DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
The Homestead of Coon Rapids	HL20532013	August 15, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
11372 Robinson Drive NW	9:15 a.m. to 4:45 p.m.	November 17, 2017
Facility City:	**Investigator's Name and Title:**	
Coon Rapids	Meghan Schulz, RN	

State:	ZIP:	County:
Minnesota	55433	Anoka

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when alleged perpetrators AP1 and AP2 failed to follow the client's service plan of using a mechanical lift during transfer. Both AP's manually transferred the client to bed resulting in a right femur fracture.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the client was transferred without the use of a mechanical lift and sustained a hip fracture.

The client received services from a provider licensed as a comprehensive home care provider. The client received assistance with medication administration, transferring, bathing, eating, and repositioning according to the service plan. The client's service plan states the client required an assist of two with the mechanical lift for transfer.

During an interview, nursing staff stated the client had in his/her care plan that a mechanical lift should be used for all transfers. Nursing staff stated that on the day of the incident, the alleged perpetrators (APs) manually transferred the client from the wheelchair to the bed. The nursing staff was notified of the deformity in the leg after the manual transfer and the client was sent to the hospital for evaluation. Nursing staff stated the AP's should have called for help when they were struggling to put the lift sling underneath the client.

Hospital records show the client sustained a right hip fracture and that non surgical intervention was

decided by the family and the medical team.

During observations and interviews, multiple direct care staff were unable to properly identify the different lifts being used in the facility. Direct care staff and facility management were unable to find different sized slings for the lifts in the building and were unable to find manuals for mechanical lifts. Some staff stated that the lift being used for the client was supplied by hospice, while other staff stated the lift being used for the client was supplied by the facility. The direct care staff stated the sling was kept on the client at all times while in the wheelchair and sometimes while lying in bed.

Document review of mechanical lift education, revealed inconsistencies with the information that was given to staff about mechanical lifts and alleged perpetrator (AP2) had no documented lift education in his/her file.

During an interview, the medical doctor stated the client's care plan indicated a mechanical lift was to be used for all transfers. MD states that the hip fracture was a contributing component to the client's end of life.

During an interview, the nurse that supplied the mechanical lift training to AP1 and AP2 after the incident, stated that it was the first time s/he did the training at the facility.

During an interview, AP1 and AP2 both state that they knew that the client was supposed to be transferred with a mechanical lift, but the sling was not all the way underneath the client, so they decided it would be safer to transfer the client manually to the bed. Both AP1 and AP2 stated when the client was put into bed after the manual transfer they noticed swelling on the client's hip and called the nurse in for evaluation. AP1 and AP2 stated the training provided after the incident was beneficial for them as they learned things they had never learned before, such as they didn't know how to reposition the sling on the client and they were unaware the sling was supposed to be removed in between lift uses. AP1 and AP2 both stated they felt uncomfortable with the lift for the client because one of the wheels would lift up when the mechanical lift was being used for the client and stated they both had made facility management aware of the issues with the lift.

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 failed to ensure that direct care staff were adequately trained and they failed to ensure policies

and procedures were in place for mechanical lifts. The facility had inconsistent lift training between staff, and some staff lacked documentation of any training. The facility had multiple types of lifts in use and multiple staff were unable to find policies and different sized slings for the lifts in the facility.

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 Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders 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

(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:

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:

- ☒ Medical Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ Service Plan

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Zero

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

Specify: none identified

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

○ Yes ◉ No ○ N/A

Specify: client is deceased

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact reporter, 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: client is deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews:Five

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Twelve

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☒ Other: Specify Hospice RN

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Restorative Care
☒ Transfers
☒ Meals
☒ Facility Tour
☒ Injury
☒ 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: Multiple lifts in the facility

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Anoka County Medical Examiners

Coon Rapids Police Department

Anoka County Attorney

Coon Rapids City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20532	A. BUILDING: _____ B. WING _____	C 11/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NORTHWEST COON RAPIDS, MN 55433

(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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On August 15, 2017, a complaint investigation was initiated to investigate complaint #HL20532013. At the time of the survey, there were 43 clients that were receiving services under the comprehensive license. The following correction order is issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on document review, observation, and interview, the licensee failed to ensure the right of one of one client (C1) reviewed to be free from maltreatment. C1 was neglected when a mechanical lift was not used for a transfer and the client sustained a hip fracture during the manual transfer, was hospitalized with a hip fracture, and subsequently died as a result of the hip fracture. This practice resulted in a level four violation (a violation in which has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in a facility) and was issued at an isolated scope (when one or a limited number of clients are affected and/or one of a limited number of staff are involved or that a situation has occurred only occasionally). Findings include: C1's record was reviewed. C1 had a diagnosis of Alzheimer's disease and received comprehensive home care services including assistance with repositioning, transferring, bathing and eating, according to service plan dated August 1, 2015. On the service plan under, "transfer assistance", it states, "assist of two with a mechanical lift." During an interview on August 15, 2017 at 2:30 p.m., the licensed practical nurse (LPN)-B stated she was the nurse that responded to the call of	0 325		

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0 325	Continued From page 2 the deformity in C1's leg after the manual transfer by nursing assistant (NA)-G and NA-H. LPN-B stated that it was in C1's service plan that a mechanical lift be used for all transfers for C1. LPN-B stated NA-G and NA-H should have called nursing staff if they needed help with the mechanical lift before manually transferring her. LPN-B stated the client was on hospice, and the lift was supplied by hospice. LPN-B stated there are four to five hospice companies used in the facility and they all supply different equipment. During an interview on August 15, 2017 at 4:08 p.m., the director of nursing (DON)-A stated that in C1's care plan it was written that a mechanical lift needed to be used all the time. DON-A stated on the date of the incident NA-G and NA-H transferred the clients manually instead of using the lift, because they thought the sling was not safe. DON-A stated that C1's right leg looked crooked and C1 was sent to the hospital for evaluation. During observations on August 15, 2017 at 3:40 p.m., multiple direct care staff were unable to properly identify the different lifts being used in the facility. Direct care staff and the facility management were unable to find different sized slings for the lifts in the building, and were unable to find policies for mechanical lifts. Some staff stated that the lift being used for the client was supplied by hospice, while others stated the lift being used for the client was supplied by the facility. The direct care staff stated that the sling was kept on the client at all times while in the wheelchair and sometimes while lying in bed. During an interview on August 18, 2017 at 2:03 p.m., the medical doctor (MD)-E stated the client's care plan indicated a mechanical lift was	0 325		

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0 325	Continued From page 3 to be used for all transfers. MD-E stated that the hip fracture was a contributing component to the client's end of life. During an interview on August 17, 2017 at 10:46 a.m., the registered nurse (RN)-C that supplied the mechanical lift training to nursing assistant (NA)-G and NA-H after the incident, stated that it was the first time he did the training at the facility. RN-C stated the training consisted of how to attach the sling, how to transfer, how to transfer in a seated position, safety features, and when to stop. Orientation checklists signed by RN-C were given to both NA-G and NA-H after the incident indicating proper training of the lifts. No other staff in the facility had this training listed in their employee file. During an interview on August 15, 2017 at 12:52 p.m., NA-G stated that she was supposed to use a mechanical lift at all times with C1 according to C1's care plan. NA-G stated on the date of the incident the sling was not on C1 properly so she and NA-H transferred the client with their arms to the bed, because she thought it would be safer that way. NA-G stated that when they placed C1 in bed they noticed her leg was not straight, so they notified nursing staff. NA-G stated she didn't feel comfortable using the mechanical lift, because one of the wheels would lift up when someone was in it. NA-G stated that the mechanical life concerns were brought forth to former management staff, but that nothing was done about it. During an interview on August 17, 2017 at 4:00 p.m., NA-H stated that she knew that a mechanical lift was supposed to be used for transferring the client, but decided to manually transfer the client with NA-G because they	0 325		

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0 325	Continued From page 4 thought it was safer. NA-H stated she was not officially trained by anyone on the use of mechanical lifts and stated the training provided after the incident was beneficial for her as she learned things she had never learned before, such as she didn't know how to reposition the sling on the client and she was unaware the sling was supposed to be removed in between lift uses. NA-H stated she was not comfortable with the lift being used on C1 because the right leg lifted up off the floor when C1 was in it, she stated nursing staff and facility management were aware of the issues with the lift. Employee files were reviewed, employee education on lifts varied and for two of the four employees reviewed were missing completely. Nursing Assistant (NA)-G had a "Home Health Aide Skill Competency" check list that has an initial by the sit to stand lift (EZ Stand) and full body lift (Hoyer) stating she has demonstrated the proper techniques and understanding of the lifts. NA-H had no records of any mechanical lift training in her employee file until after the incident. Education records for NA-H were requested, and an unsigned and undated version of the Home Health Aide Skill Competency was provided. NA-I had a competency completion checklist, and a certificate of attendance for education relating to both the EZ Stand and Hoyer lift, however this was dated August 16, 2013. NA-H also had demonstration competency check list from "The Homestead of Maplewood" with outlined steps on how to use the EZ Stand but not the full body lift (Hoyer). Education records for NA-J were requested, and no records of any mechanical lift training was provided. On August 5, 2017 there were three lifts that were present in the building, and no patient's were	0 325		

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0 325	Continued From page 5 using mechanical lifts at the time of the onsite investigation. There was a medline model MDS400SA in a client room that was unoccupied, the facility refers to this as the "EZ Stand." There was a medline model MDS400EL in the hallway, the facility staff refer to this as a "hoyer." There was a Joerns Hoyer Advance 340 mechanical lift in a common area of the building plugged into an outlet, the DON-A stated it was a new lift and has been there for two days, and that staff were not trained yet on the new lift. No operating manuals were attached to the lifts listed above, and direct care staff were unable to provide operating manuals for the lifts on request. DON-A was able to provide manuals for the MSD400EL and the Joerns Hoyer, but not for the MDS400SA. According to a undated documented titled, "Mechanical Lift Checklist", supplied by the facility it stated in part, "The sling used for the mechanical lift is only to be the sling endorsed by the manufacturer. The community must have on hand the right size slings to meet the needs of the people they serve. Using the wrong size sling causes unnecessary risk. Mechanical lift management can be complex and have a higher likelihood of error when multiple brands of lifts are used. When replacing lifts attempt to have only one manufacturer brand to reduce the types of slings requires and reduce errors." Although requested the facility did not provide a lift procedure policy. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		