DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Good Samaritan Society Redwood Falls	H5237010 and H5237011	September 25, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
200 Dekalb Street South	5:00 p.m. to 9:30 p.m.	December 29, 2017
Facility City:	**Investigator's Name and Title:**	
Redwood Falls	Pam Hovdet, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56283	Redwood

☒ Nursing Home

Allegation(s):

It is alleged that a resident was neglected when the alleged perpetrator (AP) transferred the resident in a lift and the resident fell resulting in multiple fractures.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) transfered the resident out of the bathtub in a tub lift chair The resident fell out of the tub chair and sustained multiple fractures. The resident died one week later due to complications from the fractures.

The resident was diagnosed with dementia and arthritis, and was severely cognitively impaired. The resident required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. The resident required two staff with a total lift and high back sling for transfers due to dementia and arthritis.

The AP transfered the resident from the wheelchair to the tub lift chair with a total lift by him/herself. The AP gave the resident a bath, and proceeded to lift the resident out of the tub in the tub lift chair with no other staff assistance. The AP raised the tub lift chair to the maximum height of three and a half feet and lifted the resident up and over the side of the tub, instead of waiting for the water to drain to slide the resident out through the tub door. The resident was not lowered, but remained completely elevated at three and a half feet in the tub lift chair while the AP dried the resident off with a towel. Then the AP removed the seat belt from around the resident, and attempted to place the total lift sling under the

resident. The resident was wet and slippery making it difficult for the AP to hang onto the resident. As the resident leaned forward in the chair, the AP lost his/her grip on the resident and the resident fell out the tub lift chair. The resident landed on his/her feet and fell onto the resident's left side. The resident's left ankle twisted and his/her left leg had visible broken bones. The AP left the resident alone in the tub room to obtain assistance from other staff, instead of using the phone, walkie talkie, or call light. The nurse responded and immediately and called 911 due to the severity of the injury.

The ambulance run sheet indicated upon their arrival, skin from the left side of the resident's left leg held the resident's foot on the leg. The bones of the left leg were visible. Ambulance staff notified dispatch to contact the helicopter, due to the severity of the injury. The ambulance transported the resident to the local hospital.

Hospital records indicated the resident was diagnosed with comminuted bilateral tibial and fibula fractures. The resident also had an open fracture of the left ankle. The resident was transferred to a higher level of care hospital by helicopter.

The higher level of care hospital records indicated hip fractures were suspected, however the physician indicated the resident was not a good candidate for any surgical interventions or procedures. The resident was placed on comfort cares, and five days later discharged to hospice services. The resident died two days after his/her admission to hospice.

The resident's death certificate indicated the resident died from complications of multiple skeletal fractures due to a fall from a lift raised multiple feet.

When interviewed, the AP stated s/he felt rushed to give the resident his/her scheduled bath, so the AP did not take the time to ask for staff assistance to transfer the resident into and out of the tub. The AP stated s/he did not want to wait for the water to drain out of the tub, so the AP lifted the resident up and over the side of the tub with the tub lift chair raised to the maximum height, and dried the resident off. While elevated, the AP removed the strap from around the resident that was attached to the chair, and attempted to put the lift sling under the resident. The resident tensed up, leaned forward, and fell out of the tub lift chair. The AP moved the resident away from the door by pulling on the resident's gown, and left the resident alone in the tub room to get help. The AP acknowledged s/he knew the resident required two staff to transfer, and chose not to follow the care plan. The AP stated s/he knew the injury was bad and decided to run and get help, instead of using the phone, walkie talkie, or call light available in the tub room.

The safe operation and daily maintenance instructions for the tub indicated after the bath the tub is drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. The instructions state to carefully remove the seat belt to ensure the resident does not slip out of the swivel lift chair, which may require the assistance of another staff to control the resident's transfer.

The police report indicated the AP was charged with a felony of crimes against a Vulnerable Adult. The charge was forwarded to the county attorney.

The AP was immediately suspended by the facility pending an investigation, and the nursing pool agency informed of the incident. The facility terminated their contract with the nursing pool agency.

The facility contacted the tub manufacturer, and modifications were made to reduce the height limit of the tub lift chair. The manufacturer provided education on proper tub use to staff, and the facility re-educated staff on all the facility's mechanical lifts.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place related to abuse and neglect, fall prevention and management, bathing, and the care plan. The AP was trained by the pool agency on federal, state, and local laws, rules and regulations. The facility orientated and reviewed with the AP resident care plans, safety rules, use of mechanical lifts, transfers and the safe resident handling program. The AP failed to follow policies and procedures by transferring the resident without other staff assistance, failed to follow the bathing and mechanical lift procedures, and failed to implement safe resident handling and safety rules. The agency completed a background check on the AP, and provided the facility with this information.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☐ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Weight Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records [x] Ambulance/Paramedics [x] Medical Examiner Records
- [x] Death Certificate [x] Police Report

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records

☒ Facility Policies and Procedures

☒ Other, specify: Supplemental Staffing Service Agreement.

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact reporter, attempts were made on:

Date: Time: Date: Time: Date: Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Nine

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Ten

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify:

Attempts to contact:

Date: Time: Date: Time: Date: Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Facility Tour

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A
Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A
Were photographs taken: ◉ Yes ○ No Specify: Photos of the tub and tub room.

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Redwood County Medical Examiners

Redwood Falls Police Department

Redwood County Attorney

Redwood Falls City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	R-C 12/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

(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 Post Certification revisit was conducted on 12/27/17, to follow up on deficiencies issued relate to complaints H5237010 and H5237011. Good Samaritan Society Redwood Falls is in compliance with 42 CFR Part 483, subpart B, 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}		

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

12/29/2017

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.

Minnesota Department of Health

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	00063	A. BUILDING: _____ B. WING _____	R-C 12/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaints H5237010 and H5237011. Good Samaritan Society Redwood Falls was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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{2 000}	Continued From page 1 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.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 29, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Re: Project Number H5237011

Dear Ms. Amundson:

On November 15, 2017, an investigation was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, to determine if your facility was in compliance with federal and state regulations. The investigator found federal deficiencies and violations.

The CMS form 2567 and state licensing order was sent to you previously. The investigative report is now completed and a copy is enclosed.

If you have questions related to this investigation, please contact the investigator identified in the report.

Thank you for your cooperation.

Sincerely,

Lindsey L Krueger

Lindsey Krueger, Interim Assistant Director
Health Regulation Division
Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4135 Fax: (651) 281-9796
General Information: (651) 201-4201 - 1-800-369-7994

Enclosure

LK/tn

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	245237	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5237010 & H5237011. As a result, the following deficiencies are issued related to case #H5237010 & H5237011. 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. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff followed care planned interventions for 1 of 5 residents reviewed (R1), who required two staff assistance with transfers in and out of the tub. R1 was harmed when she experinced a fall and sustained multiple fractures that resulted in R1's death one week later. Findings include: R1's quarterly Minimum Data Set (MDS) dated July 14, 2017, indicated R1 required two staff physical assistance with transferring, and one staff physical assistance with bathing.	F 282	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of	12/15/17

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

Electronically Signed | 12/15/2017

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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F 282	Continued From page 1 R1's care plan revised May 22, 2017, indicated R1 required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. R1 required two staff with total lift and large high back sling for transfers. A checklist for pool nursing assistants dated August 18, 2017, and signed by licensed practical nurse (LPN)-C and nursing assistant (NA)-E, indicated LPN-C reviewed resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program with NA-E. An incident report dated September 10, 2017, indicated NA-E informed LPN-C that R1 fell out of the tub lift chair. LPN-C observed R1 on the tub room floor. R1 was on her back with arms crossed over her chest and right leg straight out. R1's left leg was straight out with the left foot and ankle in full counter clock rotation. Dark red blood and various sizes of blood clots were pooling by the left foot and ankle. Light red blood was around R1's torso. R1 was alert and complained of right knee and neck pain. Emergency medical services (EMS) were notified, and LPN-C remained with R1 until EMS arrived. EMS records dated September 10, 2017, indicated skin from the left side of R1's left leg held R1's foot on the leg, and the bones of the left leg were visible. EMS transported the resident to the local hospital. R1's hospital records dated September 10, 2017, indicated R1 had comminuted bilateral tibial and fibula fractures (break or splinter of the bones into	F 282	compliance in accordance with section 7305 of the State Operations Manual. 1.On September 10th 2017 R1 was transferred to the hospital and did not return to Good Samaritan Society-Redwood Falls. 2.All resident care plans will be reviewed and revised to reflect resident transfer needs during bathing and reflected on the comprehensive assessment. All resident care plan Kardex will be reviewed and include the resident transfer needs during bathing. This will be communicated to the nursing assistants on the resident Kardex. 3.To ensure the deficient practice will not reoccur all nursing staff including pool and agency staff were reeducated by the DNS during a staff in service and competency testing on December 15th 2017 on GSS policy and procedure for incident reports, safety rules, whirlpool transfers, Safe Resident Handling Program. Further licensed nurses were reeducated on the importance of updating and accuracy of care plans. Further the facility has adopted a comprehensive training for agency staff. 4.To monitor performance resident care plan audits on level of assistance needed on transfers during bathing will be completed weekly for 4 weeks, monthly for 2 months. DNS or designee will be responsible for audit compliance. To monitor POC compliance audit results will be reviewed by QAPI committee for review and further recommendations.	

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F 282	Continued From page 2 more than two fragments in both lower legs). R1 had an open fracture of the left ankle (open wound or break in the skin near the site of the broken bone). R1 was transferred to a higher level of care facility by air care. R1's records at the second hospital dated September 10, 2017, indicated additional fractures were suspected, however R1 was not a good candidate for any surgical interventions or procedures. R1 was placed on comfort cares, and discharged to hospice services on September 15, 2017. The facility internal investigation dated September 11, 2017, indicated NA-E transferred R1 to the swivel lift chair with no second staff assistance, and used the hygiene sling in place of the full body transfer sling. After the bath NA-E raised the resident in the swivel lift chair up and over the side of the tub, removed the seat belt with the chair elevated, and attempted to put the sling under R1 when R1 fell out of the chair. NA-E left the resident on the floor and ran for help. R1's Physician/Medical Examiner Cause of Death Worksheet (undated) indicated R1 died on September 17, 2017, due to complications of multiple skeletal fractures, caused by a fall from a lift raised multiple feet. A police report modified September 25, 2017, indicated NA-E had pending felony charges of crimes against a Vulnerable Adult forwarded to the county attorney. When interviewed on September 25, 2017, at 6:50 p.m., LPN-C stated NA-E ran down the hallway and told LPN-C to call 911, as R1 fell and	F 282		

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F 282	Continued From page 3	F 282		

was injured. LPN-C went to the tub room and found the swivel lift chair elevated above R1, who was lying on the floor with her left ankle detached from the bottom of her leg. LPN-C saw blood and blood clots around the injury, and R1 complained of right knee, neck, and head pain. LPN-C stabilized R1's head and neck, and provided support until EMS arrived. LPN-C stated the swivel lift chair should not have been elevated, NA-E should not have been transferring R1 alone, and NA-E should have stayed with R1 and used the phone, call light, or walkie talkie to call for help.

When interviewed on September 26, 2017, at 4:10 p.m., NA-F stated she heard R1 scream and found LPN-C with R1 in the tub room and R1's left foot was almost detached from her leg. NA-F stated NA-E did not request help to transfer R1 from the tub after R1's bath, as indicated on the careplan and kardex (medical information system used by nursing staff to identify individual resident needs).

When interviewed on September 29, 2017, at 3:20 p.m., NA-G stated staff are trained on and expected to follow the resident's careplan, and to transfer residents out of the tub in the tub chair through the tub door after the water has drained from the tub.

When interviewed on October 3, 2017, at 10:35 a.m., NA-E stated he transferred R1 alone from R1's wheelchair to the tub chair and gave R1 a bath. NA-E stated he did not wait for the water to drain from the tub and transfer R1 through the tub door. Instead, NA-E removed R1 from the tub by lifting the tub chair with R1 in it up and over the side of the tub. NA-E stated R1 was elevated

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	245237	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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 282	Continued From page 4 about 3 feet at NA-E's chest level, when NA-E removed the seat belt and attempted to place the lift sling under R1. When NA-E moved R1 forward to place the sling, R1 fell out of the lift, landed on her feet, and fell onto her left side. NA-E stated R1's left ankle was twisted and the left leg broke. NA-E moved R1 away from the door by pulling on R1's gown, and left the tub room to get help. NA-E did not attempt to obtain help by using the phone, walkie talkie, or call light. When interviewed on October 3, 2017, at 2:50 p.m., LPN-D stated she reviewed the checklist for pool nursing assistants dated 8/18/17, with NA-E. The areas reviewed included resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program. When interviewed on October 9, 2017, at 4:30 p.m., the interim director of nursing (DON) stated she would expect staff to transfer R1 with two staff as directed on the careplan and kardex, and to follow the tub directions and transfer residents in and out of the tub through the tub door, and not up and over the side of the tub. The DON stated NA-E failed to follow the careplan, tub instructions, and the facility's safe resident handling program. The safe operation and daily maintenance instructions for the bathing system revised on April 19, 2013, indicated after the bath the tub is drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. Carefully remove the seat	F 282		

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F 282	Continued From page 5 belt to ensure the resident does not slip out of the swivel lift chair. This may require the assistance of another staff to control the resident's transfer. The facility Care Plan Policy revised November, 2016, indicated residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services.	F 282		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (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 the resident or resident representative and obtain	F 323		12/15/17

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F 323	Continued From page 6 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 interview and document review, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 5 residents reviewed, (R1), when staff failed to follow the careplan and manufacturer instructions. This resulted in actual harm when R1 sustained multiple fractures, and died one week later as a result of the injuries. Findings include: R1's quarterly Minimum Data Set (MDS) dated July 14, 2017, indicated R1 required two staff and physical assistance with transferring, and one staff physical assistance with bathing. R1's care plan revised May 22, 2017, indicated R1 required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. R1 required two staff and a total lift and large high back sling for transfers. A checklist for pool nursing assistants dated August 18, 2017, and signed by licensed practical nurse (LPN)-C and nursing assistant (NA)-E, indicated LPN-C reviewed resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program with NA-E. An incident report dated September 10, 2017, indicated NA-E informed LPN-C that R1 fell out of	F 323	1.On September 10th 2017 R1 was transferred to the hospital and did not return to Good Samaritan Society-Redwood Falls. 2.All resident plan of care will identify those that need assist with transfers in and out of the whirl pool tub and will specify the level of assistance required to ensure safe resident handling 3.To ensure the deficient practice will not reoccur all nursing staff including pool and agency staff were reeducated by the DNS during a staff in service and competency testing on December 15th 2017 on GSS policy and procedure for incident reports, safety rules, whirlpool transfers, Safe Resident Handling Program. Further licensed nurses were reeducated on the importance of updating and accuracy of care plans. Further the facility has adopted a comprehensive training for agency staff. 4.To monitor performance training and orientation audits will be completed on all current and newly hired licensed nurse, nursing assistants including nursing pool and or agency staff. The audits include completion of training on resident care plans, safety rules, incident reports, use of mechanical lifts transfers, whirlpool tub transfers and safe resident handling program weekly for 4 weeks and monthly for 2 months. The DNS or designee will	

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F 323	Continued From page 7 the tub lift chair. LPN-C observed R1 on the tub room floor. R1 was on her back with arms crossed over her chest and right leg straight out. R1's left leg was straight out with the left foot and ankle in full counter clock rotation. Dark red blood and various sizes of blood clots were pooling by the left foot and ankle. R1 was alert and complained of right knee and neck pain. 911 was called and LPN-C remained with R1 until the ambulance arrived. Ambulance run sheet dated September 10, 2017, indicated skin from the left side of R1's left leg held R1's foot on the leg, and the bones of the left leg were visible. The ambulance transported the resident to the local hospital. R1's hospital records dated September 10, 2017, indicated R1 arrived at the emergency room via ambulance and x-rays were done. R1's x-rays indicated R1 had comminuted bilateral tibial and fibula fractures (break or splinter of the bones into more than two fragments in both lower legs). R1 had an open fracture of the left ankle (open wound or break in the skin near the site of the broken bone). R1 was transferred to a higher level of care hospital by helicopter. R1's records at the higher level of care hospital dated September 10, 2017, indicated hip fractures were suspected, however R1 was not a good candidate for any surgical interventions or procedures. R1 was placed on comfort cares and remained at the hospital until discharged to another facility on September 15, 2017, where R1 recieved hospice services until R1's death on September 17, 2017. The facility internal investigation dated September	F 323	be responsible for audit completion. To monitor POC compliance audit results will be reviewed by QAPI committee for review and further recommendations.	

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F 323	Continued From page 8 11, 2017, indicated NA-E transferred R1 to the swivel lift chair with no second staff assistance. After the bath NA-E raised the resident in the swivel lift chair up and over the side of the tub, removed the seat belt with the chair elevated to 3 1/2 feet, and attempted to put the sling under R1 when R1 fell out of the chair. NA-E left the resident on the floor and ran for help. R1's death certificate (undated) indicated R1 died on September 17, 2017, due to complications of multiple skeletal fractures, caused by a fall from a lift raised multiple feet. When interviewed on October 3, 2017, at 10:35 a.m., NA-E stated he had worked with R1 in the past and knew R1 required two staff to transfer. NA-E was assigned to give R1 a bath on September 10, 2017. When it was time to give R1 a bath, NA-E stated he felt rushed and did not want to wait for help. NA-E transferred R1 alone from R1's wheelchair to the tub chair using the total lift, and gave R1 a bath. NA-E stated he did not want to wait for staff assistance or for the water to drain from the tub to properly transfer R1 through the tub door, so instead NA-E removed R1 from the tub by lifting the tub chair with R1 in it up and over the side of the tub. NA-E stated R1 was elevated about 3 feet, at NA-E's chest level, when NA-E dried R1 off with a towel. R1 remained elevated as NA-E removed the seat belt, and attempted to place the lift sling under R1. R1 was wet and slippery which made it difficult for NA-E to hang onto R1, as NA-E moved R1 forward in the chair to place the lift sling. As R1 leaned forward in the chair, NA-E lost his grip on R1 and R1 fell out of the chair, landed on her feet, and fell onto her left side. NA-E stated R1's left ankle was twisted and the	F 323		

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F 323	Continued From page 9 left leg broke. NA-E moved R1 away from the door by pulling on R1's gown, and left the tub room to get help. NA-E did not attempt to obtain help by using the phone, walkie talkie, or call light. When interviewed on September 25, 2017, at 6:50 p.m., LPN-C stated NA-E ran down the hallway and told LPN-C to call 911, as R1 fell and was injured. LPN-C went to the tub room and found the swivel lift chair elevated above R1, who was lying on the floor with her left ankle detached from the bottom of her leg. LPN-C saw blood and blood clots around the injury, and R1 complained of right knee, neck, and head pain. LPN-C stabilized R1's head and neck, and provided support until EMS arrived. LPN-C stated the swivel lift chair should not have been elevated, NA-E should not have been transferring R1 alone, and NA-E should have stayed with R1 and used the phone, call light, or walkie talkie to call for help. When interviewed on September 26, 2017, at 4:10 p.m., NA-F stated she heard R1 scream and found LPN-C with R1 in the tub room and R1's left foot was almost detached from her leg. NA-F stated NA-E did not request help to transfer R1 from the tub after R1's bath, as indicated on the careplan and kardex (medical information system used by nursing staff to identify individual resident needs). When interviewed on September 29, 2017, at 3:20 p.m., NA-G stated staff are trained on and expected to follow the resident's careplan, and to transfer residents out of the tub in the tub chair through the tub door after the water has drained from the tub.	F 323		

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F 323	Continued From page 10 When interviewed on October 3, 2017, at 2:50 p.m., LPN-D stated she reviewed the checklist for pool nursing assistants dated 8/18/17, with NA-E. The areas reviewed included resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program. When interviewed on October 3, 2017, at 3:50 p.m., the administrator stated he saw R1 on the tub room floor with half her left ankle bone visible through R1's skin. NA-E told the administrator R1 was elevated in the tub chair, and when NA-E prepared to transfer R1 she fell out of the chair. NA-E was immediately suspended. When interviewed on October 9, 2017, at 4:30 p.m., the interim director of nursing (DON) stated she would expect staff to transfer R1 with two staff as directed on the careplan and kardex, and to follow the tub directions and transfer residents in and out of the tub through the tub door, and not up and over the side of the tub. The DON stated NA-E failed to follow the careplan, tub instructions, and the facility's safe resident handling program. When interviewed on October 31, 2017, at 4:35 p.m., the bathing system representative stated the top front edge of the swivel lift chair seat could be raised up to 3 1/2 feet. The representative stated they train the facility staff to follow the safe operation and daily maintenance instructions. The safe operation and daily maintenance instructions for the bathing system revised on April 19, 2013, indicated after the bath the tub is	F 323		

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F 323	Continued From page 11	F 323		

drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. Carefully remove the seat belt to ensure the resident does not slip out of the swivel lift chair. This may require the assistance of another staff to control the resident's transfer.

The facility Bathing Procedure revised May, 2017, indicated the procedure for tub (whirlpool) and shower bathing included using appropriate safety measures and equipment to prevent accidents. Manufacturer's directions should be followed for use of bathing equipment. Safety belts for bathing units, shower chairs and bathing lifts should be used at all times. Do not leave resident unattended.

The facility Fall Prevention and Management Policy and Procedure revised May, 2016, indicated avoidable accidents mean that an accident occurred because the location failed to: implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident.

The facility Abuse and Neglect Policy and Procedure revised November, 2016, indicated the purpose is to ensure the location has in place an effective system that, regardless of the source, prevents mistreatment and neglect of residents, and to ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated, reported and to prevent future injuries.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2017

Mr. Marcus Parence, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

RE: Project Number H5237010 and H5237011

Dear Mr. Parence:

On November 15, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567.

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

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);

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.

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:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135 Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey 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; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 11, 2017. (42 CFR 488.422)

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, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 PoC 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 ePoC 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, Office of Health Facility Complaints 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 February 15, 2018 (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 May 15, 2018 (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 electronic 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5237010 & H5237011. As a result, the following correction orders are issued related to case #H5237010 & H5237011. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	C 11/15/2017

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2 000	Continued From page 1 Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff followed care planned interventions for 1 of 5 residents reviewed (R1), who required two staff assistance with transfers in and out of the tub. R1 was harmed when she experinced a fall and sustained multiple fractures that resulted in R1's death one week later. Findings include: R1's quarterly Minimum Data Set (MDS) dated July 14, 2017, indicated R1 required two staff physical assistance with transferring, and one	2 565	Corrected	12/15/17

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2 565	Continued From page 2 staff physical assistance with bathing. R1's care plan revised May 22, 2017, indicated R1 required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. R1 required two staff with total lift and large high back sling for transfers. A checklist for pool nursing assistants dated August 18, 2017, and signed by licensed practical nurse (LPN)-C and nursing assistant (NA)-E, indicated LPN-C reviewed resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program with NA-E. An incident report dated September 10, 2017, indicated NA-E informed LPN-C that R1 fell out of the tub lift chair. LPN-C observed R1 on the tub room floor. R1 was on her back with arms crossed over her chest and right leg straight out. R1's left leg was straight out with the left foot and ankle in full counter clock rotation. Dark red blood and various sizes of blood clots were pooling by the left foot and ankle. Light red blood was around R1's torso. R1 was alert and complained of right knee and neck pain. Emergency medical services (EMS) were notified, and LPN-C remained with R1 until EMS arrived. EMS records dated September 10, 2017, indicated skin from the left side of R1's left leg held R1's foot on the leg, and the bones of the left leg were visible. EMS transported the resident to the local hospital. R1's hospital records dated September 10, 2017, indicated R1 had comminuted bilateral tibial and fibula fractures (break or splinter of the bones into	2 565		

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2 565	Continued From page 3	2 565		

more than two fragments in both lower legs). R1 had an open fracture of the left ankle (open wound or break in the skin near the site of the broken bone). R1 was transferred to a higher level of care facility by air care.

R1's records at the second hospital dated September 10, 2017, indicated additional fractures were suspected, however R1 was not a good candidate for any surgical interventions or procedures. R1 was placed on comfort cares, and discharged to hospice services on September 15, 2017.

The facility internal investigation dated September 11, 2017, indicated NA-E transferred R1 to the swivel lift chair with no second staff assistance, and used the hygiene sling in place of the full body transfer sling. After the bath NA-E raised the resident in the swivel lift chair up and over the side of the tub, removed the seat belt with the chair elevated, and attempted to put the sling under R1 when R1 fell out of the chair. NA-E left the resident on the floor and ran for help.

R1's Physician/Medical Examiner Cause of Death Worksheet (undated) indicated R1 died on September 17, 2017, due to complications of multiple skeletal fractures, caused by a fall from a lift raised multiple feet.

A police report modified September 25, 2017, indicated NA-E had pending felony charges of crimes against a Vulnerable Adult forwarded to the county attorney.

When interviewed on September 25, 2017, at 6:50 p.m., LPN-C stated NA-E ran down the hallway and told LPN-C to call 911, as R1 fell and was injured. LPN-C went to the tub room and

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2 565	Continued From page 4 found the swivel lift chair elevated above R1, who was lying on the floor with her left ankle detached from the bottom of her leg. LPN-C saw blood and blood clots around the injury, and R1 complained of right knee, neck, and head pain. LPN-C stabilized R1's head and neck, and provided support until EMS arrived. LPN-C stated the swivel lift chair should not have been elevated, NA-E should not have been transferring R1 alone, and NA-E should have stayed with R1 and used the phone, call light, or walkie talkie to call for help. When interviewed on September 26, 2017, at 4:10 p.m., NA-F stated she heard R1 scream and found LPN-C with R1 in the tub room and R1's left foot was almost detached from her leg. NA-F stated NA-E did not request help to transfer R1 from the tub after R1's bath, as indicated on the careplan and kardex (medical information system used by nursing staff to identify individual resident needs). When interviewed on September 29, 2017, at 3:20 p.m., NA-G stated staff are trained on and expected to follow the resident's careplan, and to transfer residents out of the tub in the tub chair through the tub door after the water has drained from the tub. When interviewed on October 3, 2017, at 10:35 a.m., NA-E stated he transferred R1 alone from R1's wheelchair to the tub chair and gave R1 a bath. NA-E stated he did not wait for the water to drain from the tub and transfer R1 through the tub door. Instead, NA-E removed R1 from the tub by lifting the tub chair with R1 in it up and over the side of the tub. NA-E stated R1 was elevated about 3 feet at NA-E's chest level, when NA-E removed the seat belt and attempted to place the	2 565		

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2 565	Continued From page 5 lift sling under R1. When NA-E moved R1 forward to place the sling, R1 fell out of the lift, landed on her feet, and fell onto her left side. NA-E stated R1's left ankle was twisted and the left leg broke. NA-E moved R1 away from the door by pulling on R1's gown, and left the tub room to get help. NA-E did not attempt to obtain help by using the phone, walkie talkie, or call light. When interviewed on October 3, 2017, at 2:50 p.m., LPN-D stated she reviewed the checklist for pool nursing assistants dated 8/18/17, with NA-E. The areas reviewed included resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program. When interviewed on October 9, 2017, at 4:30 p.m., the interim director of nursing (DON) stated she would expect staff to transfer R1 with two staff as directed on the careplan and kardex, and to follow the tub directions and transfer residents in and out of the tub through the tub door, and not up and over the side of the tub. The DON stated NA-E failed to follow the careplan, tub instructions, and the facility's safe resident handling program. The safe operation and daily maintenance instructions for the bathing system revised on April 19, 2013, indicated after the bath the tub is drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. Carefully remove the seat belt to ensure the resident does not slip out of the swivel lift chair. This may require the assistance of another staff to control the resident's transfer.	2 565		

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2 565	Continued From page 6 The facility Care Plan Policy revised November, 2016, indicated residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		12/15/17

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2 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 5 residents reviewed, (R1), when staff failed to follow the careplan and manufacturer instructions. This resulted in actual harm when R1 sustained multiple fractures, and died one week later as a result of the injuries. Findings include: R1's quarterly Minimum Data Set (MDS) dated July 14, 2017, indicated R1 required two staff and physical assistance with transferring, and one staff physical assistance with bathing. R1's care plan revised May 22, 2017, indicated R1 required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. R1 required two staff and a total lift and large high back sling for transfers. A checklist for pool nursing assistants dated August 18, 2017, and signed by licensed practical nurse (LPN)-C and nursing assistant (NA)-E, indicated LPN-C reviewed resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program with NA-E. An incident report dated September 10, 2017, indicated NA-E informed LPN-C that R1 fell out of the tub lift chair. LPN-C observed R1 on the tub room floor. R1 was on her back with arms crossed over her chest and right leg straight out.	2 830	Corrected	

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2 830	Continued From page 8 R1's left leg was straight out with the left foot and ankle in full counter clock rotation. Dark red blood and various sizes of blood clots were pooling by the left foot and ankle. R1 was alert and complained of right knee and neck pain. 911 was called and LPN-C remained with R1 until the ambulance arrived. Ambulance run sheet dated September 10, 2017, indicated skin from the left side of R1's left leg held R1's foot on the leg, and the bones of the left leg were visible. The ambulance transported the resident to the local hospital. R1's hospital records dated September 10, 2017, indicated R1 arrived at the emergency room via ambulance and x-rays were done. R1's x-rays indicated R1 had comminuted bilateral tibial and fibula fractures (break or splinter of the bones into more than two fragments in both lower legs). R1 had an open fracture of the left ankle (open wound or break in the skin near the site of the broken bone). R1 was transferred to a higher level of care hospital by helicopter. R1's records at the higher level of care hospital dated September 10, 2017, indicated hip fractures were suspected, however R1 was not a good candidate for any surgical interventions or procedures. R1 was placed on comfort cares and remained at the hospital until discharged to another facility on September 15, 2017, where R1 recieved hospice services until R1's death on September 17, 2017. The facility internal investigation dated September 11, 2017, indicated NA-E transferred R1 to the swivel lift chair with no second staff assistance. After the bath NA-E raised the resident in the swivel lift chair up and over the side of the tub,	2 830		

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2 830	Continued From page 9 removed the seat belt with the chair elevated to 3 1/2 feet, and attempted to put the sling under R1 when R1 fell out of the chair. NA-E left the resident on the floor and ran for help. R1's death certificate (undated) indicated R1 died on September 17, 2017, due to complications of multiple skeletal fractures, caused by a fall from a lift raised multiple feet. When interviewed on October 3, 2017, at 10:35 a.m., NA-E stated he had worked with R1 in the past and knew R1 required two staff to transfer. NA-E was assigned to give R1 a bath on September 10, 2017. When it was time to give R1 a bath, NA-E stated he felt rushed and did not want to wait for help. NA-E transferred R1 alone from R1's wheelchair to the tub chair using the total lift, and gave R1 a bath. NA-E stated he did not want to wait for staff assistance or for the water to drain from the tub to properly transfer R1 through the tub door, so instead NA-E removed R1 from the tub by lifting the tub chair with R1 in it up and over the side of the tub. NA-E stated R1 was elevated about 3 feet, at NA-E's chest level, when NA-E dried R1 off with a towel. R1 remained elevated as NA-E removed the seat belt, and attempted to place the lift sling under R1. R1 was wet and slippery which made it difficult for NA-E to hang onto R1, as NA-E moved R1 forward in the chair to place the lift sling. As R1 leaned forward in the chair, NA-E lost his grip on R1 and R1 fell out of the chair, landed on her feet, and fell onto her left side. NA-E stated R1's left ankle was twisted and the left leg broke. NA-E moved R1 away from the door by pulling on R1's gown, and left the tub room to get help. NA-E did not attempt to obtain help by using the phone, walkie talkie, or call light.	2 830		

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2 830	Continued From page 10 When interviewed on September 25, 2017, at 6:50 p.m., LPN-C stated NA-E ran down the hallway and told LPN-C to call 911, as R1 fell and was injured. LPN-C went to the tub room and found the swivel lift chair elevated above R1, who was lying on the floor with her left ankle detached from the bottom of her leg. LPN-C saw blood and blood clots around the injury, and R1 complained of right knee, neck, and head pain. LPN-C stabilized R1's head and neck, and provided support until EMS arrived. LPN-C stated the swivel lift chair should not have been elevated, NA-E should not have been transferring R1 alone, and NA-E should have stayed with R1 and used the phone, call light, or walkie talkie to call for help. When interviewed on September 26, 2017, at 4:10 p.m., NA-F stated she heard R1 scream and found LPN-C with R1 in the tub room and R1's left foot was almost detached from her leg. NA-F stated NA-E did not request help to transfer R1 from the tub after R1's bath, as indicated on the careplan and kardex (medical information system used by nursing staff to identify individual resident needs). When interviewed on September 29, 2017, at 3:20 p.m., NA-G stated staff are trained on and expected to follow the resident's careplan, and to transfer residents out of the tub in the tub chair through the tub door after the water has drained from the tub. When interviewed on October 3, 2017, at 2:50 p.m., LPN-D stated she reviewed the checklist for pool nursing assistants dated 8/18/17, with NA-E. The areas reviewed included resident care plans, safety rules, incident reports, use of mechanical	2 830		

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2 830	Continued From page 11 lifts, transfers, and the safe resident handling program. When interviewed on October 3, 2017, at 3:50 p.m., the administrator stated he saw R1 on the tub room floor with half her left ankle bone visible through R1's skin. NA-E told the administrator R1 was elevated in the tub chair, and when NA-E prepared to transfer R1 she fell out of the chair. NA-E was immediately suspended. When interviewed on October 9, 2017, at 4:30 p.m., the interim director of nursing (DON) stated she would expect staff to transfer R1 with two staff as directed on the careplan and kardex, and to follow the tub directions and transfer residents in and out of the tub through the tub door, and not up and over the side of the tub. The DON stated NA-E failed to follow the careplan, tub instructions, and the facility's safe resident handling program. When interviewed on October 31, 2017, at 4:35 p.m., the bathing system representative stated the top front edge of the swivel lift chair seat could be raised up to 3 1/2 feet. The representative stated they train the facility staff to follow the safe operation and daily maintenance instructions. The safe operation and daily maintenance instructions for the bathing system revised on April 19, 2013, indicated after the bath the tub is drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. Carefully remove the seat belt to ensure the resident does not slip out of the swivel lift chair. This may require the assistance	2 830		

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2 830	Continued From page 12 of another staff to control the resident's transfer. The facility Bathing Procedure revised May, 2017, indicated the procedure for tub (whirlpool) and shower bathing included using appropriate safety measures and equipment to prevent accidents. Manufacturer's directions should be followed for use of bathing equipment. Safety belts for bathing units, shower chairs and bathing lifts should be used at all times. Do not leave resident unattended. The facility Fall Prevention and Management Policy and Procedure revised May, 2016, indicated avoidable accidents mean that an accident occurred because the location failed to: implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident. The facility Abuse and Neglect Policy and Procedure revised November, 2016, indicated the purpose is to ensure the location has in place an effective system that, regardless of the source, prevents mistreatment and neglect of residents, and to ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated, reported and to prevent future injuries. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTIOIN: Twenty-one (21) days.	2 830		

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GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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) COMPLETE DATE
21850	Continued From page 13	21850		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, facility staff failed to ensure 1 of 5 residents reviewed, (R1), was free from maltreatment when R1 was neglected when staff removed R1 from the tub in a swivel lift chair elevated to 3 1/2 feet, unhooked the seat belt, and R1 fell out of the chair. This resulted in actual harm when R1 sustained multiple fractures, and died one week later as a result of the injuries. Findings include: R1's quarterly Minimum Data Set (MDS) dated July 14, 2017, indicated R1 required two staff and physical assistance with transferring, and one staff physical assistance with bathing.	21850	Corrected	12/15/17

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21850	Continued From page 14 R1's care plan revised May 22, 2017, indicated R1 required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. R1 required two staff and a total lift and large high back sling for transfers. A checklist for pool nursing assistants dated August 18, 2017, and signed by licensed practical nurse (LPN)-C and nursing assistant (NA)-E, indicated LPN-C reviewed resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program with NA-E. An incident report dated September 10, 2017, indicated NA-E informed LPN-C that R1 fell out of the tub lift chair. LPN-C observed R1 on the tub room floor. R1 was on her back with arms crossed over her chest and right leg straight out. R1's left leg was straight out with the left foot and ankle in full counter clock rotation. Dark red blood and various sizes of blood clots were pooling by the left foot and ankle. R1 was alert and complained of right knee and neck pain. 911 was called and LPN-C remained with R1 until the ambulance arrived. Ambulance run sheet dated September 10, 2017, indicated skin from the left side of R1's left leg held R1's foot on the leg, and the bones of the left leg were visible. The ambulance transported the resident to the local hospital. R1's hospital records dated September 10, 2017, indicated R1 arrived at the emergency room via ambulance and x-rays were done. R1's x-rays indicated R1 had comminuted bilateral tibial and fibula fractures (break or splinter of the bones into more than two fragments in both lower legs). R1	21850		

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21850	Continued From page 15 had an open fracture of the left ankle (open wound or break in the skin near the site of the broken bone). R1 was transferred to a higher level of care hospital by helicopter. R1's records at the higher level of care hospital dated September 10, 2017, indicated hip fractures were suspected, however R1 was not a good candidate for any surgical interventions or procedures. R1 was placed on comfort cares and remained at the hospital until discharged to another facility on September 15, 2017, where R1 recieved hospice services until R1's death on September 17, 2017. The facility internal investigation dated September 11, 2017, indicated NA-E transferred R1 to the swivel lift chair with no second staff assistance. After the bath NA-E raised the resident in the swivel lift chair up and over the side of the tub, removed the seat belt with the chair elevated to 3 1/2 feet, and attempted to put the sling under R1 when R1 fell out of the chair. NA-E left the resident on the floor and ran for help. R1's death certificate (undated) indicated R1 died on September 17, 2017, due to complications of multiple skeletal fractures, caused by a fall from a lift raised multiple feet. When interviewed on October 3, 2017, at 10:35 a.m., NA-E stated he had worked with R1 in the past and knew R1 required two staff to transfer. NA-E was assigned to give R1 a bath on September 10, 2017. When it was time to give R1 a bath, NA-E stated he felt rushed and did not want to wait for help. NA-E transferred R1 alone from R1's wheelchair to the tub chair using the total lift, and gave R1 a bath. NA-E stated he did not want to wait for staff assistance or for the	21850		

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21850	Continued From page 16 water to drain from the tub to properly transfer R1 through the tub door, so instead NA-E removed R1 from the tub by lifting the tub chair with R1 in it up and over the side of the tub. NA-E stated R1 was elevated about 3 feet, at NA-E's chest level, when NA-E dried R1 off with a towel. R1 remained elevated as NA-E removed the seat belt, and attempted to place the lift sling under R1. R1 was wet and slippery which made it difficult for NA-E to hang onto R1, as NA-E moved R1 forward in the chair to place the lift sling. As R1 leaned forward in the chair, NA-E lost his grip on R1 and R1 fell out of the chair, landed on her feet, and fell onto her left side. NA-E stated R1's left ankle was twisted and the left leg broke. NA-E moved R1 away from the door by pulling on R1's gown, and left the tub room to get help. NA-E did not attempt to obtain help by using the phone, walkie talkie, or call light. When interviewed on September 25, 2017, at 6:50 p.m., LPN-C stated NA-E ran down the hallway and told LPN-C to call 911, as R1 fell and was injured. LPN-C went to the tub room and found the swivel lift chair elevated above R1, who was lying on the floor with her left ankle detached from the bottom of her leg. LPN-C saw blood and blood clots around the injury, and R1 complained of right knee, neck, and head pain. LPN-C stabilized R1's head and neck, and provided support until EMS arrived. LPN-C stated the swivel lift chair should not have been elevated, NA-E should not have been transferring R1 alone, and NA-E should have stayed with R1 and used the phone, call light, or walkie talkie to call for help. When interviewed on September 26, 2017, at 4:10 p.m., NA-F stated she heard R1 scream and	21850		

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21850	Continued From page 17 found LPN-C with R1 in the tub room and R1's left foot was almost detached from her leg. NA-F stated NA-E did not request help to transfer R1 from the tub after R1's bath, as indicated on the careplan and kardex (medical information system used by nursing staff to identify individual resident needs). When interviewed on September 29, 2017, at 3:20 p.m., NA-G stated staff are trained on and expected to follow the resident's careplan, and to transfer residents out of the tub in the tub chair through the tub door after the water has drained from the tub. When interviewed on October 3, 2017, at 2:50 p.m., LPN-D stated she reviewed the checklist for pool nursing assistants dated 8/18/17, with NA-E. The areas reviewed included resident care plans, safety rules, incident reports, use of mechanical lifts, transfers, and the safe resident handling program. When interviewed on October 3, 2017, at 3:50 p.m., the administrator stated he saw R1 on the tub room floor with half her left ankle bone visible through R1's skin. NA-E told the administrator R1 was elevated in the tub chair, and when NA-E prepared to transfer R1 she fell out of the chair. NA-E was immediately suspended. When interviewed on October 9, 2017, at 4:30 p.m., the interim director of nursing (DON) stated she would expect staff to transfer R1 with two staff as directed on the careplan and kardex, and to follow the tub directions and transfer residents in and out of the tub through the tub door, and not up and over the side of the tub. The DON stated NA-E failed to follow the careplan, tub instructions, and the facility's safe resident	21850		

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21850	Continued From page 18 handling program. When interviewed on October 31, 2017, at 4:35 p.m., the bathing system representative stated the top front edge of the swivel lift chair seat could be raised up to 3 1/2 feet. The representative stated they train the facility staff to follow the safe operation and daily maintenance instructions. The safe operation and daily maintenance instructions for the bathing system revised on April 19, 2013, indicated after the bath the tub is drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. Carefully remove the seat belt to ensure the resident does not slip out of the swivel lift chair. This may require the assistance of another staff to control the resident's transfer. The facility Bathing Procedure revised May, 2017, indicated the procedure for tub (whirlpool) and shower bathing included using appropriate safety measures and equipment to prevent accidents. Manufacturer's directions should be followed for use of bathing equipment. Safety belts for bathing units, shower chairs and bathing lifts should be used at all times. Do not leave resident unattended. The facility Fall Prevention and Management Policy and Procedure revised May, 2016, indicated avoidable accidents mean that an accident occurred because the location failed to: implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident.	21850		

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21850	Continued From page 19 The facility Abuse and Neglect Policy and Procedure revised November, 2016, indicated the purpose is to ensure the location has in place an effective system that, regardless of the source, prevents mistreatment and neglect of residents, and to ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated, reported and to prevent future injuries. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedure related to lifts, transfers, careplans, and safety. The DON or designee, could provide training for all nursing staff related to the policies and procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 6, 2017

Mr. Marcus Parence, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Re: State Nursing Home Licensing Orders - Complaint Number H5237010

Dear Mr. Parence:

A complaint investigation was completed on November 15, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697