MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Shakopee Friendship Manor	H5445022 & H5445023	November 15, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
1340 3rd Avenue West	9:00 am - 2:00 pm	January 26, 2017
Facility City:	**Investigator's Name and Title:**	
Shakopee	Deborah Neuberger, RN	

State:	ZIP:	County:
Minnesota	55379	Scott

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when the resident fell from a mechanical lift from the height of his/her bed and sustained an injury on on his/her head.

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

Conclusion:
Based on a preponderance of evidence, the resident was neglected when s/he fell from the mechanical lift and sustained a laceration to his/her head requiring stitches. Although the staff members involved stated they used the lift in the manner they were trained, the sling became detached from the lift and the resident fell from the sling. No maintenance records for the lift could be located.

Medical record review revealed the resident was admitted to the facility with diagnoses that included osteoarthritis and chronic pain. The resident's care plan indicated the resident was to be transferred with the maximum assistance of 2 staff and a mechanical lift. (A mechanical lift is a mechanical lift device that uses a sling and the device to lift a resident and move them from one surface to another such as from a bed to a chair.)

Staff interviews revealed on 9/7/2016 two staff members, AP1 and AP2, were getting the resident out of bed using the mechanical lift. During the lift, the resident fell out of the lift sling. Staff members stated they attached the sling to the lift in the usual manner and lifted the resident off the bed. When moving the resident to the wheelchair, the wheels on the lift caught and staff had to push the lift hard to get it to move. During the transfer the resident slid out of the sling head first to the floor. After the resident fell to the floor, staff observed the sling was attached by only 3 of the 4 attachment points. Staff stated the wheels on the lift had been sticking, and staff told maintenance about the issue, but the problem continued. Staff called 911 and sent the resident to the hospital for evaluation after the fall.

The hospital record revealed the resident was evaluated in the hospital, received stitches to a laceration to his/her head, but CT scan and X-Rays were negative for fracture or further injury. The resident went back to the facility the next day with his/her pain controlled with oral medication.

During an interview, the resident stated s/he fell when staff were trying to help him/her get up. The resident stated s/he is getting better, but still has some pain related to injuries sustained in the fall.

During an interview, the resident's family member stated facility staff informed him/her of the resident's fall from the lift, but s/he did not know a lot of details of what happened. The resident went to the hospital after the fall and had four stitches to his/her head. The resident is feeling better now, and did not break any bones.

During interviews, maintenance staff stated the lift involved in the incident had been discarded and was not available for observation. Maintenance staff stated they received a concern related to sticking wheels on the lift in July 2016, but they were not able to identify which lift needed repair, because there was no consistent way to identify the lifts in use at the facility. In July 2016, they lubricated and cleaned the wheels on all the lifts and the lifts seemed to be functioning correctly at that time. Maintenance staff stated they had no documentation of the maintenance done on the lift in question, because the maintenance staff use different descriptions of the lifts than the nursing assistant staff. Maintenance staff have to walk around and try to ask staff which lift they are referring to when they get a concern. Maintenance provide a monthly cleaning, dusting and oiling of the lifts, but this is not documented.

Manufacturers recommendations for maintenance of the lift includes regularly checking all areas of the lift including the hanger assembly, all bolts, cotter pins, sling hanger/spreader bar meet points, hanger spreader wear points, hooks, mounting bolts, actuator, emergency stop switch, emergency lowering feature, anti-pinch feature, wheels and brakes, and every six months use a test load to check for unusual sounds/noises and check all welds for cracks.

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:

Click Here and Type

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 failed to have policies in place and failed to maintain mechanical lifts as recommended by the manufacturer.

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:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

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 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:

Facility Corrective Action:

The facility took the following corrective action(s):

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] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records

Other pertinent medical records:

☒ Hospital Records

Additional facility records:

☒ Resident/Family Council Minutes
☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: 5

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: _____

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact complainant, 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: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: 4

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 9

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
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues

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: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Shakopee Police Department

Scott County Attorney

Shakopee City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	C 11/22/2016

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

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #H5445022 & H5445023. As a result, the following deficiency is issued.	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement policies to prohibit neglect for 1 of 6 residents reviewed, Resident #1 (R1), when the facility had no adequate scheduled maintenance system for patient lift devices, and the wheels on the EZ Way (hoyer/mechanical) lift device were sticking. During a lift, the wheels stuck, and when staff attempted to move the lift, a strap of the sling came off the lift and R1 fell from the lift. R1 was hospitalized and required stitches to her head. Findings include: Medical record review revealed R1 was admitted to the facility in 2011 with diagnoses that included Osteoarthritis and Chronic Pain. R1's care plan, dated 6/27/2016 indicated R1 was to be transferred with the maximum assistance of 2 staff and a Hoyer lift. (A Hoyer lift is a mechanical lift device that uses a sling and the device to lift a resident and move them from one surface to	F 224		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 another, such as from a bed to a chair.) Nursing notes dated 9/7/2016 and written by Licensed Practical Nurse (LPN)-D revealed R1 was on the floor on her right side after sliding out of the hoyer body sling and falling to the floor. R1 was noted to be bleeding from her head and was sent to the hospital for evaluation. Hospital records dated 9/7/2016 revealed R1 was admitted to the hospital following a fall due to mechanical reasons. R1 was diagnosed with scalp trauma and received stitches. CT scan and X-rays were negative, and R1 transferred back to the facility the next day with her pain controlled with oral medications. During an interview on 11/15/2016 at 9:30 a.m., Nursing Assistant (NA)-C stated on 9/7/2016 at about 7:00 a.m. NA-C was assisting NA-E to get R1 out of bed and ready for breakfast. NA-C stated they put the Hoyer sling under R1 and hooked the sling to the lift in the usual manner. NA-C and NA-E lifted the resident off the bed and she looked stable in the lift and sling. When they attempted to turn the Hoyer to move the resident to the wheelchair the lift wheels caught, and NA-C had to forcefully push the lift in an attempt to get it to move toward the wheelchair. R1 slid out of the sling and fell head first onto the floor. NA-C stated he thought all 4 points of the sling were attached at the time of the fall. NA-C stated the lift in use at the time this occurred was old and the wheels on the lift would lock or catch at times and the staff had to forcefully push the lift to get it to move. NA-C stated the staff had reported the issue of the lift wheels catching to maintenance on prior occasions, but the problem continued.	F 224		

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F 224	Continued From page 2 During an interview with NA-E on 11/15/2016 at 9:55 a.m., NA-E stated she was assisting NA-C with the transfer of R1 on 9/7/2016. NA-C stated she thought the straps on the sling were hooked up as usual during the lift. When the staff attempted to turn the Hoyer, the wheels stuck and the staff had to "yank" on the lift to get it to move. R1 then fell head first out of the lift. After R1 fell, NA-E noted that one of the four straps that had been attached to the lift was hanging loose. NA-E stated that the wheels on this lift had a history of sticking or catching, and this had been reported to maintenance staff, but the problem persisted. During an interview on 11/15/2016 at 10:35 a.m., LPN-D stated on 9/7/2016 she was called into R1's room and R1 was on the floor and was bleeding from her head. The Hoyer sling was hanging from the lift with 3 of the 4 sling attachment points attached to the lift. R1's vital signs were stable, but she was crying out in pain. LPN-D stated she had staff call 911 and sent R1 to the hospital for evaluation. LPN-D stated R1 has since returned from the hospital and has returned to her baseline condition. LPN-D stated the staff had no explanation as to how the sling became detached from the lift. During an interview with Maintenance staff (MS)-F and MS-G on 11/15/2016 at 12:20 p.m., they stated the lift involved in the incident had been removed from the facility and was not available for observation because they were not able to replace the wheels in the lift so the lift was discarded. MS-F and MS-G stated in July 2016 they received a concern related to wheels sticking on a lift, but they were not able to identify which lift staff were talking about, because there was no consistent way to identify the lifts in use at the	F 224		

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F 224	Continued From page 3 facility. In July 2016 they stated they lubricated the wheels and cleaned the wheels on the lifts. Maintenance staff stated they had no documentation of the maintenance done on the lift in question because the maintenance staff do not use the same descriptions of the lifts as the nursing assistant staff, so they just have to walk around and try to ask staff which lift they are referring to when they get a concern. Maintenance staff stated the maintenance they provide monthly includes a monthly cleaning, dusting and oiling of the lifts, but this is not documented anywhere. During an interview on 11/15/2016 at 1:10 p.m., R1 stated she fell when staff were helping get her up. R1 stated she did not know what happened, but she had severe pain after the fall and had stitches to her head. R1 stated she is feeling better, but still has pain related to the injuries sustained from the fall. The manufacturers instructions for the EZ way Smart Lift, provided by facility staff, revised 8/10/15 revealed: All EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. 1) Check wear of the hanger assembly bushing by moving the hanger assembly up and down. If hanger assembly moves up and down and the thickness of 2 quarters can be inserted between the hanger assembly and the load cell the hanger assembly needs to be replaced. 2) Check all bolts to ensure they are tight. 3) Check boom hanger assembly pivot bolt, peel rubber back to assure nut is tight and cotter pin is in place. Check boom to mast pivot bolt by removing plastic cap to assure nut is tight and cotter pin is in place. If plastic cap is missing order replacement. 4) Check the point	F 224		

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F 224	Continued From page 4 where the sling hanger and hanger spreader bar meet. If excessively worn, replace the bushings immediately. The hanger spreader and the sling hanger wear points need to be checked for wear. If hooks appear worn, call EZ Way for instructions...9) check all wheels and brakes to make sure they are functioning properly. Hair that gets picked up and wrapped between wheels should be cleaned out so that the lift will roll easily.	F 224		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the resident environment was free of accident hazards for 1 of 6 residents reviewed, Resident #1 (R1), when the facility had no adequate scheduled maintenance system for patient lift devices, and the wheels on the EZ Way (hoyer/mechanical) lift device were sticking. During a lift, the wheels stuck, and when staff continued to push the device, a strap of the sling came off the lift, and R1 fell from the lift. R1 was hospitalized and required stitches to her head. Findings include: Medical record review revealed R1 was admitted	F 323		

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F 323	Continued From page 5 to the facility in 2011 with diagnoses that included Osteoarthritis and Chronic Pain. R1's care plan, dated 6/27/2016 indicated R1 was to be transferred with the maximum assistance of 2 staff and a Hoyer lift. (A Hoyer lift is a mechanical lift device that uses a sling and the device to lift a resident and move them from one surface to another such as from a bed to a chair.) Nursing notes dated 9/7/2016 and written by Licensed Practical Nurse (LPN)-D revealed R1 was on the floor on her right side after sliding out of the hoyer body sling and falling to the floor. R1 was noted to be bleeding from her head and was sent to the hospital for evaluation. Hospital records dated 9/7/2016 revealed R1 was admitted to the hospital following a fall due to mechanical reasons. R1 was diagnosed with scalp trauma and received stitches. CT scan and X-rays were negative, and R1 transferred back to the facility the next day with her pain controlled with oral medications. During an interview on 11/15/2016 at 9:30 a.m., Nursing Assistant (NA)-C stated on 9/7/2016 at about 7:00 a.m. NA-C was assisting NA-E to get R1 out of bed and ready for breakfast. NA-C stated they put the Hoyer sling under R1 and hooked the sling to the lift in the usual manner. NA-C and NA-E lifted the resident off the bed and she looked stable in the lift and sling. When they attempted to turn the Hoyer to move the resident to the wheelchair, the lift wheels caught and NA-C had to forcefully push the lift in an attempt to get it to move toward the wheelchair. R1 slid out of the sling and fell head first onto the floor. NA-C stated he thought all 4 points of the sling were attached at the time of the fall. NA-C stated the lift in use at	F 323		

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F 323	Continued From page 6	F 323		

the time this occurred was old and the wheels on the lift would lock or catch at times and the staff had to forcefully push the lift to get it to move. NA-C stated the staff had reported the issue of the lift wheels catching to maintenance on prior occasions, but the problem continued.

During an interview with NA-E on 11/15/2016 at 9:55 a.m., NA-E stated she was assisting NA-C with the transfer of R1 on 9/7/2016. NA-C stated she thought the straps on the sling were hooked up as usual during the lift. When the staff attempted to turn the Hoyer, the wheels stuck and the staff had to "yank" on the lift to get it to move. R1 then fell head first out of the lift. After R1 fell NA-E noted that one of the four straps that had been attached to the lift was hanging loose. NA-E stated that the wheels on this lift had a history of sticking or catching, and this had been reported to maintenance staff, but the problem persisted.

During an interview on 11/15/2016 at 10:35 a.m., LPN-D stated on 9/7/2016 she was called into R1's room and R1 was on the floor and was bleeding from her head. The Hoyer sling was hanging from the lift with 3 of the 4 sling attachment points attached to the lift. R1's vital signs were stable, but she was crying out in pain. LPN-D stated she had staff call 911 and sent R1 to the hospital for evaluation. LPN-D stated R1 has since returned from the hospital and has returned to her baseline condition. LPN-D stated the staff had no explanation as to how the sling became detached from the lift.

During an interview with Maintenance staff (MS)-F and MS-G on 11/15/2016 at 12:20 p.m., they stated the lift involved in the incident had been removed from the facility and was not

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F 323	Continued From page 7 available for observation because they were not able to replace the wheels in the lift so the lift was discarded. MS-F and MS-G stated in July 2016 they received a concern related to wheels sticking on a lift, but they were not able to identify which lift staff were talking about, because there was no consistent way to identify the lifts in use at the facility. In July 2016 they stated they lubricated the wheels and cleaned the wheels on the lifts. Maintenance staff stated they had no documentation of the maintenance done on the lift in question because the maintenance staff do not use the same descriptions of the lifts as the nursing assistant staff, so they just have to walk around and try to ask staff which lift they are referring to when they get a concern. Maintenance staff stated the maintenance they provide monthly includes a monthly cleaning, dusting and oiling of the lifts, but this is not documented anywhere. During an interview on 11/15/2016 at 1:10 p.m., R1 stated she fell when staff were helping get her up. R1 stated she did not know what happened, but she had severe pain after the fall and had stitches to her head. R1 stated she is feeling better, but still has pain related to the injuries sustained from the fall. The manufacturers instructions for the EZ way Smart Lift, provided by facility staff, revised 8/10/15 revealed: All EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. 1) Check wear of the hanger assembly bushing by moving the hanger assembly up and down. If hanger assembly moves up and down and the thickness of 2 quarters can be inserted between the hanger assembly and the load cell the hanger assembly	F 323		

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	245445	A. BUILDING _____ B. WING _____	C 11/22/2016

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F 323	Continued From page 8 needs to be replaced. 2) Check all bolts to ensure they are tight. 3) Check boom hanger assembly pivot bolt, peel rubber back to assure nut is tight and cotter pin is in place. Check boom to mast pivot bolt by removing plastic cap to assure nut is tight and cotter pin is in place. If plastic cap is missing order replacement. 4) Check the point where the sling hanger and hanger spreader bar meet. If excessively worn, replace the bushings immediately. The hanger spreader and the sling hanger wear points need to be checked for wear. If hooks appear worn, call EZ Way for instructions...9) check all wheels and brakes to make sure they are functioning properly. Hair that gets picked up and wrapped between wheels should be cleaned out so that the lift will roll easily.	F 323		

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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 complaint investigation was conducted to investigate complaint #H5445022 and H5445023. The following correction orders are issued:	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors 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.	
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		

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21665	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide a safe physical environment for 1 of 6 residents reviewed, Resident #1 (R1), when the facility had no adequate scheduled maintenance system for patient lift devices, and the wheels on the EZ Way (hoyer/mechanical) lift device were sticking. During a lift of R1, the wheels stuck,and when staff attempted to continue to move the lift, a strap of the sling came off the lift, and R1 fell from the lift. R1 was hospitalized and required stitches to her head. Findings include: Medical record review revealed R1 was admitted to the facility in 2011 with diagnoses that included Osteoarthritis and Chronic Pain. R1's care plan, dated 6/27/2016 indicated R1 was to be transferred with the maximum assistance of 2 staff and a Hoyer lift. (A Hoyer lift is a mechanical lift device that uses a sling and the device to lift a resident and move them from one surface to another such as from a bed to a chair.) Nursing notes dated 9/7/2016 and written by Licensed Practical Nurse (LPN)-D revealed R1 was on the floor on her right side after sliding out of the hoyer body sling and falling to the floor. R1 was noted to be bleeding from her head and was sent to the hospital for evaluation. Hospital records dated 9/7/2016 revealed R1 was admitted to the hospital following a fall due to mechanical reasons. R1 was diagnosed with scalp trauma and received stitches. CT scan and X-rays were negative, and R1 transferred back to the facility the next day with her pain controlled with oral medications.	21665		

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21665	Continued From page 3 During an interview on 11/15/2016 at 9:30 a.m., Nursing Assistant (NA)-C stated on 9/7/2016 at about 7:00 a.m. NA-C was assisting NA-E to get R1 out of bed and ready for breakfast. NA-C stated they put the Hoyer sling under R1 and hooked the sling to the lift in the usual manner. NA-C and NA-E lifted the resident off the bed and she looked stable in the lift and sling. When they attempted to turn the Hoyer to move the resident to the wheelchair the lift wheels caught and NA-C had to forcefully push the lift in an attempt to get it to move toward the wheelchair. R1 slid out of the sling and fell, head first, onto the floor. NA-C stated he thought all 4 points of the sling were attached at the time of the fall. NA-C stated the lift in use at the time this occurred was old and the wheels on the lift would lock or catch at times and the staff had to forcefully push the lift to get it to move. NA-C stated the staff had reported the issue of the lift wheels catching to maintenance on prior occasions, but the problem continued. During an interview with NA-E on 11/15/2016 at 9:55 a.m., NA-E stated she was assisting NA-C with the transfer of R1 on 9/7/2016. NA-C stated she thought the straps on the sling were hooked up as usual during the lift. When the staff attempted to turn the lift, the wheels stuck and the staff had to "yank" on the lift to get it to move. R1 then fell, head first, out of the lift. After R1 fell NA-E noted that one of the four straps that had been attached to the lift was hanging loose. NA-E stated that the wheels on this lift had a history of sticking or catching, and this had been reported to maintenance staff, but the problem persisted. During an interview on 11/15/2016 at 10:35 a.m., LPN-D stated on 9/7/2016 she was called into R1's room and R1 was on the floor and was	21665		

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21665	Continued From page 4 bleeding from her head. The lift sling was hanging from the lift with 3 of the 4 sling attachment points attached to the lift. R1's vital signs were stable, but she was crying out in pain. LPN-D stated she had staff call 911 and sent R1 to the hospital for evaluation. LPN-D stated R1 has since returned from the hospital and has returned to her baseline condition. LPN-D stated the staff had no explanation as to how the sling became detached from the lift. During an interview on 11/15/2016 at 1:10 p.m., R1 stated she fell when staff were helping get her up. R1 stated she did not know what happened, but she had severe pain after the fall and had stitches to her head. R1 stated she is feeling better, but still has pain related to the injuries sustained from the fall. During an interview with Maintenance staff (MS)-F and MS-G on 11/15/2016 at 12:20 p.m., they stated the lift involved in the incident had been discarded and was not available for observation. MS-F and MS-G stated in July 2016 they received a concern related to wheels sticking on a lift, but they were not able to identify which lift staff were talking about, because there was no consistent way to identify the lifts in use at the facility. In July 2016 they stated they lubricated the wheels and cleaned the wheels on all the lifts. Maintenance staff stated they had no documentation of the maintenance done on the lift in question because the maintenance staff do not use the same descriptions of the lifts as the nursing assistant staff, so they have to walk around and try to ask staff which lift they are referring to when they get a concern. Maintenance staff stated the maintenance they provide monthly includes a monthly cleaning, dusting and oiling of the lifts, but this is not	21665		

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21665	Continued From page 5 documented anywhere. The manufacturers instructions for the EZ way Smart Lift, provided by facility staff, revised 8/10/15 revealed: All EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. 1) Check wear of the hanger assembly bushing by moving the hanger assembly up and down. If hanger assembly moves up and down and the thickness of 2 quarters can be inserted between the hanger assembly and the load cell the hanger assembly needs to be replaced. 2) Check all bolts to ensure they are tight. 3) Check boom hanger assembly pivot bolt, peel rubber back to assure nut is tight and cotter pin is in place. Check boom to mast pivot bolt by removing plastic cap to assure nut is tight and cotter pin is in place. If plastic cap is missing order replacement. 4) Check the point where the sling hanger and hanger spreader bar meet. If excessively worn, replace the bushings immediately. The hanger spreader and the sling hanger wear points need to be checked for wear. If hooks appear worn, call EZ Way for instructions...9) check all wheels and brakes to make sure they are functioning properly. Hair that gets picked up and wrapped between wheels should be cleaned out so that the lift will roll easily. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could review facility policy and procedures, update the relevant policies, train staff related to the updated policies and monitor staff implementing the policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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21850	Continued From page 6	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 the facility failed to ensure 1 of 6 residents reviewed Resident #1 (R1), was free from neglect when when the facility had no adequate scheduled maintenance system for patient lift devices, and the wheels on the EZ Way (hoyer/mechanical) lift device were sticking. During a lift of R1, the wheels stuck, and when staff attempted to continue to move the lift, a strap of the sling came off the lift and R1 fell from the lift. R1 was hospitalized and required stitches to her head. Findings include: Medical record review revealed R1 was admitted to the facility in 2011 with diagnoses that included Osteoarthritis and Chronic Pain. R1's care plan, dated 6/27/2016 indicated R1 was to be transferred with the maximum assistance of 2	21850		

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21850	Continued From page 7 staff and a Hoyer lift. (A Hoyer lift is a mechanical lift device that uses a sling and the device to lift a resident and move them from one surface to another such as from a bed to a chair.) Nursing notes dated 9/7/2016 and written by Licensed Practical Nurse (LPN)-D revealed R1 was on the floor on her right side after sliding out of the hoyer body sling and falling to the floor. R1 was noted to be bleeding from her head and was sent to the hospital for evaluation. Hospital records dated 9/7/2016 revealed R1 was admitted to the hospital following a fall due to mechanical reasons. R1 was diagnosed with scalp trauma and received stitches. CT scan and X-rays were negative, and R1 transferred back to the facility the next day with her pain controlled with oral medications. During an interview on 11/15/2016 at 9:30 a.m., Nursing Assistant (NA)-C stated on 9/7/2016 at about 7:00 a.m. NA-C was assisting NA-E to get R1 out of bed and ready for breakfast. NA-C stated they put the Hoyer sling under R1 and hooked the sling to the lift in the usual manner. NA-C and NA-E lifted the resident off the bed and she looked stable in the lift and sling. When they attempted to turn the Hoyer to move the resident to the wheelchair the lift wheels caught and NA-C had to forcefully push the lift in an attempt to get it to move toward the wheelchair. R1 slid out of the sling and fell, head first, onto the floor. NA-C stated he thought all 4 points of the sling were attached at the time of the fall. NA-C stated the lift in use at the time this occurred was old and the wheels on the lift would lock or catch at times and the staff had to forcefully push the lift to get it to move. NA-C stated the staff had reported the issue of the lift wheels catching to maintenance	21850		

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21850	Continued From page 8 on prior occasions, but the problem continued. During an interview with NA-E on 11/15/2016 at 9:55 a.m., NA-E stated she was assisting NA-C with the transfer of R1 on 9/7/2016. NA-C stated she thought the straps on the sling were hooked up as usual during the lift. When the staff attempted to turn the lift, the wheels stuck and the staff had to "yank" on the lift to get it to move. R1 then fell, head first, out of the lift. After R1 fell NA-E noted that one of the four straps that had been attached to the lift was hanging loose. NA-E stated that the wheels on this lift had a history of sticking or catching, and this had been reported to maintenance staff, but the problem persisted. During an interview on 11/15/2016 at 10:35 a.m., LPN-D stated on 9/7/2016 she was called into R1's room and R1 was on the floor and was bleeding from her head. The lift sling was hanging from the lift with 3 of the 4 sling attachment points attached to the lift. R1's vital signs were stable, but she was crying out in pain. LPN-D stated she had staff call 911 and sent R1 to the hospital for evaluation. LPN-D stated R1 has since returned from the hospital and has returned to her baseline condition. LPN-D stated the staff had no explanation as to how the sling became detached from the lift. During an interview on 11/15/2016 at 1:10 p.m., R1 stated she fell when staff were helping get her up. R1 stated she did not know what happened, but she had severe pain after the fall and had stitches to her head. R1 stated she is feeling better, but still has pain related to the injuries sustained from the fall. During an interview with Maintenance staff (MS)-F and MS-G on 11/15/2016 at 12:20 p.m.,	21850		

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21850	Continued From page 9 they stated the lift involved in the incident had been discarded and was not available for observation. MS-F and MS-G stated in July 2016 they received a concern related to wheels sticking on a lift, but they were not able to identify which lift staff were talking about, because there was no consistent way to identify the lifts in use at the facility. In July 2016 they stated they lubricated the wheels and cleaned the wheels on all the lifts. Maintenance staff stated they had no documentation of the maintenance done on the lift in question because the maintenance staff do not use the same descriptions of the lifts as the nursing assistant staff, so they have to walk around and try to ask staff which lift they are referring to when they get a concern. Maintenance staff stated the maintenance they provide monthly includes a monthly cleaning, dusting and oiling of the lifts, but this is not documented anywhere. The manufacturers instructions for the EZ way Smart Lift, provided by facility staff, revised 8/10/15 revealed: All EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. 1) Check wear of the hanger assembly bushing by moving the hanger assembly up and down. If hanger assembly moves up and down and the thickness of 2 quarters can be inserted between the hanger assembly and the load cell the hanger assembly needs to be replaced. 2) Check all bolts to ensure they are tight. 3) Check boom hanger assembly pivot bolt, peel rubber back to assure nut is tight and cotter pin is in place. Check boom to mast pivot bolt by removing plastic cap to assure nut is tight and cotter pin is in place. If plastic cap is missing order replacement. 4) Check the point where the sling hanger and hanger spreader bar meet. If excessively worn, replace the bushings	21850		

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21850	Continued From page 10 immediately. The hanger spreader and the sling hanger wear points need to be checked for wear. If hooks appear worn, call EZ Way for instructions...9) check all wheels and brakes to make sure they are functioning properly. Hair that gets picked up and wrapped between wheels should be cleaned out so that the lift will roll easily. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could review facility policy and procedures, update the relevant policies, train staff related to the updated policies and monitor staff implementing the policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		