MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
St. Michaels Health and Rehab Center

Facility Address:
1201 8th Street South

Facility City:
Virginia

State: Minnesota

ZIP: 55792

County: Saint Louis

Report Number:
H5283020

Time of Visit:
7:30 a.m. to 6:00 p.m.
7:30 p.m. to 5:00 p.m.
7:30 p.m. to 1:45 p.m.

Date of Visit:
April 11, 12, and 13, 2017

Date Concluded:
December 13, 2017

Investigator's Name and Title:
Carol Bode, RN, Special Investigator

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when a staff/alleged perpetrator (AP) failed to follow the resident's care plan which states two person for transfer with mechanical lift. The AP transferred the resident alone leading to the resident slipping off the sling and falling onto the floor. The resident sustained a closed humerus 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. The resident fell out of the bottom of the sling during a transfer with a mechanical lift sustaining a fractured humerus when the facility failed to provide proper sizes of resident slings. In addition, the slings were not compatible with the mechanical lift (sling lift or ceiling lift) according to the manufacturer's recommendations.

The resident's diagnosis included muscle weakness and dementia. The residents care plan indicated the resident was at risk for falls related to severe impaired cognition. The resident used a wheelchair for mobility and staff propelled the wheelchair. The facility utilized a mechanical lift to transfer the resident from bed to chair and chair to bed. The resident's care plan did not list the sling size or type of sling to use with the mechanical lift equipment.

During the early evening, the resident was sitting in the hallway in a wheelchair. The resident complained of a headache and wanted to go to bed. The AP looked for assistance with the transfer, but could not find anyone to help. The AP decided to transfer the resident from the chair to the bed alone using the mechanical sling lift equipment. During the transfer, the resident started flailing his/her arms and moved around. The AP could not calm the resident and the resident fell out of the bottom of the sling. The resident

landed on his/her left side on the floor between the legs of the mechanical lift. The AP was able to get a nurse who assessed the resident. The resident was sent to the hospital for an x-ray and a fractured humerus was identified. The resident was given pain medication, a sling for the arm, and returned to the facility.

During an interview, the AP stated s/he knew the resident was supposed to be transferred with two people, but she also knew the care plan said to attempt to reduce agitation for the resident. The AP was not aware s/he was using the wrong sling for the mechanical lift. The sling used was for the ceiling lift, not the mechanical lift. The facility did not have any policies or education for staff for using the correct sling with the mechanical lift for residents.

During the on-site visit, it was observed the sling for the ceiling lift was used with the mechanical lift. The facility was not completing assessments on residents to determine the correct size of sling, and the correct sling type to use with the mechanical lift.

The manufacturer confirmed it is not recommended to use the sling from the ceiling lift with the mechanical lift. The manufacture instruction provides an assessment tool and educational material for proper sling sizing. The last mechanical lift training for the staff was four years prior to the onsite investigation and did not include this information.

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 did not have a system in place to assess the resident's to determine the correct sling size, sling type. The facility was not ensuring the staff were using the correct lift equipment and sling type as the manufacturer recommends. In addition, the staff were not provided sufficient training.

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):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

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

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: 26

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

Specify: _____

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

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact complainant, attempts were made on:

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

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

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

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 22

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:

☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ 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

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Virginia Police Department

Saint Louis County Attorney

Virginia City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	R-C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on May 30, 2017, to follow up on deficiencies issued relate to complaint #H5283020 St Michaels Health and Rehab is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Electronically Signed | 06/14/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2017

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, MN 55792

RE: Project Number H5283020

Dear Ms. High:

On May 1, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 6, 2017. (42 CFR 488.422)

In addition, on May 1, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies were being 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 this Department for a partial extended survey completed on April 14, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On May 24, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a partial extended survey, completed on April 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 15, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our partial extended survey, completed on April 14, 2017, as of May 15, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 15, 2017.

However, as we notified you in our letter of May 1, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy recommended in our letter of May 1, 2017:

- Civil money penalty for deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedy, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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F 000	INITIAL COMMENTS A partial extended survey was conducted to investigate #H5283020. An Immediate Jeopardy (IJ) was identified at F323 related to the facility's failure to ensure residents were assessed for mechanical lift equipment, sling type and sling size. This resulted in a broken arm of one residnets when staff used a sling that was not compatible with the mechanical lift used and the resident fell from the lift. The IJ began on 04/1/2017 at 1:00 p.m. and was removed on 04/14/17 at 11:59 a.m. 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 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and	F 224		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was free from neglect for 1 of 26 resident's (R1) reviewed who use mechanical sling lift equipment when R1 was not assessed for the use of a mechanical lift, sling type, and sling size. R1 was transferred using a sling that was not compatible with the mechanical sling lift used. The resident fell out of the sling, onto the floor, and broke her arm. Findings include: R1's medical record was reviewed. R1 was admitted to the facility on 03/18/2015, with muscle weakness, dementia with behavioral disturbances, restlessness and agitation. R1's care plan dated 2/2/2017, indicated R1 was at risk of falls related to severe cognitive impairment impaired safety awareness and anxiety medication. In addition, the care plan dated 2/2/2017, indicated the use of a sling/mechanical lift. R1 required assistance of two staff for transfers with a mechanical lift with a sling. R1's medical record did not include a comprehensive assessment for the use of a mechanical lift, sling type, and sling size. The incident report dated 4/1/2017, indicated NA-A had R1 in a full body mechanical lift sling transfer alone from wheelchair to the bed. R1 began flaying arms and slid out of the bottom of the sling landing on the left side and hitting head,	F 224		

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F 224	Continued From page 2 R1 was lying between the legs of the mechanical lift on the floor. NA-A indicated she had the sling on correctly. NA-A indicated she couldn't find anyone to assist her so she transfer R1. Nursing progress note dated 4/1/2017 at 5:21 p.m. indicated R1 slid out of a full body sling onto the floor during a transfer and hit the left side of her head where the staples were located from a previous fall out of bed. The resident was lying on the left side between the legs of the mechanical sling lift. The nurse assessed R1 by completing neurological checks and obtaining vitals signs. The resident was sent to the hospital for an assessment. R1's hospital discharge summary to the facility dated 4/1/2017 indicated R1 had a closed fracture of the proximal end of the right humerus. R1's discharge orders included treatment for pain control hydrocodone/acetamineophin 5/325 milligrams (mg) every six hours as needed for five days. R1 was to rest her arm with a sling keeping it immobile as needed. NA-A was observed to transfer R1 on 4/11/2017 at 1:30 p.m. from the wheelchair to her bed. NA-A used a sling made for a ceiling lift to transfer R1 with the mechanical sling lift. NA-A confirmed the sling used during the observation was the sling used when R1 fell on 04/01/2017. This was brought to the administrator's attention. Staff were not aware that slings and mechanical lift equipment could not be interchanged. The facility immediately began to assess how the sling and mechanical lift equipment was being used. During an interview on 4/11/2017 at 11:10 a.m. NA-A stated R1 was sitting in the hallway getting	F 224		

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F 224	Continued From page 3	F 224		

agitated and complaining of a headache. R1 wanted to go to bed. NA-A said attempts were made to find someone to help transfer R1 by going down the hall and looking for help. NA-A couldn't find another staff and moved R1 into her room and started to transfer R1 by herself. The mechanic sling lift equipment was in the residents room. NA-A applied the sling that staff had previously used and placed it under and around R1. NA-A than hooked the sling to the mechanical lift located in R1's room. NA-A stated the sling was applied correctly, but R1 started to flail her arms, kick and suddenly slid out of the bottom of the sling. NA-A wasn't sure how R1 fell out of the sling, but insisted R1 fell out of the bottom of the sling.

During an interview on 4/11/2017, at 1:28 p.m. the administrator said NA-A told her she knew she should not transfer R1 by herself, but R1 was getting agitated, and complained of a headache. NA-A said she couldn't find anyone to help him/he so she transfer R1 by herself and R1 fell out of the bottom of the sling.

During an interview on 4/11/2017, at 2:46 p.m. the director of nurses (DON) said she was not aware of the possibility of falling out of the sling. The DON said there was no assessment tool and they have not followed the manufacturer guidelines to assess residents for the use of the mechanical lift, sling type, or sling size. The DON stated the last training for staff on using mechanical lift equipment was 3/27/2013.

During an interview on 4/11/2017, at 3:50 p.m. registered nurse (RN)-E said she does complete a sling assessment. RN-E stated the assessment consists of watching a resident transfer with a

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F 224	Continued From page 4 mechanic sling lift by looking at the resident to be sure the resident's arm fit inside of the sling. RN-E said the facility does not have an assessment tool. RN-E stated she is usually the second person for the transfer when the assessment is completed. RN-E said they don't have a specific tool or policy that addresses when or how to do the assessment. RN-E said R1 did not have an assessment for the use of the mechanical sling lift. The facility policy titled mechanical lifts dated 3/27/2017 indicated resident must have two staff for transfers using the mechanical sling lift. All staff must be trained on using the equipment. The policy did not include information to ensure the proper sling was used with the proper mechanical sling lift. The manufacturers guidelines revised 11/01/2012, indicated to use only manufactured slings and accessories designed for use with the mechanical sling lift. It also indicated to be sure to use the proper size sling using the sling sizing chart. To double check, lay a sling across the residents chest. If it's the proper size sling, you will note two to eight inches of extra material extended past the side of each arm. In addition, the manual instructions indicated to always use the correct style of sling for the resident, the most common is the divided leg sling. The manufacturer provided a guide to help develop a facility procedure and education for staff. The manufacturer also recommend a copy of the education sheet is kept in the employee file.	F 224		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 5 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assessments were completed to minimize the risk of falls for one of one resident (R1) reviewed for falls out of sling while using mechanical lift equipment. R1 was harmed when R1 fell from the use of a sling that was not compatible with the lift equipment and broke her arm. The facility failed to comprehensively assess the resident's mechanical lift, sling type, and sling size. The failure for the facility to identify the need for resident assessments before using lift equipment	F 323		

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F 323	Continued From page 6 placed all 26 residents who use lift equipment at risk for immediate jeopardy (IJ). The IJ began on 04/1/2017 at 1:00 p.m. when R1 fell from the mechanical lift equipment resulting in a fractured humerus. The resident was not assessed for the mechanical lift, sling type, or the sling size. The administrator and a clinical nurse manger were notified of the IJ on 04/12/2017 at 1:50 p.m. The IJ was removed on 04/14/2017 at 11:59 a.m. However, noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy. Findings include: R1's medical record was reviewed. R1 was admitted to the facility on 03/18/2015, with muscle weakness, dementia with behavioral disturbances, restlessness and agitation. R1's care plan dated 2/2/2017, indicated R1 was at risk of falls related to severe cognitive impairment impaired safety awareness and anxiety medication. In addition, the care plan dated 2/2/2017, indicated the use of a sling/mechanical lift. R1 required assistance of two staff for transfers with a mechanical lift with a sling. R1's medical record did not include a comprehensive assessment for the use of a mechanical lift, sling type, and sling size. The incident report dated 4/1/2017, indicated NA-A had R1 in a full body mechanical lift sling transfer alone from wheelchair to the bed. R1 began flaying arms and slid out of the bottom of the sling landing on the left side and hitting head, R1 was lying between the legs of the mechanical lift on the floor. NA-A indicated she had the sling	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 04/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 7 on correctly. NA-A indicated she couldn't find anyone to assist her so she transfer R1. Nursing progress note dated 4/1/2017 at 5:21 p.m. indicated R1 slid out of a full body sling onto the floor during a transfer and hit the left side of her head where the staples were located from a previous fall out of bed. The resident was lying on the left side between the legs of the mechanical sling lift. The nurse assessed R1 by completing neurological checks and obtaining vitals signs. The resident was sent to the hospital for an assessment. R1's hospital discharge summary to the facility dated 4/1/2017 indicated R1 had a closed fracture of the proximal end of the right humerus. R1's discharge orders included treatment for pain control hydrocodone/acetamineophin 5/325 milligrams (mg) every six hours as needed for five days. R1 was to rest her arm with a sling keeping it immobile as needed. NA-A was observed to transfer R1 on 4/11/2017 at 1:30 p.m. from the wheelchair to her bed. NA-A used a sling made for a ceiling lift to transfer R1 with the mechanical sling lift. NA-A confirmed the sling used during the observation was the sling used when R1 fell on 04/01/2017. This was brought to the administrator's attention. Staff were not aware that slings and mechanical lift equipment could not be interchanged. The facility immediately began to assess how the sling and mechanical lift equipment was being used. An interview on 4/11/2017 at 11:10 a.m. NA-A stated R1 was sitting in the hallway getting agitated and complaining of a headache. R1 wanted to go to bed. NA-A said attempts were	F 323		

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F 323	Continued From page 8 made to find someone to help transfer R1 by going down the hall and looking for help. NA-A couldn't find another staff and moved R1 into her room and started to transfer R1 by herself. The mechanic sling lift equipment was in the residents room. NA-A applied the sling that staff had previously used and placed it under and around R1. NA-A than hooked the sling to the mechanical lift located in R1's room. NA-A stated the sling was applied correctly, but R1 started to flail her arms, kick and suddenly slid out of the bottom of the sling. NA-A wasn't sure how R1 fell out of the sling, but insisted R1 fell out of the bottom of the sling. During an interview on 4/11/2017 at 1:28 p.m. the administrator said NA-A told her she knew she should not transfer R1 by herself, but R1 was getting agitated, and complained of a headache. NA-A said she couldn't find anyone to help him/he so she transfer R1 by herself and R1 fell out of the bottom of the sling. During an interview on 4/11/2017 at 2:46 p.m. the director of nurses (DON) said she was not aware of the possibility of falling out of the sling. The DON said there was no assessment tool and they have not followed the manufacturer guidelines to assess residents for the use of the mechanical lift, sling type, or sling size. The DON stated the last training for staff on using mechanical lift equipment was 3/27/2013. During an interview on 4/11/2017 at 3:50 p.m. registered nurse (RN)-E said she does complete a sling assessment. RN-E stated the assessment consists of watching a resident transfer with a mechanic sling lift by looking at the resident to be sure the resident's arm fit inside of the sling.	F 323		

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F 323	Continued From page 9 RN-E said the facility does not have an assessment tool. RN-E stated she is usually the second person for the transfer when the assessment is completed. RN-E said they don't have a specific tool or policy that addresses when or how to do the assessment. RN-E said R1 did not have an assessment for the use of the mechanical sling lift. The facility policy titled mechanical lifts dated 3/27/2013 indicated resident must have two staff for transfers using the mechanical sling lift. All staff must be trained on using the equipment. The policy did not include information to ensure the proper sling was used with the proper mechanical sling lift. The manufacturers guidelines revised 11/01/2012, indicated to use only manufactured slings and accessories designed for use with the mechanical sling lift. It also indicated to be sure to use the proper size sling using the sling sizing chart. To double check, lay a sling across the residents chest. If it's the proper size sling, you will note two to eight inches of extra material extended past the side of each arm. In addition, the manual instructions indicated to always use the correct style of sling for the resident, the most common is the divided leg sling. The manufacturer provided a guide to help develop a facility procedure and education for staff. The manufacturer also recommend a copy of the education sheet is kept in the employee file. The immediate jeopardy that began on 4/1/17 was removed and the administrative staff were notified on 4/14/2017 after the verification that the facility assessed all residents who use any mechanical lift for the type of mechanical lift, type	F 323		

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F 323	Continued From page 10 of sling and size of sling in accordance with the manufacturing instructions for the mechanical lift equipment, the facility removed all mechanical lifts out of use and removed them from the unit until correct slings were obtained, revised the facility policy on mechanical lifts, and trained all staff on the mechanical lift equipment, sling type, and sling size by written instruction that included demonstration and return demonstration by the staff. Noncompliance remained at the lower scope and severity level of isolated actual harm that is not immediate jeopardy.	F 323		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2017

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

Re: Enclosed Reinspection Results - Complaint Number H5283020

Dear Ms. High:

On May 24, 2017, 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 April 14, 2017. 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00582	A. BUILDING: _____ B. WING _____	R-C 05/24/2017

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5283020 St Michaels Health and Rehab was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5283020. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
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 observation, interview, and document review, the facility failed to ensure a resident was free from neglect for 1 of 26 resident's (R1) reviewed who use mechanical sling lift equipment	21850		

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21850	Continued From page 2 when R1 was not assessed for the use of a mechanical lift, sling type, and sling size. R1 was transferred using a sling that was not compatible with the mechanical sling lift used. The resident fell out of the sling, onto the floor, and broke her arm. Findings include: R1's medical record was reviewed. R1 was admitted to the facility on 03/18/2015, with muscle weakness, dementia with behavioral disturbances, restlessness and agitation. R1's care plan dated 2/2/2017, indicated R1 was at risk of falls related to severe cognitive impairment impaired safety awareness and anxiety medication. In addition, the care plan dated 2/2/2017, indicated the use of a sling/mechanical lift. R1 required assistance of two staff for transfers with a mechanical lift with a sling. R1's medical record did not include a comprehensive assessment for the use of a mechanical lift, sling type, and sling size. The incident report dated 4/1/2017, indicated NA-A had R1 in a full body mechanical lift sling transfer alone from wheelchair to the bed. R1 began flaying arms and slid out of the bottom of the sling landing on the left side and hitting head, R1 was lying between the legs of the mechanical lift on the floor. NA-A indicated she had the sling on correctly. NA-A indicated she couldn't find anyone to assist her so she transfer R1. Nursing progress note dated 4/1/2017 at 5:21 p.m. indicated R1 slid out of a full body sling onto the floor during a transfer and hit the left side of her head where the staples were located from a previous fall out of bed. The resident was lying on	21850		

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21850	Continued From page 3 the left side between the legs of the mechanical sling lift. The nurse assessed R1 by completing neurological checks and obtaining vitals signs. The resident was sent to the hospital for an assessment. R1's hospital discharge summary to the facility dated 4/1/2017 indicated R1 had a closed fracture of the proximal end of the right humerus. R1's discharge orders included treatment for pain control hydrocodone/acetamineophin 5/325 milligrams (mg) every six hours as needed for five days. R1 was to rest her arm with a sling keeping it immobile as needed. NA-A was observed to transfer R1 on 4/11/2017 at 1:30 p.m. from the wheelchair to her bed. NA-A used a sling made for a ceiling lift to transfer R1 with the mechanical sling lift. NA-A confirmed the sling used during the observation was the sling used when R1 fell on 04/01/2017. This was brought to the administrator's attention. Staff were not aware that slings and mechanical lift equipment could not be interchanged. The facility immediately began to assess how the sling and mechanical lift equipment was being used. During an interview on 4/11/2017 at 11:10 a.m. NA-A stated R1 was sitting in the hallway getting agitated and complaining of a headache. R1 wanted to go to bed. NA-A said attempts were made to find someone to help transfer R1 by going down the hall and looking for help. NA-A couldn't find another staff and moved R1 into her room and started to transfer R1 by herself. The mechanic sling lift equipment was in the residents room. NA-A applied the sling that staff had previously used and placed it under and around R1. NA-A than hooked the sling to the mechanical lift located in R1's room. NA-A stated the sling	21850		

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21850	Continued From page 4 was applied correctly, but R1 started to flail her arms, kick and suddenly slid out of the bottom of the sling. NA-A wasn't sure how R1 fell out of the sling, but insisted R1 fell out of the bottom of the sling. During an interview on 4/11/2017, at 1:28 p.m. the administrator said NA-A told her she knew she should not transfer R1 by herself, but R1 was getting agitated, and complained of a headache. NA-A said she couldn't find anyone to help him/he so she transfer R1 by herself and R1 fell out of the bottom of the sling. During an interview on 4/11/2017, at 2:46 p.m. the director of nurses (DON) said she was not aware of the possibility of falling out of the sling. The DON said there was no assessment tool and they have not followed the manufacturer guidelines to assess residents for the use of the mechanical lift, sling type, or sling size. The DON stated the last training for staff on using mechanical lift equipment was 3/27/2013. During an interview on 4/11/2017, at 3:50 p.m. registered nurse (RN)-E said she does complete a sling assessment. RN-E stated the assessment consists of watching a resident transfer with a mechanic sling lift by looking at the resident to be sure the resident's arm fit inside of the sling. RN-E said the facility does not have an assessment tool. RN-E stated she is usually the second person for the transfer when the assessment is completed. RN-E said they don't have a specific tool or policy that addresses when or how to do the assessment. RN-E said R1 did not have an assessment for the use of the mechanical sling lift. The facility policy titled mechanical lifts dated	21850		

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21850	Continued From page 5 3/27/2017 indicated resident must have two staff for transfers using the mechanical sling lift. All staff must be trained on using the equipment. The policy did not include information to ensure the proper sling was used with the proper mechanical sling lift. The manufacturers guidelines revised 11/01/2012, indicated to use only manufactured slings and accessories designed for use with the mechanical sling lift. It also indicated to be sure to use the proper size sling using the sling sizing chart. To double check, lay a sling across the residents chest. If it's the proper size sling, you will note two to eight inches of extra material extended past the side of each arm. In addition, the manual instructions indicated to always use the correct style of sling for the resident, the most common is the divided leg sling. The manufacturer provided a guide to help develop a facility procedure and education for staff. The manufacturer also recommend a copy of the education sheet is kept in the employee file. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		