

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Charter House			Report Number: H5282006	Date of Visit: October 19, 2017
Facility Address: 211 2ND Street NW			Time of Visit: 10:00 a.m. to 4:00 p.m.	Date Concluded: December 22, 2017
Facility City: Rochester			Investigator's Name and Christine Bluhm, RN, Spe	
State: Minnesota	ZIP: 55901	County: Olmsted		
Nursing Home				

Allegation(s):

It is alleged that a resident was exploited when the alleged perpetrator took the resident's narcotic medication for his/her own use.

- 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 Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, financial exploitation occurred when the alleged perpetrator (AP) took narcotics from a resident at the facility. The AP admitted taking narcotics from several residents.

The resident required care following knee replacement surgery and had a physician's order for narcotic pain medication. The resident was alert and oriented, able to make his/her needs known and dependent on staff for medication delivery.

Discrepancies were noted between the narcotic inventory log and the resident's chart documentation. One of the medications, hydromorphone, had been signed out by the AP as given to the resident but the resident reported his/her pain was controlled and had not requested the hydromorphone that had been signed out as given to him/her during a certain time period. The AP was interviewed by the facility and law enforcement. The police report indicated the AP admitted taking the medications, oxycodone and hydromorphone, from two or three residents within approximately the past four months. The AP stated that s/he never withheld pain medication from a resident.

The AP was interviewed and admitted s/he took hydromorphone from the resident's medication supply for

Facility Name: Char	ter House	Report Number: H5282
his/her own use. Th	ne AP stated that the resident o	lid not go without pain medication when the resident
Residents were into and received pain r	erviewed at the facility. Resider nedication when they requeste	nts stated that pain control was adequate with medication ed it.
The AP was termin	ated from the facility.	
	ble Adults Act (Minnesota Statu	utes, section 626.557)
Under the Minneso	ta Vulnerable Adults Act (Minr	nesota Statutes, section 626.557):
☐ Abuse	☐ Neglect	
Substantiated Sub	☐ Not Substantiated	☐ Inconclusive based on the following information:
determined that the ☐ Abuse	tors" in Minnesota Statutes, sec Individual(s) and/or	ection 626.557, subdivision 9c (c) were considered and it was acility is responsible for the ploitation. This determination was based on the following: stance policies in place. The alleged perpetrator was
substantiated again	st an identified employee, this reacher the finding on the abuse regis	t to appeal the maltreatment finding. If the maltreatment is report will be submitted to the nurse aide registry for stry and/or to the Minnesota Department of Human Services e provisions of the background study requirements under
Compliance:		
Federal Regulatior The requirements were not met.	ns for Long Term Care Facilities under the Federal Regulations	(42 CFR, Part 483, subpart B) - Compliance Not Met for Long Term Care Facilities (42 CFR, Part 483, subpart B),
Deficiencies are iss	sued on form 2567: 🗵 Yes	□ No
•	vailable on the MDH website.)	
State Licensing Ru The requirements	les for Nursing Homes (MN Rul under State Licensing Rules for	es Chapter 4658) - Compliance Not Met r Nursing Homes (MN Rules Chapter 4658) were not met.
State licensing ord	ers were issued: 🗵 Yes	□ No
•	ders will be available on the MI	
State Statutes for The requirements	Vulnerable Adults Act (MN Statunder State Statutes for Vulne	tutes, section 626.557) - Compliance Not Met rable Adults Act (MN Statutes, section 626.557) were not

Report Number: H5282006

Facility Name: Charter House	Report Number: H32820
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:	
Definitions:	

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Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

- (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
- (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
- (2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
 - (b) In the absence of legal authority a person:
 - (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
- (2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
- (3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
 - (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to

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perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- Medical Records
- Medication Administration Records
- Nurses Notes
- **X** Assessments
- |X| Physician Orders
- ▼ Care Plan Records
- Social Service Notes
- |x| Skin Assessments
- Facility Incident Reports
- Laboratory and X-ray Reports
- ▼ Therapy and/or Ancillary Services Records
- ▼ ADL (Activities of Daily Living) Flow Sheets
- ▼ Other, specify: Narcotic logs

Other pertinent medical records:

Police Report

Additional facility records:

- X Staff Time Sheets, Schedules, etc.
- Facility Internal Investigation Reports
- 🗓 Personnel Records/Background Check, etc.
- Facility In-service Records

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Facility Policion	es and Procedu	res				
Other, specif	y: Narcotic inv	entory logs				
lumber of addition	onal resident(s)	reviewed: Two				
		n the allegation(s)	? ● Yes	○ No	O N/A	
'n a aifu						
Vere resident(s)	identified in the	allegation(s) pres	ent in the fa	icility at th	ne time of the	investigation?
) Yes ● No						
Specify: Residen		d to home.				
			ata I dunin	the inve	etigation!	
		views were condu Yes \ No		s the mae	A.1944.	
nterview with re	porter(s)	• 1es () 100	0 14/11			
Specify:	ant roporter at	empts were made	on:			
	Time:	Date:	Time:		Date:	Time:
Date:	THIIC.					
Interview with fa	mily: O Yes	No ○ N/A	Specify:	Resident	was own per	son.
		s) identified in alleg				
• Yes • No						
Did you interview	_		○ No			
Total number of						
Interview with s		○ No ○ N/A	Specify:			
	_					
Tennessen Wai	nings	· · · · · · · · · · · · · · · ·	∩ No			
Tennessen War			O 140			
Total number o						
Physician Interv			lo.			
Nurse Practition						
Physician Assist)		⊃ N/A S	pecify:	
Interview with		ator(3). © 103	O 113 (,	·	
Attempts to co	Time:	Date:	Time	·	Date:	Time:
Date:	inne.	Date.				
Ifabla to as:	atact was subno	oena issued: O Ye	es, date subi	ooena was	sissued	
		of the following:	,		-	

☐ Emergency Personnel 🗵 Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: Personal Care Nursing Services **X** Call Light | Infection Control Medication Pass **X** Cleanliness ▼ Dignity/Privacy Issues Safety Issues Was any involved equipment inspected:

Yes O No ● N/A Was equipment being operated in safe manner: O Yes \bigcirc No • N/A Specify: Were photographs taken: O Yes No cc: **Health Regulation Division - Licensing & Certification** Minnesota Board of Examiners for Nursing Home Administrators **Minnesota Board of Nursing** The Office of Ombudsman for Long-Term Care **Rochester Police Department Olmsted County Attorney Rochester City Attorney Board of Nursing Board of Nursing Home Administrators**

Facility Name: Charter House

Report Number: H5282006



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2018

Ms. Cara Tracy, Administrator Charter House 211 Northwest Second Street Rochester, MN 55901

RE: Project Numbers S5282027, H5282006, H5282007

Dear Ms. Tracy:

On January 11, 2018, we informed you that the following enforcement remedy was being imposed:

State Monitoring effective January 16, 2018. (42 CFR 488.422)

Also, on January 11, 2018, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on December 14, 2017, and failure to achieve substantial compliance at the standard survey completed by the Minnesota Departments of Health and Public Safety on December 21, 2017.

On February 8, 2018 and February 12, 2018, the Minnesota Departments of Health, Office of Health Facility Complaints and the Minnesota Department of Health completed a Post Certification Revisits (PCR) and On January 23, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed December 14, 2017 and a standard survey, completed on December 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our surveys, as of February 8, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 8, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

Charter House March 1, 2018 Page 2

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fish Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900

St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/28/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		E SURVEY IPLETED
AND PLAN O	FORRECTION	IDENTIFICATION NOMBER.	A. BUILD	DING	R	-c
		245282	B. WING		02/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 211 NORTHWEST SECOND STREET ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETION DATE
	INITIAL COMMENTAL A Post Certification 2/8/18, to follow up related to complain Charter House is in 483, subpart B, requirements for The facility is enroll signature is not required the first page of the plan of correction is	revisit was conducted on on deficiencies issued t # H5282006 & H5282007. In compliance with 42 CFR Part Long Term Care Facilities. Led in ePOC and therefore a quired at the bottom of e CMS-2567 form. Although no is required, it is cility acknowledge receipt of	{F 0	DEFICIENCY)	OPRIATE	DAIL
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

02/21/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2018

Ms. Cara Tracy, Administrator Charter House 211 Northwest Second Street Rochester, MN 55901

Re: Enclosed Reinspection Results - Complaint Numbers H5282006, H5282007

Dear Ms.. Tracy:

On February 8, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 14, 2018. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumala Fish Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ R-C B. WING 02/08/2018 00193 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET **CHARTER HOUSE** ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) {2 000} {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 licensing order follow-up was completed to follow up on correction orders issued related to complaint H5282006 & H5282007. Charter House was found in compliance with state regulations.

Minnesota Department of Health

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

TITLE

(X6) DATE

02/21/18

PRINTED: 02/28/2018 FORM APPROVED

Minnesof	a Department of He	alth		CONCEDUCTION	(X3) DATE S	URVEY
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLE	ETED
AND FLAN	O. SOMMESTICIA		A. DOILDING		R-C	;
	•	00193	B. WING			/2018
	ADOMETICAL COLUMNIA		RESS, CITY, ST	TATE, ZIP CODE		
	ROVIDER OR SUPPLIER			OND STREET		
CHARTE	R HOUSE		ER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Continued From pa	age 1	{2 000}			
(2 000)	The facility is enroll signature is not require the first page of the plan of correction is	led in ePOC and therefore a juired at the bottom of e CMS-2567 form. Although no s required, it is icility acknowledge receipt of				

Minnesota Department of Health STATE FORM

PRINTED: 01/07/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP	LETED
		245282	B. WING			1	4/2017
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 11 NORTHWEST SECOND STREET ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F	000			
F 323 SS=G	to investigate case As a result, the foll for H5282006 and enrolled in ePOC a required at the bot CMS-2567 form. I POC will be used a FREE OF ACCIDE HAZARDS/SUPER CFR(s): 483.25(d) (d) Accidents. The facility must ensure corresponding to the following electron bed rails. If a bed of must ensure corresponding to the following electron bed rails price (2) Review the rist the resident or reginformed consent (3) Ensure that the	ensure that - nvironment remains as free ards as is possible; and receives adequate supervision evices to prevent accidents. The facility must attempt to use atives prior to installing a side of or side rail is used, the facility ect installation, use, and ed rails, including but not limited ements. Sident for risk of entrapment	r	323			
LABORATO	PY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		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 F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	COMI	PLETED
		245282	B. WING			1	14/2017
	ROVIDER OR SUPPLIER			21	REET ADDRESS, CITY, STATE, ZIP CODE 1 NORTHWEST SECOND STREET OCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RE	(X5) COMPLETION DATE
F 323	This REQUIREME by: Based on intervie facility failed to pro residents (R2) rev attachment straps were secure durin became loose and Harm occured wh and rib fracture be Findings include: R2's progress not indicates the resident residual right side communication as a full body lift for the call light to all Progress note da Registered Nurse the lift and was or right arm, but about that her right arm had fallen out of Hospital radiolog p.m., indicated Fright-sided rib fra pulmonary contu- fracture. R2 was following the fall returning to the implemented an	w and document review, the poide a safe transfer for 1 of 3 iewed by not ensuring the son the mechanical ceiling lifting the transfer. One straped the resident fell from the lift. In the R2 sustained a clavicle ecause of the fall. The dated 8/7/17 at 11:22 a.m., dent has a history of stroke with ed weakness and aphasia; bility was impaired. R2 required all transfers. R2 was able to use extract for needs. The (RN)-D indicated R2 fell from an the floor on her right side and the to follow commands. R2 state in hurt. Per the aides report, R2 the ceiling lift. The dated 8/27/17 at 5:33 actures and right associated as in hurt. Per the aides report, R2 the ceiling lift. The dated 8/27/17 at 5:33 actures and right associated as in high clavicle is hospitalized for nine days. After the hospitalization and facility, a slider sheet/board d to special wheelchair was d the mechanical ceiling lift was eliminating any fear or anxiety it	d	323			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	COM	E SURVEY IPLETED
		245282	B. WING			12	14/2017
	PROVIDER OR SUPPLIER			211 1	EET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST SECOND STREET CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEEIGIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RF	(X5) COMPLETION DATE
F 323	When interviewed Nursing Assistant in R2's room was it 'sticks.' After the and the loop popp fell out. NA-A state caused the loop to repositioning of R3 during the transfer position in the slim. On 11/7/17 at 1:20 and stated that what where and the curve ouch and the transfer and NA-C noted at the lift backward. As they moved for right side of the she lift loops were sen because R2 remains adjusting R2's ar toilet. She did no but could not ver the entire transfer gap in the track a had never seen NA-B believed the difficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the bathrodifficult and does it was a single pat the p	on 11/7/17 at 12:40 p.m., (NA)-A stated that when the lift on the curved part of the track, curve, the transfer resumed, ed out by R2's head, and R2 ed she did not know what o 'pop.' NA-A stated that 2's arm occurred at one point r. NA-A was focused on R2's g and not the loop placement. O p.m., NA-C was interviewed in the ceiling track, R2 said sfer was stopped. R2 told staff ove her right arm. Getting past the track required more force push. The transfer resumed a 'jerk' in the lift, so they moved a foot and then forward again. In the cure after repositioning R2's arm ained in an upright position. O p.m., NA-B stated that during ity, staff were talking about the track and the bathroom, right over the trace any loops loose at that tim ify if she looked at them during er. NA-B remembers thinking the at the bathroom door was big and a gap that big in a track before. The lift got hooked in between the com door making the transfer so not remember seeing anyone ps and hooks to be secure.	e e e e e e e e e e e e e e e e e e e	323			

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(V2) MUI	TIPLE C	ONSTRUCTION	(X3) DATE	SURVEY PLETED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			ļ	
AND PLAN OF	OGNILLOTTON						C 14/2017
		245282	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	1 12/	14/2011
NAME OF P	ROVIDER OR SUPPLIER				NORTHWEST SECOND STREET		
CHARTE	R HOUSE				CHESTER, MN 55901		
· ·	OUMANDV ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION SHOUL	D RE	(X5) COMPLETION
(X4) ID PREFIX	(CAOU DECICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
TAG	HEGULATORY OR	LGO IDENTIFICATION			DEI IOIEIGE 17		
				323			
F 323	Continued From p	age 3		323			
	Interview with Saf	ety Coordinator (SC)-E team 17 at 1:05 p.m., SC-E verified					
	that thara were no	nechanical of defective issues	3				
	with the cling or life	ft observed the sling was in					
	annd working ord	er; no trays or cuts in the sing					
	making it inappro						
	Interview with RN	-D on 11/9/17 at 3:07 p.m., wer	ıt				
	to R2's room afte	r hearing screams. RN-D saw nd 3 of the 4 loops were still					
	attached to the life	it.					
	I stated that he We	23 p.m., interview with FM-F us told the lift was in good					
ļ	working order an	d the fall had to be related to the	ot				
	hoing properly be	noked up. He has observed star	Ť				
	transfer R2 beto	re and feels they could have supervision during the transfers	s.				
	1						
	On 12/4/17 at 9:	35 a.m., interview with FM-G					
1	indicated that ful	I lift transfers were observed many times lifted R2 too high					
	above the group	d. lifting H2 as high as the lift					
	Lucuid ao EM-G	also observed stall belling					
	inattentive and o	conversing about non-transfer uring transfers and had to remin	d				
	staff to pay atte	ntion to the transfer.					
	In the policy title	ed Safe Lifting and Movement of d 8/22/16, it indicates: In order	to				
	nrotect the safe	ty and well-being of stall and					
	regidents and t	o promote quality of care, this					
	facility uses app to lift and move	propriate techniques and device	3				
F 43	DRUG RECOR	DS, LABEL/STORE DRUGS &		F 431			
SS=	-n BIOLOGICALS						
	CFR(s): 483.45	5(b)(2)(3)(g)(h)					
							1.15
		Front ID: K	00711	E	acility ID: 00193	ontinuation	sheet Page 4 of

PRINTED: 01/07/2018 FORM APPROVED
OMB NO. 0938-0391
(X3) DATE SURVEY

STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		СОМ	E SURVEY IPLETED
		245282	B. WING			12/	14/2017
	ROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE ST SECOND STREET , MN 55901		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY)	JULD BE	(X5) COMPLETION DATE
F 431	The facility must p drugs and biologic them under an ag	provide routine and emergency cals to its residents, or obtain reement described in		431			
	unlicensed person law permits, but of supervision of a line (a) Procedures. A pharmaceutical supervising and a dispensing and a	nnel to administer drugs it State only under the general censed nurse. A facility must provide ervices (including procedures ccurate acquiring, receiving, administering of all drugs and					
	(b) Service Consemploy or obtain pharmacist who-	ultation. The facility must the services of a licensed -	nd				
	(3) Determines t	controlled drugs in sufficient an accurate reconciliation; and that drug records are in order an of all controlled drugs is periodically reconciled.	nd				
(g) Labeling of Drugs and Bi Drugs and biologicals used in accordance with a professional principles, and appropriate accessory and a instructions, and the expirat applicable.	gicals used in the lacility must be dance with currently accepted nciples, and include the sessory and cautionary d the expiration date when	e					
	(1) In accordan	Drugs and Biologicals. Ice with State and Federal laws, t store all drugs and biologicals tments under proper temperatur	111			If continuation	n sheet Page 5
L		Event ID: K	3RZ11	Facility ID: 0019	93	II COMMINGATION	

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY IPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _			C
		245282	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			11 NORTHWEST SECOND STREET		
CHARTE	R HOUSE			OCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	(2) The facility mupermanently affixed controlled drugs ling Comprehensive Description of 197 abuse, except who package drug distinguantity stored is be readily detected. This REQUIREM by: Based on documfacility failed to enterviewed medical member took confrom the resident own personal use. Findings include: R1's medical record plan dated 8/21/following a surgivere to provide pain medication, mouth as needed Documentation record shows R once per day due to provide as needed by mouth as needed by mou	nit only authorized personnel to e keys. st provide separately locked, ed compartments for storage of sted in Schedule II of the orug Abuse Prevention and 6 and other drugs subject to en the facility uses single unit tribution systems in which the minimal and a missing dose cased. ENT is not met as evidenced enert review, and interviews, the name of 3 residents (R1) utions were secure when a staff attrolled substance medications on multiple occasions for their e.	e ic 7.			
	8/19/17. Docum	nentation from A 15 medication		Facility ID: 00193	continuation	sheet Page 6 of

PRINTED: 01/07/2018 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 12/14/2017 B. WING 245282 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET ROCHESTER, MN 55901 **CHARTER HOUSE** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG F 431 Continued From page 6 F 431 record from 8/20/17 at 12:03 p.m. to 8/23/17 at 8:00 p.m., indicated that there were eight doses of hydromorphone given by five different staff members over all shifts. Documentation from R1's medication record from 8/24/17 at 1:25 a.m. to 8/31/17 at 12:10 a.m., indicated that eight doses of hydromorphone were given by registered nurse (RN)-G all on the night shift. Two of the doses are signed out of the narcotic book but were not signed out in R1's electronic medical record. Four of the eight doses lack a patient reported pain scale. Per interview with RN-B on 10/31/17 at 9:10 a.m., RN-B stated that the facility provided training on reporting suspected drug diversion. Per interview with RN-C on 10/31/17 at 10:26 a.m., RN-C stated that all staff nurses have ongoing education on medication administration and documentation both in the electronic medical record and in the narcotic log book. RN-C also stated that residents were interviewed regarding pain control after noting inconsistencies in the narcotic log. R1 told RN-C that she had not taken hydromorphone in over a week, although it was documented in R1's record that the medication had been removed and signed out by RN-H as given to R1. R1's medication logs, showed discrepancies, lacked pain scales and pain

interventions.

Per interview with RN-D on 11/8/17 at 3:56 p.m., RN-D noted that a couple of residents were not taking narcotic medications during the overnight shift but the meds were signed out that they did.

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION С 12/14/2017 B. WING 245282 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET ROCHESTER, MN 55901 **CHARTER HOUSE** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 431 Continued From page 7 F 431 taken any pain meds. Both residents confirmed they did not take any pain meds overnight. The meds in question were signed out as taken by RN-H. Per interview with RN-E on 11/9/17 at 3:21 p.m., a resident (could not remember resident's name) was adamant that she was given pain medication during the night but it was not effective and didn't believe it was what the pain medication that the nurse (unknown name) said it was. Per interview with R1 on 11/27/17 at 4:53 p.m., R1 stated that her pain was managed primarily with the Tramadol and did not require the

hydromorphone. R1 did not go without pain

On 9-18-17 at 11:30 a.m., police interviewed RN-H. RN-H admitted taking medications from the medication cart. Per the police report, RN-H admitted to diverting medication from residents that didn't want to take their medication. He diverted oxycodone and hydromorphone from at least two residents since approximately April.

When interviewed on 12/6/17 at 9:59 a.m., RN-H admitted to taking hydromorphone from R1, but stated no residents, including R1, ever went

Per facility policy titled Controlled Substances, dated 2/6/2017, indicates nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must count and verify the number together.

Per policy titled Drug Diversion Reporting and Response dated 7/31/2017, drug diversion is

medication when it was needed.

without their pain medication.

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CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	= COHHECTION	245282	B. WING		C 12/14/2017	
NAME OF P	ROVIDER OR SUPPLIER		211	REET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST SECOND STREET OCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 431	authorization, using prescription medic	age 8 Inally and without proper Ing or taking possession of a Station from Mayo Supplies, Ithrough the use of Mayo Iring, or dispensing systems.	F 431			

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			С	
		00193	B. WING			4/2017	
			DRESS, CITY, S	TATE, ZIP CODE			
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CHARTE			TER, MN 559	DROVIDER'S PLAN OF C	CORRECTION	(X5)	
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2 000	Initial Comments		2 000				
	*****ATTE	ENTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correpursuant to a surve found that the defence herein are not cornot corrected shawith a schedule of the Minnesota Destermination of corrected require requirements of the number and MN When a rule content comply with any comply with any country in the asset	n Minnesota Statute, section ection order has been issued rey. If, upon reinspection, it is iciency or deficiencies cited rected, a fine for each violation is be assessed in accordance of fines promulgated by rule of epartment of Health. Whether a violation has been secompliance with all he rule provided at the tag Rule number indicated below. It is several items, failure to fine items will be considered be. Lack of compliance upon any item of multi-part rule will essment of a fine even if the item items in the intems in the items	m				
	that may result for orders provided	t a hearing on any assessments rom non-compliance with these that a written request is made t within 15 days of receipt of a ment for non-compliance.					
	investigate com #H5282007. As order is issued to agreed to partic	ENTS: estigation was conducted to plaint #H5282006 and a result, the following correctio for H5282006. The facility has ipate in the electronic receipt of orders consistent with the artment of Health Informational	f				
Minnesot	- t st leadth	OVIDER/SUPPLIER REPRESENTATIVE'S		TITLE		(X6) DATE	

STATE FORM 6899 K3RZ11 If continuation sheet 1 of 8

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ____ C 12/14/2017 B. WING _ 00193 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET **CHARTER HOUSE** ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 Continued From page 1 2 000 Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.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. 21850 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 bv: Based on document review and interviews, the facility failed to protect 2 of 3 residents (R1)

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reviewed from maltreatment. R1 was financially

Minneso	ta Department of He	alth	(Va) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	COMP	COMPLETED	
AND I BIII	01 0012	00193	B. WING		12/1	C 1 4/2017	
			DRESS CITY S	TATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			COND STREET			
CHARTE	R HOUSE		TER, MN 559				
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21850	Continued From pa	age 2	21850				
	medications from toccasions for their R2 was neglected lift. Staff did not su to ensure the loops Findings include: R1's medical docucare plan dated 8/following a surgical were to provide particular surgical surgical surgical were to provide particular surgical s	taff member took controlled he resident on multiple own personal use. In addition, when R2 fell from the ceiling pervise the transfer lift process were secured. Harm ment was reviewed. Per the 21/17, R1 was at risk for pain all procedure and nursing staff ain medications as ordered.					
	pain medication) 5 mouth as needed Documentation in record shows R1 once per day during date and time of each the electronic record shows and time of each paint medication.	n's order for Tramadol (narcotion 100-100 milligrams (mg) by every six hours, dated 8/19/17, the electronic medication received the medication at leasing the stay at the facility. The each dose of medication given in the entries correspond to the entries. There were no noted	t				
	by mouth as need 8/19/17. Docume record from 8/20/ 8:00 p.m., there v	ysician's order for narcotic pain medication) 1 mg ded every four hours, dated ntation from R1's medication 17 at 12:03 p.m. to 8/23/17 at vere eight doses given by five mbers over all shifts.					
	8/24/17 at 1:25 a eight doses of mo registered nurse of the doses are but are not signe	om R1's medication record from to 8/31/17 at 12:10 a.m., edication were given by (RN)-G all on the night shift. To signed out of the narcotic book dout in R1's electronic medicate eight doses lack a patient	v o				

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Minnesot	a Department of He	alth_	(Y2) MULTIPLE	CONSTRUCTION	(X3) DATE		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMP	COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, ST				
CHARTE	R HOUSE		THWEST SEC TER, MN 5590	01		0.63	
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21850	Continued From pareported pain scale		21850				
	BN-B stated that t	RN-B on 10/31/17 at 9:10 a.m., ne facility provided training on I reporting it if suspected.					
	a.m., RN-C stated ongoing education and documentation record and in the stated that resider pain control after an arcotic log. Whe clarified that she hover a week, althous record that the meand signed out by to further review of showed discrepant pain interventions.		n				
	it was found that not taking narcoti overnight shift bu they did. RN-D they had taken at confirmed they did.	RN-D on 11/8/17 at 3:56 p.m., a couple of residents that were c medications during the t the meds were signed out that en asked the two residents if my pain meds. Both residents id not take any pain meds eds in question were signed out.	t				
	a resident who we that s/he was give night but it was rewas what the partunknown name.	n RN-E on 11/9/17 at 3:21 p.m. ras interviewed, was adamant ren pain medication during the not effective and didn't believe it in medication that the nurse said it was. h R1 on 11/27/17 at 4:53 p.m.,					

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Minneso [*]	ta Department of He	alth			(Va) DATE O	IIB//EV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDEATH IONHOR HOMBELL	A. BUILDING: _		c	
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			DRESS, CITY, ST	TATE ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			OND STREET		
CHARTE	R HOUSE	-	TER, MN 559			!
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21850	Continued From pa	ige 4	21850			
	primarily with the T the hydromorphone medication when it On 9-18-17, police admitted taking medicart. Per police rep	ner pain was managed framadol and did not require e. R1 did not go without pain was needed. Interviewed RN-H. RN-H edications from the medication out # 17-44214, RN-H admitted ation from residents that didn't				
	want to take their r least two residents	medication. He diverted from at s since approximately April.			,	
	dated 2/6/2017, incount controlled dr The nurse coming	itled Controlled Substances, dicates nursing staff must rugs at the end of each shift. on duty and the nurse going off nd verify the number together.	f			
	Response dated 7 defined as intentio authorization, usin prescription medic Mayo patients, or	rug Diversion Reporting and r/31/2017, drug diversion is brally and without proper ag or taking possession of a cation from Mayo Supplies, through the use of Mayo ring, or dispensing systems.				
	indicates the residual right side communication at a full body lift for a the call light to ale R2's room was me	te dated 8/7/17 at 11:22 a.m., dent has a history of stroke with ad weakness and aphasia; bility was impaired. R2 required all transfers. R2 was able to use ert staff for needs. The lift in ounted to a ceiling track with a li control operated by staff.				
	Registered Nurse	ted 8/27/17 at 3:47 p.m., e (RN)-D indicated R2 fell from n the floor on her right side and e to follow commands. R2 state	d			

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 12/14/2017 00193 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET **CHARTER HOUSE ROCHESTER, MN 55901** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 5 that her right arm hurt. Per the aides report, R2 had fallen out of the ceiling lift. Hospital radiology note dated 8/27/17 at 5:33 p.m., indicated R1 had moderately displaced right-sided rib fractures and right associated pulmonary contusions, and a right clavicle fracture. R1 was hospitalized for nine days following the fall. After the hospitalization and returning to the facility, a slider sheet/board transfer from bed to special wheelchair was implemented and the mechanical ceiling lift was no longer used eliminating any fear or anxiety it could cause R1. On 11/7/17 at 12:40 p.m., Nursing Assistant (NA)-A stated that when the lift was on the curved part of the track, it 'sticks.' After the curve, the transfer resumed, and the loop popped out by R2's head, and R2 fell out. NA-A stated she did not know what caused the loop to 'pop.' NA-A stated that repositioning of R2's arm occurred at one point. NA-A was focused on R2's position in the sling and not the loop placement. On 11/7/17 at 1:20 p.m., NA-C was interviewed and stated that when R2 was being moved around the curve in the ceiling track, R2 said ouch and the transfer was stopped. R2 told staff they needed to move her right arm. Getting past the curve point in the track required more force and a little harder push. The transfer resumed and NA-C noted a 'jerk' in the lift, so they moved the lift backward maybe a foot and then forward again. As they moved forward, R2 started to go down with the right side of the sling fell first. NA-C stated the lift loops were secure after repositioning R2's arm because R2 remained in an upright position.

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ С 12/14/2017 B. WING 00193 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET CHARTER HOUSE **ROCHESTER, MN 55901** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 6 On 11/7/17 at 3:10 p.m., NA-B stated that during the transfer activity, staff were talking about non-transfer related things. She witnessed staff adjusting R2's arm in the bathroom, right over the toilet. She did not see any loops loose at that time but could not verify if she looked at them during the entire transfer. NA-B remembers thinking the gap in the track at the bathroom door was big and had never seen a gap that big in a track before. NA-B believed the lift got hooked in between the gap at the bathroom door making the transfer difficult and does not remember seeing anyone checking the loops and hooks to be secure. Interview with Safety Coordinator (SC)-E team member on 11/9/17 at 1:05 p.m., SC-E verified that there were no mechanical or defective issues with the sling or lift; observed the sling was in good working order; no frays or cuts in the sling making it inappropriate to use. Interview with RN-D on 11/9/17 at 3:07 p.m., went to R2's room after hearing screams. RN-D saw R2 on the floor and 3 of the 4 loops were still attached to the lift. On 11/7/17 at 2:23 p.m., interview with FM-F stated that he was told the lift was in good working order and the fall had to be related to not being properly hooked up. He has observed staff transfer R2 before and feels they could have performed more supervision during the transfers. On 12/4/17 at 9:35 a.m., interview with FM-G indicated that full lift transfers were observed before and staff many times lifted R2 too high above the ground, lifting R2 as high as the lift would go, FM-G also observed staff being inattentive and conversing about non-transfer

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related things during transfers and had to remind

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: С B. WING 12/14/2017 00193 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 211 NORTHWEST SECOND STREET **CHARTER HOUSE ROCHESTER, MN 55901** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 7 staff to pay attention to the transfer. In the policy titled Safe Lifting and Movement of Residents, dated 8/22/16 indicates, in order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Suggested Method of Correction: The administrator, director of nursing (DON), or designee could revise facility policies related to maltreatment. They could ensure all staff are aware of the importance of providing care for residents in accordance with facility policy and procedures, and could establish a system to audit. The administrator, director of nursing (DON), or designee could report that information gathered from audits to the quality assurance performance improvement (QAPI) committee, to ensure sustained correction and compliance. Time Period for Correction: Twenty-one (21) Days

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