MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Presbyterian Homes of Arden Hills	H5424039	March 20, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
3220 Lake Johanna Boulevard	8:30 a.m. to 4:00 p.m.	October 9, 2017
Facility City:	**Investigator's Name and Title:**	
Arden Hills	Peggy Boeck, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55112	Ramsey

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when the alleged perpetrator failed to follow the resident's care plan and transferred the resident without the use of a mechanical stand lift. The resident had a fall with a fractured/depressed area of the right knee.

- [x] Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- [x] State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- [x] 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 did occur. The alleged perpetrator (AP) did not use a gait belt or standing lift when s/he assisted the resident in the bathroom. The resident fell to the floor and broke a bone in his/her right knee.

The resident had been at the facility for less than one year and had recently been hospitalized for anemia. Due to weakness, the resident had not been able to walk for some time. The resident had difficulty moving his/her joints because of osteoporosis. The resident was alert, oriented, and able to make his/her needs known. The resident had been assessed to need assistance of one staff with a standing lift for transfers.

On the morning of the incident, the resident had turned on the call light to use the bathroom. The AP responded to the light and was with the resident when s/he fell from a standing position down to the floor, knees first.

When interviewed, a nurse stated s/he had gone into the resident's room that morning to give the resident medication. When the nurse walked past the resident's bathroom, s/he stated s/he saw a wheelchair in the bathroom with the resident and the AP standing next to it. The resident had both hands on the grab bar, which was attached to the wall to the right of the toilet. In the room, the nurse sat in a chair. The AP called for help and the nurse got up and went into the bathroom. The nurse said the resident was in the same position facing the wall, holding onto the grab bar, with the toilet on the resident's left and the wheelchair

on the right. The nurse saw the resident falling to his/her knees while holding the grab bar. The AP was standing behind the resident holding on to the resident by the fabric of the resident's pants on both sides at the waist. The nurse stated s/he did not see a gait belt on the resident and there was no standing lift in the room.

The hospital record indicated the resident had a fracture of the tibia at the knee, but was not a candidate for surgery. The resident was discharged back to the facility with a knee immobilizer for the fracture and a prescription for narcotic pain medication.

When interviewed, a family member stated they thought the resident required two staff for transfers at the time of the fall. When family visited the resident the next morning, the resident was in severe pain, and an ambulance was called. The family member said the hospital found a broken bone in the resident's right knee.

When interviewed, the physician stated the resident was a high surgical risk due to his/her health. The resident's broken knee was not surgically repaired.

The AP did not respond to requests for an interview.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

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

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

The facility had policies and procedures in place to follow a resident's plan of care and the AP was trained to follow the resident's care plan to use a standing lift to transfer the resident.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

(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.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Nurses Notes
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Therapy and/or Ancillary Services Records

Other pertinent medical records:

[x] Hospital Records [x] Ambulance/Paramedics [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

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 had passed away.

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact complainant, attempts were made on:

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

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

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

○ Yes ◉ No ○ N/A Specify: The resident had passed away.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ◉ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
03/24/2017	4:00 p.m.	4/25/2017	1:30 p.m.	4/28/2017	10:00 a.m.

If unable to contact was subpoena issued: ◉ Yes, date subpoena was issued 5/11/2017 ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

- [x] Personal Care
- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Use of Equipment
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Facility Tour
- [x] Injury
- [x] Incontinence

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: bathroom where incident occurred

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Arden Hills Police Department

Arden Hills City Attorney

Ramsey County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. BUILDING _____ B. WING _____	R-C 10/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF ARDEN HILLS	3220 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on October 20, 2017, to follow up on deficiencies issued relate to complaint H5424039. Presbyterian Homes of Arden Hills is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2017

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.

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate cases #H5424039 and #H5424041. As a result, the following deficiencies are issued for case #H5424039. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the care plan was followed for one of four residents, (R1), reviewed who required a standing lift for transfers, when R1 was transferred without a standing lift, fell, and broke a bone in his/her knee. Findings include: R1's medical record was reviewed. R1 diagnoses included anemia, osteoarthritis, osteoporosis, and low back pain. R1's care plan dated 8/18/2016, indicated R1 required assistance of one staff with a standing lift for transfers.	F 282		

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

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

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F 282	Continued From page 1 R1's brief interview of mental status dated 11/10/2016, with a score of 14 out of 15 indicated R1 was cognitively intact. R1's care guide sheet dated 12/30/2016, indicated R1 required the assistance of one staff with a standing lift for transfers, was unable to walk, and was at risk for falls. R1's nursing progress note dated 2/27/2017, indicated R1 was re-admitted to the facility from the hospital at 4:45 p.m. R1 required the assistance of one staff with a standing lift for transfers. R1's nursing progress note dated 2/28/2017, indicated R1 fell on her knees in the bathroom during a transfer. The facility occurrence report dated 2/28/2017 at 10:30 a.m., indicated R1 was being assisted in the bathroom by nursing assistant (NA)-G at the time of the fall. The facility falls follow up form dated 2/28/2017, indicated R1 was assessed after the fall by RN-C, who took R1's vital signs, checked R1's skin for injury, completed range of motion, and asked R1 about pain. R1 denied any pain at the time. R1 was lifted from the floor with a mechanical lift and three staff and placed into bed. R1's nursing progress note dated 3/1/2017, indicated at 5:13 a.m. R1 complained of pain in the right hip, knee, and heel. Nursing staff provided Tramadol 25 milligrams (mg) for pain. R1's nursing progress note dated 3/1/2017,	F 282		

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F 282	Continued From page 2 indicated at 6:32 a.m. R1 received a warm pack to the effected area (unknown site). R1's nursing progress note dated 3/1/2017, indicated at 6:41 a.m. R1's medication and warm pack interventions were ineffective. R1's nursing progress note dated 3/1/2017, indicated at 9:37 a.m. Family member (FM)-E requested the facility send R1 to the hospital. Orders were received from the nurse practitioner. R1's emergency room progress note dated 3/1/2017, indicated R1 was given oxycodone 5 mg for pain and an x-ray was taken of R1's knee, which revealed a fracture of the tibia of the right knee. R1 was not a candidate for surgery, R1 was given a knee immobilizer and additional prescription for oxycodone. R1's nursing progress note dated 3/1/2017, indicated R1 returned from the hospital at 7:00 p.m. with a knee immobilizer on her right leg, due to a broken bone. R1 was given Tramadol 25 mg. The facility internal investigation document dated 2/28/2017, indicated after the fall occurrence registered nurse (RN)-A interviewed R1, who stated nursing assistant (NA)-G did not use the standing lift to transfer R1. An interview was conducted with RN-A at 1:25 p.m. on 3/20/2017. RN-A stated R1 reported to him/her on 2/28/2017 that NA-G did not use the standing lift to help R1 in the bathroom. An interview was conducted with licensed practical nurse (LPN)-D at 3:23 p.m. on 5/11/2017. LPN-D stated she went to R1's room	F 282		

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F 282	Continued From page 3 to give R1 medication. LPN-D stated she witnessed NA-G holding on to R1 from behind in the bathroom with his hands holding R1's pants at the waist. LPN-D stated NA-G did not use a transfer belt or the standing lift with R1. LPN-D stated she witnessed R1 fall to the floor landing on her knees. The facility position description for nursing assistants dated 5/2016, indicated the nursing assistant is responsible for the provision of care and services to the residents in assisting residents with transfers, walking and positioning. The nursing assistant supports the resident's choices, follows regulations, and best practices. The nursing assistant works under the supervision of a registered nurse. The facility position description for registered nurses dated 11/2010, indicated the registered nurse will manage the performance of the assigned staff under his/her supervision. The facility policy for resident transfer assessment dated 2/2016, indicated all residents will be assessed for transfer needs. If a resident requires a standing lift it will be documented in the care plan and the nursing assistant care sheet.	F 282		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		

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F 323	Continued From page 4 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the use of a standing lift was used to prevent an accident during a transfer for one of four residents, (R1), reviewed who required a standing lift for transfers, when R1 was transferred without a standing lift, fell, and broke a bone in his/her knee. Findings include: R1's medical record was reviewed. R1 diagnoses included anemia, osteoarthritis, osteoporosis, and low back pain. R1's care plan dated 8/18/2016, indicated R1 required assistance of one staff with a standing lift for transfers.	F 323		

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F 323	Continued From page 5 R1's brief interview of mental status dated 11/10/2016, with a score of 14 out of 15 indicated R1 was cognitively intact. R1's care guide sheet dated 12/30/2016, indicated R1 required the assistance of one staff with a standing lift for transfers, was unable to walk, and was at risk for falls. R1's nursing progress note dated 2/27/2017, indicated R1 was re-admitted to the facility from the hospital at 4:45 p.m. R1 required the assistance of one staff with a standing lift for transfers. R1's nursing progress note dated 2/28/2017, indicated R1 fell on her knees in the bathroom during a transfer. The facility occurrence report dated 2/28/2017 at 10:30 a.m., indicated R1 was being assisted in the bathroom by nursing assistant (NA)-G at the time of the fall. The facility falls follow up form dated 2/28/2017, indicated R1 was assessed after the fall by RN-C, who took R1's vital signs, checked R1's skin for injury, completed range of motion, and asked R1 about pain. R1 denied any pain at the time. R1 was lifted from the floor with a mechanical lift and three staff and placed into bed. R1's nursing progress note dated 3/1/2017, indicated at 5:13 a.m. R1 complained of pain in the right hip, knee, and heel. Nursing staff provided Tramadol 25 milligrams (mg) for pain. R1's nursing progress note dated 3/1/2017, indicated at 6:32 a.m. R1 received a warm pack	F 323		

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F 323	Continued From page 6 to the effected area (unknown site). R1's nursing progress note dated 3/1/2017, indicated at 6:41 a.m. R1's medication and warm pack interventions were ineffective. R1's nursing progress note dated 3/1/2017, indicated at 9:37 a.m. Family member (FM)-E requested the facility send R1 to the hospital. Orders were received from the nurse practitioner. R1's emergency room progress note dated 3/1/2017, indicated R1 was given oxycodone 5 mg for pain and an x-ray was taken of R1's knee, which revealed a fracture of the tibia of the right knee. R1 was not a candidate for surgery, R1 was given a knee immobilizer and additional prescription for oxycodone. R1's nursing progress note dated 3/1/2017, indicated R1 returned from the hospital at 7:00 p.m. with a knee immobilizer on her right leg, due to a broken bone. R1 was given Tramadol 25 mg. The facility internal investigation document dated 2/28/2017, indicated after the fall occurrence registered nurse (RN)-A interviewed R1, who stated nursing assistant (NA)-G did not use the standing lift to transfer R1. An interview was conducted with RN-A at 1:25 p.m. on 3/20/2017. RN-A stated R1 reported to him/her on 2/28/2017 that NA-G did not use the standing lift to help R1 in the bathroom. An interview was conducted with licensed practical nurse (LPN)-D at 3:23 p.m. on 5/11/2017. LPN-D stated she went to R1's room to give R1 medication. LPN-D stated she	F 323		

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F 323	Continued From page 7 witnessed NA-G holding on to R1 from behind in the bathroom with his hands holding R1's pants at the waist. LPN-D stated NA-G did not use a transfer belt or the standing lift with R1. LPN-D stated she witnessed R1 fall to the floor landing on her knees. The facility position description for nursing assistants dated 5/2016, indicated the nursing assistant is responsible for the provision of care and services to the residents in assisting residents with transfers, walking and positioning. The nursing assistant supports the resident's choices, follows regulations, and best practices. The nursing assistant works under the supervision of a registered nurse. The facility position description for registered nurses dated 11/2010, indicated the registered nurse will manage the performance of the assigned staff under his/her supervision. The facility policy for resident transfer assessment dated 2/2016, indicated all residents will be assessed for transfer needs. If a resident requires a standing lift it will be documented in the care plan and the nursing assistant care sheet.	F 323		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2017

Ms. Dori Mutch, Administrator
Presbyterian Homes of Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112

Re: Reinspection Results - Complaint Numbers H5424039, H5424041

Dear Ms. Mutch:

On October 20, 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 August 8, 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00975	A. BUILDING: _____ B. WING _____	R-C 10/20/2017

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5424039. Presbyterian Homes of Arden Hills was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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

Minnesota Department of Health

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

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2 000	Continued From page 1 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the care plan was followed for one of four residents, (R1), reviewed who required a standing lift for transfers, when R1 was transferred without a standing lift, fell, and broke a bone in his/her knee. Findings include: R1's medical record was reviewed. R1 diagnoses included anemia, osteoarthritis, osteoporosis, and low back pain.	2 565		

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2 565	Continued From page 2 R1's care plan dated 8/18/2016, indicated R1 required assistance of one staff with a standing lift for transfers. R1's brief interview of mental status dated 11/10/2016, with a score of 14 out of 15 indicated R1 was cognitively intact. R1's care guide sheet dated 12/30/2016, indicated R1 required the assistance of one staff with a standing lift for transfers, was unable to walk, and was at risk for falls. R1's nursing progress note dated 2/27/2017, indicated R1 was re-admitted to the facility from the hospital at 4:45 p.m. R1 required the assistance of one staff with a standing lift for transfers. R1's nursing progress note dated 2/28/2017, indicated R1 fell on her knees in the bathroom during a transfer. The facility occurrence report dated 2/28/2017 at 10:30 a.m., indicated R1 was being assisted in the bathroom by nursing assistant (NA)-G at the time of the fall. The facility falls follow up form dated 2/28/2017, indicated R1 was assessed after the fall by RN-C, who took R1's vital signs, checked R1's skin for injury, completed range of motion, and asked R1 about pain. R1 denied any pain at the time. R1 was lifted from the floor with a mechanical lift and three staff and placed into bed. R1's nursing progress note dated 3/1/2017, indicated at 5:13 a.m. R1 complained of pain in the right hip, knee, and heel. Nursing staff provided Tramadol 25 milligrams (mg) for pain.	2 565		

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2 565	Continued From page 3 R1's nursing progress note dated 3/1/2017, indicated at 6:32 a.m. R1 received a warm pack to the effected area (unknown site). R1's nursing progress note dated 3/1/2017, indicated at 6:41 a.m. R1's medication and warm pack interventions were ineffective. R1's nursing progress note dated 3/1/2017, indicated at 9:37 a.m. Family member (FM)-E requested the facility send R1 to the hospital. Orders were received from the nurse practitioner. R1's emergency room progress note dated 3/1/2017, indicated R1 was given oxycodone 5 mg for pain and an x-ray was taken of R1's knee, which revealed a fracture of the tibia of the right knee. R1 was not a candidate for surgery, R1 was given a knee immobilizer and additional prescription for oxycodone. R1's nursing progress note dated 3/1/2017, indicated R1 returned from the hospital at 7:00 p.m. with a knee immobilizer on her right leg, due to a broken bone. R1 was given Tramadol 25 mg. The facility internal investigation document dated 2/28/2017, indicated after the fall occurrence registered nurse (RN)-A interviewed R1, who stated nursing assistant (NA)-G did not use the standing lift to transfer R1. An interview was conducted with RN-A at 1:25 p.m. on 3/20/2017. RN-A stated R1 reported to him/her on 2/28/2017 that NA-G did not use the standing lift to help R1 in the bathroom. An interview was conducted with licensed practical nurse (LPN)-D at 3:23 p.m. on	2 565		

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2 565	Continued From page 4 5/11/2017. LPN-D stated she went to R1's room to give R1 medication. LPN-D stated she witnessed NA-G holding on to R1 from behind in the bathroom with his hands holding R1's pants at the waist. LPN-D stated NA-G did not use a transfer belt or the standing lift with R1. LPN-D stated she witnessed R1 fall to the floor landing on her knees. The facility position description for nursing assistants dated 5/2016, indicated the nursing assistant is responsible for the provision of care and services to the residents in assisting residents with transfers, walking and positioning. The nursing assistant supports the resident's choices, follows regulations, and best practices. The nursing assistant works under the supervision of a registered nurse. The facility position description for registered nurses dated 11/2010, indicated the registered nurse will manage the performance of the assigned staff under his/her supervision. The facility policy for resident transfer assessment dated 2/2016, indicated all residents will be assessed for transfer needs. If a resident requires a standing lift it will be documented in the care plan and the nursing assistant care sheet. 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.	2 565		

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21850	Continued From page 5	21850		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from maltreatment for one of four residents, (R1), reviewed who required a standing lift for transfers, when R1 was transferred without a standing lift, fell, and broke a bone in his/her knee. Findings include: The facility policy titled "Understanding Maltreatment of Vulnerable Adults" (undated) indicated failing to follow a resident's plan of care is considered neglect and could result in termination of employment. NA-G signed the document 12/2/2015.	21850		

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21850	Continued From page 6 The facility position description for registered nurses dated 11/2010, indicated the registered nurse will manage the performance of the assigned staff under his/her supervision. The facility policy for resident transfer assessment dated 2/2016, indicated all residents will be assessed for transfer needs. If a resident requires a standing lift it will be documented in the care plan and the nursing assistant care sheet. The facility position description for nursing assistants dated 5/2016, indicated the nursing assistant is responsible for the provision of care and services to the residents in assisting residents with transfers, walking and positioning. The nursing assistant supports the resident's choices, follows regulations, and best practices. The nursing assistant works under the supervision of a registered nurse. R1's medical record was reviewed. R1 diagnoses included anemia, osteoarthritis, osteoporosis, and low back pain. R1's care plan dated 8/18/2016, indicated R1 required assistance of one staff with a standing lift for transfers. R1's brief interview of mental status dated 11/10/2016, with a score of 14 out of 15 indicated R1 was cognitively intact. R1's care guide sheet dated 12/30/2016, indicated R1 required the assistance of one staff with a standing lift for transfers, was unable to walk, and was at risk for falls. R1's nursing progress note dated 2/27/2017,	21850		

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