

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Augustana Healthcare Center of Apple Valley		Report Number: H5264056	Date of Visit: June 8, 9, and 10, — 2016		
Facility Address: 14650 Garrett Ave	nue		Time of Visit: 9:45 a.m. to 3:15 p.m.	Date Concluded: January 17, 2017	
Facility City: Apple Valley			7:00 a.m. to 11:30 a.m. 3:00 p.m. to 5:00 p.m. 7:00 a.m. to 1:00 p.m.	January 17, 2017	
State: Minnesota	ZIP: 55124	County: Dakota	Investigator's Name and Jane Aandal, R.N., Special		

Nursing Home

Allegation(s):

It is alleged a resident was neglected when facility staff failed to safely transfer a resident using a lift. The resident had a fall and was hospitalized with a right femur fracture.

- ▼ 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 perpetrator (AP) incorrectly transferred the resident using a standing lift. The resident fell, sustained a right femur fracture and required surgery.

The resident was cognitively intact and able to direct his/her own cares. The resident's care plan directed staff to transfer the resident with a standing lift and the assistance of one staff. Manufacturer's instruction for the standing lift indicated leg straps were to be used for resident safety with the standing lift.

Approximately two months prior to the fall, a physical therapist evaluated the resident, because the resident was refusing to use the abdominal harness of the standing lift due to difficulty breathing. The physical therapist educated the resident that all the buckles, abdominal and leg, were to be strapped when using the standing lift and the resident agreed. During interviews, three staff members indicated the resident refused the leg straps and told staff s/he could stand better without using the leg straps. However, if staff members were firm and told the resident leg straps were required during the transfer, the resident would comply. The facility policy on the standing lift equipment indicated to keep the residents feet on the footplate and secure the shin straps around the resident's leg and calf area.

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Compliance:

The AP was interviewed. On the morning of the fall, the resident put on the call light to use the toilet. The AP entered the resident's room and placed the resident in the standing lift. The resident refused the leg straps. The AP told the resident the leg straps needed to be applied for safety, but the resident still refused the leg straps. The AP requested assistance from a nurse.

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After five minutes, the resident's need to use the toilet was urgent and there was no response to the call for assistance. The AP transferred the resident to the toilet. After toileting, during the the transfer from the standing lift to the wheelchair, the resident's foot slipped off the platform. The resident slipped down in the lift while approximately one foot off the floor and was lowered to the floor.

The resident had pain in his/her right hip and requested an X-ray. The X-ray revealed an incomplete fracture of the mid-right femur. The resident was hospitalized and had hip surgery, which was complicated by acute respiratory failure related to his/her chronic respiratory difficulties. The resident returned to the facility thirteen days later, but was readmitted to the hospital that same day for respiratory distress. The resident returned to the facility four days later on hospice care and died the next day.

The resident's primary physician was interviewed and explained that the anesthesia from the surgery worsened the resident's already chronic respiratory conditions.

The death certificate indicated the resident died eighteen days after the fall. The immediate cause of death was listed as complications related to immobility due to the right hip fracture from the fall.

Minnesota Vulnerab	Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)									
Under the Minnesota	vulnerable Adults Act (Minn	esota Statutes, section 626.557):								
☐ Abuse ☐ Neglect ☐ Financial Exploitation										
Substantiated ■	☐ Not Substantiated	☐ Inconclusive based on the following information:								
Mitigating Factors:	ors" in Minnesota Statutes, sec	tion 626.557, subdivision 9c (c) were considered and it was								
0 0	☑ Individual(s) and/or ☐ Fac	. ,								
		loitation. This determination was based on the following:								
•	cies and procedures for the sta according to the manufacture	anding lift and the staff had been trained. The staff did not r's instructions.								
substantiated against possible inclusion of	an identified employee, this re the finding on the abuse regist	to appeal the maltreatment finding. If the maltreatment is eport will be submitted to the nurse aide registry for try and/or to the Minnesota Department of Human Services provisions of the background study requirements under								

Annle Valley State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Met The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued. 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: X Yes П 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: X 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: X 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): A follow-up visit was made by the Minnesota Department of Health on October 14, 2016. The facility was back in compliance with federal regulations and state licensing orders.

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Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

Facility Name: Augustana Healthcare Center of

"Neglect" means:

Definitions:

- (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.

	ility Name: Augustana Healthcare Center of	Report Number: H5264056
Miı	nnesota Statutes, section 626.5572, subdivision 19 - Substantiated	6
"Su	bstantiated" means a preponderance of the evidence shows that an act that meet treatment occurred.	s the definition of
A500000000	e Investigation included the following: cument Review: The following records were reviewed during the investigation	:
X	Medical Records	
X	Nurses Notes	
X	Physician Orders	
X	Care Plan Records	
X	Facility Incident Reports	
X	Laboratory and X-ray Reports	
X	Therapy and/or Ancillary Services Records	
V22000000	ter pertinent medical records:	
X	Hospital Records 🗵 Death Certificate	
Ado	litional facility records:	
X	Resident/Family Council Minutes	
X	Staff Time Sheets, Schedules, etc.	
X	Personnel Records/Background Check, etc.	
X	Facility In-service Records	
X	Facility Policies and Procedures	
Nur	mber of additional resident(s) reviewed: Two	
Wei	re residents selected based on the allegation(s)? Yes No N/A	

Specify:

Report Number: H5264056 Annle Valley Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation? Yes No \bigcirc N/A Specify: Deceased **Interviews:** The following interviews were conducted during the investigation: \bigcirc No N/A Specify: Facility Report If unable to contact complainant, attempts were made on: Time: Date: Time: Date: Time: Date: ○ N/A Specify: Interview with family: () Yes O No Did you interview the resident(s) identified in allegation: Yes \bigcirc No ○ N/A Specify: Did you interview additional residents? • Yes \bigcirc No Total number of resident interviews:Three Interview with staff:

Yes \bigcirc N/A \bigcirc No Specify: Tennessen Warnings Tennessen Warning given as required:

Yes O No Total number of staff interviews: Nine Physician Interviewed:

Yes O No Nurse Practitioner Interviewed: No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s):

Yes ○ N/A Specify: O No

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Attempts to contact:

Date:

Time:

Time:

Date:

Date:

Time:

Observations were conducted related to: **▼** Use of Equipment Safety Issues Transfers **x** Facility Tour Was any involved equipment inspected: () Yes N/A O No Was equipment being operated in safe manner: Yes O No N/A Were photographs taken: ○ Yes Specify: No cc: **Health Regulation Division - Licensing & Certification Minnesota Board of Examiners for Nursing Home Administrators** The Office of Ombudsman for Long-Term Care **Apple Valley Police Department Apple Valley City Attorney**

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Facility Name: Augustana Healthcare Center of

Dakota County Medical Examiner

Dakota County Attorney

Annle Valley

PRINTED: 09/02/2016 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245264	B. WING	·			C /06/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	·		STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	100/2010
AUGUST	ANA HCC OF APPLE	VALLEY			14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs .	FC)00			
F 323 SS=G	to investigate case: a result, the following related to #H526404 facility is enrolled in signature is not requipage of the CMS-25 submission of the Poerification of computation of computation of the Poerification of computation of the Poerification of computation of the Poerification of the Poerification of computation of the Poerification of	liance. FACCIDENT	F 3	323			
	by: Based on interview facility failed to ensure safely to minimize the residents (R1) who restanding lift. This resign (R1) sustained a right lowered to the floor of Findings include: The manufacturer's lift dated 6/03, indicated for transfers which p	and document review, the are staff operated equipment he risk of injury for 1 of 3 refused the leg straps on the sulted in actual harm when the femur fracture when being from a standing lift. instructions for the standing lift was used to sit on the resident's feet on a harness to hold the upper					
ABOBATORY	DIDECTOR'S OF PROVING	FR/SLIPPLIER REPRESENTATIVE'S SIGN.	ATUDE		TITI E		(YE) 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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NAME OF PROVIDER OR SUPPLIER		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION		TE SURVEY MPLETED
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PRINTED: 09/02/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	243204	D. WING		OTDEST ADDRESS OFF OTHER TIP CODE	09/	06/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE		
AUGUST	TANA HCC OF APPLE	VALLEY			APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	on hospice. R1's nursing progre R1 died. R1's death certificat the immediate caus of immobility due to fall. PT-D was interview PT-D stated the sta around the waist an during the November want to use the leg educated R1 on the and felt she was go may not have docur evaluation. PT-D stated the transfer without stated per the manustraps need to be as The assistant direct interviewed on 6/13/stated NA-H had be standing lift and med stated during orientate resident would refuseducate the resident full body lift if there is	the indicated R1 died on 2/2/16, the of death was complications the right hip fracture from the led on 6/9/16, at 4:30 p.m. Inding lift had straps that went diegs for safety. PT-D stated for 2015, evaluation R1 did not straps. PT-D stated he need to use all the straps ing to agree. PT-D stated he mented that information in the lated he would not have done using the leg straps. PT-D iffacturer directions the leg oplied. For of nursing (ADON) was 1/16, at 10:21 a.m. The ADON en trained on the use of the chanical lifts. The ADON ation the staff are told if a see the leg straps, they should the told if the nurse and use a see a continued refusal. The	F3	323	,		
	use the equipment p potentially be prever not used as intended NA-H was interviewe NA-H stated she had	ald be a standard of care to properly and felt the fall could ntable as the equipment was d. ed on 6/16/16, at 7:35 a.m. d been trained on the use of H said on the day of the fall					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY 1PLETED
		245264	B. WING	:		1	C
	PROVIDER OR SUPPLIER			S1 14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124	<u> 09/</u>	06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	R1 had her call light toilet and she had now she stated she look found out she transistaff and the standing apply the leg straps them as they were now the leg straps needs walkie talkie and as she did not feel com NA-H tried to get all for assistance for fix ahead and transferr to use the toilet. She lift from the bathroof started slipping from though the abdomin stated she didn't feel prevented the fall. Now foot off the floor. NA member used a full	t on as she needed to use the rever transferred R1 before. Red at R1's care plan and ferred with the assist of one ing lift. NA-H was going to and R1 told her not to use not needed. She instructed R1 as interested to be used. NA-H used her ked for assistance with R1 as infortable transferring her. Hold of the nurse and waited we minutes. NA-H then went red R1 due to the urgent need as brought R1 in the standing in to the wheelchair, when R1 in the top downwards even all strap was tightened. NA-H all the leg straps would of IA-H lowered R1 to about one in-H along with another staff mechanical lift to transfer R1 tated she was retrained on	F3	323		ار	
F 333 SS=D	R1 was at high risk triggering event for tworsened R1's respides 483.25(m)(2) RESID SIGNIFICANT MED. The facility must ensury significant medical	116, at 4:49 p.m. MD-J stated for death and the fall was a he surgery, anesthesia and a iratory condition. DENTS FREE OF ERRORS	F 3	33			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION			E SURVEY IPLETED
		245264	B. WING			1	C 06/2016
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	<u></u>		STREET ADDRESS, CITY, STATE, Z 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	IP CODE	1 03/	06/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 333	facility failed to ensine reviewed for medical significant medication administer Coumace by the nurse practit. Findings include: R2's medical record sheet indicated R2 placed in his left an R2's hospital transfeindicated R2 was diembolism, a blood extremity on 2/26/16 Coumadin, that rediblood. A review of hospital 3/4/16, indicated R2 International Normathat monitors the effect 2.0-3.0. A review of R2's Nuindicated R2's most 4/11/16, was for Coudaily with an INR to The INR log dated 42.4, LPN-G initialed Practitioner (NP)-K There were no nurse Coumadin order had log.	v and document review, the ure 1 of 4 residents (R2) ation errors was free of a on error when staff did not lin, a blood thinner as ordered	F 3	133			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				IPLETED
	245264	B. WING	i		i e	C 06/2016
	VALLEY		1	4650 GARRETT AVENUE	00,	00/2010
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	1		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
indicated R2 did not days on April 15, 16 The event report days of facility did not obtain NP-K, based on the NP-K was notified of immediate INR to be A review of the Inve 4/20/16, indicated R was 1.2 after 5 days investigative report Coumadin 6 mg on 4/21/16, with an INF R2's INR log dated 1.2 which was not in R2's physician order of and 4/23/16, with an R2's anticoagulation 4/25/16, indicated a in therapeutic range During an interview on 6/8/16, at 2:40 p. documented R2's IN treatment administra 2.4. RN-D stated sh responsible to obtain did not do so. During an interview (LPN)-E on 6/8/16, at 2:40 p.	treceive Coumadin for five 5, 17, 18, and 19, 2016. Ited 4/20/16, indicated R1 Coumadin because the 1 a new Coumadin order from 1/18/16. In 4/20/16, and ordered an 1 de drawn. Stigative Report dated 1/20/16, and ordered an 1/20/16, and ordered 1/20/16, and ordered 1/20/16, and ordered 1/20/16, and ordered 1/20/16, coumadin 3 mg on 1/20/16, indicated NP-K ordered 1/20/16, indicated a result of 1/20/16, indicated 1/2	F3	333			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa indicated R2 did no days on April 15, 16 The event report da missed five days of facility did not obtain NP-K, based on the NP-K was notified of immediate INR to b A review of the Inve 4/20/16, indicated R was 1.2 after 5 days investigative report Coumadin 6 mg on 4/21/16, with an INF R2's INR log dated 1.2 which was not in R2's physician orde indicated an order of and 4/23/16, with ar R2's anticoagulation 4/25/16, indicated a in therapeutic range During an interview on 6/8/16, at 2:40 p. documented R2's IN treatment administra 2.4. RN-D stated sh responsible to obtain did not do so. During an interview (LPN)-E on 6/8/16, a	DENTIFICATION NUMBER: 245264 PROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 indicated R2 did not receive Coumadin for five days on April 15, 16, 17, 18, and 19, 2016. The event report dated 4/20/16, indicated R1 missed five days of Coumadin because the facility did not obtain a new Coumadin order from NP-K, based on the INR results from 4/15/16. NP-K was notified on 4/20/16, and ordered an immediate INR to be drawn. A review of the Investigative Report dated 4/20/16, indicated R2's INR result on 4/20/16, was 1.2 after 5 days without Coumadin. The investigative report indicated NP-K ordered Coumadin 6 mg on 4/20/16, Coumadin 3 mg on 4/21/16, with an INR blood draw on 4/22/16. R2's INR log dated 4/22/16, indicated a result of 1.2 which was not in therapeutic range. R2's physician order form dated 4/22/16, indicated an order of Coumadin 6 mg on 4/25/16. R2's anticoagulation therapy flow sheet dated 4/25/16, indicated an INR result of 2.0 which was in therapeutic range. During an interview with registered nurse (RN)-D on 6/8/16, at 2:40 p.m. RN-D stated she documented R2's INR results on the electronic treatment administration record on 4/15/16, as 2.4. RN-D stated she was responsible to obtain a new Coumadin order and	PROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 indicated R2 did not receive Coumadin for five days on April 15, 16, 17, 18, and 19, 2016. The event report dated 4/20/16, indicated R1 missed five days of Coumadin because the facility did not obtain a new Coumadin order from NP-K, based on the INR results from 4/15/16. NP-K was notified on 4/20/16, and ordered an immediate INR to be drawn. 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During an interview with licensed practical nurse (LPN)-E on 6/8/16, at 2:55 p.m. LPN-E stated	PROVIDER OR SUPPLIER ANA HCC OF APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 indicated R2 did not receive Coumadin for five days on April 15, 16, 17, 18, and 19, 2016. The event report dated 4/20/16, indicated R1 missed five days of Coumadin because the facility did not obtain a new Coumadin order from NP-K, based on the INR results from 4/15/16. NP-K was notified on 4/20/16, and ordered an immediate INR to be drawn. A review of the Investigative Report dated 4/20/16, indicated R2's INR result on 4/20/16, was 1.2 after 5 days without Coumadin. The investigative report indicated NP-K ordered Coumadin 6 mg on 4/20/16, Coumadin 3 mg on 4/21/16, with an INR blood draw on 4/22/16. R2's INR log dated 4/22/16, indicated a result of 1.2 which was not in therapeutic range. 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During an interview with licensed practical nurse (LPN)-E on 6/8/16, at 2.55 p.m. LPN-E stated	A BUILDING 245264 245264 B. WING 3TREET ADDRESS, CITY, STATE, ZIP CODE 14859 GARRETT AVENUE APPLE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 indicated R2 did not receive Coumadin for five days on April 15, 16, 17, 18, and 19, 2016. The event report dated 4/20/16, indicated R1 missed five days of Coumadin because the facility did not obtain a new Coumadin order from NP-K, based on the INR results from 4/15/16, NP-K-was notified on 4/20/16, coumadin. The investigative report indicated NP-K ordered an immediate INR to be drawn. A review of the Investigative Report dated 4/20/16, indicated R2 SINR result on 4/20/16, was 1.2 after 5 days without Coumadin. The investigative report indicated NP-K ordered Coumadin 6 mg on 4/20/16, Coumadin 3 mg on 4/21/16, with an INR blood draw on 4/22/16, indicated an order of Coumadin 6 mg on 4/22/16, indicated an order of Coumadin 6 mg on 4/22/16, indicated an INR result of 2.0 which was in therapeutic range. During an interview with registered nurse (RN)-D on 6/8/16, at 2:40 p.m. RN-D stated she documented R2's INR results on the electronic treatment administration record on 4/16/16, as 2.4, RN-D stated she was responsible to obtain a new Coumadin order and did not do so.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC NG		(X3) DATE SURVEY COMPLETED	
		245264	B. WING				C 06/2016
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		14650 GARRE	ESS, CITY, STATE, ZIP CODE ETT AVENUE LEY, MN 55124	1 00.	30/2310
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	OVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	A review of the Couprocedure revised 7 incident revealed th coordinator/nurse w computer lab orders entered into the cordorder on the day an	not received his Coumadin for hys. madin and INR policy and 7/15, in use at the time of the	F3	33			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING			;
		00979	B. WING			6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE · DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.		·		
	investigate complain #H5264058. As a re- orders are issued re- #H5264058. The fac- in the electronic rec	ation was conducted to				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00979	B. WING		09/0	06/2016
	PROVIDER OR SUPPLIER	14650 GA	DRESS, CITY, RRETT AV E	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	LLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSED TO THE APPROPOSED CORRECTION OF THE APPROP	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	Continued From page 1				
	Health Informational http://www.health.st obul.htm The State delineated on the at Department of Heal electronically. Althonecessary for State the word "corrected Then indicate in the process, under the date your orders will electronically submit Department of Heal	al Bulletin 14-01, available at cate.mn.us/divs/fpc/profinfo/infectionsing orders are attached Minnesota atthorders being submitted bugh no plan of correction is Statutes/Rules, please enter in the box available for text. The electronic State licensure heading completion date, the I be corrected prior to tting to the Minnesota th.	2 000			
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and	2 830			
-	Subpart 1. Care in receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursin of bed as much as pwritten order from the	general. A resident must e and treatment, personal and supervision based on dipreferences as identified in resident assessment and cribed in parts 4658.0400 and highome resident must be out possible unless there is a ne attending physician that the n in bed or the resident				
·	by: Based on interview a facility failed to ensu safely to minimize th residents (R1) who r	and document review, the are staff operated equipment are risk of injury for 1 of 3 refused the leg straps on the sulted in actual harm when				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		00979	B. WING		C 09/06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
700001	ANATIOU OF AFFEE	APPLE VA	LLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 2	2 830			
		ht femur fracture when being from a standing lift.				
	Findings include:					
	lift dated 6/03, indic for transfers which a platform and use body. The lower leg used to ensure that resident's legs staye	instructions for the standing ated the standing lift was used position the resident's feet on a harness to hold the upper straps were an accessory the lower parts of the ed close to the knee support, he knee supports, then a lower calves.				
	The facility's undated policy for the Sara 3000 sit to stand lift indicated to keep the resident's feet on the footplate and secure the shin straps around the resident's legs and calf area.					
	sheet indicated R1 diagnosis of a fibula with acute and chro	I was reviewed. R1's face was admitted 1/2015 with fracture of the right leg and nic respiratory failure, onea and chronic obstructive (COPD).				,
	summary dated 6/2/	by (PT) discharge progress 115 indicated R1 was not able use of the standing lift.				
	on 11/2/15, due to F proper use abdomin	ner ordered a PT evaluation R1's non-compliance with the lal strap of the standing lift difficult for R1 to breath.				
	was assessed for the abdominal strap bed	dated 11/4/15, indicated R1 e appropriate size of cause R1 was refusing to lated to difficulty breathing.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		c	
		00979	B. WING			6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
	OLUMBIA DV OTA		LLEY, MN	I	ON	1 000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	educated R1 that ea	e with the smaller strap. PT-D ach time the abdominal strap ckles were to be secure. R1 nd continue with the standing				
	indicated R1 was co	ssment dated 1/6/16, ognitively intact and required ne staff and the standing lift for				
	R1's care plan review date of 1/14/16, indicated R1 transferred with the assist on one staff and the standing lift.					
	documented by lice indicated R1 was be standing lift when he platform of the stan assistant (NA)-H low complained of pain Tylenol was administrational results.	report dated 1/15/16, nsed practical nurse (LPN)-A eing transferred in the er right foot slipped off the ding lift resulting in nursing wering R1 to the floor. R1 in her right hip and femur. stered. Nurse practitioner and ordered an X-ray of R1's				
		ated 1/15/16, indicated an of the mid right femur.				
	8:00 p.m. indicated	ss notes dated 1/15/16, at after R1's x-ray was dered to transfer R1 to the on.				
·	indicated R1 was ho through 1/28/16, this surgery. R1 experie course including res	ess note dated 2/2/16, ospitalized from 1/15/16, rteen days for right hip nced a complicated hospital spiratory failure and required airway pressure (BiPAP)				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	·		
		00979	B. WING		C 09/06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY 14650 GA	RRETT AVE	NUE		
A00031	ANATICE OF AFFEL	APPLE VA	ALLEY, MN	55124		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	lungs open to supply was discharged from facility and then trained was readmitted evening for respirate four days later R1 won hospice. R1's nursing progrem R1 died. R1's death certificate the immediate cause.	keep the upper airways of the ort breathing. On 1/28/16, R1 m the hospital back to the asferred back to the facility to the hospital that same ory depression. On 2/1/16, was discharged to the facility as note date 2/2/16 indicated the indicated R1 died on 2/2/16, we of death was complications the right hip fracture from the	•			
	PT-D was interviewed on 6/9/16, at 4:30 p.m. PT-D stated the standing lift had straps that went around the waist and legs for safety. PT-D stated during the November 2015, evaluation R1 did not want to use the leg straps. PT-D stated he educated R1 on the need to use all the straps and felt she was going to agree. PT-D stated he may not have documented that information in the evaluation. PT-D stated he would not have done the transfer without using the leg straps. PT-D stated per the manufacturer directions the leg straps need to be applied. The assistant director of nursing (ADON) was interviewed on 6/13/16, at 10:21 a.m. The ADON stated NA-H had been trained on the use of the standing lift and mechanical lifts. The ADON stated during orientation the staff are told if a resident would refuse the leg straps, they should educate the resident, notify the nurse and use a full body lift if there is a continued refusal. The ADON stated it should be a standard of care to					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMP	PLETED
					С	
		00979	B. WING		09/0	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VΔIIFY	RRETT AVE ALLEY, MN			
	OLUMBANA DV. OTA		1	1		000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 5		2 830			
,	potentially be preve not used as intende	ntable as the equipment was ed.				
	NA-H was interview	red on 6/16/16, at 7:35 a.m.				
	NA-H stated she ha	d been trained on the use of				
		-H said on the day of the fall ton as she needed to use the				
	toilet and she had n	ever transferred R1 before.				
	She stated she looked at R1's care plan and found out she transferred with the assist of one staff and the standing lift. NA-H was going to					
-		and R1 told her not to use				
		not needed. She instructed R1 ed to be used. NA-H used her				
	walkie talkie and as	ked for assistance with R1 as				
		nfortable transferring her. hold of the nurse and waited				
	for assistance for five	ve minutes. NA-H then went				
		ed R1 due to the urgent need brought R1 in the standing				
	lift from the bathroo	m to the wheelchair, when R1				
		n the top downwards even nal strap was tightened. NA-H				
	stated she didn't fee	el the leg straps would of				
	•	IA-H lowered R1 to about one				
		A-H along with another staff mechanical lift to transfer R1				
		tated she was retrained on				
	the standing lift after	r the incident.				
		al doctor (MD)-J was				
		/16, at 4:49 p.m. MD-J stated for death and the fall was a				
	triggering event for t	the surgery, anesthesia and a				
	worsened R1's resp	iratory condition.				
	SUGGESTED MET	HOD OF CORRECTION: The				
		ould review and revise the				
		es for the standing lift. All erapy staff could receive				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		l ,	•
00979		00979	B. WING		09/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
7.0000.	ATTEL	APPLE V	ALLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	quality assessment could implement m ensure residents ar care and treatment.	olicies and procedures. The and assurance committee control on all shifts to e receiving the appropriate				
21545	, ,	A.B.C Medication Errors	21545			
	percent as describe Guidelines for Code 42, section 483.25 (the State Operation Surveyors for Long- incorporated by refe purposes of this par	on error rate is less than five and in the Interpretive of Federal Regulations, title (m), found in Appendix P of s Manual, Guidance to Term Care Facilities, which is better in part 4658.1315. For t, a medication error means: the medications are actually dents in the nursing home; or estration of expired				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00979	B. WING		C 09/06/2016	
NAME OF	PROVIDER OR SUPPLIER	. STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	TANA HCC OF APPLE	VALLEY	RRETT AVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21545	resident reactions in physician or the phyresident or the resident or the residesignated represemust be made in the C. All medication prescribed. An incide report must be filed occurs. Any significant reactions in physician or the phyresident or the resident or the resi	ge 7 nust be reported to the visician's designee and the lent's legal guardian or intative and an explanation e resident's clinical record. One are administered as ident report or medication error for any medication error that cant medication errors or inust be reported to the visician's designee and the lent's legal guardian or intative and an explanation erresident's clinical record.	21545			
	reviewed for medical significant medication administer Coumadiby the nurse practition. Findings include: R2's medical record sheet indicated R2 valued in his left ant R2's hospital transfer indicated R2 was dialembolism, a blood destremity on 2/26/16 Coumadin, that redublood.	ntion errors was free of a on error when staff did not in, a blood thinner as ordered				,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		C	
		00979	B. WING		E .)6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
	I		ALLEY, MN	1		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 8	21545			
	International Norma	2's therapeutic range for alized Ratio (INR), a blood test fects of the blood thinner, was				
	indicated R2's most 4/11/16, was for Co	rse Practitioner orders t recent coumadin order dated umadin 3 milligrams (mg) be drawn on 4/15/16.				
	The INR log dated 4/15/16, indicated a result of 2.4, LPN-G initialed on the INR log that Nurse Practitioner (NP)-K was notified on 4/15/16. There were no nurse initials indicating a Coumadin order had been received on the INR log.					
	indicated R2 did not	lication administration record t receive Coumadin for five , 17, 18, and 19, 2016.				
	missed five days of facility did not obtain NP-K, based on the	ted 4/20/16, indicated R1 Coumadin because the n a new Coumadin order from INR results from 4/15/16. n 4/20/16, and ordered an e drawn.				
	4/20/16, indicated R was 1.2 after 5 days investigative report i Coumadin 6 mg on	stigative Report dated 2's INR result on 4/20/16, without Coumadin. The indicated NP-K ordered 4/20/16, Coumadin 3 mg on 8 blood draw on 4/22/16.				
	R2's INR log dated 4 1.2 which was not in	4/22/16, indicated a result of therapeutic range.				
		form dated 4/22/16, f Coumadin 6 mg on 4/22/16,			:	

. .*. .

Minnesota Department of Health						APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00979	B. WING		09/0) 6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	ARRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 9	21545			
	and 4/23/16, with a	n INR blood draw on 4/25/16.				
		n therapy flow sheet dated an INR result of 2.0 which was e.				
	on 6/8/16, at 2:40 p documented R2's In treatment administr 2.4. RN-D stated sh	with registered nurse (RN)-D .m. RN-D stated she NR results on the electronic ation record on 4/15/16, as he was not aware she was in a new Coumadin order and				
	(LPN)-E on 6/8/16, when she worked 4	with licensed practical nurse at 2:55 p.m. LPN-E stated /20/16, on the evening shift ot received his Coumadin for ys.				
	procedure revised 7 incident revealed the coordinator/nurse we computer lab orders entered into the conforder on the day and	madin and INR policy and 7/15, in use at the time of the e health information rould add the INR to the s. The INR result would be nputer system as a twice daily d evening shift to ensure it a new Coumadin order had				
	The director of nurs review and revise th procedure. The DOI all appropriate staff The quality assessn committee could de- ensure ongoing com	velop a monitoring systems to appliance.				
	TIME PERIOD FOR	CORRECTION: Twenty-one		· · · · · · · · · · · · · · · · · · ·		

AND PLAN OF CORRECTION (X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
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21545	Continued From pa	ge 10	21545				
	(21) days						
21850	Residents of HC Fa Subd. 14. Freedo Residents shall be the defined in the Vulne "Maltreatment" mea section 626.5572, sintentional and non-	om from maltreatment. Free from maltreatment as erable Adults Protection Act. Fins conduct described in ubdivision 15, or the therapeutic infliction of	21850	·			
	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.						
	by: Based on interview facility failed to ensu safely to minimize the residents (R1) who standing lift. This residents	and document review, the are staff operated equipment ne risk of injury for 1 of 3 refused the leg straps on the sulted in actual harm when ht femur fracture when being from a standing lift.					
	lift dated 6/03, indicator for transfers which partial platform and use a	instructions for the standing ated the standing lift was used position the resident's feet on a harness to hold the upper straps were an accessory					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00979	B. WING			C 0 6/2016
NAME OF	PROVIDER OR SUPPLIER	. STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	TANA HCC OF APPLE	VALLEY	RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21850	Continued From pa	ge 11	21850			
	resident's legs staye	the lower parts of the ed close to the knee support. he knee supports, then lower calves.				
	to stand lift indicated on the footplate and	ed policy for the Sara 3000 sit d to keep the resident's feet I secure the shin straps 's legs and calf area.				
	sheet indicated R1 v diagnosis of a fibula with acute and chro	was reviewed. R1's face was admitted 1/2015 with fracture of the right leg and nic respiratory failure, onea and chronic obstructive (COPD).				
To the state of th	summary dated 6/2/	by (PT) discharge progress 15 indicated R1 was not able use of the standing lift.			:	
	on 11/2/15, due to R proper use abdomin	ner ordered a PT evaluation t1's non-compliance with the lal strap of the standing lift lifficult for R1 to breath.				
·	was assessed for the abdominal strap bed buckle the straps released R1 felt more secure educated R1 that eas was used all the buckless.	dated 11/4/15, indicated R1 e appropriate size of cause R1 was refusing to lated to difficulty breathing. with the smaller strap. PT-D ich time the abdominal strap ckles were to be secure. R1 d continue with the standing				
	indicated R1 was co	esment dated 1/6/16, gnitively intact and required e staff and the standing lift for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		00979	B. WING		1	06/2016
NAME OF	PROVIDER OR SUPPLIER		DDEEC CITY	STATE, ZIP CODE		
IVAIVIE OF	-KOVIDER OR SUFFLIER		RRETT AVE			
AUGUST	ANA HCC OF APPLE	VALLEY	ALLEY, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ·	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
21850	Continued From pa	ge 12	21850			
	R1's care plan review date of 1/14/16, indicated R1 transferred with the assist on one staff and the standing lift.					
	documented by lice indicated R1 was be standing lift when he platform of the stan assistant (NA)-H low complained of pain Tylenol was administrational results.	report dated 1/15/16, nsed practical nurse (LPN)-A eing transferred in the er right foot slipped off the ding lift resulting in nursing wering R1 to the floor. R1 in her right hip and femur. stered. Nurse practitioner and ordered an X-ray of R1's				
		ated 1/15/16, indicated an of the mid right femur.				
	R1's nursing progress notes dated 1/15/16, at 8:00 p.m. indicated after R1's x-ray was completed, NP-K ordered to transfer R1 to the hospital for evaluation.					
	indicated R1 was he through 1/28/16, this surgery. R1 experie course including res the bi-level positive machine that helps lungs open to suppo was discharged fror facility and then tran and was readmitted evening for respirate four days later R1 w on hospice.	ess note dated 2/2/16, popitalized from 1/15/16, reteen days for right hip need a complicated hospital epiratory failure and required airway pressure (BiPAP) keep the upper airways of the port breathing. On 1/28/16, R1 in the hospital back to the asferred back to the facility to the hospital that same bry depression. On 2/1/16, ras discharged to the facility			·	
	R1's nursing progre	ss note date 2/2/16 indicated				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED	
		00979	B. WING	·	1	C 06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE			
		14650 GA	RRETT AVE				
AUGUST	TANA HCC OF APPLE	VALLEY	ALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETE DATE		
21850	Continued From pa	ge 13	21850				
	R1 died.	-					
	R1's death certificate the immediate cause	te indicated R1 died on 2/2/16, se of death was complications the right hip fracture from the					
	PT-D stated the sta around the waist an during the Novembe want to use the leg educated R1 on the and felt she was go may not have docur evaluation. PT-D sta the transfer without	ed on 6/9/16, at 4:30 p.m. nding lift had straps that went d legs for safety. PT-D stated er 2015, evaluation R1 did not straps. PT-D stated he need to use all the straps ing to agree. PT-D stated he mented that information in the ated he would not have done using the leg straps. PT-D ufacturer directions the leg opplied.		·			
•	interviewed on 6/13, stated NA-H had be standing lift and me stated during orientaresident would refuseducate the residen full body lift if there in ADON stated it should use the equipment property.	or of nursing (ADON) was /16, at 10:21 a.m. The ADON en trained on the use of the chanical lifts. The ADON ation the staff are told if a se the leg straps, they should t, notify the nurse and use a s a continued refusal. The uld be a standard of care to properly and felt the fall could ntable as the equipment was d.					
	NA-H stated she had the standing lift. NA- R1 had her call light toilet and she had no She stated she look	ed on 6/16/16, at 7:35 a.m. d been trained on the use of -H said on the day of the fall on as she needed to use the ever transferred R1 before. ed at R1's care plan and ferred with the assist of one					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		152, 111, 10, 11, 11, 11, 11, 11, 11, 11, 1	A. BUILDING:				
		00979	B. WING		C 09/06/2016		
NAME OF	PROVIDER OR SUPPLIER	STATE, ZIP CODE					
14650 GARRETT AVENUE							
AUGUSTANA HCC OF APPLE VALLEY APPLE VALLEY, MN 55124							
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21850	Continued From pa	ge 14	21850				
	staff and the standing lift. NA-H was going to apply the leg straps and R1 told her not to use them as they were not needed. She instructed R1 the leg straps needed to be used. NA-H used her walkie talkie and asked for assistance with R1 as she did not feel comfortable transferring her. NA-H tried to get a hold of the nurse and waited for assistance for five minutes. NA-H then went ahead and transferred R1 due to the urgent need to use the toilet. She brought R1 in the standing lift from the bathroom to the wheelchair, when R1 started slipping from the top downwards even though the abdominal strap was tightened. NA-H stated she didn't feel the leg straps would of prevented the fall. NA-H lowered R1 to about one foot off the floor. NA-H along with another staff member used a full mechanical lift to transfer R1 off the floor. NA-H stated she was retrained on the standing lift after the incident.						
	interviewed on 6/22/ R1 was at high risk	al doctor (MD)-J was /16, at 4:49 p.m. MD-J stated for death and the fall was a the surgery, anesthesia and a iratory condition.	·			·	
	The director of nursi the policy and proce nursing staff and the education on the po- quality assessment could implement me	HOD OF CORRECTION: ing could review and revise dures for the standing lift. All erapy staff could receive blicies and procedures. The and assurance committee onitoring on all shifts to e receiving the appropriate					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one					

			POST-0	CERTI	FICATION	N REVISIT F	REPORT		
	R / SUPPLIER CATION NUMB		MULTIPLE CON A. Building	NSTRUCTIO	N			DATE	OF REVISIT
245264	OATION NOWB		B. Wing					Y2 10/14	/2016 _{Y3}
NAME OF FACILITY							CITY, STATE, ZIP CODE		
AUGUS ⁻	TANA HCC OF	APPLE '	VALLEY			14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
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program corrected provision	, to show thosed and the date	e deficier such cor the identi	ncies previously rective action	y reported was accom	on the CMS-256 plished. Each d	7, Statement of Defic eficiency should be for	al Laboratory Improver iencies and Plan of Co ully identified using eitl codes shown to the le	orrection, that her the regu	t have been lation or LSC
ITEM DATE		ITEM		DATE	ITEM		DATE		
Y4			Y5	Y4		Y5	Y4		Y5
ID Prefix	F0323		Correction	ID Prefix	F0333	Correction	ID Prefix		Correction
Reg. #	483.25(h)		Completed	Reg. #	483.25(m)(2)	Completed	Reg. #		Completed
LSC			10/10/2016	LSC		10/10/2016	LSC		-
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #			Completed	Reg. #		Completed	Reg. #		Completed
LSC			.	LSC			LSC		-
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
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LSC				LSC		· ·	LSC		· -
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_SC				LSC			LSC		
REVIEWED BY STATE AGENCY [INITIALS]		DATE	SIGNATU	RE OF SURVEYOR		DATE			
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE	TITLE	, , , , , , , , , , , , , , , , , , ,		DATE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
FOLLOWUP TO SURVEY COMPLETED ON 9/6/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO						

STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building B. Wing 10/14/2016 00979 NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE AUGUSTANA HCC OF APPLE VALLEY 14650 GARRETT AVENUE APPLE VALLEY, MN 55124 This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 Y5 Y4 Y5 Y4 Y5 ID Prefix 20830 Correction ID Prefix 21545 Correction ID Prefix 21850 Correction MN Rule 4658.0520 MN Rule 4658.1320 MN St. Statute 144.651 Reg. # Completed Reg. # Completed Completed Reg. # Subp. 1 A.B.C Subd. 14 LSC 10/10/2016 10/10/2016 10/10/2016 LSC LSC **ID Prefix** Correction **ID Prefix ID Prefix** Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix** Correction Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix ID Prefix** Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC Correction ID Prefix **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) **REVIEWED BY REVIEWED BY** DATE TITLE DATE CMS RO (INITIALS)

Page 1 of 1

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

EVENT ID:

YPQ312

YES NO

9/6/2016

FOLLOWUP TO SURVEY COMPLETED ON