MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417
Hennepin County

Report#: H5620010

Date: ~~May 19~~ August 25, 2016

Date of Visit: August 18, 2015
August 19, 2015

Time of Visit: 8:30 a.m. – 5:00 p.m.
8:00 a.m. – 12:00 p.m.

By: Lisa Ciesinski, RN, Special Investigator
Kris Lohrke, RN, Director

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that a resident was neglected when s/he had a fall out of a full body lift causing a cervical fracture. The resident passed away 11 days later, cause of death was determined to be cardiorespiratory complications of immobility, blunt force neck injury, and a fall.

In addition, the facility failed to provide proper lift sheet and equipment for lift being used.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)

☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect is substantiated ~~inconclusive~~. The resident fell out of a sling during a mechanical lift transfer~~; however, it could not be determined that the fall was a result of neglect~~.

The resident had left sided weakness and received staff assistance for repositioning and transfers. The resident's care plan directed two staff to use a mechanical full body lift and a medium sling for all transfers. The resident used a Broda (specialized positioning wheelchair) for mobility. The resident had cognitive impairment.

Interviews and document review revealed prior to the fall, the resident was in bed. Two staff placed a medium lift sling under the resident and attached the four loops on the sling to the corresponding four hooks on the lift. Three staff were present during the lift/transfer process. One staff used the controller to lift the resident, one staff was located at the resident's head, and one staff was located at the resident's feet to help guide the resident into the chair. Staff indicated that prior to lifting the resident; all four of the sling loops were securely on the lift hooks. After lifting the resident, staff began to move the lift to align with the resident's Broda chair per protocol. Staff indicated the sling support bar suddenly tilted vertically, the left shoulder loop became unattached from the lift, and the resident slipped out of the sling onto the floor. Staff immediately notified the nurse of the fall. The resident complained of left shoulder pain with movement. The resident had a 4x1.5x0.5 centimeter laceration on the top of her/his head. The nurse arranged for emergency transportation to the hospital. Staff removed the lift and sling from service.

After the fall, a manufacture representative of the lift came out to the facility and examined the lift and the sling. The representative stated the lift was in good working order and the sling was in good condition. The representative stated the lifts had no history of the hanger bars tilting as described. The sling used was not the same manufacturer of the lift; however, used the same loop system and was compatible with the lift. The manufacture's operation manual did not indicate the manufacture's sling was required to use the lift. The

manual did indicate the manufacture's slings could be used with other lifts that used a four-point hanger bar loop system. However, the manufacturer later submitted a Manufacturer And User-facility Device Experience (MAUDE) report which stated the root cause of the incident was "caregiver inattention and technique."

The resident returned to the facility 8 days later on hospice care due to her/his injuries, which included a cervical neck fracture. The resident passed away 3 days later. The certificate of death indicated the cause of death as cardiorespiratory complication of immobility, due to blunt force neck injury from a fall.

A nurse who was on duty at the time of the incident subsequently stated that the sling used to transfer the resident was a white mesh sling, intended for use in the shower. She stated that staff on duty at the time indicated the shower sling had "a little bit of stretch to it" and that "when they lifted him, that allowed a shifting of the weight." The nurse stated she had not given permission for the staff to use a shower sling for the transfer, and if she had been aware they were doing so, she would have instructed them to find a regular sling. The nurse stated that there had been a previous fall from a lift, while other staff members were using a shower sling.

The investigation indicated there were also incidents where staff members transferred vulnerable adults with a full body lift, using the incorrect size sling for the vulnerable adult.

Safe transferring was a service which was reasonable and necessary to maintain the safety of the vulnerable adult. In this incident, the facility failed to provide this service, and therefore neglect is substantiated.

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 ensure staff members used the correct slings when transferring vulnerable adults using full body lifts.

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

Compliance:

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____

(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 If no, specify: _____
(State licensing orders will be available on the MDH website.)

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 Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):
A post certification revisit was conducted on 10/23/15. The facility was found to be in compliance with Federal regulations and State Licensing rules.

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:

☒ Medical Records
☐ Care Guide
☒ Medication Administration Records
☒ Treatment Sheets
☒ Facility Incident Reports
☐ Physician Progress Notes
☐ ADL (Activities of Daily Living) Flow Sheets
☐ Laboratory and X-ray Reports
☒ Physician Orders
☐ Social Service Notes
☒ Nurses Notes
☐ Meal Intake Records
☐ Activities Reports
☐ Weight Records
☐ Therapy and/or Ancillary Services Records
☒ Assessments
☐ Skin Assessments
☒ Care Plan Records
☐ Service Plan
☐ Other, specify: _____

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☒ Resident/Family Council Minutes
☒ Personnel Records/Background Check, etc.
☒ Staff Time Sheets, Schedules, etc.
☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

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: deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: facility report

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: deceased

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 1

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

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 Lift manufacturer representative

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☒ Safety Issues	☐ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☒ Use of Equipment	☒ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A Specify: _____

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A Specify: _____

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	C 09/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5620010. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that staff followed the care plan interventions when using a full body lift for 3 of 18 (R2, R13, R18) residents reviewed for transfers. Findings include: R2's care plan revealed "I require total assist of 2 staff and full body mechanical lift with medium sling for all transfers." "2nd staff to ensure safe guidance of LE (lower extremities) during transfer to avoid trauma related to wounds." "Total assist of 2 to place and remove lift sling." An internal investigation summary dated 7/23/15 of a fall involving R2 on 7/12/15 revealed the following: Human service technician (HST)-A did not follow R2's care plan when HST-A transferred	F 282		

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 282	Continued From page 1 R2 using a full body mechanical lift alone. HST-A indicated that during the transfer, R2's elbow started to come out of the sling. HST-A pulled the sling to keep the elbow inside the sling. As HST-A pulled on the sling, the upper left sling loop came off the hook on the lift, resulting in R2 falling out of the sling onto the floor. HST-A was aware R2 required 2 staff and a full body mechanical lift with all transfers. HST-A indicated that he looked for assistance, could not find anyone to help, and took a "short cut." Observations on 8/19/15 at 10:20 a.m. with registered nurse (RN)-B revealed the following: R13's nursing assistant care sheet, located in the R13's bathroom, indicated R13 required "Total assist of 2 staff and mechanical full body lift for all transfers. I use a large, blue mesh sling and to leave under me when I am in my judy chair." R13 was observed sitting in his judy chair in the lounge. R13 had a sling positioned under him in the wheelchair. The label on the sling read extra-large. RN-B confirmed the sling size was extra-large. RN-B informed RN-C of the sling size discrepancy. R13's current care plan revealed " Total assist of 2 staff and mechanical full body lift for all transfers. I use a large, blue mesh sling and to leave under me when I am in my judy chair." When interviewed at 10:20 a.m. Registered nurse (RN)-C confirmed that R13's care plan directed staff to transfer R13 with a full body mechanical lift and a large sling. RN-C stated that staff did not follow R13's care plan and transferred R13 using the incorrect size sling. Observations on 8/19/15 at 10:58 a.m. with RN-B	F 282		

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F 282	Continued From page 2	F 282		

revealed the following: R18's nursing assistant care sheet, located in the closet in R18's room, indicated " I require assist of 2 staff and Mechanical FULL BODY LIFT with a medium Sling for all transfers." R18 was observed sitting in his wheelchair in his room. R18 had a sling positioned under him in the wheelchair. RN-B could not confirm the sling size related to the way R18 was sitting in the chair. RN-B stated that the size could also be confirmed by the color an tags located on the sling. RN-B stated the color had faded; however, the sling size appeared to be large. RN-B confirmed R18 was care planned for a medium sling.

R18's care plan revealed "I require assist of 2 staff and Mechanical FULL BODY LIFT with medium Sling for all transfers."

When interviewed on 8/19/2015 at 11:25 a.m. human service technician (HST)-D stated resident care plans are located in their closets. The care plan directs staff on how a resident transfers, and the size of sling to use. HST-D stated that she had assisted with transferring R18 from his bed to his wheelchair with 2 staff. HST-D confirmed that she had used a large sling when transferring R18. HST-D stated that she was aware that R18's care plan directed to use a medium sling. When asked why she used a large sling, HST-D stated that she was running late, in a rush, and could not locate a medium sling in the laundry.

When interviewed on 9/1/15 at 2:00 p.m. RN-B stated that staff are expected to follow the care plan to determine how to transfer residents and when determining the size of slings to use for a full body mechanical lift. RN-B confirmed that

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F 282	Continued From page 3 staff did not use the correct size sling when transferring R13 and R18 on 8/19/15. RN-B also confirmed that HST-A did not follow the care plan when transferring R2 alone with a full body lift, contributing to a fall.	F 282		
F 323 SS=D	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 document review, the facility failed to ensure safe transfer techniques during a full body mechanical lift were implemented for 1 of 2 (R2) residents reviewed for falls, when staff transferred R2 alone resulting in a fall. Findings include: R2's medical record was reviewed and included a diagnosis, which included, but not limited to contractures (permanent shortening of the muscles) of legs and arms and dementia with behavioral disturbance. R2's annual MDS dated 4/6/15, indicated R2 was severely cognitively impaired and required assistance of 2+ person physical assistance for transfers. R2's care plan revealed "I require total assist of 2 staff and full body mechanical lift with medium sling for all	F 323		

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F 323	Continued From page 4	F 323		

transfers." "2nd staff to ensure safe guidance of LE (lower extremities) during transfer to avoid trauma related to wounds." "Total assist of 2 to place and remove lift sling."

A progress note dated 7/12/15 revealed that R2 fell during a full body lift transfer when the upper left loop slipped off the hook. R2 flipped out of the sling and landed at the base of the lift. Range of motion to R2's extremities were normal with so signs of discomfort. R2 had several small "cuts" 1.2 centimeter (cm) x 1 cm, 0.5 cm x 0.1 cm and one abrasion 1 cm x 0.2 cm on R2's left forehead. Staff applied an ice pack, called 911 and the resident was transferred to the hospital. The progress note indicated that the care plan was not followed when the HST (unidentified) did not get a second staff to participate with the transfer. A progress note dated 7/13/15 at 12:51 a.m. indicated that R2 returned from the hospital with no new orders.

An internal investigation summary dated 7/23/15 of a fall involving R2 on 7/12/15 revealed the following: Human service technician (HST)-A did not follow R2's care plan when HST-A transferred R2 using a full body mechanical lift alone. HST-A indicated that during the transfer, R2's elbow started to come out of the sling. HST-A pulled the sling to keep the elbow inside the sling, the upper left sling loop came off the hook on the lift, resulting in R2 falling out of the sling striking his head on the floor. HST-A was aware R2 required 2 staff and a full body mechanical lift with all transfers. HST-A indicated that he looked for assistance, could not find anyone to help, and took a "short cut."

When interviewed on 9/1/15 at 2:00 p.m. RN-B

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F 323	Continued From page 5 stated that staff are expected to follow the care plan to determine how to transfer residents. RN-B stated it was the facility's policy, for resident safety, to have at least 2 staff for all full body lifts. RN-B also confirmed that HST-A did not follow the care plan when transferring R2 alone with a full body lift, contributing to a fall. The lifts manufacture's operation manual indicated "While we believe that one person can safely operate our equipment, each facility has its own policies and procedures regarding the safe lifting and transfer of patients/residents. In the event that your facility's policies require more than one staff member to safely perform a patient/resident lift/transfer with a mechanical lifting device, that policy should be followed. We advocate that your facility staff members follow your policies and procedures in all circumstances." The facilities policy last revised on 6/09 revealed "The RN will assess each resident upon admission, quarterly and change of status to determine the type of transfer (manual assist level, standing assist mechanical lift, full body mechanical lift) to be used with that resident. Transfer method will be noted on the careplan." "Full body mechanical lifts: Used for residents who have limited weight-bearing ability or are totally dependent. Use of this lift requires assistance of two staff unless otherwise care planned."	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 #H5620010. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that staff followed the care plan interventions when using a full body lift for 3 of 18 (R2, R13, R18) residents reviewed for transfers. Findings include: R2's care plan revealed "I require total assist of 2 staff and full body mechanical lift with medium sling for all transfers." "2nd staff to ensure safe guidance of LE (lower extremities) during transfer to avoid trauma related to wounds." "Total assist of 2 to place and remove lift sling."	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	C 09/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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2 565	Continued From page 2 An internal investigation summary dated 7/23/15 of a fall involving R2 on 7/12/15 revealed the following: Human service technician (HST)-A did not follow R2's care plan when HST-A transferred R2 using a full body mechanical lift alone. HST-A indicated that during the transfer, R2's elbow started to come out of the sling. HST-A pulled the sling to keep the elbow inside the sling. As HST-A pulled on the sling, the upper left sling loop came off the hook on the lift, resulting in R2 falling out of the sling onto the floor. HST-A was aware R2 required 2 staff and a full body mechanical lift with all transfers. HST-A indicated that he looked for assistance, could not find anyone to help, and took a "short cut." Observations on 8/19/15 at 10:20 a.m. with registered nurse (RN)-B revealed the following: R13's nursing assistant care sheet, located in the R13's bathroom, indicated R13 required "Total assist of 2 staff and mechanical full body lift for all transfers. I use a large, blue mesh sling and to leave under me when I am in my judy chair." R13 was observed sitting in his judy chair in the lounge. R13 had a sling positioned under him in the wheelchair. The label on the sling read extra-large. RN-B confirmed the sling size was extra-large. RN-B informed RN-C of the sling size discrepancy. R13's current care plan revealed " Total assist of 2 staff and mechanical full body lift for all transfers. I use a large, blue mesh sling and to leave under me when I am in my judy chair." When interviewed at 10:20 a.m. Registered nurse (RN)-C confirmed that R13's care plan directed staff to transfer R13 with a full body mechanical lift and a large sling. RN-C stated that staff did not	2 565		

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2 565	Continued From page 3 follow R13's care plan and transferred R13 using the incorrect size sling. Observations on 8/19/15 at 10:58 a.m. with RN-B revealed the following: R18's nursing assistant care sheet, located in the closet in R18's room, indicated " I require assist of 2 staff and Mechanical FULL BODY LIFT with a medium Sling for all transfers." R18 was observed sitting in his wheelchair in his room. R18 had a sling positioned under him in the wheelchair. RN-B could not confirm the sling size related to the way R18 was sitting in the chair. RN-B stated that the size could also be confirmed by the color an tags located on the sling. RN-B stated the color had faded; however, the sling size appeared to be large. RN-B confirmed R18 was care planned for a medium sling. R18's care plan revealed "I require assist of 2 staff and Mechanical FULL BODY LIFT with medium Sling for all transfers." When interviewed on 8/19/2015 at 11:25 a.m. human service technician (HST)-D stated resident care plans are located in their closets. The care plan directs staff on how a resident transfers, and the size of sling to use. HST-D stated that she had assisted with transferring R18 from his bed to his wheelchair with 2 staff. HST-D confirmed that she had used a large sling when transferring R18. HST-D stated that she was aware that R18's care plan directed to use a medium sling. When asked why she used a large sling, HST-D stated that she was running late, in a rush, and could not locate a medium sling in the laundry. When interviewed on 9/1/15 at 2:00 p.m. RN-B stated that staff are expected to follow the care	2 565		

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2 565	Continued From page 4 plan to determine how to transfer residents and when determining the size of slings to use for a full body mechanical lift. RN-B confirmed that staff did not use the correct size sling when transferring R13 and R18 on 8/19/15. RN-B also confirmed that HST-A did not follow the care plan when transferring R2 alone with a full body lift, contributing to a fall. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure safe transfer techniques during a full body mechanical lift were implemented for 1 of 2 (R2) residents reviewed for falls, when staff transferred R2 alone resulting in a fall. Findings include: R2's medical record was reviewed and included a diagnosis, which included, but not limited to contractures (permanent shortening of the muscles) of legs and arms and dementia with behavioral disturbance. R2's annual MDS dated 4/6/15, indicated R2 was severely cognitively impaired and required assistance of 2+ person physical assistance for transfers. R2's care plan revealed "I require total assist of 2 staff and full body mechanical lift with medium sling for all transfers." "2nd staff to ensure safe guidance of LE (lower extremities) during transfer to avoid trauma related to wounds." "Total assist of 2 to place and remove lift sling." A progress note dated 7/12/15 revealed that R2 fell during a full body lift transfer when the upper left loop slipped off the hook. R2 flipped out of the sling and landed at the base of the lift. Range of motion to R2's extremities were normal with so signs of discomfort. R2 had several small "cuts" 1.2 centimeter (cm) x 1 cm, 0.5 cm x 0.1 cm and one abrasion 1 cm x 0.2 cm on R2's left forehead. Staff applied an ice pack, called 911 and the resident was transferred to the hospital. The progress note indicated that the care plan	2 830		

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2 830	Continued From page 6 was not followed when the HST (unidentified) did not get a second staff to participate with the transfer. A progress note dated 7/13/15 at 12:51 a.m. indicated that R2 returned from the hospital with no new orders. An internal investigation summary dated 7/23/15 of a fall involving R2 on 7/12/15 revealed the following: Human service technician (HST)-A did not follow R2's care plan when HST-A transferred R2 using a full body mechanical lift alone. HST-A indicated that during the transfer, R2's elbow started to come out of the sling. HST-A pulled the sling to keep the elbow inside the sling, the upper left sling loop came off the hook on the lift, resulting in R2 falling out of the sling striking his head on the floor. HST-A was aware R2 required 2 staff and a full body mechanical lift with all transfers. HST-A indicated that he looked for assistance, could not find anyone to help, and took a "short cut." When interviewed on 9/1/15 at 2:00 p.m. RN-B stated that staff are expected to follow the care plan to determine how to transfer residents. RN-B stated it was the facility's policy, for resident safety, to have at least 2 staff for all full body lifts. RN-B also confirmed that HST-A did not follow the care plan when transferring R2 alone with a full body lift, contributing to a fall. The lifts manufacture's operation manual indicated "While we believe that one person can safely operate our equipment, each facility has its own policies and procedures regarding the safe lifting and transfer of patients/residents. In the event that your facility's policies require more than one staff member to safely perform a patient/resident lift/transfer with a mechanical lifting device, that policy should be followed. We	2 830		

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2 830	Continued From page 7 advocate that your facility staff members follow your policies and procedures in all circumstances." The facilities policy last revised on 6/09 revealed "The RN will assess each resident upon admission, quarterly and change of status to determine the type of transfer (manual assist level, standing assist mechanical lift, full body mechanical lift) to be used with that resident. Transfer method will be noted on the careplan." "Full body mechanical lifts: Used for residents who have limited weight-bearing ability or are totally dependent. Use of this lift requires assistance of two staff unless otherwise care planned." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could: (1) Develop and implement a system that ensures accuracy of care delivery to residents. (2) Monitor nursing assistants for compliance with care plan interventions. (3) Monitor the use of mechanical full body lifts during resident care, as outlined in the facility's policy. (4) If leadership staff identifies any noncompliance with proper care delivery to residents, ensure staff are re-educated and subsequently monitored for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245620 Y1	A. Building B. Wing Y2	10/23/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/24/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 09/24/2015	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
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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)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/1/2015		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00233 Y1	A. Building B. Wing Y2	10/23/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20830	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. #	Completed
LSC	09/24/2015	LSC	09/24/2015	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/1/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: 7OFE12