MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Augustana Healthcare Center of Apple Valley

Facility Address:
14650 Garrett Avenue

Facility City:
Apple Valley

State: Minnesota | **ZIP:** 55124 | **County:** Dakota

Report Number:
H5264056

Time of Visit:
9:45 a.m. to 3:15 p.m.
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.

Date of Visit:
June 8, 9, and 10, 2016

Date Concluded:
January 17, 2017

Investigator's Name and Title:
Jane Aandal, R.N., Special Investigator

☒ **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.

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.

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 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 for the standing lift and the staff had been trained. The staff did not use the standing lift according to the manufacturer's instructions.

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:

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: ☒ 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 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):

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.

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] 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

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional 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

Number of additional resident(s) reviewed: Two

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

Specify: _____

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

◯ Yes ◉ No ◯ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◯ Yes ◯ No ◉ N/A

Specify: Facility Report

If unable to contact complainant, attempts were made on:

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

Interview with family: ◉ Yes ◯ No ◯ N/A Specify:

Did you interview the resident(s) identified in allegation:

◉ Yes ◯ No ◯ N/A Specify:

Did you interview additional residents? ◉ Yes ◯ No

Total number of resident interviews: Three

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ◯ No

Total number of staff interviews: Nine

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:

- [x] Use of Equipment
- [x] Safety Issues
- [x] Transfers
- [x] Facility Tour

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

Apple Valley Police Department

Apple Valley City Attorney

Dakota County Medical Examiner
Dakota County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 #H5264056 & #H5264058. As a result, the following deficiencies are issued related to #H5264056 and #H5264058. 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(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff operated equipment safely to minimize the risk of injury for 1 of 3 residents (R1) who refused the leg straps on the standing lift. This resulted in actual harm when (R1) sustained a right femur fracture when being lowered to the floor from a standing lift. Findings include: The manufacturer's instructions for the standing lift dated 6/03, indicated the standing lift was used for transfers which position the resident's feet on a platform and use a harness to hold the upper	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 323	Continued From page 1	F 323		

body. The lower leg straps were an accessory used to ensure that the lower parts of the resident's legs stayed close to the knee support. They pass around the knee supports, then around the patient's 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.

R1's medical record was reviewed. R1's face sheet indicated R1 was admitted 1/2015 with diagnosis of a fibula fracture of the right leg and with acute and chronic respiratory failure, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD).

R1's physical therapy (PT) discharge progress summary dated 6/2/15 indicated R1 was not able to stand without the use of the standing lift.

R1's nurse practitioner ordered a PT evaluation on 11/2/15, due to R1's non-compliance with the proper use abdominal strap of the standing lift because it made it difficult for R1 to breath.

R1's PT evaluation dated 11/4/15, indicated R1 was assessed for the appropriate size of abdominal strap because R1 was refusing to buckle the straps related to difficulty breathing. R1 felt more secure with the smaller strap. PT-D educated R1 that each time the abdominal strap was used all the buckles were to be secure. R1 agreed to do this and continue with the standing lift.

R1's cognitive assessment dated 1/6/16, indicated R1 was cognitively intact and required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 323	Continued From page 2 the assistance of one staff and the standing lift for all transfers. R1's care plan review date of 1/14/16, indicated R1 transferred with the assist on one staff and the standing lift. The facility's event report dated 1/15/16, documented by licensed practical nurse (LPN)-A indicated R1 was being transferred in the standing lift when her right foot slipped off the platform of the standing lift resulting in nursing assistant (NA)-H lowering R1 to the floor. R1 complained of pain in her right hip and femur. Tylenol was administered. Nurse practitioner (NP)-K was notified and ordered an X-ray of R1's right hip and femur. R1's X-ray report dated 1/15/16, indicated an incomplete fracture 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. R1's hospital progress note dated 2/2/16, indicated R1 was hospitalized from 1/15/16, through 1/28/16, thirteen days for right hip surgery. R1 experienced a complicated hospital course including respiratory failure and required the bi-level positive airway pressure (BiPAP) machine that helps keep the upper airways of the lungs open to support breathing. On 1/28/16, R1 was discharged from the hospital back to the facility and then transferred back to the facility and was readmitted to the hospital that same evening for respiratory depression. On 2/1/16, four days later R1 was discharged to the facility	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 323	Continued From page 3 on hospice. R1's nursing progress note date 2/2/16 indicated R1 died. R1's death certificate indicated R1 died on 2/2/16, the immediate cause of death was complications of immobility due to the right hip fracture from the fall. 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 use the equipment properly and felt the fall could potentially be preventable as the equipment was not used as intended. NA-H was interviewed on 6/16/16, at 7:35 a.m. NA-H stated she had been trained on the use of the standing lift. NA-H said on the day of the fall	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 323	Continued From page 4 R1 had her call light on as she needed to use the toilet and she had never 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 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. R1's primary medical doctor (MD)-J was interviewed on 6/22/16, at 4:49 p.m. MD-J stated R1 was at high risk for death and the fall was a triggering event for the surgery, anesthesia and a worsened R1's respiratory condition.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 333	Continued From page 5 Based on interview and document review, the facility failed to ensure 1 of 4 residents (R2) reviewed for medication errors was free of a significant medication error when staff did not administer Coumadin, a blood thinner as ordered by the nurse practitioner for five days. Findings include: R2's medical record was reviewed. R2's face sheet indicated R2 was diagnosed with a stent placed in his left anterior descending artery. R2's hospital transfer form dated 2/28/16, indicated R2 was diagnosed with an acute embolism, a blood clot, of his right upper extremity on 2/26/16 and started the medication, Coumadin, that reduces clot formation in the blood. A review of hospital discharge orders dated 3/4/16, indicated R2's therapeutic range for International Normalized Ratio (INR), a blood test that monitors the effects of the blood thinner, was 2.0-3.0. A review of R2's Nurse Practitioner orders indicated R2's most recent coumadin order dated 4/11/16, was for Coumadin 3 milligrams (mg) daily with an INR to 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. R2's electronic medication administration record	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 333	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 4/22/16, and 4/23/16, with an INR blood draw 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 not aware she was responsible to obtain a new Coumadin order and did not do so. During an interview with licensed practical nurse (LPN)-E on 6/8/16, at 2:55 p.m. LPN-E stated when she worked 4/20/16, on the evening shift	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 333	Continued From page 7 she noted R2 had not received his Coumadin for the previous five days. A review of the Coumadin and INR policy and procedure revised 7/15, in use at the time of the incident revealed the health information coordinator/nurse would add the INR to the computer lab orders. The INR result would be entered into the computer system as a twice daily order on the day and evening shift to ensure it was completed and a new Coumadin order had been received.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5264056 and #H5264058. As a result, the following correction orders are issued related to #H5264056 and #H5264058. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 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		
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 document review, the facility failed to ensure staff operated equipment safely to minimize the risk of injury for 1 of 3 residents (R1) who refused the leg straps on the standing lift. This resulted in actual harm when	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 (R1) sustained a right femur fracture when being lowered to the floor from a standing lift. Findings include: The manufacturer's instructions for the standing lift dated 6/03, indicated the standing lift was used for transfers which position the resident's feet on a platform and use a harness to hold the upper body. The lower leg straps were an accessory used to ensure that the lower parts of the resident's legs stayed close to the knee support. They pass around the knee supports, then around the patient's 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. R1's medical record was reviewed. R1's face sheet indicated R1 was admitted 1/2015 with diagnosis of a fibula fracture of the right leg and with acute and chronic respiratory failure, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD). R1's physical therapy (PT) discharge progress summary dated 6/2/15 indicated R1 was not able to stand without the use of the standing lift. R1's nurse practitioner ordered a PT evaluation on 11/2/15, due to R1's non-compliance with the proper use abdominal strap of the standing lift because it made it difficult for R1 to breath. R1's PT evaluation dated 11/4/15, indicated R1 was assessed for the appropriate size of abdominal strap because R1 was refusing to buckle the straps related to difficulty breathing.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 R1 felt more secure with the smaller strap. PT-D educated R1 that each time the abdominal strap was used all the buckles were to be secure. R1 agreed to do this and continue with the standing lift. R1's cognitive assessment dated 1/6/16, indicated R1 was cognitively intact and required the assistance of one staff and the standing lift for all transfers. R1's care plan review date of 1/14/16, indicated R1 transferred with the assist on one staff and the standing lift. The facility's event report dated 1/15/16, documented by licensed practical nurse (LPN)-A indicated R1 was being transferred in the standing lift when her right foot slipped off the platform of the standing lift resulting in nursing assistant (NA)-H lowering R1 to the floor. R1 complained of pain in her right hip and femur. Tylenol was administered. Nurse practitioner (NP)-K was notified and ordered an X-ray of R1's right hip and femur. R1's X-ray report dated 1/15/16, indicated an incomplete fracture 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. R1's hospital progress note dated 2/2/16, indicated R1 was hospitalized from 1/15/16, through 1/28/16, thirteen days for right hip surgery. R1 experienced a complicated hospital course including respiratory failure and required the bi-level positive airway pressure (BiPAP)	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 machine that helps keep the upper airways of the lungs open to support breathing. On 1/28/16, R1 was discharged from the hospital back to the facility and then transferred back to the facility and was readmitted to the hospital that same evening for respiratory depression. On 2/1/16, four days later R1 was discharged to the facility on hospice. R1's nursing progress note date 2/2/16 indicated R1 died. R1's death certificate indicated R1 died on 2/2/16, the immediate cause of death was complications of immobility due to the right hip fracture from the fall. 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 use the equipment properly and felt the fall could	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 potentially be preventable as the equipment was not used as intended. NA-H was interviewed on 6/16/16, at 7:35 a.m. NA-H stated she had been trained on the use of the standing lift. NA-H said on the day of the fall R1 had her call light on as she needed to use the toilet and she had never 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 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. R1's primary medical doctor (MD)-J was interviewed on 6/22/16, at 4:49 p.m. MD-J stated R1 was at high risk for death and the fall was a triggering event for the surgery, anesthesia and a worsened R1's respiratory condition. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise the policy and procedures for the standing lift. All nursing staff and therapy staff could receive	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 education on the policies and procedures. The quality assessment and assurance committee could implement monitoring on all shifts to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 7 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 4 residents (R2) reviewed for medication errors was free of a significant medication error when staff did not administer Coumadin, a blood thinner as ordered by the nurse practitioner for five days. Findings include: R2's medical record was reviewed. R2's face sheet indicated R2 was diagnosed with a stent placed in his left anterior descending artery. R2's hospital transfer form dated 2/28/16, indicated R2 was diagnosed with an acute embolism, a blood clot, of his right upper extremity on 2/26/16 and started the medication, Coumadin, that reduces clot formation in the blood. A review of hospital discharge orders dated	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 8 3/4/16, indicated R2's therapeutic range for International Normalized Ratio (INR), a blood test that monitors the effects of the blood thinner, was 2.0-3.0. A review of R2's Nurse Practitioner orders indicated R2's most recent coumadin order dated 4/11/16, was for Coumadin 3 milligrams (mg) daily with an INR to 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. R2's electronic medication administration record 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 4/22/16,	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 9 and 4/23/16, with an INR blood draw 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 not aware she was responsible to obtain a new Coumadin order and did not do so. During an interview with licensed practical nurse (LPN)-E on 6/8/16, at 2:55 p.m. LPN-E stated when she worked 4/20/16, on the evening shift she noted R2 had not received his Coumadin for the previous five days. A review of the Coumadin and INR policy and procedure revised 7/15, in use at the time of the incident revealed the health information coordinator/nurse would add the INR to the computer lab orders. The INR result would be entered into the computer system as a twice daily order on the day and evening shift to ensure it was completed and a new Coumadin order had been received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise the Coumadin/INR policy and procedure. The DON or designee could educate all appropriate staff on the policy and procedure. The quality assessment and assurance committee could develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 10 (21) days	21545		
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 staff operated equipment safely to minimize the risk of injury for 1 of 3 residents (R1) who refused the leg straps on the standing lift. This resulted in actual harm when (R1) sustained a right femur fracture when being lowered to the floor from a standing lift. Findings include: The manufacturer's instructions for the standing lift dated 6/03, indicated the standing lift was used for transfers which position the resident's feet on a platform and use a harness to hold the upper body. The lower leg straps were an accessory	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 11 used to ensure that the lower parts of the resident's legs stayed close to the knee support. They pass around the knee supports, then around the patient's 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. R1's medical record was reviewed. R1's face sheet indicated R1 was admitted 1/2015 with diagnosis of a fibula fracture of the right leg and with acute and chronic respiratory failure, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD). R1's physical therapy (PT) discharge progress summary dated 6/2/15 indicated R1 was not able to stand without the use of the standing lift. R1's nurse practitioner ordered a PT evaluation on 11/2/15, due to R1's non-compliance with the proper use abdominal strap of the standing lift because it made it difficult for R1 to breath. R1's PT evaluation dated 11/4/15, indicated R1 was assessed for the appropriate size of abdominal strap because R1 was refusing to buckle the straps related to difficulty breathing. R1 felt more secure with the smaller strap. PT-D educated R1 that each time the abdominal strap was used all the buckles were to be secure. R1 agreed to do this and continue with the standing lift. R1's cognitive assessment dated 1/6/16, indicated R1 was cognitively intact and required the assistance of one staff and the standing lift for all transfers.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 12 R1's care plan review date of 1/14/16, indicated R1 transferred with the assist on one staff and the standing lift. The facility's event report dated 1/15/16, documented by licensed practical nurse (LPN)-A indicated R1 was being transferred in the standing lift when her right foot slipped off the platform of the standing lift resulting in nursing assistant (NA)-H lowering R1 to the floor. R1 complained of pain in her right hip and femur. Tylenol was administered. Nurse practitioner (NP)-K was notified and ordered an X-ray of R1's right hip and femur. R1's X-ray report dated 1/15/16, indicated an incomplete fracture 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. R1's hospital progress note dated 2/2/16, indicated R1 was hospitalized from 1/15/16, through 1/28/16, thirteen days for right hip surgery. R1 experienced a complicated hospital course including respiratory failure and required the bi-level positive airway pressure (BiPAP) machine that helps keep the upper airways of the lungs open to support breathing. On 1/28/16, R1 was discharged from the hospital back to the facility and then transferred back to the facility and was readmitted to the hospital that same evening for respiratory depression. On 2/1/16, four days later R1 was discharged to the facility on hospice. R1's nursing progress note date 2/2/16 indicated	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 13 R1 died. R1's death certificate indicated R1 died on 2/2/16, the immediate cause of death was complications of immobility due to the right hip fracture from the fall. 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 use the equipment properly and felt the fall could potentially be preventable as the equipment was not used as intended. NA-H was interviewed on 6/16/16, at 7:35 a.m. NA-H stated she had been trained on the use of the standing lift. NA-H said on the day of the fall R1 had her call light on as she needed to use the toilet and she had never transferred R1 before. She stated she looked at R1's care plan and found out she transferred with the assist of one	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 14 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. R1's primary medical doctor (MD)-J was interviewed on 6/22/16, at 4:49 p.m. MD-J stated R1 was at high risk for death and the fall was a triggering event for the surgery, anesthesia and a worsened R1's respiratory condition. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise the policy and procedures for the standing lift. All nursing staff and therapy staff could receive education on the policies and procedures. The quality assessment and assurance committee could implement monitoring on all shifts to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245264 Y1	A. Building B. Wing Y2	10/14/2016 Y3

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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 10/10/2016	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	Correction Completed 10/10/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00979 Y1	A. Building B. Wing Y2	10/14/2016 Y3

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 10/10/2016	ID Prefix 21545 Reg. # MN Rule 4658.1320 A.B.C LSC	Correction Completed 10/10/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 10/10/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			