MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Woodbury Health Care Center	H5235081	December 30, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
7012 Lake Road	8:00 a.m. to 2:30 p.m.	March 3, 2017
Facility City:	**Investigator's Name and Title:**	
Woodbury	Peggy Boeck, R.N., Special Investigator	

State:	ZIP:	County:
Minnesota	55125	Washington

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when the alleged perpetrators failed to crisscross the sling, which resulted in the resident falling from a mechanical lift. The resident experienced pain, bruising, and a black eye.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect occurred when the alleged perpetrators (AP #1 and AP #2) did not follow the facility mechanical lift policy or manufacturer's guidelines and incorrectly secured the resident's sling on the mechanical lift. The resident slipped forward out of the sling and fell on the floor. The fall resulted in arm pain and facial bruising.

The resident was cognitively impaired, not able to bear weight, and required a mechanical lift for all transfers. According to the care plan, the resident required two staff with a full mechanical lift with a crisscross sling for transfers. The crisscross sling had leg straps that crossed under each thigh and over the opposite thigh before connecting to the lift.

AP #1 was in the resident's room to bring the resident to the dining room for dinner. When the resident was in bed, AP #1 placed the sling under the resident. AP #1 requested help from AP #2 to transfer the resident with a mechanical lift to the wheelchair. AP #1 positioned the lift equipment on the left side of the bed and operated the controls. AP #1 remained on the left side of the bed and attached the sling on the left side of the mechanical lift. AP #2 was on the right side of the bed and attached the right side of the sling to the mechanical lift. Neither AP #1 nor AP #2 crisscrossed the leg straps before attaching that portion of the sling to the mechanical lift. AP #1 raised the resident off the bed, moving the mechanical lift to where AP #2 was with the wheelchair. AP #1 moved the resident off the bed. The resident was approximately four feet off

the floor and had not reached the wheelchair yet. The resident slipped out of the front of the sling and fell on the floor. The resident sustained facial bruising and arm pain. X-rays were taken of the resident's right shoulder, arm, elbow, wrist, pelvic region, hip, knee, and ankle. X-rays indicated the resident did not have any fractures.

A facility procedure and the manufacturer's instructions indicated staff were to place the leg straps under the resident's thigh and crisscross the straps over the opposite leg. Next, staff were to then move the lift into position, lower the hanger bar, hook the straps to the lift, raise the lift until the resident was slightly above the bed, stop, check the straps, and resume the lift. AP #1 and AP #2 did not follow the facility procedure or manufacturer's guidelines when securing the sling onto the mechanical lift.

AP #1 was interview and stated s/he had transferred the resident many times and knew the required sling used for the resident. AP #1 stated s/he knew the leg straps needed to be crisscrossed. AP #1 did not do this during the transfer the day the resident fell, because s/he was feeling rushed.

AP #2 was interviewed and stated she did not look at the resident's care worksheet for the type of sling used and followed the lead of AP #1.

After the incident the facility administration re-educated AP #1 and AP #2 on the correct use of the sling and mechanical lift equipment.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place for using a mechanical lift . The resident's mechanical lift sling information was on the care plan. AP #1 and AP #2 had training in using a mechanical lift and following the care plan.

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

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes 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

(State licensing orders will be available on the MDH website.)

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

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Nurses Notes
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Five

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: Severely cognitively impaired

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 13

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ◉ Yes ○ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Facility Tour
☒ Injury

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A
Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Woodbury Police Department

Woodbury City Attorney

Washington County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5235081. As a result, the following deficiency is 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 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

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 323	Continued From page 1	F 323		

Based on interview and record review the facility failed to ensure transfer equipment was used in accordance with manufacturer's guidelines and facility policy for one of four residents (R1) reviewed for falls. R1 had left sided facial bruising and generalized body pain on the right side.

Findings include:

R1's medical record was reviewed. R1 had dementia and kyphosis (a curving of the spine that caused a rounding of the back, which leads to a slouching posture). R1's care plan, dated 3/31/2014, indicated R1 required a mechanical lift for transfers. R1 was assessed to require a sling with two leg straps that crossed over the opposite thigh and attached to the mechanical lift.

A review of a facility incident report dated 11/5/2016 indicated at 5:40 p.m. R1 fell out of a sling when transferred from the bed to his/her wheelchair. R1 fell four feet to the floor. R1 landed on the floor hitting the right side of his/her body and the left side of his/her face. R1 complained of pain and sustained a black eye. At 8:00 p.m. x-rays of R1's right shoulder, arm, elbow, wrist, pelvic region, hip, knee, and ankle were taken. X-rays indicated R1 did not have any fractures.

An interview was conducted on 12/30/2016 at 1:20 p.m. with nursing assistant (NA)-B who stated on the day of the incident, s/he went to R1's room to bring R1 to the dining room for dinner. NA-B stated s/he put the sling under R1 while R1 was in bed and had looked for a second staff to help with the transfer. NA-B asked NA-C to assist with the transfer. NA-B brought the lift into R1's room, positioning it on the left side of

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F 323	Continued From page 2	F 323		

the bed, and operated the controls of the lift. NA-B stated NA-C was on the right side of the bed and attached the right sling hooks to the right side of the lift. NA-B attached the left sling hooks to the left side of the lift. NA-B raised R1 up while NA-C was moving the wheelchair toward R1. NA-B stated R1 was about four feet from the floor when R1 slipped out of the front of the sling, landing on the floor. NA-B stated that when R1 fell to the ground, the sling was still attached to the mechanical lift. The sling's two leg straps were not crossed over the opposite thigh of R1 when attached to the mechanical lift.

An interview was conducted on 1/11/2017, at 2:39 p.m. with NA-C who stated s/he assisted NA-B to transfer R1. NA-C stated the sling was already under R1 when s/he entered R1's room and the lift was placed on the left side R1's bed. NA-C stated s/he attached the right side of the sling to the right side of lift and NA-B attached the left side of the sling to the left side of the lift. NA-B was operating the lift equipment and started to raise R1 up. NA-C stated while s/he was on the right side of the bed, s/he realized the wheelchair was not positioned near the resident. NA-C left the right side of the bed to move the wheelchair near R1, who was now on the left side of the bed. NA-C stated R1 slipped forward out of the sling. NA-C did not have hands on R1 when R1 fell to the floor.

An interview was conducted on 1/11/2017 at 3:17 p.m. with the nurse practitioner (NP)-E who stated R1's kyphosis and contracted muscles made spontaneous movement impossible, and R1 could not have contributed to the fall.

The Volaro mechanical lift manufacturer's manual

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F 323	Continued From page 3 dated 11/1/12 provided instructions for lifting a resident from a bed to a chair. It directed staff to place the sling under the resident, cross the leg straps, bring the lift to the bed, place the hanger near the center of the resident, hook the straps, raise the resident up until there is no tension, and double check the hooks. The facility policy and procedure titled Full Mechanical Lift dated June 2016 included instructions for use of a sling for transfer of a resident from a bed to a wheelchair. It directed staff to place the leg straps under the resident's thighs, cross the straps over, move the lift into position, lower the hanger bar, hook the straps to the lift, raise the lift until the resident is slightly above the bed, stop, check the straps, and resume the lift.	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 #H5235081. 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		
2 830	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. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure transfer equipment was used in accordance with manufacturer's guidelines and facility policy for one of four residents (R1) reviewed for falls. R1 had left sided facial bruising and generalized body pain on the right side.	2 830		

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2 830	Continued From page 2 Findings include: R1's medical record was reviewed. R1 had dementia and kyphosis (a curving of the spine that caused a rounding of the back, which leads to a slouching posture). R1's care plan, dated 3/31/2014, indicated R1 required a mechanical lift for transfers. R1 was assessed to require a sling with two leg straps that crossed over the opposite thigh and attached to the mechanical lift. A review of a facility incident report dated 11/5/2016 indicated at 5:40 p.m. R1 fell out of a sling when transferred from the bed to his/her wheelchair. R1 fell four feet to the floor. R1 landed on the floor hitting the right side of his/her body and the left side of his/her face. R1 complained of pain and sustained a black eye. At 8:00 p.m. x-rays of R1's right shoulder, arm, elbow, wrist, pelvic region, hip, knee, and ankle were taken. X-rays indicated R1 did not have any fractures. An interview was conducted on 12/30/2016 at 1:20 p.m. with nursing assistant (NA)-B who stated on the day of the incident, s/he went to R1's room to bring R1 to the dining room for dinner. NA-B stated s/he put the sling under R1 while R1 was in bed and had looked for a second staff to help with the transfer. NA-B asked NA-C to assist with the transfer. NA-B brought the lift into R1's room, positioning it on the left side of the bed, and operated the controls of the lift. NA-B stated NA-C was on the right side of the bed and attached the right sling hooks to the right side of the lift. NA-B attached the left sling hooks to the left side of the lift. NA-B raised R1 up while NA-C was moving the wheelchair toward R1. NA-B stated R1 was about four feet from the floor	2 830		

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2 830	Continued From page 3 when R1 slipped out of the front of the sling, landing on the floor. NA-B stated that when R1 fell to the ground, the sling was still attached to the mechanical lift. The sling's two leg straps were not crossed over the opposite thigh of R1 when attached to the mechanical lift. An interview was conducted on 1/11/2017, at 2:39 p.m. with NA-C who stated s/he assisted NA-B to transfer R1. NA-C stated the sling was already under R1 when s/he entered R1's room and the lift was placed on the left side R1's bed. NA-C stated s/he attached the right side of the sling to the right side of lift and NA-B attached the left side of the sling to the left side of the lift. NA-B was operating the lift equipment and started to raise R1 up. NA-C stated while s/he was on the right side of the bed, s/he realized the wheelchair was not positioned near the resident. NA-C left the right side of the bed to move the wheelchair near R1, who was now on the left side of the bed. NA-C stated R1 slipped forward out of the sling. NA-C did not have hands on R1 when R1 fell to the floor. An interview was conducted on 1/11/2017 at 3:17 p.m. with the nurse practitioner (NP)-E who stated R1's kyphosis and contracted muscles made spontaneous movement impossible, and R1 could not have contributed to the fall. The Volaro mechanical lift manufacturer's manual dated 11/1/12 provided instructions for lifting a resident from a bed to a chair. It directed staff to place the sling under the resident, cross the leg straps, bring the lift to the bed, place the hanger near the center of the resident, hook the straps, raise the resident up until there is no tension, and double check the hooks.	2 830		

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2 830	Continued From page 4 The facility policy and procedure titled Full Mechanical Lift dated June 2016 included instructions for use of a sling for transfer of a resident from a bed to a wheelchair. It directed staff to place the leg straps under the resident's thighs, cross the straps over, move the lift into position, lower the hanger bar, hook the straps to the lift, raise the lift until the resident is slightly above the bed, stop, check the straps, and resume the lift. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00803	A. BUILDING: _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

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21850	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free from neglect when transfer equipment was not used in accordance with manufacturer's guidelines and facility policy for one of four residents (R1) reviewed for falls. R1 had left sided facial bruising and generalized body pain on the right side. Findings include: The facility policy titled Vulnerable Adult dated 12/30/13 indicated neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The Volaro mechanical lift manufacturer's manual dated 11/1/12 provided instructions for lifting a resident from a bed to a chair. It directed staff to place the sling under the resident, cross the leg straps, bring the lift to the bed, place the hanger near the center of the resident, hook the straps, raise the resident up until there is no tension, and double check the hooks. The facility policy and procedure titled Full Mechanical Lift dated June 2016 included instructions for use of a "crisscross" sling for transfer of a resident from a bed to a wheelchair. It directed staff to place the leg straps under the resident's thighs, cross the straps over, move the lift into position, lower the hanger bar, hook the straps to the lift, raise the lift until the resident is slightly above the bed, stop, check the straps, and resume the lift. R1's medical record was reviewed. R1 had dementia and kyphosis (a curving of the spine	21850		

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21850	Continued From page 6	21850		

that caused a rounding of the back, which leads to a slouching posture). R1's care plan, dated 3/31/2014, indicated R1 required a mechanical lift for transfers. R1 was assessed to require a sling with two leg straps that crossed over the opposite thigh and attached to the mechanical lift.

A review of a facility incident report dated 11/5/2016 indicated at 5:40 p.m. R1 fell out of a sling when transferred from the bed to his/her wheelchair. R1 fell four feet to the floor. R1 landed on the floor hitting the right side of his/her body and the left side of his/her face. R1 complained of pain and sustained a black eye. At 8:00 p.m. x-rays of R1's right shoulder, arm, elbow, wrist, pelvic region, hip, knee, and ankle were taken. X-rays indicated R1 did not have any fractures.

An interview was conducted on 12/30/2016 at 1:20 p.m. with nursing assistant (NA)-B who stated on the day of the incident, s/he went to R1's room to bring R1 to the dining room for dinner. NA-B stated s/he put the sling under R1 while R1 was in bed and had looked for a second staff to help with the transfer. NA-B asked NA-C to assist with the transfer. NA-B brought the lift into R1's room, positioning it on the left side of the bed, and operated the controls of the lift. NA-B stated NA-C was on the right side of the bed and attached the right sling hooks to the right side of the lift. NA-B attached the left sling hooks to the left side of the lift. NA-B raised R1 up while NA-C was moving the wheelchair toward R1. NA-B stated R1 was about four feet from the floor when R1 slipped out of the front of the sling, landing on the floor. NA-B stated that when R1 fell to the ground, the sling was still attached to the mechanical lift. The sling's two leg straps were not crossed over the opposite thigh of R1

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21850	Continued From page 7 when attached to the mechanical lift. An interview was conducted on 1/11/2017, at 2:39 p.m. with NA-C who stated s/he assisted NA-B to transfer R1. NA-C stated the sling was already under R1 when s/he entered R1's room and the lift was placed on the left side R1's bed. NA-C stated s/he attached the right side of the sling to the right side of lift and NA-B attached the left side of the sling to the left side of the lift. NA-B was operating the lift equipment and started to raise R1 up. NA-C stated while s/he was on the right side of the bed, s/he realized the wheelchair was not positioned near the resident. NA-C left the right side of the bed to move the wheelchair near R1, who was now on the left side of the bed. NA-C stated R1 slipped forward out of the sling. NA-C did not have hands on R1 when R1 fell to the floor. An interview was conducted on 1/11/2017 at 3:17 p.m. with the nurse practitioner (NP)-E who stated R1's kyphosis and contracted muscles made spontaneous movement impossible, and R1 could not have contributed to the fall. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		