MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Lake Winona Manor

Facility Address:
865 Mankato Avenue

Facility City:
Winona

State:	ZIP:	County:
Minnesota	55987	Winona

Report Number:
H5240016 and H5240017

Time of Visit:
12:15 p.m. to 5:15 p.m.
7:30 a.m. to 11:15 a.m.

Date of Visit:
January 3 and 4, 2017

Date Concluded:
April 25, 2017

Investigator's Name and Title:
Christie Bluhm, R.N., Special Investigator

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when the resident was left unattended while seated on an unlocked commode and suspended in the ceiling lift. The resident had a fall and suffered fractures to both legs.

- [x] Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- [x] State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect occurred when the facility staff left the resident unattended and unsupervised while attached to the ceiling lift, against manufacturer's guidelines. The resident had a fall and sustained bilateral leg fractures.

The resident had a history of stroke and congestive heart failure. The resident required assistance of two staff for toileting and bathing. The resident was non-weight bearing and required the use of the mechanical ceiling lift for transfers to and from bed, the chair, and the commode. The resident was alert and oriented. The use of a mechanical lift for transfers or level of supervision while the resident was seated on the commode was not specified in the resident's care plan.

On the day of the incident, the resident was being toileted by two facility staff. The mechanical ceiling lift was used to transfer the resident to the commode positioned in the middle of the resident's room. While seated on the commode, the resident used the wheelchair pedals for feet support and the ceiling lift bar for upper body arm support. Two staff assisted the resident into this position and then left the room to provide privacy which was the routine. The resident was still attached to the ceiling lift while on the commode. A short time later, facility staff heard the resident scream and immediately went to the resident's room. The resident was found suspended by the ceiling lift with the resident's buttocks touching the floor. The commode wheels were not locked, and the commode rolled away from the resident.

During the post fall assessment, the resident complained of severe pain. The resident refused evaluation at first, but family convinced the resident to be evaluated and accompanied the resident for x-rays in the emergency room. Imaging showed the resident suffered bilateral leg fractures. The resident refused transfer to the hospital for treatment and comfort care was initiated. The resident died several days later.

The resident's death certificate identified the resident's cause of death was related to complications of a stroke; blunt force trauma with fracture was a significant condition that contributed to the death.

When interviewed, the physician stated the resident's death was related to the fall.

The manufacturer's guidelines state, "Never leave a patient unattended in a lifting situation."

The facility immediately took action to ensure the safety of all residents. Focus discussions were held with staff on every shift to discuss the incident and safety implementation. Reminder labels were placed on all transfer devices and lifts that directed staying with the resident while connected to the transfer or lift device. Labels were placed on the receiving devices, commodes and wheelchairs, with reminders to lock the receiving device during the transfer. Staff education, with return competency requirements, was completed.

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 failed to have a policy in place for staff to follow regarding supervision of residents while connected to the mechanical lift. The facility failed to follow the lift manufacturers guidelines for resident safety.

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.

(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
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Treatment Sheets
- ☒ Care Plan Records
- ☒ Social Service Notes
- ☒ Skin Assessments
- ☒ Facility Incident Reports
- ☒ Activities Reports
- ☒ ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- ☒ Death Certificate

Additional facility records:

- ☒ Resident/Family Council Minutes
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: Residents with lift transfers

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:

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: 11

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

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
☒ Call Light
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ 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

Winona Police Department

Winona City Attorney

Winona County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING _____ B. WING _____	C 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

(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 #H5240016 and case #H5240017. As a result, the following deficiency is issued related to case #H5240016 and case #H5240017. 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.	F 323		4/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2017

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 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to supervise 1 of 4 residents reviewed (R1), when facility staff left the resident alone, connected to a mechanical ceiling lift, and seated on a commode. This resulted in actual harm to R1 when R1 fell off of the commode and sustained bilateral leg fractures. The resident died several days later. Findings include: R1's care plan dated 10/1/15, indicated an admission diagnosis of hemiplegia and hemiparesis following cerebral infarction. R1 required assistance of two staff with all aspects of mobility. The Quarterly Minimum Data Set (MDS) dated 10/27/16, indicated R1 was totally dependent for transfers and toileting. Progress notes dated 12/29/16 at 2:17 p.m., indicate R1 was toileted on the commode in her room. When staff entered the room, they found her with her bottom touching the floor, but still connected to the ceiling lift. When R1 was asked if the commode slid out from under her, she responded yes. The commode chair was found unlocked. R1 had a skin tear on the left shin and complained of increased pain in the left knee. X-rays were ordered. Progress note dated 12/29/16 at 4:42 p.m. notes that a family member accompanied R1 for x-rays and results showed both of R1's legs were fractured.	F 323	F323 On 12/29/16, education was initiated on each shift with staff regarding the supervision needs of a mechanical lift as well as locking wheels of transfer surfaces. By end of day 12/30/2016, all mechanical lift devices were labeled with specific warnings not to leave residents unattended in device and to lock any wheels of transfer surfaces. Manufacturer s instructions are affixed to all lift devices. On 12/29/16, R1 was placed on bed rest and did not require a mechanical lift device after this event. Residents identified at risk for this potential error include any resident using the mechanical lift devices or wheeled commode chairs. The standard work for transfers using an EZ stand or full body lift (both portable and ceiling) was reviewed for accuracy on 3/30/17. All current nursing assistants were required to do a return demonstration and written test regarding transfer safety by 2/21/17. Nursing staff hired after this date are required to attend a formal lift training and complete a written test. Licensed nursing staff will be required to obtain 1:1 training or Computer Based Training for updates to the standard work by 4/4/17 or prior to the next scheduled shift thereafter. Annual refresher courses will be held for all nursing staff. To monitor staff compliance, the nursing managers performed 75 staff observations between 1/16/17 and	

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F 323	Continued From page 2 During an interview on 1/3/17 at 2:15 p.m., certified nursing assistant (CNA)-B stated that R1 was transferred to the commode in the middle of the room, and stayed in the sling connected to the lift while on the commode. R1 was given the call light and staff left the room. It was R1's routine to be left alone to give privacy, and this is how the staff had routinely performed the care for R1. Per interview dated 1/3/17 at 2:44 p.m., CNA-E stated he heard R1 scream and immediately went to her room. CNA-E saw R1 suspended in the lift sling with R1's bottom touching the floor. The commode was near the door and the wheels were not locked. CNA-E stated that leaving R1 alone while on the commode was R1's normal privacy routine, which could last up to thirty minutes. Per interview dated 1/4/17 at 9:37 a.m., registered nurse (RN)-A stated that R1 complained of left leg pain immediately after the fall. The provider was notified and x-rays were ordered. During this time, RN-A noted swelling in R1's right leg. R1 refused an emergency room evaluation. RN-A stated R1, when on the commode, was given privacy, the lift bar to hold on to, the wheelchair pedals to set feet on, and had become a comfort measure while R1 was seated on the commode, but it was not reflected in her care plan. During interview on 1/4/17 at 10:10 a.m., the director of nursing (DON) stated that for R1, it was standard to use the commode in the middle of the room as the lift does not go into the bathroom. It appeared the commode was not locked, based on the 'found' position. The DON	F 323	2/20/17. Bi-monthly audits will be done by Gemba Coordinators (Nurse Manager) or designee until 5/1/17. Results were reported at the QA&I on 1/17/17 and will be reviewed again at the QA&I on 5/4/2017 for further action.	

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F 323	Continued From page 3 also stated that the lift manufacturer's guidelines suggest not to leave the resident alone in an upright position in the lift. The use of the mechanical lift for transfers or level of supervision while on the commode was not specified in R1's care plan. The physician was interviewed on 1/12/17 at 10:05 a.m. and stated R1 had refused further treatment after the fall, therefore comfort measures were initiated. The resident had a broken femur that occurred during the fall which caused significant swelling and pain in the leg. The resident was put on a morphine pump for comfort. R1 died several days later, and the death was related to the fall. During an interview on 1/13/17 at 2:30 p.m., CNA-F states the resident was toileted per her routine. This routine included transferring R1 to the commode, giving R1 the hand controller for the lift and the call light. Staff then left the room to give R1 privacy per her request. The commode did not roll back at that time, but CNA-F does not remember looking at commode wheels to know if they were locked. The Liko brand mechanical lift product description lists under safety instructions, to "Never leave a patient unattended in a lifting situation." There was not a facility policy that specified the amount of supervision required related to mechanical lift connection while using the commode. The facility did have a policy that all mechanical lifts require two staff to be present at the time of the transfer.	F 323		

Minnesota Department of Health

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	00701	A. BUILDING: _____ B. WING _____	C 02/28/2017

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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 #H5240016 and #H5240017. As a result, the following correction order is issued related to complaint #H5240016 and #H5240017. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota	2 000		

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

Electronically Signed | 03/31/17

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2 000	Continued From page 1 Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the 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		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident was free from	21850	1850 On 12/29/16, education was initiated on	4/4/17

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21850	Continued From page 2 maltreatment for 1 of 4 residents reviewed (R1), when the resident was neglected when facility staff left the resident alone, connected to a mechanical ceiling lift, and seated on a commode. This resulted in actual harm to R1 when R1 fell off of the commode and sustained bilateral leg fractures. The resident died several days later. Findings include: R1's care plan dated 10/1/15, indicated an admission diagnosis of hemiplegia and hemiparesis following cerebral infarction. R1 required assistance of two staff with all aspects of mobility. The Quarterly Minimum Data Set (MDS) dated 10/27/16, indicated R1 was totally dependent for transfers and toileting. Progress notes dated 12/29/16 at 2:17 p.m., indicate R1 was toileted on the commode in her room. When staff entered the room, they found her with her bottom touching the floor, but still connected to the ceiling lift. When R1 was asked if the commode slid out from under her, she responded yes. The commode chair was found unlocked. R1 had a skin tear on the left shin and complained of increased pain in the left knee. X-rays were ordered. Progress note dated 12/29/16 at 4:42 p.m. notes that a family member accompanied R1 for x-rays and results showed both of R1's legs were fractured. During an interview on 1/3/17 at 2:15 p.m., certified nursing assistant (CNA)-B stated that R1 was transferred to the commode in the middle of	21850	each shift with staff regarding the supervision needs of a mechanical lift as well as locking wheels of transfer surfaces. By end of day 12/30/2016, all mechanical lift devices were labeled with specific warnings not to leave residents unattended in device and to lock any wheels of transfer surfaces. Manufacturer s instructions are affixed to all lift devices. On 12/29/16, R1 was placed on bed rest and did not require a mechanical lift device after this event. Residents identified at risk for this potential error include any resident using the mechanical lift devices or wheeled commode chairs. The standard work for transfers using an EZ stand or full body lift (both portable and ceiling) was reviewed for accuracy on 3/30/17. All current nursing assistants were required to do a return demonstration and written test regarding transfer safety by 2/21/17. Nursing staff hired after this date are required to attend a formal lift training and complete a written test. Licensed nursing staff will be required to obtain 1:1 training or Computer Based Training for updates to the standard work by 4/4/17 or prior to the next scheduled shift thereafter. Annual refresher courses will be held for all nursing staff. To monitor staff compliance, the nursing managers performed 75 staff observations between 1/16/17 and 2/20/17. Bi-monthly audits will be done by Gemba Coordinators (Nurse Manager)or designee until 5/1/17. Results were reported at the QA&I on 1/17/17 and will be reviewed again at the QA&I on 5/4/2017 for further	

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LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

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21850	Continued From page 3 the room, and stayed in the sling connected to the lift while on the commode. R1 was given the call light and staff left the room. It was R1's routine to be left alone to give privacy, and this is how the staff had routinely performed the care for R1. Per interview dated 1/3/17 at 2:44 p.m., CNA-E stated he heard R1 scream and immediately went to her room. CNA-E saw R1 suspended in the lift sling with R1's bottom touching the floor. The commode was near the door and the wheels were not locked. CNA-E stated that leaving R1 alone while on the commode was R1's normal privacy routine, which could last up to thirty minutes. Per interview dated 1/4/17 at 9:37 a.m., registered nurse (RN)-A stated that R1 complained of left leg pain immediately after the fall. The provider was notified and x-rays were ordered. During this time, RN-A noted swelling in R1's right leg. R1 refused an emergency room evaluation. RN-A stated R1, when on the commode, was given privacy, the lift bar to hold on to, the wheelchair pedals to set feet on, and had become a comfort measure while R1 was seated on the commode, but it was not reflected in her care plan. During interview on 1/4/17 at 10:10 a.m., the director of nursing (DON) stated that for R1, it was standard to use the commode in the middle of the room as the lift does not go into the bathroom. It appeared the commode was not locked, based on the 'found' position. The DON also stated that the lift manufacturer's guidelines suggest not to leave the resident alone in an upright position in the lift. The use of the mechanical lift for transfers or level of supervision	21850	action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00701	A. BUILDING: _____ B. WING _____	C 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21850	Continued From page 4 while on the commode was not specified in R1's care plan. The physician was interviewed on 1/12/17 at 10:05 a.m. and stated R1 had refused further treatment after the fall, therefore comfort measures were initiated. The resident had a broken femur that occurred during the fall which caused significant swelling and pain in the leg. The resident was put on a morphine pump for comfort. R1 died several days later, and the death was related to the fall. During an interview on 1/13/17 at 2:30 p.m., CNA-F states the resident was toileted per her routine. This routine included transferring R1 to the commode, giving R1 the hand controller for the lift and the call light. Staff then left the room to give R1 privacy per her request. The commode did not roll back at that time, but CNA-F does not remember looking at commode wheels to know if they were locked. The Liko brand mechanical lift product description lists under safety instructions, to "Never leave a patient unattended in a lifting situation." There was not a facility policy that specified the amount of supervision required related to mechanical lift connection while using the commode. The facility did have a policy that all mechanical lifts require two staff to be present at the time of the transfer. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could create interventions to ensure resident's are supervised while still connected to mechanical lifts. Interventions to be sure all receiving devices with	21850		

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21850	Continued From page 5 wheels are locked or secured to prevent injury. If a variance is indicated, this must be communicated in the resident's care plan and resident has been explained the risks. The administrator and/or designee could provide monitoring for compliance and effectiveness of the policy interventions as necessary in accordance with current standards of practice. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21850		