### Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: St. Michaels Health and Rehab Center			Report Number: H5283020	<b>Date of Visit:</b> April 11, 12, and 13, — 2017	
Facility Address: 1201 8th Street So	uth		Time of Visit: 7:30 a.m. to 6:00 p.m.	Date Concluded: December 13, 2017	
Facility City: Virginia			7:30 p.m. to 5:00 p.m. 7:30 p.m. to 1:45 p.m.		
State: Minnesota	<b>ZIP:</b> County: 55792 Saint Louis		Carol Bode, RN, Special II		

**⊠** 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 Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- **X** State Statutes Chapters 144 and 144A

#### **Conclusion:**

Based on a preponderance of evidence, neglect occurred. 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

Facility Name: St. Michaels Health and Rehab Report Number: H5283020 Center 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): ☐ Financial Exploitation **⊠** Neglect ☐ Abuse ☐ Inconclusive based on the following information: ☐ Not Substantiated **☒** Substantiated **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 Neglect ☐ Financial Exploitation. This determination was based on the following: ☐ Abuse 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:

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes,

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Met

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. □ No Deficiencies are issued on form 2567: X Yes (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. x Yes □ No State licensing orders were issued: (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 (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.

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Center

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

#### Other pertinent medical records:

**▼** Hospital Records

#### Additional facility records:

- **|** Resident/Family Council Minutes
- Staff Time Sheets, Schedules, etc.
- **X** Facility Internal Investigation Reports
- Personnel Records/Background Check, etc.

**▼** Facility In-service Records **X** Facility Policies and Procedures Number of additional resident(s) reviewed: 26 Were residents selected based on the allegation(s)? ( ) Yes  $\bigcirc$  No  $\bigcirc$  N/A Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation? Specify: Interviews: The following interviews were conducted during the investigation:  $\bigcirc$  No 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  $\bigcirc$  No Total number of resident interviews:Two Interview with staff: 

Yes ○ No ○ N/A Specify: **Tennessen Warnings** Tennessen Warning given as required: 

Yes O No Total number of staff interviews: 22 Physician Interviewed: ( ) Yes  $\bigcirc$  No Nurse Practitioner Interviewed: Yes No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s): (a) Yes ○ No Attempts to contact: Date: Time: Date: Time: Date: Time: If unable to contact was subpoena issued: ( ) Yes, date subpoena was issued Were contacts made with any of the following:

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Center

Faci Cen	lity Name: St. Michaels Health and Rehab	Report Number: H5283020
	Emergency Personnel  Police Officers  Medical Examiner  Other:	Specify
Obs	servations were conducted related to:	
X	Nursing Services	
X	Call Light	
X	Infection Control	
X	Use of Equipment	
X	Cleanliness	
X	Dignity/Privacy Issues	
X	Safety Issues	
X	Transfers	
X	Facility Tour	
Was	s any involved equipment inspected:   Yes   No   N/A	
Was	s equipment being operated in safe manner: O Yes No N/A	
Wei	re photographs taken:   Yes   No Specify:	
cc:		
Hea	olth Regulation Division - Licensing & Certification	
Mir	nesota Board of Examiners for Nursing Home Administrators	
Mir	nnesota Board of Nursing	
The	Office of Ombudsman for Long-Term Care	
Virg	zinia Police Department	
Sair	nt Louis County Attorney	

**Virginia City Attorney** 

PRINTED: 01/24/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	) CO	TE SURVEY MPLETED R-C
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{F 000}	30, 2017, to follow relate to complaint Health and Rehab Part 483, subpart E Care Facilities.  The facility is enroll signature is not requal page of the CMS-2 correction is require	revisit was conducted on May up on deficiencies issued #H5283020 St Michaels is in compliance with 42 CFR requirements for Long Term led in ePOC and therefore a puired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility pt of the electronic documents.	{F 0	00}			
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 06/14/2017
Flootron	rically Signed						UD/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.

**Electronically Signed** 



#### 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.

St Michaels Health & Rehabilitation Center June 14, 2017 Page 2

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

PRINTED: 05/01/2017 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 000	INITIAL COMMEN	гѕ	F	000			
F 224 SS=D	investigate #H5283 (IJ) was identified a failure to ensure remechanical lift equisize. This resulted iresidnets when starcompatible with the resident fell from the 04/1/2017 at 1:00 p 04/14/17 at 11:59 a.  The facility is enroll signature is not requage of the CMS-2 submission of the Everification of computation of computation of the Everification of t	ed in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as pliance ROHIBIT NEGLECT/MISAPPROPRIATN and thas the right to be free from sappropriation of resident pliation as defined in this also but is not limited to boral punishment, involuntary physical or chemical restraint at the resident's symptoms. The resident's symptoms. The revent abuse, neglect, and lents and misappropriation of the icies and procedures to hallegations, and	•	224			
LABORATOR\	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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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	\$483.95, This REQUIREMENT by: Based on observatoreview, the facility for free from neglect for reviewed who use in when R1 was not a mechanical lift, sling transferred using a with the mechanical fell out of the sling, arm.  Findings include: R1's medical record admitted to the facion muscle weakness, disturbances, restled care plan dated 2/2 risk of falls related impaired safety away medication. In additional lift, R1 required assistantsfers with a me R1's medical record comprehensive assistantsfers with a me R1's medical record comprehensive assistantsfers alone from began flaying arms	Ing as required at paragraph  NT is not met as evidenced  Ition, interview, and document ailed to ensure a resident was or 1 of 26 resident's (R1) mechanical sling lift equipment ssessed for the use of a g type, and sling size. R1 was sling that was not compatible il sling lift used. The resident onto the floor, and broke her  It was reviewed. R1 was lity on 03/18/2015, with dementia with behavioral essness and agitation. R1's /2017, indicated R1 was at to severe cognitive impairment areness and anxiety tion, the care plan dated the use of a sling/mechanical sistance of two staff for chanical lift with a sling.  It did not include a sessment for the use of a g type, and sling size.  It dated 4/1/2017, indicated all body mechanical lift sling wheelchair to the bed. R1 and slid out of the bottom of the left side and hitting head,				

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F 224	lift on the floor. NA on correctly. NA-A anyone to assist he Nursing progress rp.m. indicated R1 sthe floor during a the head where the previous fall out of the left side betwee sling lift. The nursineurological check The resident was assessment.  R1's hospital disch dated 4/1/2017 ind fracture of the prox R1's discharge ord control hydrocodor milligrams (mg) ev five days. R1 was tkeeping it immobile NA-A was observe at 1:30 p.m. from the NA-A used a sling transfer R1 with the confirmed the sling was the sling used This was brought the Staff were not awallift equipment could facility immediately and mechanical lift.	een the legs of the mechanical A indicated she had the sling indicated she couldn't find er so she transfer R1.  Inote dated 4/1/2017 at 5:21 slid out of a full body sling onto ransfer and hit the left side of e staples were located from a bed. The resident was lying on en the legs of the mechanical e assessed R1 by completing and obtaining vitals signs. Sent to the hospital for an arge summary to the facility icated R1 had a closed simal end of the right humerus. Hers included treatment for pain ne/acetamineophin 5/325 ery six hours as needed for to rest her arm with a sling er as needed.  In the date of the right humerus are needed.  In the date of the right humerus are needed for the rest her arm with a sling er as needed.  In the date of the right humerus are needed for the rest her arm with a sling er as needed.  In the date of the right humerus are needed for a ceiling lift to be mechanical sling lift. NA-A gused during the observation when R1 fell on 04/01/2017, or the administrator's attention. The that slings and mechanical do not be interchanged. The properties of the properties of the requipment was being used.  In the volume of the sling in the sling is equipment was being used.	F2	224			
		as sitting in the hallway getting					

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F 224	agitated and comple wanted to go to been made to find some going down the hall couldn't find another room and started to mechanic sling lift or room. NA-A applied previously used and R1. NA-A than hoo lift located in R1's rewas applied correct arms, kick and sud the sling. NA-A was sling, but insisted Fishing.  During an interview administrator said I should not transfer getting agitated, and NA-A said she could so she transfer R1 the bottom of the simple of the possibility of DON said there was have not followed the assess residents for lift, sling type, or slill last training for staff equipment was 3/2.  During an interview registered nurse (Ra sling assessments)	laining of a headache. R1 d. NA-A said attempts were one to help transfer R1 by I and looking for help. NA-A er staff and moved R1 into her of transfer R1 by herself. The equipment was in the residents d the sling that staff had d placed it under and around ked the sling to the mechanical room. NA-A stated the sling tly, but R1 started to flail her denly slid out of the bottom of en't sure how R1 fell out of the R1 fell out of the bottom of the R1 by herself, but R1 was and complained of a headache. Idn't find anyone to help him/he by herself and R1 fell out of ling.  on 4/11/2017, at 2:46 p.m. the DON) said she was not aware falling out of the sling. The is no assessment tool and they he manufacturer guidelines to or the use of the mechanical ing size. The DON stated the eff on using mechanical lift	F	2224			

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F 323 SS=J	sure the resident's RN-E said the facilit assessment tool. It second person for the assessment is compared to assessment is compared to a specific tool or how to do the assessmechanical sling lift. The facility policy tit 3/27/2017 indicated for transfers using the staff must be trained the proper sling was mechanical sling lift. The manufacturers 11/01/2012, indicated slings and accesson mechanical sling lift use the proper size chart. To double chart. To double charts chest. If it will note two to eight extended past the standard past the stand	by looking at the resident to be arm fit inside of the sling. Ity does not have an RN-E stated she is usually the the transfer when the pleted. RN-E said they don't or policy that addresses when sessment. RN-E said R1 did ament for the use of the t.  Iteled mechanical lifts dated a resident must have two staff the mechanical sling lift. All d on using the equipment. Include information to ensure is used with the proper t.  It also indicated to be sure to sling using the sling sizing eck, lay a sling across the the proper size sling, you at inches of extra material side of each arm. In addition, ions indicated to always use sling for the resident, the most ded leg sling. The ded a guide to help develop a and education for staff. The recommend a copy of the kept in the employee file.  1)-(3) FREE OF ACCIDENT	F 2			

PRINTED: 05/01/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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F 323	from accident haza  (2) Each resident rand assistance dev  (n) - Bed Rails. Thappropriate alternated bed rail. If a bed of must ensure correct maintenance of betto the following election the following election bed rails prior (2) Review the risk the resident or resignation formed consent propriate for the This REQUIREME by:  Based on observative review, the facility were completed to one of one resident sling while using mass harmed when that was not compared and broke her arm comprehensively a mechanical lift, slinfailure for the facility failure for the facility and the sling while using mass harmed when that was not compared the facility of th	nsure that - nvironment remains as free ards as is possible; and ecceives adequate supervision vices to prevent accidents. The facility must attempt to use attives prior to installing a side or ar side rail is used, the facility to installation, use, and d rails, including but not limited ments.  dent for risk of entrapment to installation.  s and benefits of bed rails with dent representative and obtain	F 3	23			

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F 323	placed all 26 residerisk for immediate just for immediate justing from the mecha a fractured humerul assessed for the manger were notificated in the lower scope and that is not immediated in the lower scope and that is not immediated impaired safety award medication. In additional experience with a medication in additional experience with a medication in the incident report NA-A had R1 in a fit transfer alone from began flaying arms the sling landing or R1 was lying between a series with a medical in the sling landing or R1 was lying between assigned the sling landing or R1 was lying landing or R	ents who use lift equipment at reopardy (IJ).  A/1/2017 at 1:00 p.m. when R1 anical lift equipment resulting in its. The resident was not rechanical lift, sling type, or the ministrator and a clinical nurse end of the IJ on 04/12/2017 at as removed on 04/14/2017 at er, noncompliance remained at d severity level of actual harm the jeopardy.  If was reviewed. R1 was ality on 03/18/2015, with dementia with behavioral essness and agitation. R1's expressed and anxiety tion, the care plan dated the use of a sling/mechanical sistance of two staff for echanical lift with a sling.	F3	323			

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		245283	B. WING			1	C <b>14/2017</b>
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 323	anyone to assist h  Nursing progress p.m. indicated R1 the floor during a f her head where th previous fall out of the left side betwe sling lift. The nurs neurological check The resident was assessment.  R1's hospital discl dated 4/1/2017 ind fracture of the pro R1's discharge ord control hydrocodo milligrams (mg) ev five days. R1 was keeping it immobil  NA-A was observe at 1:30 p.m. from NA-A used a sling transfer R1 with th confirmed the sling was the sling used This was brought Staff were not awa lift equipment coul facility immediatel and mechanical lift  An interview on 4/ stated R1 was sitt agitated and comp	A indicated she couldn't find er so she transfer R1.  note dated 4/1/2017 at 5:21 slid out of a full body sling onto transfer and hit the left side of e staples were located from a f bed. The resident was lying on en the legs of the mechanical se assessed R1 by completing as and obtaining vitals signs. Sent to the hospital for an energy summary to the facility dicated R1 had a closed aximal end of the right humerus. Here included treatment for pain the new part of the right humerus included treatment for pain the new part of the right humerus included treatment for pain the new part of the right humerus included treatment for pain the new part of the right humerus included treatment for pain the new part of the right humerus included treatment for pain the new part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the part of the right humerus included treatment for pain the rig	F	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`′		E CONSTRUCTION	COM	E SURVEY PLETED
		245283	B. WING			ł	14/2017
	PROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH STREET SOUTH IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	made to find some going down the har couldn't find anoth room and started mechanic sling lift room. NA-A applie previously used at R1. NA-A than hoo lift located in R1's was applied correcarms, kick and such the sling. NA-A wasling, but insisted sling.  During an interview administrator said should not transfe getting agitated, a NA-A said she cous on the bottom of the some so the possibility on DON said there we have not followed assess residents for lift, sling type, or slast training for state equipment was 3/2.  During an interview registered nurse (a sling assessmer consists of watchimechanic sling lift mechanic sling lift.	eone to help transfer R1 by all and looking for help. NA-A er staff and moved R1 into her to transfer R1 by herself. The equipment was in the residents and the sling that staff had not placed it under and around oked the sling to the mechanical room. NA-A stated the sling citly, but R1 started to flail her didenly slid out of the bottom of isn't sure how R1 fell out of the R1 fell out of the bottom of the r R1 by herself, but R1 was and complained of a headache. Indicate the sling out of the lout of sling.  W on 4/11/2017 at 1:28 p.m. the py herself and R1 fell out of sling.  W on 4/11/2017 at 2:46 p.m. the (DON) said she was not aware falling out of the sling. The as no assessment tool and they the manufacturer guidelines to for the use of the mechanical ling size. The DON stated the aff on using mechanical lift	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245283	B. WING				C <b>14/2017</b>	
NAME OF PROVIDER OR SUPPLIER  ST MICHAELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  1201 8TH STREET SOUTH  VIRGINIA, MN 55792				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 323	assessment tool. second person for assessment is conhave a specific too or how to do the as not have an asses mechanical sling li  The facility policy to 3/27/2013 indicate for transfers using staff must be trained. The policy did not in the proper sling was mechanical sling li  The manufacturers 11/01/2012, indicate slings and accessor mechanical sling lift use the proper size chart. To double chart. To double chart. To double chart. To double chart. If will note two to eigentended past the the manual instruction the correct style of common is the diving manufacturer proving facility procedure a manufacturer also education sheet is  The immediate jeo was removed and notified on 4/14/20 facility assessed a	lity does not have an RN-E stated she is usually the the transfer when the inpleted. RN-E said they don't of or policy that addresses when essessment. RN-E said R1 did sment for the use of the ft.  Itled mechanical lifts dated do resident must have two staff the mechanical sling lift. Alled on using the equipment. Include information to ensure as used with the proper ft.  It guidelines revised the to use only manufactured ories designed for use with the ft. It also indicated to be sure to be sling using the sling sizing neck, lay a sling across the it's the proper size sling, you the inches of extra material side of each arm. In addition, tions indicated to always use sling for the resident, the most	F3	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
245283		B. WING			C <b>04/14/2017</b>		
NAME OF PROVIDER OR SUPPLIER  ST MICHAELS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1201 8TH STREET SOUTH  VIRGINIA, MN 55792				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	of sling and size of manufacturing instrequipment, the facilifts out of use and until correct slings of facility policy on mestaff on the mechanand sling size by widemonstration and staff.	sling in accordance with the fuctions for the mechanical lift lity removed all mechanical removed them from the unit were obtained, revised the echanical lifts, and trained all nical lift equipment, sling type, ritten instruction that included return demonstration by the mained at the lower scope and lated actual harm that is not	F3	323			



#### 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

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: R-C B WING 05/24/2017 00582 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH ST MICHAELS HEALTH & REHAB CENTER VIRGINIA. MN 55792 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (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) {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 #H5283020 St Michaels Health and Rehab was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a

Minnesota Department of Health

Minnesota Department of Health

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

**Electronically Signed** 

TITLE

(X6) DATE 06/14/17

PRINTED: 01/24/2018 FORM APPROVED

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C B. WING 05/24/2017 00582 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 8TH STREET SOUTH ST MICHAELS HEALTH & REHAB CENTER VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} Continued From page 1 {2 000} 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.

Minnesota Department of Health

6899

PRINTED: 05/01/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_ C B. WING 00582 04/14/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH ST MICHAELS HEALTH & REHAB CENTER VIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE 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.

Minnesota Department of Health

**INITIAL COMMENTS:** 

Bulletin 14-01, available at

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

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00582		B. WING		C <b>04/14/2017</b>			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ST MICHAELS HEALTH & REHAB CENTER  1201 8TH STREET SOUTH VIRGINIA, MN 55792							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	obul.htm The Stat delineated on the a Department of Hea electronically. Althous necessary for State the word "corrected Then indicate in the process, under the date your orders wi	tate.mn.us/divs/fpc/profinfo/inf te licensing orders are ttached Minnesota Ith orders being submitted ough no plan of correction is statutes/Rules, please enter " in the box available for text. te electronic State licensure heading completion date, the Il be corrected prior to itting to the Minnesota	2 000				
21850	Residents of HC Far Subd. 14. Freedon Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, sintentional and non- physical pain or injuconduct intended to distress. Every resident on- therapeutic che except in fully docu authorized in writing resident's physician period of time, and protect the resident others.  This MN Requirements by: Based on observation review, the facility force from neglect force.	ac.Bill of Rights  om from maltreatment.  free from maltreatment as erable Adults Protection Act.  ans conduct described in subdivision 15, or the etherapeutic infliction of any, or any persistent course of a produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as a after examination by a for a specified and limited only when necessary to a from self-injury or injury to ent is not met as evidenced  on, interview, and document ailed to ensure a resident was or 1 of 26 resident's (R1) mechanical sling lift equipment	21850				

0U8V11

PRINTED: 05/01/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: C B. WING 04/14/2017 00582 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 8TH STREET SOUTH ST MICHAELS HEALTH & REHAB CENTER VIRGINIA, MN 55792 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 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

PRINTED: 05/01/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 04/14/2017 00582 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH ST MICHAELS HEALTH & REHAB CENTER VIRGINIA, MN 55792 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 21850 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED			
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		00582			04/1	4/2017			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  1201 8TH STREET SOUTH								
ST MICH	ST MICHAELS HEALTH & REHAB CENTER VIRGINIA, MN 55792								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
21850	Continued From pa	ge 4	21850						
	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.								
	administrator said N should not transfer getting agitated, and NA-A said she could	on 4/11/2017, at 1:28 p.m. the NA-A told her she knew she R1 by herself, but R1 was d complained of a headache. dn't find anyone to help him/he by herself and R1 fell out of ing.							
	director of nurses (I of the possibility of DON said there was have not followed the assess residents follift, sling type, or slin	on 4/11/2017, at 2:46 p.m. the DON) said she was not aware falling out of the sling. The s no assessment tool and they he manufacturer guidelines to r the use of the mechanical hig size. The DON stated the f on using mechanical lift 7/2013.							
	registered nurse (R a sling assessment consists of watching mechanic sling lift is sure the resident's a RN-E said the facili assessment tool. It is second person for the assessment is compared a specific tool or how to do the assessmechanical sling lift.	on 4/11/2017, at 3:50 p.m. N)-E said she does complete . RN-E stated the assessment g a resident transfer with a by looking at the resident to be arm fit inside of the sling. ty does not have an RN-E stated she is usually the he transfer when the pleted. RN-E said they don't or policy that addresses when sessment. RN-E said R1 did ment for the use of the it.							

0U8V11

PRINTED: 05/01/2017 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: С B. WING 04/14/2017 00582 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH ST MICHAELS HEALTH & REHAB CENTER VIRGINIA, MN 55792 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21850 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.