



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Faribault Senior Living
843 Faribault Road
Faribault, MN 55021
Rice County

Report #: HL27967002

Date: May 14, 2013

Date of Visit: December 5, 2012

Time of Visit: 10:35 a.m.-4:00 p.m.

By: Suzette Miller, 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 the agency did not follow state statutes/rules when staff routinely utilized an EZ stand lift to transfer a client although she was unable to follow instructions and keep her legs straight.

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:

A violation is substantiated related to the licensee failing to ensure staff were competent to use the EZ stand.

During a time prior to the onsite investigation, staff transferred a client with the use of the EZ stand. During this transfer, the client became unresponsive. Staff members hit the emergency stop button more than once and the lift just stopped. Staff did not know of any emergency lowering procedures for the EZ stand. Staff could not recall how the client was assisted out of the EZ stand. A family member witness interview indicated the client was lifted up out of the support straps by this family member and a staff person. Staff also indicated that, prior to the client suddenly becoming unresponsive; the client did not have any problems with bearing weight or holding the handles of the EZ stand. After a short while, the client was assisted to a seated position. The client was seen in the emergency department and diagnosed with a vasovagal response (a fainting or near fainting episode), with no identified specific cause for the vasovagal response. The client returned back to the facility that same day.

Facility documentation for staff competency regarding the use of the EZ stand showed the staff could locate the emergency stop button and the emergency lowering handle; however, there was no evidence that staff knew how to use these emergency features.

Although the allegation indicates that the EZ stand was used when the client was unable to follow instructions and keep her legs straight, prior to the vasovagal response, the client had been assessed by physical therapy as safe to transfer using the EZ stand. After the incident the resident was re-assessed by physical therapy and it was determined the use of the EZ stand would cease and it was determined the resident required a full mechanical lift for transfers.

Compliance:**State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met**

The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met

The requirements under State Statutes for Chapters 144 & 144A 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:

The Investigation included the following:

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

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input checked="" type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Treatment Sheets |
| <input type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input type="checkbox"/> Social Service Notes |
| <input checked="" type="checkbox"/> Nurses Notes | <input type="checkbox"/> Meal Intake Records |
| <input type="checkbox"/> Activities Reports | <input type="checkbox"/> Weight Records |
| <input checked="" type="checkbox"/> Therapy and/or Ancillary Services Records | <input checked="" type="checkbox"/> Assessments |
| <input type="checkbox"/> Skin Assessments | <input checked="" type="checkbox"/> Care Plan Records |

Other pertinent medical records:

- Hospital Records Ambulance/Paramedics Medical Examiner Records Death Certificate
- Police Report

Additional facility records:

- | | |
|---|--|
| <input type="checkbox"/> Resident/Family Council Minutes | <input checked="" type="checkbox"/> Personnel Records/Background Check, etc. |
| <input checked="" type="checkbox"/> Staff Time Sheets, Schedules, etc. | <input checked="" type="checkbox"/> Facility In-service Records |
| <input checked="" type="checkbox"/> Facility Internal Investigation Reports | <input checked="" type="checkbox"/> Facility Policies and Procedures |
| <input type="checkbox"/> Call Light Audits | <input checked="" type="checkbox"/> Other, specify: Service Plan |

Number of additional resident(s) reviewed: 0

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: transferred to a skilled facility

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: not available

Did you interview additional residents: Yes No

Total number of resident interviews: _____

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

Tennessee Warning given as required: Yes No

Total number of staff interviews: 4

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

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

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

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

Were contacts made with any of the following:

Emergency personnel Police Officers Medical Examiner Other: Specify _____

Observations were conducted related to:

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: No clients used the EZ stand at the time of the onsite investigation; a general observation of clients in the Memory Care unit occurred during this visit.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H27967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2013
NAME OF PROVIDER OR SUPPLIER FARIBAULT SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 843 FARIBAULT ROAD FARIBAULT, MN 55021	
(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	<p>Initial comments</p> <p>A complaint investigation was conducted to investigate complaint #HL27967002. The following licensing order is issued:</p> <p>When corrections are completed please sign and date, make a copy of the form for your records and return the original to the MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota 55164-0970.</p>	0 000	<p>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 Home Care Providers. 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. 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>
0 085	<p>144A.44 Subd.1(13) Served by people who are competent</p> <p>Subdivision 1. Statement of rights. A person who receives home care services has these rights:</p> <p>(13) the right to be served by people who are</p>	0 085	

Minnesota Department of Health

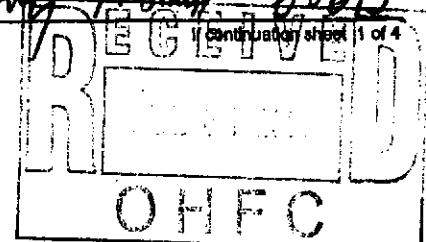
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] (X6) DATE 6/26/13

STATE FORM

5899

QKHY11



Minnesota Department of Health

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0 085	<p>Continued From page 1</p> <p>properly trained and competent to perform their duties;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff knew how to use the emergency stop and emergency lowering features of the EZ stand (a mechanical lift device in which the client bears some weight during the transfer) for 1 of 1 clients (C1) reviewed for EZ stand transfers.</p> <p>Findings include:</p> <p>A Physical Therapy Evaluation for C1 dated 07/05/2012 contained documentation that C1 is non-ambulatory, dependent on staff for transfers and used an EZ stand lift for transfers. C1 had dementia and rarely spoke. C1 had multiple joint contractures and received therapy services to allow C1 to place the heel of the foot down flat during transfers.</p> <p>Review of C1's Nurses Notes dated 08/30/2012 showed that staff transferred C1 via the EZ stand to the bathroom and C1's entire body suddenly went limp; C1's hands dropped off the handles, C1's knees went weak, C1 did not bear any weight and C1's head dropped. This entry showed that the sling of the lift was the only thing keeping C1 from falling. This entry indicated C1 was removed from the sling, 911 was called and C1 was transferred to the hospital emergency</p>	0 085		

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0 085	<p>Continued From page 2 room (ER).</p> <p>When interviewed on 12/05/2012 at 1:23 p.m., unlicensed personnel (ULP)-B stated both ULP-A and ULP-B hit the emergency stop button after C1 became unresponsive. ULP-B thought the EZ stand would lower after this; ULP-B indicated the EZ stand just stopped working. ULP-B indicated nothing else was done with the emergency stop button. ULP-B was not aware of any other emergency lowering features for the EZ stand. ULP-B recalled trying to lift the support straps off of C1 and could not recall exactly how C1 was removed from the EZ stand.</p> <p>When interviewed on 12/05/2012 at 12:28 p.m., ULP-A indicated there was no way to manually lower the client in an EZ stand device. ULP-A knew the EZ stand contained an emergency button and could not describe how to enable the EZ stand once the emergency button was pushed. ULP-A did not know how C1 was removed from the EZ stand.</p> <p>When interviewed on 03/08/2013 at 4:45 p.m., family member (F)-D indicated C1's face became discolored and they needed to get C1 down from the lift. C1 was lifted up out of the support straps by F-D and a staff person. C1's skin coloration to C1's face improved after this.</p> <p>Review of the facility's product information for the EZ stand, dated 08/26/2009, showed if the emergency stop button is engaged, the unit will not operate. Once the emergency stop button is engaged, it must be turned in the direction of the arrow on the top of the button to release it. This product information also included instructions for emergency lowering procedures that involved pulling up on the emergency lowering handle and</p>	0 085			

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0 085	<p>Continued From page 3</p> <p>continuing to hold it up in order to lower the client.</p> <p>Review of the facility's EZ Way Smart Stand Competency Checklists for 2011 and 2012 showed unlicensed personnel ULP-A and ULP-B could locate the emergency stop button and emergency lowering handle; this training did not include a ULP demonstration of the use of these emergency features.</p> <p>Time Period of Correction: Thirty (30) days.</p>	0 085		



Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up
PUBLIC DATA

Facility:

Faribault Senior Living
843 Faribault Road
Faribault, MN 55021
Rice County

Report #: HL27967002

Date: August 2, 2013

Date of Visit: July 30, 2013
Time of Visit: 10:30 a.m.

By: Elizabeth Swan, R.N.
Special Investigator

Nature of Visit

An unannounced visit was made in order to follow-up one state licensing order which were issued on May 29, 2013, as the result of an investigation which had been completed on May 14, 2013.

The status of the order is as follow:
1 144A.44 Subd.1(13) - Corrected

xc: Minnesota Department of Health – Licensing and Certification

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number H27967	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 7/30/2013
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Name of Facility FARIBAULT SENIOR LIVING	Street Address, City, State, Zip Code 843 FARIBAULT ROAD FARIBAULT, MN 55021
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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 <u>00085</u>	Correction Completed 07/30/2013	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>144A.44 Subd.1(13)</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By <u>KL/sd</u>	Date: <u>08/17/13</u>	Signature of Surveyor: <u>14811</u>	Date: <u>07/30/13</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>5/14/2013</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO