Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007
Freeborn County

Report #: H5338021

Date: May 13, 2014

Date of Visit: April 16 & 17, 2014
Time of Visit: 10:45 a.m. – 4:00 p.m.
8:00 a.m. – 11:30 a.m.

By: Deborah Neuberger, R.N., Special Investigator

Type of Facility:
- ☒ Nursing Home
- ☐ SLF
- ☐ Hospital
- ☐ HHA
- ☐ ICF/IID
- ☐ Other: ____________
- ☐ Home Care Provider/Assisted Living
- ☐ Home Care

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect occurred when a resident had a fall with injuries when the alleged perpetrator (AP) transferred the resident in a manner not in accordance with the care plan.

An unannounced visit was made at this facility and an investigation was conducted under:

- ☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- ☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- ☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- ☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- ☐ Federal Regulations for EMTALA (42 CFR Part 489)
- ☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- ☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☐ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

A preponderance of evidence revealed that the resident was neglected when the AP transferred the resident without the use of a transfer belt as required in the resident's care plan. The resident fell during the transfer and sustained a fractured hip.

Interview and document review revealed the resident was recently admitted to the facility with diagnoses that included a history of falls, and a fractured radius, ulna and pelvis. The resident was assessed as being alert and oriented, had a history of falls, required physical support to stand, had experienced a recent fracture, and was at high risk for falls. The resident's temporary care plan required the extensive assist of 2 staff and the use of a transfer (gait) belt for all transfers. The resident was being assisted by the AP to transfer to a wheelchair at 6:20 a.m. on 4/12/2014. The AP was not using a transfer belt as required in the residents care plan. The resident lost his/her balance, stepped on his/her own shoes and fell hard to the ground, falling towards the head of the bed and away from the wheelchair. The resident was unable to move, crying out in pain and was sent to the emergency room immediately.

Hospital records dated 4/12/2014 were reviewed and revealed R-1 was admitted to the hospital and diagnosed with a left hip fracture. R-1 underwent surgery at the hospital to repair the fracture.

A licensed nursing staff member was interviewed and stated when s/he arrived at the resident's room on 4/12/2014 at about 6:20 a.m. the resident was on the floor on his/her left side. The resident stated s/he fell and was in a great deal of pain from his/her left hip. 911 was called and the resident was sent to the hospital. S/he did not see a gait belt on the resident when s/he arrived and asked the AP if s/he had used one while transferring the resident. The AP admitted she had not been using a gait belt with the resident during the transfer.

An administrative Nurse was interviewed and stated s/he interviewed the AP. The AP stated s/he was assisting the resident to the bathroom on 4/12/2014 and the resident lost his/her balance and fell. The AP stated s/he did not have a gait belt on the resident at the time of the transfer and fall. The AP stated s/he always follows the care plan and uses a gait belt, except this time. NA-D's employment was terminated after the investigation into the resident's fall.

The resident was interviewed and stated the AP had worked with the resident on more than 1 occasion. The AP was transferring the resident on 4/12/2/14 without using a transfer belt. The resident stated s/he fell during the transfer.

Attempts were made to interview the AP, including a subpoena, but the AP did not call back or present him/herself for interview.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ individual(s) and/or ☐ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had adequate care plans, policies, training, supervision and staffing in place at the time of the incident. The AP had training and access to all of the above and had access to additional resources including transfer belts. Despite this the AP transferred the resident without a transfer belt resulting in a resident fall with injury.

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:

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 If no, specify: ___________
(The 2567 will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

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

☒ Medical Records

☐ Medication Administration Records

☒ Facility Incident Reports

☐ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☒ Care Guide

☒ Treatment Sheets

☒ Physician Progress Notes

☒ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☐ Activities Reports

☐ Weight Records

☒ Therapy and/or Ancillary Services Records

☒ Assessments

☐ Skin Assessments

☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☒ Resident/Family Council Minutes

☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☒ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: ________

Number of additional resident(s) reviewed: 2

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: The resident was hospitalized.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ( ) Yes ( ) No (•) N/A Specify: This was a facility self-report.

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: (•) Yes ( ) No ( ) N/A Specify: ________

Did you interview the resident(s) identified in allegation: (•) Yes ( ) No ( ) N/A Specify: ________

Did you interview additional residents: (•) Yes ( ) No

Total number of resident interviews: 4

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: ________

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: 15

Physician interviewed: ( ) Yes (•) No

Nurse Practitioner interviewed: ( ) Yes (•) No

Interview with Alleged Perpetrator(s): ( ) Yes (•) No ( ) N/A Specify: The AP did not respond to messages left and the subpoena was undeliverable.

Attempts to contact: Date/time: 4/16/14 11:55a.m. Date/time: 4/18/14 2:30 p.m. Date/time: 4/23/14 2:25 p.m.

If unable to contact was subpoena issued: (•) Yes , date subpoena was issued 4/18/14 ( ) No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify ________

Observations were conducted related to:

☐ Wound Care ☐ Medication Pass ☐ Meals

☒ Personal Care ☒ Dignity/Privacy Issues ☐ Restorative Care

☒ Nursing Services ☒ Safety Issues ☒ Facility Tour

☒ Infection Control ☒ Cleanliness ☐ Injury

☒ Use of Equipment ☒ Transfers ☐ Incontinence

☐ Call Light ☐ Other: ________

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: ________

xc: Division of Compliance Monitoring - Licensing & Certification
Albert Lea City Police Department
Freeborn County Attorney
Albert Lea City Attorney

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

PRINTED: 05/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING ______ B. WING ______	C 04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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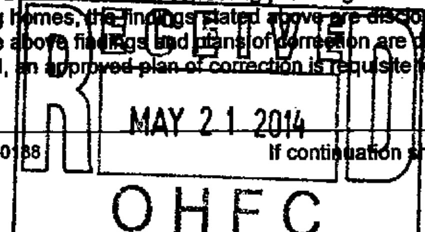
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5338021. As a result, the following deficiencies are issued.	F 000	F225	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	St. John's Lutheran Home staff will report allegations of maltreatment immediately to the administrator and other officials as required by State law. All staff were re-educated on facility's Abuse Prevention Plan and reporting obligations with Annual Education. Nurses, CNA's, and social workers attended training on 4/22/14 regarding the Abuse Prevention Plan and reporting obligations. Education on facility's Abuse Prevention Plan and reporting obligations will be included with the nursing newsletter every pay day times two months. Social Services Director and the Director of Nursing will audit policy compliance weekly x 4 and monthly until next QA meeting. Audit results will be reviewed at the Quality Assurance Meeting for further recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scot Spates
TITLE: CEO/Administrator
(X6) DATE: 5-16-14

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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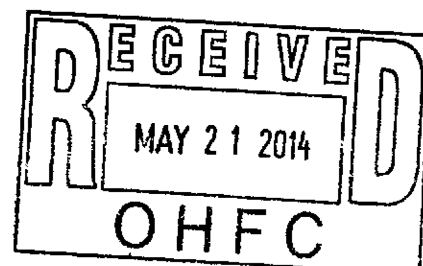
F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based in interview and document review the facility failed to immediately report an incident of alleged neglect to the administrator and other officials in accordance with state law for 1 of 3 residents reviewed, Resident #1 (R-1), when Nursing Assistant D (NA-D), failed to follow the care plan while transferring R-1 and R-1 fell, sustaining a fractured hip and the facility did not report the incident until 2 days later. Findings include: Medical record review revealed R-1 was admitted to the facility 3/1/2014 with diagnoses that included a history of falls, and a fractured radius, ulna and pelvis. R-1's fall risk assessment dated 3/2/2014 was reviewed and revealed R-1 was assessed as being alert and oriented, had a history of falls, required physical support to stand, had experienced a recent fracture, and was at high risk for falls. R-1's nursing assistant care plan dated 3/2/2014 was reviewed and revealed R-1 required the extensive assist of 1 to 2 staff and the use of a transfer (gait) belt for all transfers. The facility's Fall Investigation Report dated 4/12/2014 was reviewed and revealed R-1 was being assisted by NA-D to transfer to a wheelchair at 6:20 a.m. on 4/12/2014. NA-D was not using a transfer belt as required in R-1's care	F 225		



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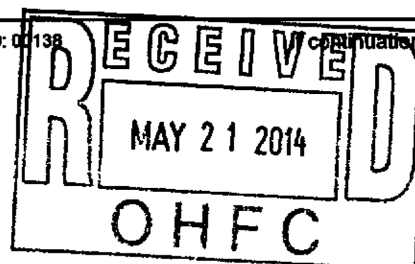
F 225	Continued From page 2 plan. R-1 lost her balance and fell to the ground. R-1 was unable to move, crying out in pain and was sent to the emergency room immediately. Nursing notes dated 4/12/14 at 9:15 a.m. were reviewed and revealed R-1 fell to the floor at 6:20 a.m. with NA-D in attendance. R-1 stated she had severe left hip pain and was unable to turn herself to her back. 911 was called and R-1 was sent to the hospital. Nursing notes dated 4/12/2014 at 9:53 a.m. were reviewed and revealed R-1's daughter was contacted and stated R-1 had a broken left hip and was scheduled to have surgery to repair the fracture that afternoon. Hospital records dated 4/12/2014 was reviewed and revealed R-1 was admitted to the hospital and diagnosed with a left hip fracture. R-1 underwent surgery at the hospital to repair the fracture. Registered Nurse E (RN-E) was interviewed on 4/17/2014 at 8:30 a.m. and stated She was working on 4/12/2014 and was called at about 6:20 a.m. and notified that R-1 had fallen. When RN-E got to R-1's room R-1 was on the floor on her left side. R-1 stated she fell and she she was in a great deal of pain from her left hip. RN-E stated she called 911 and sent R-1 to the hospital. RN-E stated she did not see a gait belt on R-1 and asked NA-D if she had used one while transferring R-1. NA-D admitted she had not been using a gait belt with R-1 during the transfer. When asked where her gait belt was NA-D stated she did not have one. RN-E stated all staff members have a gait belt supplied to them when they are hired and if they forget a gait	F 225		



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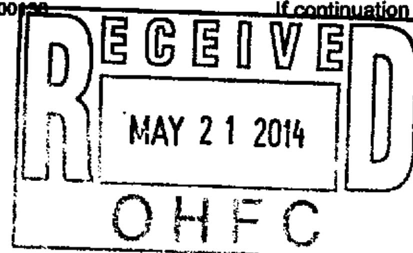
F 225	Continued From page 3 belt, there is a supply at the facility that staff can use. RN-E stated she did not call the administrator or director of nursing until the following day to inform them of R-1's fall, nor did she immediately call the state agency, as required by state law, until 2 days after the fall on 4/14/2014. When queried as to why she did not immediately inform the administrator of the serious incident, RN-E stated she didn't have his number available. When queried as to why she did not report the incident to the state agency, she stated she did not understand her role in the reporting of possible neglect to the state agency. The administrator was interviewed on 4/16/2014 at 3:20 p.m. and stated although the incident occurred on 4/12/2014 at about 6:20 a.m., he was not informed of the incident until about 9:00 a.m. on 4/13/2014. The administrator stated the facility policy would be to immediately inform the administrator of incidents, but this did not occur. The administrator stated he did not know why he was not immediately informed of the incident. The administrator stated facility policy requires a report to the state agency be made immediately, but this did not occur. The Director of Nursing (DON) was interviewed on 4/17/2014 at 9:15 a.m. and stated she found out about R-1's fall on 4/14/2014 when she reviewed fall reports from over the weekend. The DON stated she interviewed NA-D and NA-D stated she was assisting R-1 to the bathroom on 4/12/2014 and R-1 lost her balance and fell. NA-D stated she did not have a gait belt on R-1 at the time of the transfer and fall. NA-D stated she always follows the care plan and uses a gait belt, except this time. NA-D's employment was terminated after the investigation into R-1's fall,	F 225		



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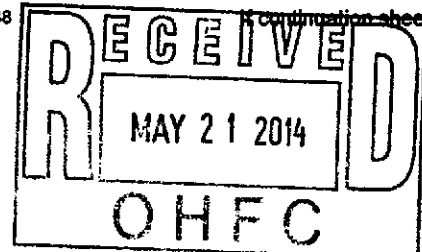
F 225	Continued From page 4 for failure to follow the care plan. R-1 was interviewed on 4/21/2014 at 1:30 p.m. and stated NA-D worked with R-1 on more than 1 occasion. NA-D was transferring R-1 on 4/12/2-14 without using a transfer belt. R-1 stated staff usually used a transfer belt for transfers, but NA-D did not use one for this transfer, and had previously not used a transfer belt for other transfers. R-1 stated she fell during the transfer. The facility policy titled Abuse Prevention Plan dated revised 9/15/11, provided by the facility was reviewed. The policy included the following: Administrator will be notified immediately of all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property. The facility policy titled General Guidelines For Reporting dated revised 9/20/13 and provided by the facility was reviewed. Under section 1 the following was observed: Contact Administrator and DON immediately, (phone numbers provided.) Under the section titled FALLS the following was observed: Report falls to (the state agency) only if care plan interventions were not being followed. Review the resident's care plan problems to determine if care plan interventions were being followed at the time of the fall.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F 226 St. John's Lutheran Home staff will report allegations of maltreatment immediately to the administrator and other officials as required by State law.	



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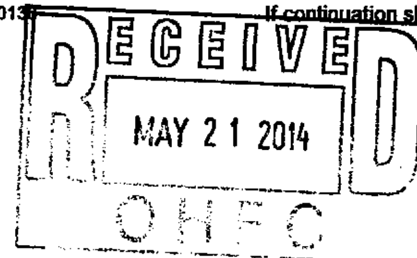
F 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement written policies that prohibit neglect when they failed to immediately report alleged neglect for 1 of 3 Residents reviewed, Resident #1 (R-1) when NA-D failed to use a gait belt and R-1 fell and experienced a hip fracture as a result of the fall. Findings include: The facility policy titled Abuse Prevention Plan dated revised 9/15/11, provided by the facility was reviewed. The policy included the following: Administrator will be notified immediately of all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property. The facility policy titled General Guidelines For Reporting dated revised 9/20/13 and provided by the facility was reviewed. Under section 1 the following was observed: Contact Administrator and DON immediately, (phone numbers provided.) Under the section titled FALLS the following was observed: Report falls to (the state agency) only if care plan interventions were not being followed. Review the resident's care plan problems to determine if care plan interventions were being followed at the time of the fall. Medical record review revealed R-1 was admitted to the facility 3/1/2014 with diagnoses that included a history of falls, and a fractured radius, ulna and pelvis. R-1's fall risk assessment dated 3/2/2014 was reviewed and revealed R-1 was	F 226	All staff were re-educated on facility's Abuse Prevention Plan and reporting obligations with Annual Education. Nurses, CNA's, and social workers attended training on 4/22/14 regarding the Abuse Prevention Plan and reporting obligations. Education on facility's Abuse Prevention Plan and reporting obligations will be included with the nursing newsletter every pay day times two months. Social Services Director and the Director of Nursing will audit policy compliance weekly x 4 and monthly until next QA meeting. Audit results will be reviewed at the Quality Assurance Meeting for further recommendations.	



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F 226	Continued From page 6	F 226		

assessed as being alert and oriented, had a history of falls, required physical support to stand, had experienced a recent fracture, and was at high risk for falls. R-1's nursing assistant care plan dated 3/2/2014 was reviewed and revealed R-1 required the extensive assist of 1 to 2 staff and the use of a transfer (gait) belt for all transfers.

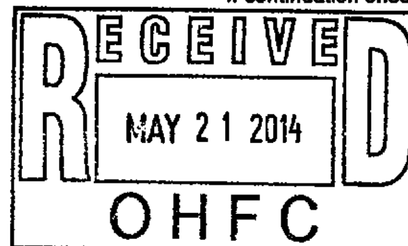
The facility's Fall Investigation Report dated 4/12/2014 was reviewed and revealed R-1 was being assisted by NA-D to transfer to a wheelchair at 6:20 a.m. on 4/12/2014. NA-D was not using a transfer belt as required in R-1's care plan. R-1 lost her balance and fell to the ground. R-1 was unable to move, crying out in pain and was sent to the emergency room immediately.

Nursing notes dated 4/12/14 at 9:15 a.m. were reviewed and revealed R-1 fell to the floor at 6:20 a.m. with NA-D in attendance. R-1 stated she had severe left hip pain and was unable to turn herself to her back. 911 was called and R-1 was sent to the hospital.

Nursing notes dated 4/12/2014 at 9:53 a.m. were reviewed and revealed R-1's daughter was contacted and stated R-1 had a broken left hip and was scheduled to have surgery to repair the fracture that afternoon.

Hospital records dated 4/12/2014 was reviewed and revealed R-1 was admitted to the hospital and diagnosed with a left hip fracture. R-1 underwent surgery at the hospital to repair the fracture.

Registered Nurse E (RN-E) was interviewed on 4/17/2014 at 8:30 a.m. and stated She was



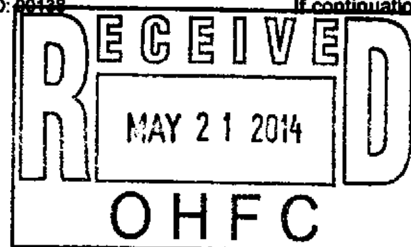
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING ______ B. WING ______	C 04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7	F 226		

working on 4/12/2014 and was called at about 6:20 a.m. and notified that R-1 had fallen. When RN-E got to R-1's room R-1 was on the floor on her left side. R-1 stated she fell and she she was in a great deal of pain from her left hip. RN-E stated she called 911 and sent R-1 to the hospital. RN-E stated she did not see a gait belt on R-1 and asked NA-D if she had used one while transferring R-1. NA-D admitted she had not been using a gait belt with R-1 during the transfer. When asked where her gait belt was NA-D stated she did not have one. RN-E stated all staff members have a gait belt supplied to them when they are hired and if they forget a gait belt, there is a supply at the facility that staff can use. RN-E stated she did not call the administrator or director of nursing until the following day to inform them of R-1's fall, nor did she immediately call the state agency, as required by state law, until 2 days after the fall on 4/14/2014. When queried as to why she did not immediately inform the administrator of the serious incident, RN-E stated she didn't have his number available. When queried as to why she did not report the incident to the state agency, she stated she did not understand her role in the reporting of possible neglect to the state agency.

The administrator was interviewed on 4/16/2014 at 3:20 p.m. and stated although the incident occurred on 4/12/2014 at about 6:20 a.m., he was not informed of the incident until about 9:00 a.m. on 4/13/2014. The administrator stated the facility policy would be to immediately inform the administrator of incidents, but this did not occur. The administrator stated he did not know why he was not immediately informed of the incident. The administrator stated facility policy requires a report to the state agency be made immediately,



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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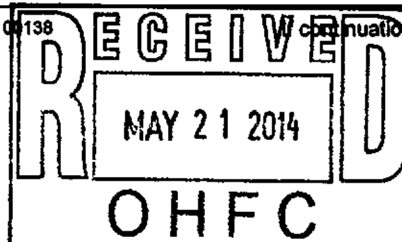
F 226	Continued From page 8 but this did not occur. The Director of Nursing (DON) was interviewed on 4/17/2014 at 9:15 a.m. and stated she found out about R-1's fall on 4/14/2014 when she reviewed fall reports from over the weekend. The DON stated she interviewed NA-D and NA-D stated she was assisting R-1 to the bathroom on 4/12/2014 and R-1 lost her balance and fell. NA-D stated she did not have a gait belt on R-1 at the time of the transfer and fall. NA-D stated she always follows the care plan and uses a gait belt, except this time. NA-D's employment was terminated after the investigation into R-1's fall, for failure to follow the care plan. R-1 was interviewed on 4/21/2014 at 1:30 p.m. and stated NA-D had worked with R-1 on more than 1 occasion. NA-D was transferring R-1 on 4/12/2/14 without using a transfer belt. R-1 stated staff usually used a transfer belt for transfers, but NA-D did not use one for this transfer, and had previously not used a transfer belt for other transfers. R-1 stated she fell during the transfer.	F 226		



Addendum to F 225

Audits of resident transfers to ensure care plan compliance will be done by licensed nurses every shift three times per week for one week, then every shift once weekly for one week, and as needed to monitor compliance until next QA meeting. Audit results will be reviewed at the next QA meeting for further recommendations.

The Social Services Director and the Director of Nursing will audit that all allegations of mistreatment are reported to the administrator and director of nursing immediately and reports are made to the MDH/CEP as required by state law. Audit results will be reviewed at the next QA meeting for further recommendations.

Completion date: June 02, 2014

Addendum F226

Audits of resident transfers to ensure care plan compliance will be done by licensed nurses every shift three times per week for one week, then every shift once weekly for one week, and as needed to monitor compliance until next QA meeting. Audit results will be reviewed at the next QA meeting for further recommendations.

The Social Services Director and the Director of Nursing will audit that all allegations of mistreatment are reported to the administrator and director of nursing immediately and reports are made to the MDH/CEP as required by state law. Audit results will be reviewed at the next QA meeting for further recommendations.

Completion date: June 02, 2014

Administrator 5/29/14

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00138	A. BUILDING: ______ B. WING ______	C 04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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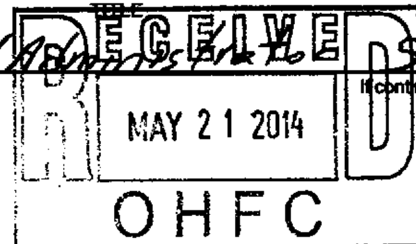
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for 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 #H5338021. The following correction order is issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scot Spates — TITLE: CEO/Administrator — (X6) DATE: 5-16-14



Minnesota Department of Health

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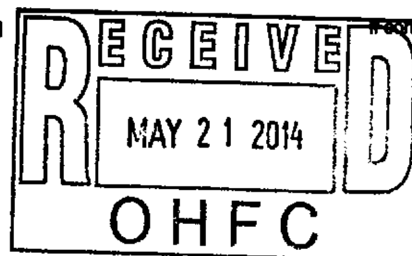
2 000	Continued From page 1 Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 22, St. Paul, Minnesota, 55164-0970.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult	21980		



Minnesota Department of Health

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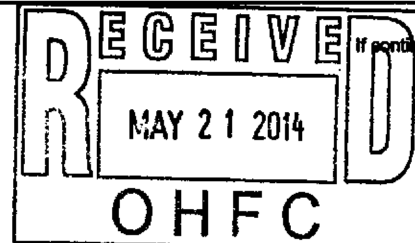
21980	Continued From page 2 has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section	21980		



Minnesota Department of Health

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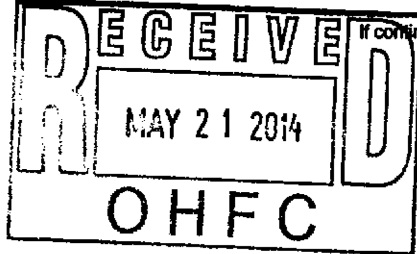
21980	Continued From page 3 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to immediately report an incident of alleged maltreatment to the common entry point (CEP) for 1 of 3 residents reviewed, Resident #1 (R-1), when Nursing Assistant D (NA-D), failed to follow the care plan while transferring R-1 and R-1 fell, sustaining a fractured hip and the facility did not report the incident until 2 days later. Findings include: Medical record review revealed R-1 was admitted to the facility 3/1/2014 with diagnoses that included a history of falls, and a fractured radius, ulna and pelvis. R-1's fall risk assessment dated 3/2/2014 was reviewed and revealed R-1 was assessed as being alert and oriented, had a history of falls, required physical support to stand, had experienced a recent fracture, and was at high risk for falls. R-1's nursing assistant care plan dated 3/2/2014 was reviewed and revealed R-1 required the extensive assist of 1 to 2 staff and the use of a transfer (gait) belt for all transfers. The facility's Fall Investigation Report dated 4/12/2014 was reviewed and revealed R-1 was being assisted by NA-D to transfer to a wheelchair at 6:20 a.m. on 4/12/2014. NA-D was not using a transfer belt as required in R-1's care plan. R-1 lost her balance and fell to the ground. R-1 was unable to move, crying out in pain and	21980		



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21980	Continued From page 4	21980		

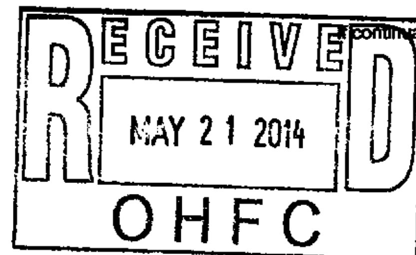
was sent to the emergency room immediately.

Nursing notes dated 4/12/14 at 9:15 a.m. were reviewed and revealed R-1 fell to the floor at 6:20 a.m. with NA-D in attendance. R-1 stated she had severe left hip pain and was unable to turn herself to her back. 911 was called and R-1 was sent to the hospital.

Nursing notes dated 4/12/2014 at 9:53 a.m. were reviewed and revealed R-1's daughter was contacted and stated R-1 had a broken left hip and was scheduled to have surgery to repair the fracture that afternoon.

Hospital records dated 4/12/2014 was reviewed and revealed R-1 was admitted to the hospital and diagnosed with a left hip fracture. R-1 underwent surgery at the hospital to repair the fracture.

Registered Nurse E (RN-E) was interviewed on 4/17/2014 at 8:30 a.m. and stated She was working on 4/12/2014 and was called at about 6:20 a.m. and notified that R-1 had fallen. When RN-E got to R-1's room R-1 was on the floor on her left side. R-1 stated she fell and she she was in a great deal of pain from her left hip. RN-E stated she called 911 and sent R-1 to the hospital. RN-E stated she did not see a gait belt on R-1 and asked NA-D if she had used one while transferring R-1. NA-D admitted she had not been using a gait belt with R-1 during the transfer. When asked where her gait belt was NA-D stated she did not have one. RN-E stated all staff members have a gait belt supplied to them when they are hired and if they forget a gait belt, there is a supply at the facility that staff can use. RN-E stated she did not call the administrator or director of nursing until the



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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 5	21980		

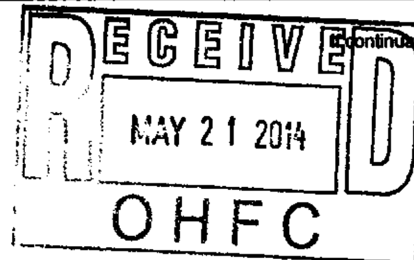
following day to inform them of R-1's fall, nor did she immediately report the incident to the CEP, as required by state law, until 2 days after the fall on 4/14/2014. When queried as to why she did not report the incident to the CEP, she stated she did not understand her role in the reporting of possible neglect to the CEP.

The administrator was interviewed on 4/16/2014 at 3:20 p.m. and stated although the incident occurred on 4/12/2014 at about 6:20 a.m., he was not informed of the incident until about 9:00 a.m. on 4/13/2014. The administrator stated facility policy requires a report to the CEP be made immediately, but this did not occur.

The Director of Nursing (DON) was interviewed on 4/17/2014 at 9:15 a.m. and stated she found out about R-1's fall on 4/14/2014 when she reviewed fall reports from over the weekend. The DON stated she interviewed NA-D and NA-D stated she was assisting R-1 to the bathroom on 4/12/2014 and R-1 lost her balance and fell. NA-D stated she did not have a gait belt on R-1 at the time of the transfer and fall. NA-D stated she always follows the care plan and uses a gait belt, except this time. NA-D's employment was terminated after the investigation into R-1's fall, for failure to follow the care plan.

R-1 was interviewed on 4/21/2014 at 1:30 p.m. and stated NA-D had worked with R-1 on more than 1 occasion. NA-D was transferring R-1 on 4/12/2-14 without using a transfer belt. R-1 stated staff usually used a transfer belt for transfers, but NA-D did not use one for this transfer, and had previously not used a transfer belt on other occasions. R-1 stated she fell during the transfer.

The facility policy titled General Guidelines For



Minnesota Department of Health

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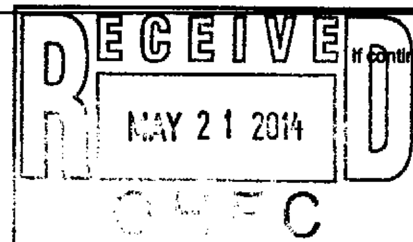
21980	Continued From page 6 Reporting dated revised 9/20/13 and provided by the facility was reviewed. Under the section titled FALLS the following was observed: Report falls to CEP only if care plan interventions were not being followed. Review the resident's care plan problems to determine if care plan interventions were being followed at the time of the fall. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could update policies related to immediate reporting of maltreatment, train staff related to the updated policies and monitor staff compliance with the policies. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21980		



Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007
Freeborn County

Report #: H5338021
Date: June 30, 2014

Date of Visit: June 23, 2014
Time of Visit: 10:30 a.m.

By: Deborah Neuberger, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up two federal deficiencies and one state licensing order which were issued on May 7, 2014, as the result of an investigation which had been completed on April 23, 2014.

The status of the order is as follow:
1 MN St. Statute 626.557 Subd 3 – Corrected

See Attached 2567B for status of federal deficiencies.

xc: Minnesota Department of Health -Licensing & Certification Division

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245338	A. Building B. Wing	6/23/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	06/02/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	06/02/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/23/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved
6/30/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00138	A. Building B. Wing	6/23/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 21980 Reg. # MN St. Statute 626.557 Sul LSC	Correction Completed 06/02/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/23/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO