Electronically delivered
August 18, 2020

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

RE: CCN: 245617
Cycle Start Date: August 5, 2020

Dear Administrator:

On August 12, 2020, we informed you of imposed enforcement remedies.

On August 5, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a) is effective August 27, 2020.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 27, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 27, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new

admissions.

As we notified you in our letter of August 12, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 30, 2020.

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:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 January 30, 2021 (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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	245617	A. BUILDING _____ B. WING _____	C 08/05/2020

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CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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F 000	INITIAL COMMENTS On 8/4/20 and 8/5/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated at F689, for past non-compliance. H5617011C. Although the provider implemented corrective action prior to survey, harm was sustained prior to correction. Deficiency issued at F689. The following complaints were found to be unsubstantiated: H5617009C and H5617010C. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on document review, interview, and observation, the facility failed to ensure the safety of 1 of 9 residents (R1) who required a full body mechanical lift for transfer. This resulted in harm	F 689	Past noncompliance: no plan of correction required.	8/21/20

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

Electronically Signed | 08/21/2020

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for R1, who fell from the lift and sustained a traumatic subarachnoid hemorrhage (blunt force trauma that caused the brain to move inside the skull, resulting in bleeding between the brain and the tissue that covers it). However, the facility implemented corrective action on 8/3/20, therefore the deficiency is being cited at past non-compliance.

Findings include:

R1's Minimum Data Set (MDS) dated 7/1/20, included, cognitively intact, had impairment on both sides of the lower body, and one side of the upper body, and did not walk. R1 required extensive assist of two staff for bed mobility, and was dependent on two staff for transfers. R1's Care Area Assessments for falls and activities of daily living from the comprehensive MDS dated 1/3/20, described R1 to have diagnoses of multiple sclerosis and paraplegia (paralysis of lower extremities), unable to walk, needing extensive assist with bed mobility, and total assist with a full body mechanical lift for transfers, and being cognitively intact with the ability to make her needs known. Care plans were to be developed in these areas to minimize risks.

R1's mobility care plan dated 7/24/12, included, limited physical mobility related to paraplegia secondary to diagnosis of multiple sclerosis. Staff were directed to utilize a full body mechanical lift with a medium sized sling and two staff.

R1's progress note dated 7/31/20, at 3:50 p.m. Included, "Called [nurse practitioner] at 3:00 p.m. regarding Fall of resident [R1's initials] from the Full lift and getting orders to send resident out for evaluation. Informed NP [nurse practitioner] that

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resident fell during transfer from Full Lift. During transfer resident fell from a high height and hit her head on the iron bar on the lift. Resident has a bump on the right side at the back of her head. No bleeding." The nurse practitioner (NP) gave orders to send to the emergency department.

R1's progress note dated 7/31/20, at 4:10 p.m. read, "Staff (aide) reported to writer that resident had a fall from the full lift while she was being transferred from the bed to the chair. Writer found resident on her back on the floor wearing her day clothes and shoes. Head resting on the floor and the metal part of the leg of the full lift. Sling still hanging on the full lift except for the bottom part of the sling (leg area) - left side of resident, which was off from the machine. Resident found near/adjacent to the bed. Resident is conscious, alert, coherent, and oriented; able to move upper extremities. Neuro [neurological exam] VS [vital signs] within normal limits. VS: BP [blood pressure] 150/100, HR [heart rate] 85, O2 [oxygen level] 92% RA [room air], RR [respiratory rate] 16, T [temperature] 96.1; mild headache. Resident said she hit her head on the metal part of the leg of the full lift. No skin tears, abrasions, or fractures noted. Lump noted at the back of head. No bleeding noted. Power wheelchair near the sink. Resident transferred to the wheelchair using a different full lift machine. Resident reassessed, lump on head has petechial red spots, no bleeding and skin is intact. Resident stated she is also scratching her head when her scalp itches. Neurochecks started as per protocol. Writer called [NP] and updated with resident's status (level of consciousness, how the resident fell, lump at the back of head, VS, ROM [range of motion], neuros)." "Interventions based on root cause analysis: Checked full lift machine,

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pin (that holds the sling) on left side (resident's left side) not present."

R1's progress note dated 7/31/20, at 10:43 p.m. noted R1 was admitted to the hospital with acute subarachnoid hemorrhage of the right temporal lobe.

R1's progress note dated 8/1/20, at 11:46 a.m. staff talked to a social worker at the hospital regarding R1. Neurology gave consent for R1 to be released from the hospital. Staff spoke with a hospital neurologist who said the right side temporal area subarachnoid bleed had resolved, and R1 had no neurological changes, no symptoms, and was at baseline of arrival at hospital.

R1's Discharge Summary from the hospital dated 8/1/20, included, R1, "Presented to the [emergency department] after head trauma when she hit her head against a metal rod. The patient was being transferred from the bed to the chair using a [full body mechanical lift] when the hook of the [lift] failed that resulted in a fall from a height of 4-5 feet with the patient hitting her head." The note indicated imaging was done and showed a small subarachnoid hemorrhage and repeat imaging shoed a decrease in the bleeding.

R1's Comprehensive Nursing Data Collection dated 8/1/20, upon R1's return from the hospital, assessed R1 was non-weight bearing and needed to transfer with two person assist using the full body mechanical lift. R1 needed a size medium sling for the full body mechanical lift.

R1's progress note on 8/3/20, at 5:47 p.m. included follow-up from the interdisciplinary team.

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F 689	Continued From page 4 After reviewing the fall, the root cause was determined to be the clip from the sling coming off during resident transfer. Staff were re-educated on transferring residents using the full lift, and audits of transfers began. The lift involved in the fall was taken out of use until it was checked by engineering for defaults. When interviewed on 8/4/20, at 10:42 a.m. the administrator stated R1's fall happened on Friday 7/31/20, and staff stayed late to make sure everything was safe for residents. Administrator explained re-education started right away, and everyone was trained right as they came on for their shifts. The lift manufacturer had also come out to inspect the lift involved in the fall, as there was a pin, or safety latch, that, "flew off," during the transfer at the time of R1's fall. Staff later found the safety latch on the bedside nightstand. The lift company put the safety latch back in place. Administrator described the safety latch to be used to keep the sling loop over the hook of the lift bar. R1 was described as alert, and having said nothing was unusual during the transfer that day. Various nursing home staff had performed three re-enactments, and were unable to figure out what occurred to cause the sling loop to become unhooked from the lift bar, or the safety latch to, "fly off." Staff were transferring R1 from the bed to the wheelchair, and had R1 in the sling, connected to the lift bar hooks with two upper sling loops by the shoulders, and two sling loops that cross at the inner thigh before attaching to the lift bar hooks. Staff lifted R1 off the bed in the sling, and then paused to check everything looked good, before starting to move the lift with one staff operating the lift, and the other guiding R1's legs. Once they started moving the lift, that is when the leg sling loop on the right	F 689		

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side of the lift bar (that was crossed at the inner thigh, and coming from the left side of the sling) detached, and the safety latch flew off, and the resident slid from the sling.

When interviewed on 8/4/20, at 11:58 a.m. environmental service director (ESD) described the facility lift maintenance schedule. Every mechanical lift in the building was inspected monthly by ESD. The last monthly check took place on 7/24/20, and there were no concerns with the lift involved in the accident. ESD stated the facility will replace wheels, batteries, charging cord, or clean hair out from the wheels, but anything else would be called in to the manufacturer for service. The monthly maintenance check followed a manufacturer form that was recommended at least quarterly by the manufacturer. In addition to the monthly checks performed by ESD, the manufacturer performed annual maintenance on all the lifts, last completed 10/10/19, with no concerns found on the lift involved in the accident. If nursing staff had any concerns on the lift, they can enter it into the TELS building management system for ESD to take a look, and contact the manufacturer for service if required. There had been no recent TELS system requests for maintenance on the lift. ESD stated after the fall, they contacted the manufacturer to come out and perform a field investigation on the lift. The manufacturer investigated the lift on 8/3/20.

The Liko [brand name of the full body mechanical lift] Periodic Inspection form dated 7/24/20, had the lift checked off, including the clips, as being inspected with no maintenance required.

The Liko Periodic Inspection form dated 7/31/20,

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after the incident indicated the inspection of the safety latch, "Right side not attached but not broken-came loose."

A Field Investigation Service Work Order Form from the manufacturer dated 8/3/20, noted in the comments section that the customer reported that the sling bar latch came off during a lift. The technician inspected the lift and sling bar latch. No malfunctions were found. The Lift and sling bar latch were functioning as designed.

When interviewed on 8/5/20, at 11:50 a.m. the manufacturer technician (T)-D stated the work order was created to complete a field investigation. That meant T-D was going to check the lift for full functionality, to make sure everything was functioning as designed. When T-D checked the lift on 8/3/20, everything was functioning as designed. The facility asked T-D to put the latch on and ensure it was functioning correctly. T-D stated the latch was functioning correctly. T-D did not look into the fall, just looked at the lift to ensure functionality.

On 8/4/20 at 12:53 p.m. observed the Golvo 7007 ES full body mechanical lift that was in use at the time of R1's fall. Administrator attached a size medium, divided leg sling to the lift. Administrator stated that when R1 was lifted off the bed, both staff had visualized the sling loops were hooked in the right place on the lift bar. The safety latches were spring loaded plastic clips that closed the hook to help hold the loops in place. The latch had flown off at the time of the fall, and when found, was not broken. ESD stated during monthly maintenance, the latch was checked to ensure they were in place and spring loaded. The nursing home leader in training (LIT) stated from

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experience, when a person was in the sling and attached to the lift, the lifts became harder to push on the carpeted floor and staff would, "have to give some good force," and that was why they had two staff operating the lift at a time. The administrator thought perhaps R1's body did not move with the lift when the lift was moved, and caused some swinging motion during the transfer. The administrator stated R1 had been audited for the proper sling use, and they found she was using the correct sized sling (medium) per manufacturers guidance, so they kept R1 in the same sling upon return as well.

During interview on 8/4/20, at 1:38 p.m. nursing assistant (NA)-A stated care plans say which sling to use for each resident, and also each resident had their own sling in their room to use.

On 8/4/20, at 1:43 p.m. R1 was observed in her room seated in an electric wheelchair. R1 stated she ended up in the hospital with bleeding on the brain, and then six hours later the bleeding had stopped but they kept R1 overnight in the hospital to keep an eye on her. R1 described before the fall, R1 was on the bed after cares, and NA-C and NA-D were going to transfer R1 from the bed to the wheelchair. R1 stated one staff kept a hand on her legs, and helped her legs clear the bed frame. The other staff was operating the lift. It happened so fast, R1 believed she blacked out for a few seconds. The next thing R1 knew, she was laying on the floor and staring up to see the sling, "swinging away in the breeze." R1 stated NA-C and NA-D stopped the lift when they first started to raise her up in the sling, to make sure things looked good. R1 stated everything seemed normal to her, although she can't say whether she actually looked at the sling loops to see where

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they were positioned in the lift bar hooks. R1 remembered they did put them on correctly initially. R1 stated although she did not look at the loops during the visual check, NA-C and NA-D did pause and look at the loop placement. R1 heard NA-C and NA-D talking after the fall, and discussing that they both heard a pop or a snapping noise. R1 felt the lift manufacturer should have something more than plastic latches to hold the sling loops in place. R1 felt the latch was, "just puny," at around one eighth of an inch wide. R1 did not feel like she was swinging around in the lift before she fell. Since coming back from the hospital, R1 stated the transfers had gone well.

When interviewed on 8/4/20, at 2:47 p.m. NA-C described R1's fall. NA-C stated, "It happened so fast that it was unbelievable." NA-C did not believe anything could have gone wrong, because she ensured that R1 was balanced in the sling. The only difference that day, was that the three of them (R1, NA-C, and NA-D) had been talking during the transfer. NA-C described being between the bed and the wall, while NA-D operated the Golvo lift. They lifted R1 off the bed and then stopped the lift so that NA-C could move around from the side of the bed to the foot of the bed. NA-C looked, and everything was balanced, and none of the four sling loops were coming up out of the hook. NA-C stated R1's sling loops were good and stiff, and when they were stiffer, they laid nice and flat inside the hook. NA-C scooped up R1's feet to guide them toward the corner of the bed, and NA-D was good to start backing up the lift, and was going nice and slow. "Then it was like someone snapped their fingers, and they heard a 'pop' and R1's feet were out of [NA-C's] hands, and [R1] was on the floor 'that

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

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F 689	Continued From page 9	F 689		

fast.' It happened so fast." NA-C did not know what happened, or whether R1 hit her head or feet first. NA-C described the sling bar as still moving while R1 was on the floor. NA-C stopped the bar from swinging with her hand, and that is when NA-C noticed the latch was gone from the side where the loop had become unattached from the sling bar hook.

When interviewed on 8/4/20, at 3:15 p.m. NA-D stated there was nothing unusual before R1's fall. NA-D and NA-C had finished three full lifts already that day. At this time, they had just finished changing R1, and were going to transfer R1 from the bed. NA-D was operating the lift, and as always, when the lift picked up the sling and started to take on tension, NA-D checked that the lift was holding the sling. NA-D described looking at the two sling loops on either side to be on the down the side of the hook, because occasionally they did get stuck on the top. So NA-D saw they were down inside the hook. NA-D started pulling the lift out from the bed. NA-C started on the opposite side of the bed, but was walking around to NA-D's side of the bed, and held R1's legs to help them clear the mattress. NA-D started to move the lift to get the lift legs in the right place to go towards the chair, and that's when it happened. NA-D described feeling momentum, as if there were a lot of forces at once, like there was swinging, and then it happened so fast and R1 was on the ground. NA-D did not know if momentum made the sling loop go up and over the hook, but was concerned that a plastic latch would not be able to hold up to the momentum. NA-C described the lift legs as starting under the bed, and needing to be turned 90 degrees from where they started to get R1 to her wheelchair. NA-D was using her upper body to torque the lift,

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and reported frequently needing to use her leg to pivot the lifts too, "You really have to muscle it." NA-D reported difficulty pivoting the lift on the carpet with bodyweight in the sling, and the wheels not seeming to move well. NA-D felt like R1 might have swung, and that's when she heard a loud, "snap." NA-D described feeling a swing in her body, because NA-D was holding the lift with both of her hands. In a tight space, NA-D really had to pivot that lift, which might cause more swinging. NA-D explained the snap heard was the clip flying off. NA-D mentioned that someone from the facility was trying to recreate the scenario, and yanked up on the sling loop with force, and caused the loop to come off the bar and the plastic latch to fly off, making the same snap sound.

When interviewed on 8/4/20, at 4:08 p.m. the administrator confirmed that during the facility investigation, one staff was able to hold onto the lift bar with one hand, and use the other hand to quickly yank the sling loop upward, causing the plastic latch to fly off, and the loop to come off the hook. That was unable to be duplicated again by others.

On 8/5/20, at 9:50 a.m. R1 was observed in bed with a green transfer sling underneath her. R1 was transferred from the bed to a shower chair. Just as R1 cleared the bed, NA-B paused the lift and stated, "pause for a cause" and tugged down on the sling loops to ensure they were fully seated in the bottom of the hooks, and the safety latches were in place. NA-A had hands on R1 to help guide R1's legs, and NA-B operated the lift and smoothly transferred R1 to the shower chair. There was no momentum, or swaying of the sling or lift bar while R1 was in the air. NA-B stated,

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this was how transfers normally went with R1. NA-B did not normally have to push the lift hard to move it on the carpet. NA-B said it was more difficult if you had to push the lift over any cords, and then you had to give a quick tug to move the lift over a cord, but the carpet was not an issue for NA-B.

When interviewed on 8/5/20, at 11:22 a.m. the lift manufacturer's regional representative (RR) spoke generally about accidents involving their lifts. RR was unaware of the details of the accident involving R1, and stated that accidents like this could be a result of human error, or mechanical failure. RR explained there were multiple possibilities on how this occurred, and without having the details of the incident and performing an investigation, RR would be unable to say what caused the latch to come off the hook, and the sling loop to detach from the lift. RR felt the facility did a nice job of training staff to operate the lifts.

The Liko Golvo Instruction Guide dated 7/3/09, required before lifting to always make certain that the patient has the correct type, size, material, and design of the slings and accessories to safely meet the patients lifting needs, and the sling's strap loops were correctly fastened to the sling bar hooks when the sling strap was extended, but before the patient was lifted from the underlying surface. The Liko UniversalSling Instruction Guide copyright 2012, guided before lifting to keep the following points in mind: "Although the Liko sling bars are equipped with latches, special caution must be exercised: before the patient is lifted from the underlying surface, but when the straps are fully extended, make sure the straps are correctly connected to the sling bar hooks."

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When interviewed on 8/5/20, at 1:13 p.m. the administrator stated after the fall, and after talking to the staff involved, they decided to add a verbal check when lifting a resident. So after the fall, staff were being trained to stop the lift transfer and say out loud, "pause for cause." At this time staff were to stop everything and double check that the sling loops were correctly attached before continuing the lift. Staff were being re-trained as they arrived for work.

When interviewed on 8/5/20, at 2:02 p.m. R1's family member (FM) stated that the way the fall was reported by staff, R1 was in the full body lift, and one of the straps came undone from the latch above, and R1 fell and hit her head on the base of the lift and the floor. FM stated that R1 thought she fell from about four feet in the air. FM was very happy R1 was sent to the hospital, because they were able to find the internal brain bleed. FM stated this was the second time R1 fell during a transfer and sustained injury. FM estimated it was early 2016 when R1 was transferring with staff and fell off the bed and broke a femur. FM felt the facility had great surroundings and provided generally good care, but was concerned about staff training around resident transfer needs.

Education documentation provided evidence that NA-C had been trained on operating the Golvo lift on 8/14/19, and NA-D had been trained on the lift 6/23/20. A sign in sheet, "Education for RN's & TMA's, RA's" dated 8/4/20, showed staff were being retrained prior to the start of their shift.

On 8/4/20, the survey team verified the facility had investigated R1's fall, inspected all

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F 689	Continued From page 13 mechanical lifts, reviewed and revised lift procedure to include a, "pause for cause," to ensure the loops were attached correctly, and educated all staff prior to their shift, which had been completed prior 8/4/20. Mechanical Lift Transfer Policy modified 11/18, had the purpose to provide safe resident transfers for each resident who has non-weight bearing status or is requiring the assistance of staff to provide weight bearing support. The policy required staff to always follow manufacturer's recommendations for the proper use of the equipment and slings. Two staff must be present for attaching the sling to the lift, and ensuring proper placement of the loops by each employee to confirm that the sling loops are attached properly.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2020

Administrator
Carondelet Village Care Center
525 Fairview Avenue South
Saint Paul, MN 55116

Re: Event ID: 6DJU11

Dear Administrator:

The above facility survey was completed on August 5, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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 on 8/4/20 and 8/5/20, to investigate complaint H5617011C, H5617009C and H5617010C. As a result the following was identified: The following complaint was found to be substantiated: H5617011C. However, no	2 000		

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2 000	Continued From page 1 licensing orders were issued. The following complaints were found to be unsubstantiated: H5617009C and H5617010C. 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.	2 000		