This facility has requested a reconsideration of the maltreatment finding

The conclusion in dispute may change based on the final outcome of the reconsideration process.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, MN 55454
Hennepin County

Report #: H5170018

Date: April 5, 2013

Date of Visit: March 13, 2013
Time of Visit: 8:00 a.m.-3-30 p.m.

By: Rita Lucking, R.N., Special Investigator

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

☒ Facility Self Report ☐ Complaint

Allegation(s): It is alleged that neglect occurred when a resident did not receive his ordered heparin for fourteen days.

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 Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ 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 the evidence, neglect is substantiated when a resident did not receive heparin during the fourteen days that he was at the facility. The resident received heparin during the hospitalization that preceded the resident's admission to the nursing home, and the heparin had been discontinued prior to the resident's transfer to the nursing home. Transfer documentation that came from the hospital at the time of the resident's admission to the nursing home did not contain an order for heparin to be administered to the resident. However, the history and physical documentation that was completed the day after the resident's admission to the nursing home did include information that indicated the resident should receive heparin. The nursing staff at the nursing home failed to review the medical information pertaining to the resident.

The resident's hospital discharge summary was reviewed. The summary indicated the resident was transferred from the hospital to the nursing home due to continued nursing and wound care needs and a continued need for physical therapy and occupational therapy. The discharge summary did not identify heparin (anticoagulant medication) as one of the resident's medications when the resident was discharged from the hospital and admitted to the nursing home. The resident's nursing home history and physical, completed by physician (E) the day after the resident was admitted to the nursing home, was reviewed. Physician (E's) documentation included an assessment and plan which indicated the resident would receive deep venous thrombosis prophylaxis, and the resident would receive heparin 5,000 units every twelve hours.

Review of the resident's physicians' orders and medication record did not include an order for heparin written by either physician (E) or physician assistant (C).

When interviewed by the investigator, physician (E) stated he completed resident #1's history and physical at the nursing home, and he stated he intended to start the resident on heparin and included that information in the resident's history and physical. He stated he did not write an order for the resident's heparin. Physician (E) stated it was his expectation that physician assistant (C) would have reviewed the resident's history and physical and ordered the heparin for the resident.

When interviewed by the investigator, physician assistant (C) examined and evaluated the resident four times while the resident was at the nursing home. The resident received heparin in the past, but he was not admitted to the nursing home with an order for heparin. Physician assistant (C) stated she read the resident's history and physical a couple days after the resident was admitted and recalled reading physician (E's) notation about heparin. Physician assistant (C) assumed physician (E) ordered the heparin and did not do any further checking

related to the heparin.

When interviewed in person on 3/13/13 and by phone on 3/15/13, employee (B) stated although resident #1's written history and physical was included in the resident's medical record, the nursing staff did not review the information. Employee (B) stated she would not expect the nurses to review the information.

A nursing home discharge summary/interagency transfer form was reviewed. It indicated the resident had a cardiopulmonary arrest while at the nursing home, and the resident was transferred back to the hospital for further care. The resident expired at the hospital. A chest CT revealed the resident had large bilateral pulmonary emboli. The resident's death certificate indicated the immediate cause of death was massive pulmonary emboli.

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's policies and procedures did not provide an effective system of reviewing all medical information pertaining to treatment of the resident.

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

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

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

☒ Medical Records

☒ Medication Administration Records

☒ Facility Incident Reports

☐ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☐ Therapy and/or Ancillary Services Records

☐ Skin Assessments

☒ Care Guide

☒ Treatment Sheets

☒ Physician Progress Notes

☐ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☐ Weight Records

☒ Assessments

☒ Care Plan Records

Other pertinent medical records:

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

☐ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☐ Personnel Records/Background Check, etc.

☐ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 1

Were residents selected based on the allegation(s)? (•) Yes ( ) No ( ) N/A Specify: _____

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

( ) Yes (•) No ( ) N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ( ) Yes ( ) No (•) N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: (•) Yes ( ) No ( ) N/A Specify: _____

Did you interview the resident(s) identified in allegation: ( ) Yes (•) No ( ) N/A Specify: _____

Did you interview additional residents: ( ) Yes (•) No

Total number of resident interviews: 0

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: _____

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: 7

Physician interviewed: (•) Yes ( ) No

Nurse Practitioner 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:

☐ 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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Medical Practice
Minnesota Board of Nursing
Minneapolis Police Department
Hennepin County Attorney
Minneapolis City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BUILDING _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

(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 completed on 3/29/13 in order to investigate complaint #H5170018. The following deficiencies are issued: F 224 SS=G 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on documentation and interviews, the facility failed to ensure that policies and procedures were developed and implemented to prevent neglect of residents in one of two residents (resident #1) reviewed who required deep venous thrombosis prophylaxis. Findings include: Resident #1's hospital discharge summary, dated 1/2/13, was reviewed. The summary indicated the resident was transferred from the hospital to the nursing home on 1/2/13. Resident #1's admission diagnoses when admitted to the nursing home included bladder cancer, status post bladder surgery and dehydration. The discharge summary did not identify heparin (anticoagulant medication) as one of the resident's medications when he was discharged from the hospital and admitted to the	F 000 F 224	**Plan of Correction** *How corrective action will be accomplished for those residents found to have been affected by deficient practice* The Fairview-University Transitional Care Unit has a robust interdisciplinary care team and care planning process, and provides daily attendance on the Unit by Physician Assistants, Nurse Practitioners, and Physicians. In addition, the RN staffing ratio is very high (5 or 6 patients to nurse) and the unit is well-served by CNA's and therapists and other staff. The facility admits approximately 60 - 70 patients/month and provides care often for uniquely medically complex patients with medical oversight provided by a highly skilled, interdisciplinary care team on site. The finding of maltreatment/neglect is not supported as evidenced by a robust interdisciplinary care team and the care planning, attention and services provided by the entire care team to all of our residents, including the resident involved in this complaint.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn Johnson, Administrator — TITLE — (X6) DATE: 5/3/13

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

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F 224	Continued From page 1 nursing home. Resident #1's 1/3/13 nursing home history and physical, completed by physician (E), was reviewed. Physician (E's) assessment and plan related to resident #1's care at the nursing home indicated the resident would receive deep venous thrombosis prophylaxis, and the resident would receive heparin 5,000 units every twelve hours. Review of resident #1's 1/2/13 through 1/17/13 physicians' orders and medication record did not reveal that an order for heparin was written by either physician (E) or physician assistant (C) or that the resident received heparin during the nursing home admission. A nursing home discharge summary/interagency transfer form, dated 1/17/13, was reviewed. It indicated resident #1 had a cardiopulmonary arrest on 1/17/13 while at the nursing home. A code was called, and CPR was performed. The resident was transferred back to the hospital on 1/17/13 for further care, and resident #1 expired at the hospital on 1/22/13. Resident #1's death certificate was reviewed. The death certificate indicated the immediate cause of death was Massive Pulmonary Emboli. The facility did not have a policy and procedure in place that addressed the review of residents' history and physicals and the clarification of pertinent information contained in the history and physicals. When interviewed in person on 3/13/13 and by phone on 3/15/13, administrative nurse (B) stated	F 224	The patient identified in this report was admitted to UMMC for surgery for bladder cancer on 12/11/12. He was discharged home on 12/18/12. He was readmitted to the hospital on 12/26/12 for dehydration, confusion, and superficial stomal necrosis. He was discharged from the hospital and admitted to the TCU on 1/2/13. The discharging physician did not continue orders for heparin, and in interview stated he was intentional in not continuing the orders for heparin. The process for admission to the Transitional Care Unit involves the MD taking the intake call, and immediately assigning an APP (Nurse Practitioner or Physician Assistant) to the patient. The APP is responsible for completing medication reconciliation and entering any necessary orders. The History and Physical is generally completed by the physician within several days of the patient's admission.	

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F 224	Continued From page 2 the heparin error was noted at the time of the resident's transfer to the hospital on 1/17/13. Physician (E's) 1/3/13 history and physical/transcription documentation referred to physician E's intent to start the resident on heparin following resident #1's admission to the nursing home. Both physician (E) and physician assistant (C) failed to write an order for the resident's heparin. When interviewed in person on 3/13/13, pharmacist (D) stated resident #1's heparin was discontinued prior to resident #1's discharge from the hospital and admission to the nursing home on 1/2/13. Physician (E) and physician assistant (C) did not enter an order for heparin following resident #1's admission to the nursing home. The pharmacy reviews that were conducted while the resident was at the nursing home did not pick up on physician (E's) note in the history and physical that referred to physician (E's) intent to start the resident on heparin.	F 224	In this isolated event, the MD who performed the H & P documented his intention to start the patient on a sub-therapeutic dose of heparin, which would have been in addition to the mechanical prophylaxis in place. The patient also was placed on 325 mg aspirin QD, which may also be considered a prophylactic medication dose for prevention of blood clots. The MD did not enter the order for heparin, and stated he thought the PA would enter the order. In the sequence of events, the PA and pharmacist had reviewed the medications ordered prior to the completion of the H&P. Dr. Stein, Medical Director, has issued a directive clarifying that any order which an MD wishes to initiate upon completing an H&P must be entered by that same physician. (copy attached). Physicians interviewed, and the TCU Medical Director, have stated that it is unlikely that the failure to order low dose prophylaxis heparin led to the development of a pulmonary embolism in a patient who was ambulating well a month out from surgery. There are varying medical opinions, especially in light of the patient's previous discharge home, as to the therapeutic value of	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on documentation and interviews, the facility failed to ensure that residents received the	F 309		

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F 309	Continued From page 3 necessary care for one of two residents (resident #1) reviewed who required deep venous thrombosis prophylaxis. Findings include: Resident #1's hospital discharge summary, dated 1/2/13, was reviewed. Resident #1's discharge diagnoses were bladder cancer and dehydration. During resident #1's prior hospitalizations, resident #1 had bladder surgery which involved a complicated post-op course and ongoing problems. The summary indicated the resident was transferred from the hospital to the nursing home on 1/2/13 due to continued nursing and wound care needs and a continued need for physical therapy and occupational therapy. It was determined that the resident was stable at the time of discharge to the nursing home. The discharge summary did not identify heparin (anticoagulant medication) as one of the resident's medications when he was discharged from the hospital and admitted to the nursing home. Resident #1's 1/3/13 nursing home history and physical, completed by physician (E), was reviewed. Physician (E's) assessment and plan related to resident #1's care at the nursing home indicated the resident would receive deep venous thrombosis prophylaxis, and the resident would receive heparin 5,000 units every twelve hours. Review of resident #1's 1/2/13 through 1/17/13 physicians' orders and medication record did not reveal that an order for heparin was written by either physician (E) or physician assistant (C) or that the resident received heparin for deep venous thrombosis prophylaxis during the nursing	F 309	**ordering heparin for the nursing home setting in this clinical circumstance, as evidenced by the discharging physician who determined to discontinue heparin at the time of hospital discharge.** However, in order to assure that medications which are identified to be ordered in an H&P by an admitting physician are in fact ordered for future patients, the facility will initiate the practices identified below. *Address how the facility will identify other residents having the potential to be affected by the same deficient practice* The physician is responsible for the completion of the H&P. The physician performing the H & P is responsible for entering any orders indicated in their assessment. The medical director on the Transitional Care Unit communicated with all care providers via email dated April 5, 2013, reminding each medical provider who is assigned to the floor of this **responsibility.** 4/5/13	

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F 309	Continued From page 4 home admission. A nursing home discharge summary/interagency transfer form, dated 1/17/13, was reviewed. It indicated resident #1 had a cardiopulmonary arrest on 1/17/13 while at the nursing home. A code was called and CPR was performed. The resident was transferred back to the hospital's emergency department for stabilization and further care on 1/17/13. Resident #1 expired at the hospital on 1/22/13. A chest CT was performed, and the CT revealed large bilateral pulmonary emboli. Resident #1's death certificate was reviewed. The death certificate indicated the immediate cause of death was massive pulmonary emboli. When interviewed by phone on 3/15/13 at 12:10 p.m., and 3/22/13 at 10:00 a.m., physician (E) stated he visited the resident twice at the nursing home. Physician (E) completed the nursing home history and physical on 1/3/13, and he stated he intended to start the resident on heparin and included that notation in resident #1's history and physical. He stated he did not write an order for the resident's heparin. When interviewed in person on 3/13/13 at 11:00 a.m., physician assistant (C) stated she visited the resident four times during his stay at the nursing home. Resident #1 took heparin in the past, but he was not admitted to the nursing home with an order for heparin. When interviewed in person on 3/13/13 and by phone on 3/15/13, administrative nurse (B) stated resident #1 was admitted to the facility on	F 30[illegible]	As an additional quality measure, the Nurse Practitioner/Physician Assistant initially assigned to the patient will review the physician's H&P upon completion, and confirm the ordering of any medication recommendations. The NP/PA will document their review and any actions subsequent to the completion of the physician's admitting H&P. As a further quality measure, it has been reinforced that the unit pharmacist will review the H&P upon the physician's completion of the H&P in their process of performing medication reconcilation, and will check any medication recommendations indicated in the H&P. The pharmacist will document this review in the note section of the medical record. In addition, in concordance with current practice, nursing staff have been reminded that any time they have a concern that there is a discrepancy between documentation and practice, or about medical provider actions or inactions, they are to raise those issues with the Charge Nurse, Director of Nursing, Administrator, or Medical	5/8/13 5/8/13 5/3/13

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F 309	Continued From page 5 1/2/13, and the history and physical was not completed at the hospital prior to the resident's admission to the facility. Resident #1's history and physical was dictated on 1/3/13, signed by the physician on 1/4/13 and placed in resident #1's medical record on 1/4/13. Administrative nurse (B) stated she would not expect the nursing staff to go back and review resident #1's history and physical and make note of physician (E's) plan to start resident #1 on heparin. Administrative nurse (B) stated the failure to write the heparin order is not a nursing issue.	F 309	Director, as soon as possible. Anonymous reporting is also available through Fairview's quality reporting system. *Address what measures will be put into place or systemic changes made to ensure that the deficient practices will not recur.* As reflected, responsibility has been assigned to the physician for the H&P, and the physician is responsible for entering any orders s/he has identified. The NP/PA assigned to the patient will be responsible for reviewing the H&P, and checking that any medication orders identified in the H&P are entered. The NP/PA will document their review and any actions in a progress note. In addition, pharmacy will assess any medication recommendations in their medication reconciliation process.	5/8/13

note. In addition, pharmacy will assess any medication recommendations in their medication reconciliation process.

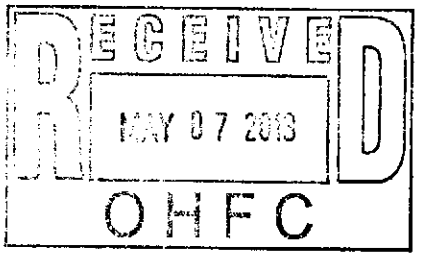
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.

Beginning May 8, 2013, all files will be audited for appropriate documentation by the administrator, medical director, or director of nursing (nurse manager).

Once 95% compliance is achieved, the administrator, nurse manager, or medical director will monitor, for six months subsequently, 80%, 60%, 40%, 20%, 10% and 10% of files. If at any time the audit compliance is below 95%, the frequency will revert back to 100% until 95% compliance is supported.

Include the dates when corrective action will be implemented.

May 8, 2013

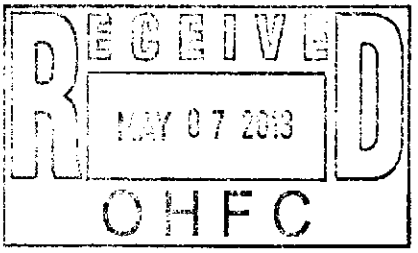


Attachments

Email from Dr. Stein, Medical Director

Policy for Admissions for Provider Team

Email from Nurse Manager



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00259	A. BUILDING: _____ B. WING _____	C 03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5170018. The following licensing orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Sharon A Johnson — TITLE: Administrator — (X6) DATE: 5/3/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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2 000	Continued From page 1 Division of Compliance Monitoring, Office of Health Facility Complaints, 85 East Seventh Place, Suite 220, PO BOX 64970, St. Paul, Minnesota 55164	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	2 830		

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2 830	Continued From page 2 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on documentation and interviews, the facility failed to ensure that policies and procedures were developed and implemented to prevent neglect of residents in one of two residents (resident #1) reviewed who required deep venous thrombosis prophylaxis. Findings include: Resident #1's hospital discharge summary, dated 1/2/13, was reviewed. The summary indicated the resident was transferred from the hospital to the nursing home on 1/2/13. Resident #1's admission diagnoses when admitted to the nursing home included bladder cancer, status post bladder surgery and dehydration. The discharge summary did not identify heparin (anticoagulant medication) as one of the resident's medications when he was discharged from the hospital and admitted to the nursing home. Resident #1's 1/3/13 nursing home history and physical, completed by physician (E), was reviewed. Physician (E's) assessment and plan related to resident #1's care at the nursing home indicated the resident would receive deep venous thrombosis prophylaxis, and the resident would receive heparin 5,000 units every twelve hours. Review of resident #1's 1/2/13 through 1/17/13 physicians' orders and medication record did not reveal that an order for heparin was written by either physician (E) or physician assistant (C) or	2 830		

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2 830	Continued From page 3 that the resident received heparin during the nursing home admission. A nursing home discharge summary/interagency transfer form, dated 1/17/13, was reviewed. It indicated resident #1 had a cardiopulmonary arrest on 1/17/13 while at the nursing home. A code was called, and CPR was performed. The resident was transferred back to the hospital on 1/17/13 for further care, and resident #1 expired at the hospital on 1/22/13. Resident #1's death certificate was reviewed. The death certificate indicated the immediate cause of death was Massive Pulmonary Emboli. The facility did not have a policy and procedure in place that addressed the review of residents' history and physicals and the clarification of pertinent information contained in the history and physical. When interviewed in person on 3/13/13 and by phone on 3/15/13, administrative nurse (B) stated the heparin error was noted at the time of the resident's transfer to the hospital on 1/17/13. Physician (E's) 1/3/13 history and physical/transcription documentation referred to physician (E's) intent to start the resident on heparin following resident #1's admission to the nursing home. Both physician (E) and physician assistant (C) failed to write an order for the resident's heparin. When interviewed in person on 3/13/13, pharmacist (D) stated resident #1's heparin was discontinued prior to resident #1's discharge from the hospital and admission to the nursing home on 1/2/13. Physician (E) and physician assistant (C) did not enter an order for heparin following	2 830		

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2 830	Continued From page 4 resident #1's admission to the nursing home. The pharmacy reviews that were conducted while the resident was at the nursing home did not pick up on physician (E's) note in the history and physical that referred to physician (E's) intent to start the resident on heparin. SUGGESTED METHOD OF CORRECTION: 1) Take appropriate measures to ensure that staff are familiar with this regulation and that residents receive the necessary care and services. 2) Document any corrective action taken. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 830		
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 documentation and interviews, the facility failed to ensure that residents received the	21850		

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21850	Continued From page 5 necessary care for one of two residents (resident #1) reviewed who required deep venous thrombosis prophylaxis. Findings include: Resident #1's hospital discharge summary, dated 1/2/13, was reviewed. Resident #1's discharge diagnoses were bladder cancer and dehydration. During resident #1's prior hospitalizations, resident #1 had bladder surgery which involved a complicated post-op course and ongoing problems. The summary indicated the resident was transferred from the hospital to the nursing home on 1/2/13 due to continued nursing and wound care needs and a continued need for physical therapy and occupational therapy. It was determine that the resident was stable at the time of discharge to the nursing home. The discharge summary did not identify heparin (anticoagulant medication) as one of the resident's medications when he was discharged from the hospital and admitted to the nursing home. Resident #1's 1/3/13 nursing home history and physical, completed by physician (E), was reviewed. Physician (E's) assessment and plan related to resident #1's care at the nursing home indicated the resident would receive deep venous thrombosis prophylaxis, and the resident would receive heparin 5,000 units every twelve hours. Review of resident #1's 1/2/13 through 1/17/13 physicians' orders and medication record did not reveal that a order for heparin was written by either physician (E) or physician assistant (C) or that the resident received heparin for deep venous thrombosis prophylaxis during the nursing home admission. A nursing home discharge summary/interagency	21850		

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21850	Continued From page 6	21850		

transfer form, dated 1/17/13, was reviewed. It indicated resident #1 had a cardiopulmonary arrest on 1/17/13 while at the nursing home. A code was called and CPR was performed. The resident was transferred back to the hospital's emergency department for stabilization and further care on 1/17/13. Resident #1 expired at the hospital on 1/22/13. A chest CT was performed, and the CT revealed large bilateral pulmonary emboli.

Resident #1's death certificate was reviewed. The death certificate indicated the immediate cause of death was massive pulmonary emboli.

When interviewed by phone on 3/15/13 at 12:10 p.m., and 3/22/13 at 10:00 a.m., physician (E) stated he visited the resident twice at the nursing home. Physician (E) completed the nursing home history and physical on 1/3/13, and he stated he intended to start the resident on heparin and included that notation in resident #1's history and physical. He stated he did not write an order for the resident's heparin.

When interviewed in person on 3/13/13 at 11:00 a.m., physician assistant (C) stated she visited the resident four times during his stay at the nursing home. Resident #1 took heparin in the past, but he was not admitted to the nursing home with an order for heparin. Physician assistant (C) stated she read the resident's history and physical on 1/4/13 and recalled reading physician (E's) notation about heparin.

When interviewed in person on 3/13/13 and by phone on 3/15/13, administrative nurse (B) stated resident #1 was admitted to the facility on 1/2/13, and the history and physical was not completed at the hospital prior to the resident's admission to

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21850	Continued From page 7 the facility. Resident #1's history and physical was dictated on 1/3/13, signed by the physician on 1/4/13 and placed in resident #1's medical record on 1/4/13. Administrative nurse (B) stated she would not expect the nursing staff to go back and review resident #1's history and physical and make note of physician (E's) plan to start resident #1 on heparin. Administrative nurse (B) stated the failure to write the heparin order is not a nursing issue. SUGGESTED METHOD OF CORRECTION: 1) Take appropriate measures to ensure that staff are familiar with this regulation and that residents are provided the necessary care and services. 2) Document any corrective action taken. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21850		

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Fairview University Trans Services
2450 Riverside Avenue South
Minneapolis, MN 55454
Hennepin County

Report #: H5170018

Date: June 6, 2013

Date of Visit: May 22, 2013
Time of Visit: 8:30 a.m.

By: Rita Lucking, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up two federal deficiencies and two state licensing orders which were issued on April 22, 2013, as the result of an investigation which had been completed on March 29, 2013.

The status of each order is as follow:
1 MN Rule 4658.0520 Subp. 1 – Corrected
2 MN St. Statute 144.651 Subd. 14 - Corrected

See Attached 2567B for status of federal deficiencies.

xc: Minnesota Department of Health -Licensing & Certification Division

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245170	A. Building B. Wing	5/22/2013

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0224 Reg. # 483.13(c) LSC	Correction Completed 05/22/2013	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 05/22/2013	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KL/sd	06/06/13	06981	05/22/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
3/29/2013		

AH Form Approved
6/6/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00259	A. Building B. Wing	5/22/2013

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 05/22/2013	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 1 LSC	Correction Completed 05/22/2013	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 KL/sd	Date: 06/06/13	Signature of Surveyor: 06981	Date: 05/22/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/29/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO