub chairs according to the manufacturer's recommendation.

In its Initial Memorandum and during the IIDR proceeding, SBSC contends that it was in substantial compliance with the requirements of the federal regulations relating to both of the alleged deficiencies and that the deficiencies should be removed or, in the alternative, reduced to a scope and severity level of D because there is no pattern of non-compliance. The Facility argues that its investigation of R7's incident was thorough

and complied with relevant fall prevention and incident reporting policies. SBSC asserts that it properly determined within a short period of time that NA-H had followed her training and R7's plan of care at the time of the fall and ascertained that the fall was the result of a mechanical failure that caused the bath chair to separate from its base. The Facility argues that its maintenance department found in its post-accident inspection of the tub system that the primary locking mechanism on the bath chair worked properly when it conducted testing without a load, and believed that repairing the bent metal brackets on the secondary locking system was a sufficient way to correct the mechanical problem. The Facility acknowledges that, with the assistance of the manufacturer's representative, it was ultimately determined that the incident involving R7 was caused by a malfunctioning primary locking mechanism, but contends that this would not have been apparent upon inspection by its maintenance employees because those inspections would have been conducted without a load (i.e., without a person in the bath chair). In the Facility's view, it took reasonable steps to prevent an isolated, unforeseeable, and unavoidable accident caused by the failure of the Apollo primary locking mechanism, took proper steps to investigate the March 9, 2017, incident, and continues to properly maintain its equipment and ensure a safe environment for residents.

The Facility also contends that it did, in fact, have a system in place to ensure that its environment, including the tub systems, remained as free from accident hazards as possible. It asserts that this system was composed of annual and ongoing training and education of nursing staff (including training of NAs upon hire, annually, and on an as-needed basis regarding operation of the tub systems); awareness and observation by staff of equipment and assistive devices that might need repairs; and completion of work orders and "continuous observation of all essential equipment" by maintenance staff. It also points out that the Facility's Safety and Health Committee was available to review issues and concerns that affected resident safety throughout the facility. SBSC further argues that it had an unwritten preventative maintenance program in place for the bathing systems prior to R7's fal, since its maintenance employees routinely observed components of the system when they responded to various work orders involving the tubs.

After careful consideration of the parties' arguments and the record in this matter, the Administrative Law Judge concludes that the Department has presented a sufficient factual basis to support each of the cited deficiencies and recommends that the Commissioner affirm each as to scope and severity. As a threshold matter, however, the Administrative Law Judge disagrees with the Department's determination that the Immediate Jeopardy under F323 began on February 7, 2017. The work order request submitted by Facility staff on February 7, 2017, regarding the bathing system on Second Floor North of the Facility merely involved the rails of the tub system needing adjustment because they were off by 1/8 inch. Based upon comments of maintenance workers at the IIDR proceeding, there is some tolerance built into the rail system, and it does not appear that this minor issue with rail alignment posed a threat of injury to a resident. The maintenance employees indicated that, at most, a slight misalignment of the rails would have caused a somewhat bumpy transfer of a resident to a tub. There is no connection between the February 7, 2017, work order and the March 9, 2017,

incident and no logical reason to conclude that the February 7 need for rail adjustment put the Facility on notice of the possibility that a much more serious incident like the one that occurred on March 9 could occur. It is recommended that the Commissioner revise the Statement of Deficiencies to state that the Immediate Jeopardy began on March 9, 2017, when R7's fall occurred.

The Department has established ample grounds for a finding that a deficiency under F323 that rose to the level of Immediate Jeopardy occurred between March 9 and March 31, 2017, when the Immediate Jeopardy was removed. F323 requires that the Facility ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent avoidable accidents. The Apollo Bathing System is an assistive device used by residents. Even assuming, as the Facility argues, that the March 9 failure of the primary safety mechanism was unforeseeable and unpreventable, and would not have been detected even if the Facility had been following the manufacturer's recommended preventative maintenance schedule prior to March 9—which is something that is not possible to know at this point—it is clear that the incident on March 9 put the Facility on notice of a serious issue with the bathing system that could have grave consequences for residents. The Facility's actions after the March 9 incident occurred were at odds with its obligation to ensure that the resident environment was as free of accident hazards as possible and the bathing system was adequate to prevent accidents.

There are several reasons for this conclusion. First, it is evident that the Facility failed to conduct a comprehensive investigation of R7's fall from the bath chair. The Apollo Bathing System was designed to operate with two locking mechanisms in place when the bath chair is attached to the carrier: the primary gravity lock and the secondary U-shaped metal brackets attached to the base of the chair on the rail assembly system. If the primary locking mechanism fails or is not properly engaged, the secondary locking mechanism is in place to prevent the resident's bath chair from falling off of the carrier. When R7's bath chair separated from the carrier, it obviously involved a situation in which both locking mechanisms had failed or were not properly engaged. Thus, even if the maintenance employees found that the primary locking mechanism seemed to function properly when tested without a load after the incident, they should have known that there was some issue that caused it to fail on March 9, 2017, and they should have continued to investigate and/or sought assistance from the manufacturer or others familiar with the bathing system until they figured out the problem. By focusing only on repairing the bent portion of the secondary locking mechanism before placing the bathing system back in service, the Facility's maintenance workers overlooked or ignored the importance of having both the primary and secondary systems fully operational to protect resident safety. Moreover, by failing to continue investigating the reason why the secondary locking mechanism bent, the potential that it would bend again and another resident would fall remained. This situation clearly placed the health and safety of the 104 residents using the Apollo Bathing Systems at risk. Despite the fact that R7 incurred only minor injuries, there can be no question that a fall from a bath chair poses a high potential for serious harm, injury, impairment, or death for Facility residents.

The Facility also failed to put preventative measures such as NA re-education into place following R7's fall. While it appears that NA-H followed her training when she transferred R7 into and out of the tub, she and other NAs interviewed by nursing staff and the surveyors seemed to believe that hearing a "click" when moving a resident out of the tub onto the carrier meant that the bath chair was properly secured to the carrier. There is nothing in the Apollo manual that mentions the need to hear a clicking sound. Moreover, as the Apollo sales representative pointed out to the Facility and surveyors on March 31, 2017, a click "can be heard without the chair fully locking into place" and "listening for the click was not a substitution for a visual verification that the chair was locked into place."[135] The Facility failed to pay attention to this apparent misunderstanding by NAs and did not take steps to educate them about the need to visually confirm that the chair was locked in place rather than listen for a click. This misunderstanding, if left uncorrected, increases the potential that another resident will be seriously harmed when a bath chair is not secured to the carrier.

Finally, the Facility failed to implement a preventative maintenance program for the bathing tubs and chairs according to manufacturer's recommendations after R7's fall, in violation of both F323 and F456. The Apollo Bathing Systems are important pieces of patient care equipment, and it is reasonable to expect that a facility will comply with the manufacturer's recommended preventative maintenance when using such equipment. Moreover, the Facility was on notice after the March 9, 2017, incident that a fall with the potential for significant injury or death could occur without staff noticing any maintenance issue in advance. The Director of Maintenance and a long-time employee of the Maintenance Department asserted during the IIDR meeting that they, in essence, performed preventative maintenance on the tub systems every time that they responded to work orders involving the scale on the carrier or other issues. They pointed out that the bath chair has to be maneuvered in some way or docked or undocked from the tub to accomplish many of these repairs, and contended that, in the process of fixing whatever issue had been reported, they would also notice any issues with the primary and secondary locks, rollers, castors and other components of the bathing systems. The Administrative Law Judge is not persuaded that this constitutes the type of focused and thorough maintenance recommended by the manufacturer, or that it would meet the specific timelines recommended in the manufacturer's preventative maintenance schedule. As the Apollo representative interviewed by surveyors noted, "routine maintenance [is] essential to prevent part failure, and a facility not performing maintenance per manufacturer's recommendation [is] 'running a high risk' of a resident falling and possibly sustaining 'serious injury.'"[136] The representative also indicated that "the U-shaped metal brackets on the rail system would not bend on their own" and, "[i]f the secondary system had been maintained properly, it should have prevented a resident from falling."[137]

Under all of the circumstances, the Administrative Law Judge finds that there is a sufficient basis for the cited deficiencies under F323 and F456 at the recommended

[135] Ex. E at 36-37.
[136] Ex. E at 34-35.
[137] *Id*. at 35.

scope and severity levels. The Facility challenges the Department's determination that the scope of the deficiencies should be considered a "pattern." Under the SOM and federal regulations, scope is considered to be a pattern "when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice" and "[t]he effect of the deficient practice is not found to be pervasive throughout the facility."[138] Since 104 residents of the Facility use the Apollo Bathing Systems involved in this case, the Department properly concluded that the scope rises to the level of a "pattern."

It is very unfortunate that Apollo did not inform the Facility of any potential issues with the design of the components of the bathing systems and, in particular, the availability of more reliable primary locking mechanisms. It does appear that the Facility could have obtained that information more quickly if it had spoken with Apollo representatives when the March 9, 2017, incident first occurred. The Facility is commended for taking proactive steps to replace all of the gravity locks in the Facility with spring-loaded locks and for working effectively with the Department to remove the Immediate Jeopardy in such a prompt manner.

B. L. N.

[138] Ex. D (SOM Appendix P); 42 C.F.R. 488.404(b)(2).

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NTOJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00774

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245350**

2.STATE VENDOR OR MEDICAID NO.
(L2) **885740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **1810 MINNESOTA BOULEVARD SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/26/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **198** (L18)

13.Total Certified Beds **198** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	196			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II — 05/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/17/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/15/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/26/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245350
July 17, 2017

Ms. Susan Kratzke, Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

Dear Ms. Kratzke:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 10, 2017 the above facility is certified for or recommended for:

198 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 198 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 18, 2017

Ms. Susan Kratzke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: Project Number S5350027

Dear Ms. Kratzke:

On April 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 19, 2017. (42 CFR 488.422)

Additionally on April 14, 2017, we informed the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies were recommended for imposition:

- Civil Money Penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard an extended survey completed on March 31, 2017. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On May 26, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 15, 2017, the MN Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 31, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on March 31, 2017, as of May 10, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 10, 2017.

However, as we notified you in our letter of April 14, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 30, 2017.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	R-C 05/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An on-site post certification revisit (PCR) was completed on 5/26/17, and the facility was found to have corrected all deficiencies issued as a result of the survey exited on 3/31/17. The facility has again achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		
{F 465} SS=B	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by:	{F 465}		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NTOJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00774

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245350**

2.STATE VENDOR OR MEDICAID NO.
(L2) **885740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **1810 MINNESOTA BOULEVARD SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/31/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **198** (L18)

13.Total Certified Beds **198** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	196			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susan Miller, HFE NE II — 05/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/22/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/15/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
April 14, 2017

Ms. Christine Bakke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: Project Number S5350027, H5350058 & H5350060

Dear Ms. Bakke:

On March 31, 2017, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the March 31, 2017 extended survey the Minnesota Department of Health completed an investigation of complaint numbers H5350058 & H5350060 that were found to be unsubstantiated.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 31, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 19, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Benedicts Senior Community is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 31, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 1, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on March 27, 2017 through March 31, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F323 when the facility failed to provide a preventative maintenance program for the bathing tubs and chairs according to manufacturer's recommendations; failed to comprehensively investigate a fall from a bath chair for 1 residents; and put into place preventative measures following the fall. This practice resulted in a risk for serious harm, injury or death to 104 out of 155 residents who received baths in the facility. The IJ began March 30, 2017, at 5:42 p.m. and was removed on March 31, 2017, at 3:38 p.m. In addition, two complaint investigations were completed for H5350060 and H5350058, which were not substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 3/30/2017, and 3/31/2017.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

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F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		5/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 2 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an adverse event to the administrator and State Agency (SA), and thoroughly investigate the adverse event for 1 of 3 residents (R7) reviewed for accidents. In addition, the facility failed to thoroughly investigate a report of allegation of abuse to the SA for 1 of 3 residents (R221) who reported alleged abuse. Findings include: R7's annual Minimum Data Set (MDS) dated 1/24/17, indicated R7 had short term memory	F 225	F225—INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS -Corrective action for those residents found to have been affected by the deficient practice: The bathing system representative inspected and replaced the safety latch mechanism on the bathing system that was involved in the incident with R7 on 3/31/17. R7 continues to use the tub without fear. Resident and staff interviews were conducted on April 21, 2017 on the floor where R221 resides to complete the investigation. No additional concerns were identified from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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F 225	Continued From page 3 impairment, but intact long term memory. The MDS indicated R7 had no behaviors, and required assistance with bathing. The MDS identified diagnoses of dementia and Parkinson's disease. R7's care plan dated 1/17/17, indicated R7 had a self-care deficit related to Parkinson's disease with fluctuations in participation ability, resting tremors, and decreased hearing. The care plan indicated R7 needed an assist of one staff to bathe, and assistance of two staff and a standing lift to transfer. R7's progress notes indicated the following: - On 3/9/17, at 7:55 a.m. R7 had a fall at 6:15 a.m. in the tub room. "Resident received tub bath. When RCA [facility nursing assistant] was using tub chair to remove resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair separated from the base. Injuries: skin tear to right hip and right shoulder measures 0.2 x 0.2 cm [centimeters]. Intervention/care provided: assessed for injuries, vitals BP [blood pressure] 140/80, RR [respiration rate] 20, sats [oxygen saturation percent] 92% on RA [room air], T [temperature] 95.5, HR [heart rate] 79. Use of FML [full mechanical lift] to w/c [wheelchair]." - On 3/9/17, at 9:25 a.m. "Resident experienced a fall out of tub chair d/t [do to] mechanical failure. This incident is not suspicious in nature. Resident's POC [plan of care] was being followed at time of fall. Resident was lowered to the ground by staff and did not experience any significant injury or head strike. Resident does not have any c/o [complaints of] pain. Staff	F 225	interviews. -Identification of other residents having the potential to be affected by the deficient practice: All facility residents who experience an incident or reportable occurrence under State and Federal Vulnerable Adult reporting guidelines have the potential to be affected by the alleged deficient practice. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: The facility policy "Vulnerable Adult Immediate Reporting to the Administrator" was modified to require the delegated administrative chain-of-command employee to notify the facility Administrator of Record by telephone or email of any reportable event received by them. The facility policy "Incident Reports" policy was modified to include initiation of an investigation including root cause analysis, staff interviews, and non-incident involved resident interviews to determine if similar situations have occurred previously. Employees with administrative responsibilities were trained on the revised policy and procedure. -Facility monitoring of performance to make sure that solutions are maintained: Administrator, DON, or designee will review all Vulnerable Adult Occurrence Reports to ensure that the Administrator was notified per facility policy. The Administrator, DON, or designee will review all incidents reports to ensure an investigation is initiated per policy, a thorough investigation done, and an incident summary completed. Results of	

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	245350	A. BUILDING _____ B. WING _____	C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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F 225	Continued From page 4 immediately deemed tub room out of use and maintenance contacted. After review, this incident is not deemed a VA [vulnerable adult] reportable event." R7's Fall Report dated 3/9/17, revised on 3/17/17, indicated, "Resident was given a bath. When he was taken out of the tub chair an unknown issue occurred with equipment and the tub chair tilted backwards off the track and the resident fell backwards to floor - staff member was with resident and lowered to ground as best possible and no head strike occurred. MD [medical doctor] updated via fax." Injuries noted were abrasion to right scapula (shoulder blade) and right trochanter (hip) and resident was alert. No predisposing environmental, physiological or situation factors indicated. The report indicated, "Tub chair possible mechanical issue." An interview dated 3/9/17, with the nursing assistant (NA)-H included on the fall report indicated, "I gave resident a bath. When taking him out of the tub I pulled the chair forward on the track and heard the click. I stepped on the pedal to release the track from the tub and the chair tipped backwards and fell off the track. I lowered him to the ground the best I could and he did not hit his head." A note on the Fall Report dated 3/10/17, from RN-C indicated "Resident received tub bath. When RCA was using tub chair to remove resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair separated from the base." On 3/30/17, at 9:20 a.m. registered nurse (RN)-C was interviewed and stated on the morning of 3/9/17, following R7's fall from the tub chair, she was notified via telephone by RN-E about the incident. RN-C stated RN-E followed up with	F 225	these two reviews will be presented to the facility Quality Assurance Committee for a period of six months to determine if compliance has been attained. -Date completed: May 10, 2017	

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F 225	Continued From page 5	F 225		

maintenance, and it sounded like there was something bent on the secondary safety that caused the chair to tip backwards. RN-C further stated that RN-E reported to her NA-H had re-enacted her steps, regarding the fall with R7, and demonstrated them to RN-E. RN-C stated she believed NA-H did everything right, and there was no indication of possible human error. RN-C stated the assistant director of nursing (ADON) was also notified of the incident.

On 3/30/17, at 1:33 p.m. the ADON was interviewed and stated the incident was reported to her when it occurred. The ADON stated she thought it was a mechanical error as soon as she entered the tub room. Maintenance was called, and a sign was placed for the staff not to use the tub. The ADON stated she did not think human error was involved by the look of the chair, and NA-H's explanation of what happened. The ADON stated no further investigation was completed to determine if the fall was a result of human error or if the primary locking system failed. The ADON stated there should have been further investigation into the cause of the fall. The ADON further stated she thought mechanical issues were the reason for the fall. The ADON stated the incident was not reported to the administrator, or the State Agency (SA) as a possible VA incident, as the fall was witnessed by staff. The ADON stated there was no conversation with the DM after his review of the chair see why the primary lock did not keep the chair in place over the base. The ADON stated she was not sure what was reviewed in the IDT review, and she was unaware if all possible sceneries had been covered to implement interventions to prevent another incident. The ADON stated she was not aware of any other

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F 225	Continued From page 6	F 225		

incidents regarding falls from the tub chairs. The ADON stated that she had no further information regarding the incident. The ADON stated in hind sight a more complete investigation should have been completed, and the incident should have been reported immediately to the administrator and the SA. The ADON also stated following the incident, no education had been given to the nursing assistants, and no preventative maintenance program on the tubs and tub chairs had been implemented. The ADON stated nursing assistants were trained on the tub function upon hire, but were not trained on the various tub systems in the facility. The DON further stated the third floor tub was not being used, as it leaked.

R221's Admission Record identified diagnoses that included dementia and peripheral vascular disease.
R221's significant change MDS dated 2/14/17, indicated R221 had moderate cognitive impairment and needed extensive assistance of staff for activities of daily living (ADLs).
R221's progress note dated 2/9/17, at 6:22 p.m. indicated R221 reported to nurse on duty an incident of alleged abuse. After thorough investigation, this was deemed to be a VA reportable event. A VA report was submitted on 2/9/17, to SA.
R221's initial report submitted to the SA dated 2/9/17, indicated, "Resident stated that alleged perpetrator was 'rough with me when putting me in the bath. I also told him that the water was too hot and he told me it was not. The water was halfway up to my shin. I then told him it was too hot me and he then took the shower handle and turned cold water on my head and back.' "
R221's investigative report submitted to the State

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F 225	Continued From page 7 Agency dated 2/13/17, indicated that R221's skin had been checked after his bath and there were no red marks, bruises, skin tears, or abrasions present. The report indicated R221 had a diagnosis of dementia with cognitive impairment. The alleged perpetrator (AP) was placed on administrative leave pending the investigation. The AP was interviewed and stated that he had given R221 a bath many times before without any comfort problems arising. The AP stated that he received assistance from another nursing assistant to get R221 into the tub. The AP stated that when the water was up to R221's shin level R221 reported it was warm. AP then noted that the tub water temperature was in the safe range of 95- 105 degrees. The AP stated he turned down the temperature of the water and had R221 test the water while the AP was washing R221 with soap and water using the spray attachment. AP stated that R221 then reported the water was too cold. The AP stated that he adjusted to water to a warmer temperature and continued the bath. The report continued that two other nursing assistants came into the tub room to relieve the AP for his break and they tested the water on R221's arm and R221 had stated it was. The facility concluded it was likely the adjusting of the water temperatures to meet R221's water preferences could have caused R221 the sensation of the water being too hot and/ or too cold during the adjustments. After thorough review, based on resident and staff interviews, the facility concluded there was no indication of abuse. R221's care plan was reviewed and remained current. The investigation did not address the concerns of rough handling. The investigation did not include interviews from other residents for potential concerns of rough handling or temperature concerns in the tub. The	F 225		

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investigation did not include other staff interviews regarding reports from other residents of rough handling or problems with the water temperature in the tub.

On 3/31/17, at 11:48 a.m. the ADON verified there was no further investigation.

On 3/31/17, at 1:55 p.m. the interim administrator stated the investigation did not include other resident or staff interviews, and should have.

The facility Vulnerable Adults - Abuse and/ or Neglect Reporting and Protection Plan policy dated 10/16, directed "It was the responsibility of the CentraCare Health - St Benedict's Senior Community to report ...an adverse event...immediately as mandated by law." The policy defined an adverse event as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. The policy further directed all employees, contracted employees, students and volunteers are to report actual and or suspected situations of maltreatment immediately to their supervisor or the person in charge. In the absence of the facility administrator of record the delegated administrative 'chain of command' is as follows: Director of Nursing, Assistant Director of Nursing, House Charge Nurse, Registered Nurse 'On-Call'. The policy also directed staff to complete an internal investigation: Interview the resident/residents involved, staff involved, staff witnesses available. Review the residents medical record, all circumstances surrounding the incident, and incident reports related to the vulnerable adult incident being investigated. The policy did not direct specifically direct staff to interview other residents for possible

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F 225	Continued From page 9 mistreatment or interview other staff about possible reports by staff and residents about possible mistreatment.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.	F 226		5/10/17

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F 226	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their facility policy to report to the administrator and state agency and comprehensively investigate an adverse event for 1 of 3 residents (R7). In addition the facility failed to thoroughly investigate a report to the state agency for 1 of 3 residents (R221) who reported alleged abuse. Findings include: The facility Vulnerable Adults - Abuse and/ or Neglect Reporting and Protection Plan policy dated 10/16, directed "It was the responsibility of the CentraCare Health - St Benedict's Senior Community to report ...an adverse event...immediately as mandated by law." The policy defined an adverse event as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. The policy further directed all employees, contracted employees, students and volunteers are to report actual and or suspected situations of maltreatment immediately to their supervisor or the person in charge. In the absence of the facility administrator of record the delegated administrative 'chain of command' is as follows: Director of Nursing, Assistant Director of Nursing, House Charge Nurse, Registered Nurse 'On-Call'. The policy also directed staff to complete an internal investigation: Interview the resident/residents involved, staff involved, staff witnesses available. Review the residents medical record, all circumstances surrounding the incident, and incident reports related to the vulnerable adult incident being investigated. The policy did not direct specifically direct staff to	F 226	F226—DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES -Corrective action for those residents found to have been affected by the deficient practice: The bathing system representative inspected and replaced the safety latch mechanism on the bathing system that was involved in the incident with R7 on 3/31/17. R7 continues to use the tub without fear. Resident interviews were conducted on April 21, 2017 on the floor where R221 resides to complete the investigation. No additional concerns were identified from the interviews. -Identification of other residents having the potential to be affected by the deficient practice: All facility residents who experience an adverse event or reportable occurrence under State and Federal Vulnerable Adult reporting guidelines have the potential to be affected by the alleged deficient practice. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: The facility policy “Vulnerable Adult Immediate Reporting to the Administrator” was modified to require the delegated administrative chain-of-command employee to notify the facility Administrator of Record by telephone or email of any reportable event received by them. The facility policy “Incident Reports” policy was modified to include initiation of an investigation including root cause analysis, staff interviews, and non-incident involved resident interviews to determine if similar	

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F 226	Continued From page 11 interview other residents for possible mistreatment or interview other staff about possible reports by staff and residents about possible mistreatment. R7's annual Minimum Data Set (MDS) dated 1/24/17, indicated R7 had short term memory impairment, but intact long term memory. The MDS indicated R7 had no behaviors, and required assistance with bathing. The MDS identified diagnoses of dementia and Parkinson's disease. R7's care plan dated 1/17/17, indicated R7 had a self-care deficit related to Parkinson's disease with fluctuations in participation ability, resting tremors, and decreased hearing. The care plan indicated R7 needed an assist of one staff to bathe, and assistance of two staff and a standing lift to transfer. R7's progress notes indicated the following: - On 3/9/17, at 7:55 a.m. R7 had a fall at 6:15 a.m. in the tub room. "Resident received tub bath. When RCA [facility nursing assistant] was using tub chair to remove resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair separated from the base. Injuries: skin tear to right hip and right shoulder measures 0.2 x 0.2 cm [centimeters]. Intervention/care provided: assessed for injuries, vitals BP [blood pressure] 140/80, RR [respiration rate] 20, sats [oxygen saturation percent] 92% on RA [room air], T [temperature] 95.5, HR [heart rate] 79. Use of FML [full mechanical lift] to w/c [wheelchair]." - On 3/9/17, at 9:25 a.m. "Resident experienced a	F 226	situations have occurred previously. Employees with administrative responsibilities were trained on the revised policy and procedure. -Facility monitoring of performance to make sure that solutions are maintained: Administrator, DON, or designee will review all Vulnerable Adult Occurrence Reports to ensure that the Administrator was notified per facility policy. The Administrator, DON, or designee will review all incidents reports to ensure an investigation is initiated per policy, a thorough investigation done, and an incident summary completed. Results of these two reviews will be presented to the facility Quality Assurance Committee for a period of six months to determine if compliance has been attained. -Date completed: May 10, 2017	

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F 226	Continued From page 12 fall out of tub chair d/t [do to] mechanical failure. This incident is not suspicious in nature. Resident's POC [plan of care] was being followed at time of fall. Resident was lowered to the ground by staff and did not experience any significant injury or head strike. Resident does not have any c/o [complaints of] pain. Staff immediately deemed tub room out of use and maintenance contacted. After review, this incident is not deemed a VA [vulnerable adult] reportable event." R7's fall report dated 3/9/17, revised on 3/17/17, indicated "Resident was given a bath. When he was taken out of the tub chair an unknown issue occurred with equipment and the tub chair tilted backwards off the track and the resident fell backwards to floor - staff member was with resident and lowered to ground as best possible and no head strike occurred. MD [medical doctor] updated via fax." Injuries noted were abrasion to right scapula (shoulder blade) and right trochanter (hip) and resident was alert. No predisposing environmental, physiological or situation factors indicated. The report indicated a "Tub chair possible mechanical issue." An interview dated 3/9/17, with the nursing assistant (NA)-H included on the fall report indicated, "I gave resident a bath. When taking him out of the tub I pulled the chair forward on the track and heard the click. I stepped on the pedal to release the track from the tub and the chair tipped backwards and fell off the track. I lowered him to the ground the best I could and he did not hit his head." A note on the fall report dated 3/10/17, from RN-C indicated "Resident received tub bath. When RCA was using tub chair to remove resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair	F 226		

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F 226	Continued From page 13 separated from the base." On 3/30/17, at 9:20 a.m. RN-C was interviewed and stated on the morning of 3/9/17, following R7's fall from the tub chair, she was notified via telephone by RN-E about the incident. RN-C stated RN-E followed up with maintenance, and it sounded like there was something bent on the secondary safety that caused the chair to tip backwards. RN-C further stated that RN-E reported to her NA-H had re-enacted her steps, regarding the fall with R7, and demonstrated them to RN-E. RN-C stated she believed NA-H did everything right, and there was no indication of possible human error. RN-C stated the ADON was also notified of the incident. On 3/30/17, at 1:33 p.m. the ADON was interviewed and stated the incident was reported to her when it occurred. The ADON stated she thought it was a mechanical error as soon as she entered the tub room. Maintenance was called, and a sign was placed for the staff not to use the tub. The ADON stated she didn't think human error involved by the look of the chair, and NA-H's explanation of what happened. The ADON stated no further investigation was completed to determine if the fall was a result of human error or if the primary locking system failed. The ADON stated there should have been further investigation into the cause of the fall. The ADON further stated she thought mechanical issues were the reason for the fall. The ADON stated the incident was not reported to the administrator, or the State Agency (SA) as a possible VA incident, as the fall was witnessed by staff. The ADON stated there was no conversation with the DM after his review of the chair see why the primary lock did not keep the chair in place over the base.	F 226		

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The ADON stated she was not sure what was reviewed in the IDT review, and she was unaware if all possible sceneries had been covered to implement interventions to prevent another incident. The ADON stated she was not aware of any other incidents regarding falls from the tub chairs. The ADON stated that she had no further information regarding the incident. The ADON stated in hind sight a more complete investigation should have been completed, and the incident should have been reported immediately to the administrator and the SA. The ADON also stated following the incident, no education had been given to the nursing assistants, and no preventative maintenance program on the tubs and tub chairs had been implemented. The ADON stated nursing assistants were trained on the tub function upon hire, but were not trained on the various tub systems in the facility. The DON further stated the third floor tub was not being used, as it leaked.

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R221's significant change MDS dated 2/14/17, indicated R221 had moderate cognitive impairment and needed extensive assistance of staff for activities of daily living (ADLs).

R221's progress note dated 2/9/17, at 6:22 p.m. indicated R221 reported to nurse on duty an incident of alleged abuse. After thorough investigation, this was deemed to be a VA reportable event. VA report submitted to SA.

R221's initial report submitted to the state agency dated 2/9/17, indicated "Resident stated that

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alleged perpetrator was 'rough with me when putting me in the bath. I also told him that the water was too hot and he told me it was not. The water was halfway up to my shin. I then told him it was too hot me and he then took the shower handle and turned cold water on my head and back.' "

R221's investigative report submitted to the state agency dated 2/13/17, indicated that R221's skin had been checked after his bath and there were no red marks, bruises, skin tears, or abrasions present. The report indicated R221 had a diagnosis of dementia with cognitive impairment. The alleged perpetrator (AP) was placed on administrative leave pending the investigation. The AP was interviewed and stated that he had given R221 a bath many times before without any comfort problems arising. The AP stated that he received assistance from another nursing assistant to get R221 into the tub. The AP stated that when the water was up to R221's shin level R221 reported it was warm. AP then noted that the tub water temperature was in the safe range of 95- 105 degrees. The AP stated he turned down the temperature of the water and had R221 test the water while the AP was washing R221 with soap and water using the spray attachment. AP stated that R221 then reported the water was too cold. The AP stated that he adjusted to water to a warmer temperature and continued the bath. The report continued that two other nursing assistants came into the tub room to relieve the AP for his break and they tested the water on R221's arm and R221 had stated it was. The facility concluded it was likely the adjusting of the water temperatures to meet R221's water preferences could have caused R221 the sensation of the water being too hot and/ or too

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F 226	Continued From page 16 cold during the adjustments. After thorough review, based on resident and staff interviews, the facility concluded there was no indication of abuse. R221's care plan was reviewed and remained current. The investigation did not address the concerns of rough handling. The investigation did not include interviews from other residents for potential concerns of rough handling or temperature concerns in the tub. The investigation did not include other staff interviews regarding reports from other residents of rough handling or problems with the water temperature in the tub. On 3/31/17, at 11:48 a.m. the ADON verified there was no further investigation. On 3/31/17, at 1:55 p.m. the interim administrator stated the investigation did not include other resident or staff interviews, and should have.	F 226		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 242		5/10/17

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F 242	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate bathing frequency for 2 of 3 residents (R166, R206) reviewed for choices. Findings include: R166's Admission Record identified R166 had diagnoses that included Alzheimer's disease, and essential tremor. R166's significant change Minimum Data Set (MDS) dated 2/6/17, identified R166 was cognitively intact, and required assistance of one staff for bathing. The MDS further identified R166 had no behaviors. On 3/27/17, at 10:11 a.m. R166 was interviewed. R166 stated she could not seem to, "Get into any kind of routine" for a bath or shower. R166 stated she never knew when her shower was going to be. "Sometimes staff say Saturday night, sometimes they say Sunday." R166 further stated, "Staff skip me so many times." R166 stated when she was unable to shower she was washing in this teeny, tiny bowl and was washing like she was a little girl when she did not have running water. On 3/28/17, at 8:52 a.m. R166 stated she "showers every week, if I can." R166 stated when a shower was unavailable, she completed a sponge bath independently. On 3/30/17, at 1:30 p.m. nursing assistant (NA)-M was interviewed and stated when a resident refused to shower, staff would re-approach at a later time. NA-M stated most residents received only one bath or shower	F 242	F242—SELF-DETERMINATION-RIGHT TO MAKE CHOICES -Corrective action for those residents found to have been affected by the deficient practice: R166 bathing frequency preference was reviewed with the resident. The resident preference listing, Kardex, and care plan were updated to reflect the current bathing frequency preference. R206 bathing frequency preference was reviewed with resident/resident representative. The resident preference listing, Kardex, and care plan were updated to reflect the current bathing frequency preference. -Identification of other residents having the potential to be affected by the deficient practice: Resident preferences for bathing frequency were audited for all facility residents. Preference listings, Kardex, and care plans were updated to reflect any changes. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: The resident preference listing was revised to include bathing frequency. The facility policy Resident Free Choice/Right to Refuse Care was modified to include reporting a refusal or schedule change to a staff nurse for the purposes of resident follow-up and documentation. Nursing staff were educated on the Resident Free Choice/Right to Refuse Care revised policy. -Facility monitoring of performance to make sure that solutions are maintained:	

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F 242	Continued From page 18 weekly, so when they did not take their bath or shower on their bath day, it was offered again the next day. On 3/30/17, at 1:43 p.m. NA-B stated residents have the right to refuse their bath or shower. NA-B stated when residents continued to refuse their bath or shower, the nurse was informed and would documented the information. NA-B stated when a resident refused a bath or shower, the nurse rescheduled either the next day, or at an alternate time. On 3/30/17, at 2:44 p.m. NA-A stated when a resident refused their bath or shower, staff will fit it in the next day if they can. NA-A stated if they were unable to fit it into the schedule on the following day, they would wait until the next scheduled bath or shower day the following week. On 3/31/17, at 9:18 a.m. R166 was interviewed again and stated she would like to have a shower at least once a week, stating she had been "skipped" a lot of times. R166 if she declined a shower on her scheduled day, she was not offered a shower the following day, rather she had to wait until the next Saturday to get a shower. On 3/31/17, at 9:59 a.m. registered nurse (RN)-A stated last November R166 was consulted regarding her bathing preferences. At that time R166 requested a bath on Saturday evening. RN-A stated when a bath is refused, the resident is given options of a bath at that time, or later on. RN-A stated the nurse would document this information as to reason for refusal and the plan to complete the bath if appropriate.	F 242	DON, ADON, or designee will audit ten resident charts, monthly, for a period of six months to ensure that resident bathing preferences are being honored and that Kardex and care plans are current. Results of the audit will be presented to the facility Quality Assurance Committee to verify that compliance has been attained. -Date completed: May 10, 2017	

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F 242	Continued From page 19 The 4th Floor Bath Schedule AM and 4th Floor Bath Schedule PM (undated) identified that R166 was scheduled for a shower on Saturday evening shift. The notes section of the schedule identified R166 received two showers per week, however, upon review of the document, a second shower time was not identified. Record review indicated R166 was noted to have refused her shower on the resident care assistant's documentation sheets as denoted by "Resident Refused" on the following dates: 3/25/17, 3/11/17, 3/4/17, 2/11/17, 2/4/17, 1/21/17, 12/24/17, 12/17/16, 12/10/16, 11/26/16, 11/5/16, 10/22/16, and 10/8/16. R116 received a shower on 13 occasions out of 26 opportunities for showers to be completed. On 1/21/17, R116's progress notes indicated she refused shower, and when re-approached, stated she was, "Too tired." No subsequent documentation provided regarding follow up after the initial date. On 3/4/17, the progress notes indicated R116 refused her evening shower as was not feeling well. No subsequent follow through was documented. R206's admission MDS dated 1/12/17, identified R206 had severe cognitive impairment, had a diagnosis of dementia, and needed one person physical assist with bathing. R206's care plan dated 1/5/17, indicated R206	F 242		

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required assist of one staff with bathing.

R206's Care Area Assessment (CAA) dated 1/13/17, indicated R206 had impaired decision, processing, judgement and comprehension skills related to her health and safety. The CAA further indicated R206's family was involved and supportive, and made all of her major choices.

R206's Interview for Daily Preferences and Activity completed 1/11/17, posed the question, "How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?" R206 answered the question by stating she did not care about the method "as long as she gets clean." The document indicated the interview was completed with R206, no family were involved. The interview lacked any questions regarding the frequency of bathing.

On 3/27/17, at 3:14 p.m. family member (FM)-A was interviewed. FM-A stated R206 received one bath per week, but wished it was more than once per week. FM-A stated R206 had previously bathed almost every day. FM-A stated she would not expect that now, however, thought twice a week would be nice. FM-A stated she had not been asked about R206's bathing choices on admission.

On 3/29/17, at 10:57 a.m. NA-D was interviewed and stated there was a bath schedule for the residents, and all the nursing assistants gave baths on the unit. NA-D further stated R206 did not refuse baths/showers. NA-D stated if a resident requested another bath, they would try and fit it in. NA-D stated it would be difficult to give another bath.

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F 242	Continued From page 21 On 3/29/17, at 11:36 a.m. RN-B stated she looked over the bath schedule, however, therapeutic recreation asked the resident preferences questions regarding bathing. RN-B stated concerns regarding bathing could be brought up by family in care conferences, further stating R206 had only had one care conference and family had not brought up any bathing concerns. RN-B further reported she also asked about preferences with bathing, however, no documentation was found. On 3/30/17, at 9:08 a.m. the therapeutic recreation coordinator (TRC) stated she completed the Interview for Daily Preferences and Activities. TRC verified the frequency of bathing was not specifically asked. TRC stated if a resident or family member specifically asked about frequency of bathing, she would alert nursing staff to the resident or family's preference. TRC further stated she attempted to complete the preferences interview with the resident, and would involve the family if the interview could not be completed by the resident. TRC stated R206 had been able to answer the questions, and the family had not been involved in the interview. R206's initial Multidisciplinary Care Conference dated 1/24/17, at 1:00 p.m. identified a family member was present but did not list whom attended. The care conference identified R206 needed extensive assistance with personal hygiene and the activities R206 attended, however, there was no documentation to suggest any bathing related choices were discussed. The facility policy Resident Free Choice/Right to Refuse Care, dated 10/10, directed:	F 242		

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F 242	Continued From page 22 1. A resident's choice to refuse treatment, medication, or dietary restrictions will be reviewed with the resident based on an understanding of current information about their diagnosis, treatment, alternatives, risk and prognosis. This information will be communicated to the resident and/or responsible party in a manner appropriate to the intellectual capabilities, language, and emotional condition of the resident. The resident and/or responsible party has the opportunity to ask questions, request additional information, or consult with others as desired. 2. The resident's medical record will document that the risks associated with the resident's refusal have been explained.	F 242		
F 323 SS=K	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		5/10/17

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F 323	Continued From page 23 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a preventative maintenance program for the bathing tubs and chairs according to manufacturer's recommendations; failed to comprehensively investigate a fall from a bath chair for 1 of 1 residents (R7); and failed to put into place preventative measures following the fall. This practice resulted in a risk for serious harm, injury or death to 104 out of 155 residents who received baths in the facility. Findings include: The immediate jeopardy began on 2/7/17, when the maintenance department was notified, in writing, that the bathroom tub rails on second floor north were not aligned correctly, and the facility did not implement preventative maintenance to the bathing tubs and chairs according to manufacturer's recommendations. R7 sustained a fall while in the tub chair on 3/9/17. Following the incident, the facility failed to comprehensively assess the fall, failed to implement interventions to include nursing assistant re-education, and failed to implement a preventative maintenance program for the tubs per manufacturer's recommendations. The administrator, via telephone, the assistant director of nursing (ADON) and unit manager registered nurse (RN)-C, were notified of the immediate jeopardy at 5:42 p.m. on 3/30/17. The immediate	F 323	F323—FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES -Corrective action for those residents found to have been affected by the deficient practice: The bathing system representative inspected and replaced the defective safety latch mechanism on the bathing system that was involved in the incident with R7 on 3/31/17. R7 continues to use the tub without fear. The maintenance program for the bathing systems was modified to incorporate the manufacturer's recommended guidelines for preventive maintenance. -Identification of other residents having the potential to be affected by the deficient practice: Facility residents who receive baths in the facility are at risk for being affected by the alleged deficient practice. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: A preventive maintenance program for the bathing systems was developed based on manufacturer guidelines. Maintenance staff were trained on the program. The facility policy "Incident Reports" policy was modified to include initiation of an investigation including root cause analysis, staff interviews, and non-incident involved resident interviews to determine if similar situations have occurred	

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F 323	Continued From page 24 jeopardy was removed on 3/31/17, at 3:38 p.m. but noncompliance remained at the lower scope and severity level of a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). R7's annual Minimum Data Set (MDS) dated 1/24/17, indicated R7 had short term memory impairment, but intact long term memory. The MDS indicated R7 had no behaviors, and required extensive assistance with transfers. The MDS identified R7 required physical help in part in bathing. The MDS further identified diagnoses of dementia and Parkinson's disease. R7's care plan dated 1/17/17, indicated R7 had a self-care deficit related to Parkinson's disease with fluctuations in participation ability, resting tremors, and decreased hearing. The care plan indicated R7 needed assistance of one staff to bathe, and assistance of two staff and a standing lift to transfer. R7's progress notes indicated the following: - On 3/9/17, at 7:55 a.m. R7 had a fall at 6:15 a.m. in the tub room. "Resident received tub bath. When RCA [facility nursing assistant] was using tub chair to remove resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair separated from the base. Injuries: skin tear to right hip and right shoulder measures 0.2 x 0.2 cm [centimeters]. Intervention/care provided: assessed for injuries, vitals BP [blood pressure] 140/80, RR [respiration rate] 20, sats [oxygen saturation percent] 92% on RA [room air], T [temperature] 95.5, HR [heart rate] 79. Use of FML [full mechanical lift] to w/c [wheelchair]."	F 323	previously. Employees with administrative responsibilities were trained on the revised policy and procedure. -Facility monitoring of performance to make sure that solutions are maintained: The Maintenance Director will audit the bathing system preventive maintenance inspection forms monthly for timely completion. Results of the audit will be presented to the facility Quality Assurance Committee for a period of six-months to verify that compliance has been attained. The Administrator, DON, or designee will review all incidents reports to ensure an investigation is initiated per policy, a thorough investigation done, and an incident summary completed. Results of this review will be presented to the facility Quality Assurance Committee for a period of six months to determine if compliance has been attained. -Date completed: May 10, 2017	

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- On 3/9/17, at 9:25 a.m. "Resident experienced a fall out of tub chair d/t [do to] mechanical failure. This incident is not suspicious in nature. Resident's POC [plan of care] was being followed at time of fall. Resident was lowered to the ground by staff and did not experience any significant injury or head strike. Resident does not have any c/o [complaints of] pain. Staff immediately deemed tub room out of use and maintenance contacted. After review, this incident is not deemed a VA [vulnerable adult] reportable event."

R7's Fall Report dated 3/9/17, revised on 3/17/17, indicated, "Resident was given a bath. When he was taken out of the tub chair an unknown issue occurred with equipment and the tub chair tilted backwards off the track and the resident fell backwards to floor - staff member was with resident and lowered to ground as best possible and no head strike occurred. MD [medical doctor] updated via fax." Injuries noted were abrasion to right scapula (shoulder blade) and right trochanter (hip) and resident was alert. No predisposing environmental, physiological or situation factors indicated. The report indicated, "Tub chair possible mechanical issue." An interview dated 3/9/17, with nursing assistant (NA)-H included on the fall report indicated, "I gave resident a bath. When taking him out of the tub I pulled the chair forward on the track and heard the click. I stepped on the pedal to release the track from the tub and the chair tipped backwards and fell off the track. I lowered him to the ground the best I could and he did not hit his head." A note on the Fall Report dated 3/10/17, from RN-C indicated, "Resident received tub bath. When RCA was using tub chair to remove

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resident from tub mechanical failure occurred and resident was lowered to ground as the tub chair separated from the base."

R7's Post Fall Follow Up dated 3/9/17, indicated R7 had a fall on 3/9/17, at 6:15 a.m. R7 was sitting on the tub chair lying on the floor on his back in a seated position. The follow up indicated there was "Mechanical failure of equipment. No new interventions identified. Tub chair out of order until maintenance assessed." The Post Fall Follow Up indicated an interdisciplinary team (IDT) reviewed the incident on 3/14/17 (5 days later), however, did not include the IDT notes, what mechanical failures occurred, or what was done to prevent an incident from occurring again.

On 3/29/17, at 8:07 a.m. R7 was interviewed and stated he fell from the tub chair when the track or connection was not tight and came apart. R7 stated that he did not receive any serious injury, but his bottom hurt that day. R7 stated he had continued to use the tub for bathing, without fear. R7 stated he didn't know what exactly happened, or what the facility did to fix the situation.

On 3/29/17, at 8:58 a.m. the second floor north tub room was observed with nursing assistant (NA)-F. An Apollo 6000 tub and chair system was in place. NA-F demonstrated how the tub system worked. NA-F stated the tub chair was locked onto the base (which also acted as a scale) with a primary safety lever. After the resident was seated on the chair, belts were used to secure the resident to the chair; with one belt around the resident's waist and one belt around the resident's torso. The end of the tub was opened, the chair along with the base was secured to the tub with a locking pin at the bottom of the tub,

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with a foot pedal to engage the lock. Metal rails were on both sides of the tub and the back of chair base, and NA-F stated the rails needed to be lined up. When the rails were lined up, the primary safety lever was released, the chair was released from the base, and it glided on the rails into the tub. The chair was then secured to a buckle in the tub, so the chair did not move. The base was then released with the foot pedal, moved away from the tub, and the door would be closed. Staff would then fill the tub with water. NA-F stated after the bath was finished, the tub was drained, and the door at the end of the tub was opened. Once the rails were lined up, the base was locked into placed, the security buckle on the back of the chair was released. The chair would then slide into place over the base, and it would click into place. The base was then released from the tub. NA-F stated the chair could fall if it was not completely on top of the base before releasing the base from the tub, or if the rails were not lined up properly. NA-F stated she had heard R7 had a fall from the bath chair, but was not sure what happened. NA-F stated there had not been any education about the tub system following R7's fall.

On 3/29/17, at 2:30 p.m. NA-G was interviewed and stated she had heard about R7's fall a few days following the fall. NA-G stated she heard the chair malfunctioned and R7 fell backwards from the tub chair. NA-G stated it was important to hear a click before removing the base from the tub. NA-G stated when she was hired she was trained in how to use the tub. NA-G stated there was no follow up on education following the incident with R7.

On 3/30/17, at 8:35 a.m. the director of

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maintenance (DM) stated he thought there was a work order put in for a tub on 2/8/17, but the order "was pretty vague." DM stated a maintenance worker adjusted the rails the chair slides onto and adjusted a screw. DM stated that there was not a maintenance slip filled out following the incident with R7, but he had received an immediate phone call, and he found issues with the secondary safety on the chair. DM stated he made the needed adjustments the chair, and was confident that was the solution. DM stated that no follow up inspections had been made to the tub chair system on second floor north. DM further stated the facility relied on maintenance slips or phone calls if there were issues with the tubs or the chairs. DM stated following the incident, the maintenance department checked on all the facility's tubs and tub chairs. DM stated a work order was submitted on 3/19/17, regarding the second floor north tub chair scale. A maintenance worker fixed the scale on 3/20/17, and also ensured the chair was in working order. DM further stated along with mechanical errors, human error could have occurred, but it was hard to tell. DM also stated the facility had no preventative maintenance schedule to inspect the tubs and tub chairs prior to the incident on 3/9/17, and the facility had not implemented a system for preventative maintenance following the incident. DM stated only when the maintenance department was alerted to a potential issue with the tubs or tub chairs, do they get looked at. DM stated he verbally told someone that the issue had been resolved but was not sure who he told.

On 3/30/17, at 8:51 a.m. during follow up observation of the second floor tub system with DM, DM pointed out the secondary safety was bent on both sides of the chair. The secondary

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safety was a U-shaped metal bracket attached to the base of the chair on the rail assembly system. If the primary locking lever was not engaged, and the chair was sliding back off, the base would come in contact with metal pieces that hung off the end of the rails on both sides of the chair, preventing the chair from falling off the base. DM stated there was not anything wrong with the primary lever when inspected on 3/9/17, and that should have locked the chair in place. DM added the secondary safety was there in case the primary locking lever failed. After walking through potential scenarios of how the chair could have fallen off the base, DM stated that the base had to have been released from the chair, the primary safety lever was not engaged, and the secondary U- shaped brackets were bent causing the chair to fall backwards off the base. The DM stated he did not walk through any possible scenarios with the nursing staff, he just assumed the secondary safety failed. DM stated no thought was put into the primary locking lever. The DM further stated if it was human error by not engaging the lock, or if it was engaged, then how did the primary locking lever fail? The DM further stated the incident was not thoroughly investigated.

The DM provided the following Maintenance Work Order forms:

- 2/7/17, second floor north tub room. Location of repairs needed: Tub chair does not go on correctly. Off track? Work completed on 2/8/17. Type of repairs made: Tightened screw and adjusted rail.

-3/19/17, second floor north tub room. Location of repairs needed: Tub chair scale not weighing correctly. Work completed on 3/20/17. Type of

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repairs made: Recalibrated scale. The work order did not identify checking the function of the chair or locking systems.

The Safety and Health Committee Meeting Minutes from 1/12/17, 2/9/17, and 3/9/17, did not address any concerns with the tub systems, nor were any concerns brought up regarding the tub systems. However, R7 had fallen that morning while be transferred out of the tub.

On 3/30/17, at 9:20 a.m. registered nurse (RN)-C was interviewed and stated on the morning of 3/9/17, following R7's fall from the tub chair, she was notified via telephone by RN-E about the incident. RN-C stated RN-E followed up with maintenance, and it sounded like there was something bent on the secondary safety that caused the chair to tip backwards. RN-C further stated that RN-E reported to her NA-H had re-enacted her steps, regarding the fall with R7, and demonstrated them to RN-E. RN-C stated she believed NA-H did everything right, and there was no indication of possible human error. RN-C stated the assistant director of nursing (ADON) was also notified of the incident.

On 3/30/17, at 1:32 p.m. NA-L stated some staff do not get the base lined up with the track correctly, and they would call for assistance to push the chair off the base into the tub. NA-L further stated the chairs have "stoppers" (secondary locking system) that prevent the chair from going any further if the rails are not lined up.

On 3/30/17, at 1:33 p.m. the ADON was interviewed and stated the incident was reported to her when it occurred. The ADON stated she thought it was a mechanical error as soon as she

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entered the tub room. Maintenance was called, and a sign was placed for the staff not to use the tub. The ADON stated she did not think human error was involved by the look of the chair, and NA-H's explanation of what happened. The ADON stated no further investigation was completed to determine if the fall was a result of human error or if the primary locking system failed. The ADON stated there should have been further investigation into the cause of the fall. The ADON further stated she thought mechanical issues were the reason for the fall. The ADON stated the incident was not reported to the administrator, or the State Agency (SA) as a possible VA incident, as the fall was witnessed by staff. The ADON stated there was no conversation with the DM after his review of the chair see why the primary lock did not keep the chair in place over the base. The ADON stated she was not sure what was reviewed in the IDT review, and she was unaware if all possible sceneries had been covered to implement interventions to prevent another incident. The ADON stated she was not aware of any other incidents regarding falls from the tub chairs. The ADON stated that she had no further information regarding the incident. The ADON stated in hind sight a more complete investigation should have been completed, and the incident should have been reported immediately to the administrator and the SA. The ADON also stated following the incident, no education had been given to the nursing assistants, and no preventative maintenance program on the tubs and tub chairs had been implemented. The ADON stated nursing assistants were trained on the tub function upon hire, but were not trained on the various tub systems in the facility. The DON further stated the third floor tub was not being

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F 323	Continued From page 32 used, as it leaked. On 3/30/17, at 1:59 p.m. NA-H was interviewed via telephone. NA-H stated she was the NA who had given R7 his bath on 3/9/17. NA-H stated she was not sure how to explain what happened when R7 fell. NA-H stated R7 had finished his bath, she slid the chair out of the tub onto the scale (chair base) and heard the click indicating the chair was in position over the base. NA-H stated she used the foot pedal to release the base from the tub, and when she started to move the base with the chair on it, R7 started falling backwards towards the floor. NA-H stated she was 99 percent sure she heard the click but was not 100 percent sure as she gave a lot of baths. On 3/30/17, at 2:15 p.m. licensed practical nurse (LPN)-A stated the third floor nursing assistants often needed to get help from a second person when putting a resident into and out of the tub. LPN-B stated the second person was needed to hold the base in place when the rails did not line up so the base did not separate from the tub. On 3/30/17, at 2:19 p.m. DM stated he thought there were six Apollo tubs in the facility that worked the same way as the tub on second floor north. DM stated when the second floor north tub chair was fixed, new parts were not ordered and he bent the U-shaped metal brackets back into place so the secondary lock system would lock. The DM stated that the Apollo 6000 model tubs had been in the facility since 2003, and there had never been preventative maintenance preformed on the tubs by the maintenance department. DM further stated that the facility did not contract with any other company to do routine inspection or maintenance on the tubs or tub chairs.	F 323		

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F 323	Continued From page 33 On 3/30/17, at 2:20 p.m. NA-I demonstrated the third floor tub system. NA-I stated if the chair does not not get pulled far enough forward onto the base, it could by-pass the secondary locking system and fall off the base backwards. On 3/30/17, at 2:29 p.m. DM observed the third floor tub room. DM stated he was not sure why staff were not using the tub, as he did not have a work order for it. The DM stated that the leak to the tub had been fixed previously. DM demonstrated if staff put too much pressure on the front of the tub chair when moving it, the back of the chair can come off the rails, and by-pass the secondary locking system. The DM further stated it should never take two people to move a resident from the base to the tub and vice versa, and staff should stop immediately if they are having issues and contact the maintenance department. On 3/30/17, at 4:56 p.m. DM stated in the last year he had been called a few times about the tub rails not lining up, and the rails were adjusted. DM further stated there was no written record of maintenance phone calls that are received and followed up on. On 3/31/17, at 8:38 a.m. a technical representative (TR)-A for Apollo bathing systems was interviewed via telephone. TR-A stated he was familiar with the Apollo 6000 tub system. TR-A stated it is recommended the facility perform routine inspections on the tub system per the manufacturer's recommendations at intervals of monthly, quarterly and yearly. TR-A stated each facility is given a checklist on what needed to be inspected and when. TR-A further stated routine maintenance was essential to prevent part	F 323		

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failure; and a facility not performing maintenance per manufacturer's recommendation was "running a high risk" of a resident falling and possibly sustaining "serious injury." TR-A stated in the event the primary locking lever failed, or if by user error it was not engaged, the secondary locking system was in place to prevent a resident from falling. TR-A stated during normal operation of the chair, the U-shaped metal brackets on the rail system would not bend on their own. If the secondary system had been maintained properly, it should have prevented a resident from falling. TR-A stated the facility was responsible for checking the rails, primary and secondary locking systems monthly, along with the pin that locks the base to the tub. TR-A stated the facility needed to contact Apollo in the event of a resident fall from an Apollo bathing system, "It was extremely important" as the company tracks adverse events. TR-A further stated the company could help the facility investigate what had occurred. TR-A stated the facility had not reported the incident to Apollo, and if a tub chair was repaired without following manufacturer's recommendations, the chair would not be safe to continue using.

On 3/31/17, at 12:26 p.m. the director of education (DE)-A was interviewed and stated nursing assistants and licensed staff are given training about disinfecting the tubs upon hire, while in the classroom setting. DE-A stated nursing assistants are assigned a preceptor when hired, and the preceptors train the nursing assistants on how to use the tub system on the unit they are working on. DE-A stated the preceptors do not go through any special orientation or preceptor program. DE-A stated nursing assistants were expected to utilize the

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manufacturer's instructions for the tub systems that were posted in each tub room. DE-A stated if a nursing assistant floated to a different unit they were expected to have someone show them how to utilize the tub system if it was a different tub than what they were trained to use. DE-A further stated the education department was not contacted following the incident on 3/9/17, to ensure nursing assistants were using the tub systems accurately. DE-A stated since being alerted to potential education issues regarding the tub systems, the facility was working on a new process of using the manufacturer's checklist for training, with a return demonstration. The DE-A stated the tub system should be treated like a mechanical lift. DE-A further stated the ADON and nurse unit managers were doing training each nursing assistant in the tub rooms at the beginning of their shifts, and had started this morning.

On 3/31/17, at 2:30 p.m. TR-B stated he had been called today by the facility to ensure that the Apollo bathing systems were in safe working order. TR-B stated he would look at all tubs and fix or replace what was needed per administration approval. TR-B stated facility maintenance staff were responsible to maintain the bathing systems. TR-B stated when a nursing assistant trains another nursing assistant on how to use the tub system, they may miss details. TR-B further explained the "click" staff listen for (so they know the chair is locked over the base) can be heard without the chair fully locking into place. TR-B stated listening for the click was not a substitution for a visual verification that the chair was locked into place. The tub system on second floor north was observed with TR-B and DM. TR-B demonstrated how you can still hear a click

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when positioning the chair over the base without fully locking it. TR-B inspected the chair, then stated it was okay to bend the U-shaped metal bracket into place; this does not alter the strength. DM stated human error should be negated because there were a few missing screws on the chair at the time of the incident on 3/9/17. After a brief overview, TR-B stated he thought the chair was safe to use, but recommended some upgraded safety enhancements to the primary lock lever. TR-B stated he would complete a thorough inspection of all the facility tubs.

On 3/31/17, at 3:15 p.m. the interim administrator stated TR-B and the DM actually sat on the tub chair and noted the primary locking lever was not in working condition, and was not safe for use. The administrator assured all defects found on all bathing systems would be fixed before use.

A tub system training curriculum was requested and not provided.

A preventative maintenance program policy was requested and not provided.

The undated manufacturer guide Apollo Bathing System Series 6000 Owner's Manual and Operator's Guide included information on operation, installation instructions, operation remedy, level glide transfer, and rada valve. The guide informed "Improper adjustment of the Patient Transfer System or failure to lock patient chair onto carrier could allow patients to drop to the floor resulting in serious injury. Before moving carrier, check to be sure patient chair is locked to carrier and will not accidentally roll off carrier. Warning! Patient carrier could drop if rails are

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loose or transfer chair wheels are not aligned with rails. Inspect chair fastener screws periodically to insure they remain tight during use (Refer to maintenance schedule)."

The guide signed and initialed on 3/03, included Recommended Maintenance Schedule Carriers and Scales to include preventative maintenance on the following items at the following intervals:
- Docking Pin Setting to receiver every three months
- Carrier Locks (should freely work) monthly
- Carrier Rail Alignment (align to tub rails) monthly
- Chair Release Lever monthly
- Castor Lock every three months
- Safety Straps and Buckles monthly
- Chair Mounting Bolts (wheels, arms, etc.) every six months
- Bottom Chair retaining Tabs (All fasteners tight) monthly
- Chair Wheel Bearings every 12 months

The facility Fall Management policy dated 8/15, directed "The staff will identify interventions related to the resident/ patient's specific risks and causes to try to prevent the resident/ patient from falling and try to minimize complications from falling. Staff will identify and implement relevant interventions as applicable to try to minimize serious consequences of falling. The Clinical Nurse Manager and /or designee will ensure Post Fall Analysis-Resident Worksheet is completed with input from the unit's fall team.

The immediate jeopardy that began on 2/7/17, was removed on 3/31/17, at 3:38 p.m., when the facility:
- Implemented a facility preventative maintenance

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F 323	Continued From page 38 program for the tub systems per manufacturer's recommendations, and contacted Apollo technicians to inspect the tub systems and were on site 3/31/17. - Comprehensively completed an investigation regarding the incident with R7 on 3/9/17. Two tub systems were taken out of use pending manufacturer inspection. Licensed staff in charge received education related to incident reports and investigations. - Nursing assistants were being educated on the process of reporting equipment needing to be serviced. Nursing assistants are being required to perform a return demonstration on how to use the tub system at the beginning of their shifts, and at a skills fair on 4/4/17. - Audits of the preventative maintenance program will be turned in to the administrator and reviewed at the quality assurance meeting. The noncompliance remained at the lower scope and severity level of a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as all staff training had not been completed, and Apollo representative had not inspected all the Apollo tubs for safety nor completed any repairs that may have been needed for safe functioning. On 3/31/17, from 1:50 p.m. to 2:15 p.m. nursing assistants were interviewed and verified they had been re-educated on the tub systems, they provided a return demonstration, and were educated on notifying maintenance of potential concerns with the tub systems.	F 323		
F 456 SS=E	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		5/10/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 39 (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a preventative maintenance program for their bathtubs and tub chairs according to manufacturer's recommendation. This had the potential to affect 104 of 155 residents in the facility who used the bathtub. Findings include: The undated manufacturer guide Apollo Bathing System Series 6000 Owner's Manual and Operator's Guide included information on operation, installation instructions, operation remedy, level glide transfer, and rada valve. The guide signed and initialed on 3/03, included Recommended Maintenance Schedule Carriers and Scales to include preventative maintenance on the following items at the following intervals: - Docking Pin Setting to receiver every three months - Carrier Locks (should freely work) monthly - Carrier Rail Alignment (align to tub rails) monthly - Chair Release Lever monthly - Castor Lock every three months - Safety Straps and Buckles monthly - Chair Mounting Bolts (wheels, arms, etc.) every six months - Bottom Chair retaining Tabs (All fasteners tight)	F 456	F456—ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION -Corrective action for those residents found to have been affected by the deficient practice: No specific resident was identified as being affected by the alleged deficient practice. -Identification of other residents having the potential to be affected by the deficient practice: Facility residents who receive baths in the facility are at risk for being affected by the alleged deficient practice. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: A preventive maintenance program for the bathing systems was developed based on manufacturer guidelines. Maintenance staff were trained on the program on March 31, 2017. -Facility monitoring of performance to make sure that solutions are maintained: The Maintenance Director will audit the bathing system preventive maintenance inspection forms monthly for timely completion. Results of the audit will be presented to the facility Quality Assurance Committee for a period of six-months completion for a period of six months to	

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F 456	Continued From page 40 monthly - Chair Wheel Bearings every 12 months On 3/30/17, at 8:35 a.m. director of maintenance (DM) verified the bathing systems were not checked according to manufacturer's recommendations. The DM stated he was speaking to someone about implementing an electronic system, which required the maintenance department to input manufacturer recommended checks into the system for all patient safety equipment, but that it had not been implemented yet. The DM stated he did not know when it would implemented. The DM further stated patient equipment is it looked at and repaired only when a work order or phone call is received about. A policy was requested not received.	F 456	verify that compliance has been attained. -Date completed: May 10, 2017	
F 465 SS=B	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure furniture	F 465	F465—SAFE/FUNCTIONAL/SANITARY/C	5/10/17

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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F 465	Continued From page 41 located in the common areas of the locked dementia unit were kept clean and in good repair. This had the potential to affect all 29 residents residing on the unit. Findings include: On 3/30/17, at 11:15 a.m. a green recliner and blue striped couch were observed in the day room of the locked dementia unit. The green recliner had a large round brownish-orange stain on its left side. The back of the chair had several tears in the seams. In addition, the rounded metal frame jutted out of both top corners of the back of the recliner and were visible. The blue striped couch contained two cushions. A dark stain was observed on the left cushion and arm rest, while a long tear was observed on the right cushion. On 3/30/17, at 11:15 a.m. environmental services aide (EA)-A stated she had not noticed the stains or tears before, further stating nonresident furniture was cleaned once a week. EA-A stated if housekeeping were to observe furniture in disrepair, they would fill out a maintenance report. EA-A thought the brown-orange stain on the recliner could be glue, and would be a cleanable surface with a glue remover and surface cleaner. EA-A observed the tears in the recliner and rubbed her thumb over the metal corners and stated the corner felt sharp, and the chair needed to be replaced. EA-A observed the blue striped couch, noted the dark stain and stated she thought the couches were shampooed weekly, too. EA-A further stated they couldn't always get the stains out, and it could be a dark shadow from an old stain. EA-A acknowledged the tear in the right cushion and attempted to flip the cushions over; however, the backside of the	F 465	OMFORTABLE ENVIRONMENT -Corrective action for those residents found to have been affected by the deficient practice: No specific resident was identified as being affected by the alleged deficient practice. -Identification of other residents having the potential to be affected by the deficient practice: Facility residents who use common areas of the facility have the potential to be affected by the alleged deficient practice. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: The Daily Clean Schedules for each area of the facility were modified to include daily inspection of common area furniture for tears or stains with completion of a maintenance work order as necessary. Environmental Services employees were educated on the revised form and process. -Facility monitoring of performance to make sure that solutions are maintained: The Director of Environmental Services will audit the Daily Clean schedules monthly for completeness. Results of the audit will be presented to the facility Quality Assurance Committee for a period of six-months to verify that compliance has been attained. -Date completed: May 10, 2017	

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F 465	Continued From page 42	F 465		

cushions were observed dirtier and contained larger tears. EA-A reported the backs were worse and the couch needed to be replaced. EA-A further stated the furniture had been there, "Forever" and although the room wasn't used much, EA-A stated the condition of the furniture was "unacceptable."

On 3/31/17, at 8:51 a.m. registered nurse (RN)-B stated environmental services were responsible for cleaning the furniture, and the chair had been there forever.

On 3/31/17, at 9:36 the director of maintenance (DM) stated he had just received a work order the previous day for the recliner (after questioning by the surveyor); however, had not taken care of it yet because there had been someone sitting in the recliner the previous day. DM stated he had observed the corners of the recliner, measuring the left corner tear at 0.5 inches, and the right corner tear at 1 inch. DM stated he was planning on pounding down the metal pieces jutting out of the corners, or would attempt to fold them over. In addition, DM stated the safety officer might need to be informed of the chair. DM reported he was informed of maintenance issues regarding furniture via work orders filled out by staff.

The facility policy Repair Requests revised 3/21/16, directed when necessary repairs are noted, a Maintenance Work Order is filled out stating the purpose of the work order and the area in which the repairs are needed.

The facility policy Cleaning Furniture undated, directed the frequency of cleaning should be done daily and, "If fabric is soiled, follow the extraction procedure." The policy did not identify

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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F 465	Continued From page 43 what the extraction procedure was. The facility policy Furnishing Requests revised 3/21/16, directed "Furnishing needs are accommodated, when possible, for meetings and activities along with resident/patient needs on each living unit. Furniture is to be monitored for tears, etc. as staff clean on a daily basis." Furnishing requests were to go through the Environmental Services Director.	F 465		

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	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST** **SAINT CLOUD, MN 56304**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, St. Benedicts Senior Community was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2017

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2 story addition was added to the northeast that was determined to be of Type II(111) construction. Also in 2008, there was a 2 story, with no basement determined to be a Type II (III) Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a	K 000		

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K 000	Continued From page 2 capacity of 197 beds and had a census of 157 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain smoke dampers in accordance with The Standard for Fire Doors and Other Opening Protective's, NFPA 80 , 2010 edition section 19.4.1.1. This deficient practice could allow smoke to travel throughout smoke compartments affecting the exiting capabilities of all residents and an undetermined amount of staff and visitors. Findings include: On the facility tour on 03/28/2017 record review and staff interview revealed there was limited documentation for the current inspections of the	K 372	K372—NFPA 101 SUBDIVISION OF BUILDING SPACES-SMOKE BARRIERS -Description of what has been, or will be, done to correct the deficiency: All facility fire dampers have been inspected. Replacement motors have been ordered and received. Dampers requiring replacement of fusible links or motors are currently being repaired or replaced. -Actual, or proposed, completion date: May 10, 2017 -The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency: The Maintenance Director will	4/21/17

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K 372	Continued From page 3 90 plus smoke dampers. Last full documented damper inspections were January 2013. This deficient condition was confirmed by the Facility Maintenance Director.	K 372	be responsible for monitoring fire damper four-year inspection requirement.	
K 511 SS=C	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On 03/28/2017, during the facility tour between noon and 17:30pm, observations and staff interview revealed an extension cord plugged into heat tape that was wrapped around a sprinkler pipe that was in a walk in cooler. This deficient condition was verified by the Facility Maintenance Director.	K 511	K511—NFPA 101 UTILITIES-GAS AND ELECTRIC -Description of what has been, or will be, done to correct the deficiency: The extension cord connecting the heat tape was removed and replaced with a new heat tape unit containing GFI protection plugged directly into the wall outlet. -Actual, or proposed, completion date: April 11, 2017 -The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency: The Director of Maintenance will be responsible for monitoring the heat tape unit for correct use for a period of six months to determine if compliance has been maintained. The Director of	4/21/17

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K 511	Continued From page 4	K 511	Maintenance will report findings of his audit to the facility Quality Assurance Committee for a period of six months.	
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2012 NFPA 101 - 9.1.3 and 2010 NFPA 110 Chapter 6-4.1. The deficient practice could affect all residents. Findings include:	K 914	K914—NFPA 101 ELECTRICAL SYSTEMS-MAINTENANCE AND TESTING -Description of what has been, or will be, done to correct the deficiency: The generator testing log format has been modified to separate monthly and weekly testing items. Ambient temperature and fuel level were added to the weekly testing	4/21/17

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K 914	Continued From page 5 On 03/28/2017, during the facility tour between noon and 17:30pm, observations and staff interview revealed, documentation review of the weekly and monthly inspection logs of the diesel generator showed incomplete emergency generator testing requirements. Temporary generator was present from 11/18/2016 until 02/06/2017. This deficient condition was verified by the Facility Maintenance Director.	K 914	log. -Actual, or proposed, completion date: April 17, 2017 -The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency: The Director of Maintenance will be responsible for monitoring the weekly and monthly generator testing logs to verify that the logs have been completed timely. Results of the audit will be presented to the facility Quality Assurance Committee for a period of six months to verify that compliance has been attained.	