MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Mala Strana Care & Rehab Ctr.	H5514012	May 17, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
1001 Columbus Avenue North	7:30 a.m. - 4:00 p.m.	August 30, 2016
Facility City:	**Investigator's Name and Title:**	
New Prague	Debora Palmer RN/Special Investigator	

State:	ZIP:	County:
Minnesota	56071	Scott

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when an employee, the Alleged Perpetrator (AP), did not follow the resident's care plan and the resident fell, resulting in multiple facial injuries.

- ☒ 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 did occur when the AP did not adhere to the resident's fall risk care plan interventions to maintain the resident's safety. The AP transferred the resident to bed with a mechanical lift and did not obtain the assistance of a second staff person to safeguard the resident. The AP then left the resident's room but did not move the mechanical lift away from resident's bedside, did not lower the bed from the high position, and did not place the fall mattress on the floor next to the resident's bed. While unattended, the resident rolled out of the bed, struck his/her head on the mechanical lift, and sustained a hematoma to the forehead and lacerations to the inner cheek and inner lip.

The resident was admitted to the facility with a terminal diagnosis. The resident was declining rapidly, receiving hospice care, and had stopped eating. The resident had severe cognitive impairment and was legally blind. The resident was completely reliant on staff to meet all of his/her care needs. The resident had intense abdominal pain related to end-stage disease, resulting in continual restlessness and agitation, despite the administration of comfort medications. The resident slept only short intervals of one to two hours. The resident constantly tried to get out of bed or out of the Broda chair. For all these reasons, the resident was at high risk for falls. The resident's care plan indicated that staff were to maintain the resident's safety by transferring the resident with a mechanical lift (full body lift) and the assistance of two staff, positioning the resident in bed with pillows, and keeping the bed in the low position with a fall mattress on the floor next to the bed. Staff were to check on the resident every hour when s/he was in bed. When the resident was awake, the resident was transferred to a Broda chair which was placed at the nurse's station or within eyesight of staff for 1:1 monitoring, due to the resident's level of restlessness and

high risk for falls.

The resident resided in the facility for thirteen days before s/he died from the terminal condition. The resident had seven falls during the first ten days in the facility. Six of seven falls occurred when the resident rolled out of bed; one fall occurred when the resident wiggled out of the Broda chair. Only one fall resulted in injury, which occurred during the evening shift of the resident's tenth day in the facility when the AP was assigned to the resident's care. That evening, the resident had been restless and agitated per usual so the resident was reclined in the Broda chair at the nurse's station under 1:1 supervision. Around 9:00 p.m., the AP took the resident to his/her room to do bedtime care. The AP cleansed the upper half of the resident's body while the resident sat in the Broda chair. The AP then attached the resident's transfer sling, which was underneath the resident in the Broda chair, to the mechanical lift. The AP used the walkie to call for a second staff to come and assist with the resident's transfer. No one immediately responded and the AP did not wait for assistance (length of time unknown). The AP used the mechanical lift alone, without the second staff. The AP raised the resident up out of the Broda chair and cleansed the lower half of the resident's body while the resident was suspended in the sling. Afterward, the AP transferred the resident to bed and removed the transfer sling from underneath the resident. The resident's bed was in the high position. The AP then left the resident's room to go to the linen room to get clean gripper socks. The AP did not lower the resident's bed, place the resident's fall mattress on the floor next to the resident's bed, or remove the mechanical lift from the resident's bedside, prior to leaving the resident's room. The AP returned to the resident's room one to two minutes later. The resident had rolled out of bed onto the floor on top of the mechanical lift. The resident's head struck the mechanical lift during the fall. The resident was moaning. The resident was bleeding from his/her mouth and had a hematoma on the forehead. When interviewed, the AP stated that s/he knew the resident's care plan included fall risk safety interventions for two staff to transfer the resident, to keep the resident's bed in the lowest position, and to keep a fall mattress on the floor next to the resident's bed, due to the number of falls the resident had as a result of restless behavior. The AP did not know why s/he failed to follow the resident's care plan and expressed remorse about the incident. The AP stated s/he used the walkie and called for a nurse who immediately responded and assessed the resident. Several staff assisted with the resident's mechanical lift transfer to the Broda chair and the resident was taken to the nurse's station for 1:1 monitoring. The nurse notified the hospice provider and family about the resident's fall and injuries. Aggressive intervention was declined. Additional comfort measures were undertaken. The resident was unresponsive within fourteen hours and died two days later. The resident's cause of death was related to the resident's end-stage disease process.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 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 had provided the AP with orientation and training relative to her job responsibilities, including mechanical lift transfers, care of residents with cognitive impairments, the importance of following individualized care plans, abuse and neglect prohibition, and resident rights. The AP was familiar with the resident's needs, had provided the resident's care previously, and had assisted other staff several times with the resident's mechanical lift transfers. On the evening of the resident's fall, the unit was fully staffed with the normal complement of care givers.

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 Met
The facility was found to be in compliance with Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B). No deficiencies were issued.

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

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.

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.

The Investigation included the following:

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

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Care Plan Records
- ☒ Skin Assessments
- ☒ Facility Incident Reports
- ☒ Therapy and/or Ancillary Services Records
- ☒ Other, specify:

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] 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: The resident was deceased.

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: 6

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 5

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
☒ Use of Equipment
☒ 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: _____

cc:

Health Regulation Division - Licensing & Certification

Scott County Medical Examiners

New Prague Police Department

Scott County Attorney

New Prague City Attorney

Office of the Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245514	A. BUILDING _____ B. WING _____	C 08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CENTER	1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaints #H5514010 and #H5514012. Mala Strana Care & Rehab Center 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 you acknowledge receipt of the electronic documents.	F 000		

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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	00811	A. BUILDING: _____ B. WING _____	C 08/03/2016

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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: Complaint investigations were conducted to investigate complaints #H5514010 and #H5514012. The following correction order is issued: The facility has agreed to participate in the electronic receipt of State licensure orders	2 000		

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2 000	Continued From page 1 consistent with the Minnesota Department of 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 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		
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, neglect did occur when facility staff failed to adhere to the	21850		

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21850	Continued From page 2	21850		

resident's fall risk care plan interventions (R1) to maintain the resident's safety and the resident fell from bed, sustaining a hematoma to the forehead and lacerations to the inner cheek and inner lip.

The admission history and assessment indicated that R1 was admitted to the facility on 02/05/16 with a terminal diagnosis and was rapidly declining. R1 was receiving hospice care and had stopped eating. R1 had severe cognitive impairment and was legally blind. R1 was completely reliant on staff to meet all of his/her care needs. R1 had intense abdominal pain related to end-stage disease, resulting in continual restlessness and agitation, despite the administration of comfort medications. R1 slept only short intervals of one to two hours. R1 constantly tried to get out of bed or out of the Broda chair. For all these reasons, R1 was at high risk for falls.

R1's admission care plan, dated 02/06/16, indicated that staff were to maintain R1's safety by transferring R1 with a mechanical lift (full body lift) and the assistance of two staff, positioning R1 in bed with pillows, and keeping R1's bed in the low position with a fall mattress on the floor next to the bed.

Daily documentation in the nursing progress notes by facility and hospice staff from 02/05/16 to 02/15/16 depicted R1's ongoing struggle with restlessness, agitation, abdominal pain, confusion, and unsafe movement. When R1 was awake, R1 was to be transferred to a Broda chair and positioned at the nurse's station or within eyesight of staff, due to R1's level of restlessness and high risk for falls. R1 was maintained on 1:1 staffing during all waking hours. Staff were to check on R1 every hour when R1 was in bed.

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Incident reports indicated that R1 had seven falls during the first 10 days in the facility. One fall occurred when R1 wiggled out of the Broda chair on 02/06/16. Five falls occurred when R1 rolled out of bed onto the floor mattress on 02/05/16, 02/06/16, 02/11/16, 02/14/16, and the early morning of 02/15/16. R1 was not injured during any of these falls. R1's last fall occurred during the evening of 02/15/16 when R1 rolled out of bed onto the mechanical lift and was found bleeding from the mouth with a large "goose egg" in the middle of the forehead.
The facility's staffing schedule indicated that Nursing Assistant (NA)/F was assigned to R1's care during the evening of 02/15/16.

An interview was conducted with NA/F on 05/17/16 at 2:00 p.m. NA/F stated she was familiar with R1, had performed R1's care prior to 02/15/16, and had also assisted other staff with R1's transfers in the full body mechanical lift. NA/F stated she was aware of R1's need for close supervision due to restless behavior resulting in several falls. During the evening shift of 02/15/16, R1 had been restless and agitated per usual so R1 was reclined in the Broda chair at the nurse's station on 1:1 monitoring. Around 9:00 p.m., NA/F took R1 to R1's room to do bedtime care. NA/F cleansed the upper half of R1's body while R1 sat in the Broda chair. The transfer sling was underneath R1 in the Broda chair. NA/F then attached the transfer sling to the mechanical lift. NA/F used the walkie to call for a second staff to come and assist with R1's transfer. No one immediately responded. NA/F did not wait for assistance from a second staff (length of time unknown). NA/F used the mechanical lift alone, without the second staff. NA/F raised R1 up out of the Broda chair and cleansed the lower half of R1's body while R1

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21850	Continued From page 4 was suspended in the sling. Afterward, NA/F transferred R1 to bed and removed the transfer sling from underneath R1. R1's bed was in the high position. NA/F then left R1's room to go to the linen room to get clean gripper socks. NA/F did not lower R1's bed, place R1's fall mattress on the floor next to R1's bed, or remove the mechanical lift from R1's bedside, prior to leaving R1's room. NA/F returned to R1's room one to two minutes later and found that R1 had rolled out of bed onto the floor on top of the mechanical lift. R1's head struck the mechanical lift during the fall. R1 was moaning. R1 was bleeding from the mouth and had a bump on the forehead. NA/F used the walkie and called for a nurse who immediately responded and assessed R1. Several staff assisted with R1's mechanical lift transfer to the Broda chair and R1 was taken to the nurse's station for close monitoring. The progress notes, dated 02/15/16 at 11:12 p.m., indicated that LPN/B assessed R1 and observed that R1 had a large hematoma on the forehead (size not documented) and teeth marks on the right lower lip and inside the right cheek, which was the source of blood from the mouth. The bleeding was quickly remedied with a gauze pack. LPN/B notified the hospice provider and family about R1's fall and injuries. Aggressive intervention was declined. Additional comfort measures were undertaken. The progress notes, dated 02/16/16 at 1:34 p.m., indicated that R1 was unresponsive and close to actively dying. R1 died two days later on 02/18/16. R1's death certificate identified R1's immediate cause of death as mesenteric ischemia, which was R1's end-stage disease process. The facility's policy on Mechanical Lifts, dated May 2013, indicated "All lifting and transferring of residents has to be done by a mechanical	21850		

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21850	Continued From page 5 lift/stand when the use of a mechanical device is indicated on the resident's care plan. Mechanical lift transfers must be done with a minimum of two assistants. " The facility's policy on Preventing or Eliminating Falls (undated) indicated "It is the policy of Monarch Healthcare Management Health Care facility to utilize safety precautions which would decrease or eliminate the chance of accidents. Falls can be common if unsafe practices are used. All employees should use safe habits to prevent falls." A Suggested Method of Correction: 1. Develop and implement a system which ensures that care givers comply with care plan interventions designed for resident safety; educate all care givers. 2. Ensure there is an accountable system of supervisory oversight of resident care. 3. Conduct random audits to ensure caregivers are implementing all care plan interventions pertaining to resident safety. 4. Document all corrective action taken. Time Period for Correction: Thirty (30) days.	21850		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00811 Y1	A. Building B. Wing Y2	10/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MALA STRANA CARE & REHABILITATION CENTER	1001 COLUMBUS AVENUE NORTH NEW PRAGUE, MN 56071

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 10/28/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) LK/mm	DATE 10/31/2016	SIGNATURE OF SURVEYOR 05455	DATE 10/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			