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Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

White Community Hospital
5211 Highway 100
Aurora, MN 55705
Saint Louis County

Report #: H5469007

Date: 06/24/2009

Date of Visit: 06/09/2009
Time of Visit: 8:30 a.m.

By: Kim Jacobson, R.N.
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of neglect in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minnesota Statutes §626.557 and state nursing home licensing rules, Chapter 4658.

The allegation is: Resident #1 was neglected. It is alleged that on 05/21/2009 a staff person, alleged perpetrator (AP), transferred resident #1 by herself with a Hoyer lift, not in accordance with the care plan. The resident slid down the sling and fell to the floor, which resulted in a suspected femur fracture. The resident was transported to the hospital where she expired on 05/23/2009. The resident's care plan indicated she was to be transferred with two staff and an EZ lift.

Investigative Findings:

All employees and persons were interviewed in private as desired and given the Tennessee Statement.

The investigation included the review of the following: Resident #1's medical records, including portions of the hospital record; staff schedules and assignments for 05/18/2009 through 05/31/2009 and 06/09/2009; policies and procedures related to the Vulnerable Adults Act, transferring residents, new employee orientation and staff training; incident and accident reports for April, May and June 2009 to present; manufacturer's specifications for the EZ lift (also known as a Hoyer lift); the EZ lift training video; the facility's EZ lift training; the facility's internal investigation; three personnel files and medical records for two additional residents who use the EZ lift; the care plan for all residents using EZ lifts and the facility's corrective action related to the incident. Seven additional residents were visited and observations of resident and staff interactions were completed with no concerns noted. On 06/09/2009, observations were conducted of two EZ lift transfers with no concerns noted. Interviews with staff, family and residents were conducted during the course of the investigation.

Medical Records review and interviews revealed the following:

Medical Record:

- Resident #1 was admitted to the facility in September 2007, with diagnoses including severe osteoporosis with a history of fractures, cerebral vascular accident (CVA) with left sided hemiparesis and dementia. Resident #1 was alert and oriented and she was able to verbalize her needs.
- Resident #1's care plan indicated she required the assistance of one to two staff for all activities of daily living (ADLs). Resident #1 did not ambulate and she required the assistance of two staff for transfers using an EZ lift (Hoyer lift).
- Nursing notes dated 05/21/2009 indicate that during a transfer, resident #1 fell out of the EZ lift onto the floor. Resident #1 complained of shoulder hip and thigh pain. Resident #1 was transported to the emergency room. Resident #1's physician and family were notified of the fall.

Hospital Records:

On 05/21/2009 resident #1 was admitted to the hospital with diagnoses of a left humerus fracture and a left femur fracture. Shortly after her admission she developed breathing difficulty. It was determined that she was not a surgical candidate because of her multiple medical conditions and she was transferred to hospice care. Resident #1 died on 05/23/2009.

Medical Examiner Record:

The record of death notes cause of death to be complications following a fall from a Hoyer lift during a transfer. Other contributing conditions were osteoporosis, congestive heart failure, chronic obstructive pulmonary disease, and dementia. Manner of death was accident.

Internal Investigation:

The facility's internal investigation concluded that the AP did not follow the care plan when transferring resident #1 by herself using the EZ lift. Resident #1's care plan noted that resident #1 was to be transferred with the assistance of two staff when using the EZ lift. The internal investigation also identified that the following problems contributed to the incident: The wording of the care plan was confusing and there was a limited training program for use of the EZ lift for new hires.

Interviews:

The alleged perpetrator/AP was interviewed on 06/09/2009 at 11:16 a.m. and stated the following:

- Resident #1 was alert and oriented and she could verbalize her needs.
- She has worked approximately sixteen hours a week at the facility since July 2008.
- On 05/21/2009 she worked the day shift. At approximately 1:00 p.m. she was transferring resident #1 by herself, from her bed to her wheelchair using the EZ lift. She placed the EZ lift sling underneath resident #1 with the wings of the sling criss-crossed under her thighs. She lifted resident #1 approximately four feet in the air and turned to grab the wheelchair to move it into position. She stated she only turned away for about 10 seconds. When she turned back she saw resident #1's whole body slipping forward out of the sling, feet first. She tried to hold resident #1 up, but she was too heavy to hold. Resident #1 fell to the floor and landed on her buttocks. She laid resident #1 down on her back and put a pillow under her head. She went to get help.
- She stated she thought the care plan noted resident #1 was to have one to two staff persons when transferring using the EZ lift. She has always transferred resident #1 with the EZ lift by herself and she has always crossed the wings of the EZ lift sling under her thighs. She stated she does not know how resident #1 slipped out of the EZ lift sling.

- When she was hired, the EZ lift training she received consisted of observing other NAs utilizing the EZ lift. She does not remember who trained her and she did not complete an orientation skills check list.
- After the incident she was re-orientated and filled out an orientation skills check list, which documented the skill competencies she completed. She was also re-trained on using the EZ lift safely. She has not returned to work since the incident.

Employee (F)/administrative nurse was interviewed on 06/09/2009 at 8:30 a.m. and stated the following:

- Resident #1's care plan noted she was to be transferred with the assistance of two staff using the EZ lift.
- The facility policy notes there is to be two staff present when using the EZ lift.
- Resident #1 had a very rigid body and the EZ lift manufacturers instructions state that crossing the sling wings under the resident's thighs is appropriate for resident with a rigid body.
- She conducted the investigation of the resident #1's fall and believes the AP used the EZ lift sling appropriately. However, she found that the AP did not follow the care plan and transferred resident #1 alone while using the EZ lift. She believes resident #1 was tipped slightly while being transferred and without the second staff member there to assist, resident #1 slid out of the sling.
- She stated the AP thought resident #1's care plan indicated she required the assistance of one to two staff persons for transferring with the EZ lift. She reviewed resident #1's care plan and found that the care plan could have been confusing to the AP, by the way it was written.
- In April 2009, the facility developed a new employee orientation program which covers the equipment more efficiently and implements a NA skills check list the preceptor must sign.
- They are looking at a new format for the care plan that is easier to read.
- During the course of the investigation, she discovered there was no documentation of the AP's training in the use of the EZ lift. She is unsure of the AP's orientation and it is possible the AP was told it that she could transfer resident #1 using the EZ lift with one staff person.
- After the incident they did an immediate re-education with the AP and of the staff working that day. All staff are being re-educated on the safe use of the EZ lift and the facility's policy regarding the EZ lift. All but three NAs have been re-trained on the safe use of the EZ lift.
- There are four residents at the facility who required the assistance of the EZ lift and their care plans have been reviewed and updated to clearly state that two staff are required when transferring a resident using a EZ lift.

Employee (B)/nurse was interviewed on 06/09/2009 at 1:16 p.m. and stated the following:

- On 05/21/2009, at approximately 1:30 p.m., she observed resident #1 lying on her back, on the floor with a pillow under her head. One of her legs was tucked under the other leg. She remembers seeing the EZ lift sling under the upper part of resident #1's body, but she does not remember seeing the bottom part of the EZ lift sling. Resident #1 complained of pain in her hip and shoulder. Resident #1 was transferred to the emergency room.
- She stated the AP told her resident #1 slipped out of the EZ lift sling when she was transferring her from the bed to the wheelchair.
- She stated the facility's policy is to use two staff when using the EZ lift. She stated she has always used two staff when transferring a resident with the EZ lift. After the incident she went through the mandatory re-training for the EZ lift.

Employee (C)/NA was interviewed on 06/11/2009 at 10:00 a.m. and stated the following:

- She had worked at the facility for many years and she was trained to always use two staff when transferring using the EZ lift. She stated the EZ lift is "awkward" to use and you need two people in order to use the equipment properly.
- She stated resident #1's care plan noted she required two staff when transferring with the EZ lift.

Employee (D)/NA was interviewed on 06/09/2009 at 12:00 p.m. and stated the following:

- She was trained to always use two staff when transferring a resident with the EZ lift.
- Resident #1's care plan noted she was to be transferred with the assistance of two staff using the EZ lift. She stated she has never seen anyone use the EZ lift without the assistance of two staff.
- New NA's are oriented using a check list of competencies. She stated the AP is a casual employee and she has never worked with her, so she does not know how she was trained.

Employee (E)/NA was interviewed on 06/09/2009 at 12:44 p.m. and stated the following:

- Resident #1's care plan noted she was to be transferred with the assistance of two staff using the EZ lift.
- She has worked with the AP and the AP is a very good NA. The AP is kind and caring to the residents.

Employee (G)/NA was interviewed on 06/16/2009 at 11:02 a.m. and stated the following:

- She has worked at the facility for approximately one year as a casual NA.
- It is the facility policy to use two staff when transferring a resident using the EZ lift.
- She received "a lot" of training when she started at the facility. She can't remember who trained her, or the specifics of the training, but she remembers having to fill out a training check list documenting her competencies. She believes she received adequate training on the EZ lift.
- She stated the AP was hired after her and she does not think the AP received as much training as she did. She doesn't know why the AP received less training, she just thinks she got less training.

Personnel Files: The AP's personnel file was reviewed and there was no documentation related to initial training regarding the EZ lift. Her file did contain a "Certified Nursing Assistant Clinical Skills Validation" form, dated 05/28/2009, that included training on the use of the EZ lift.

Policies/Procedures:

- "Limited Lift Policy" dated 02/02/2003, notes that the EZ lift is to be used with a minimum of two caregivers.

Manufacturer's Specification:

EZ lift training video was viewed on 06/09/2009 at 2:12 p.m. and the operating instructions were reviewed and revealed the following:

- The lift was designed to be operated safely by one person. However, with some residents it is best to use two people.
- If the resident's legs are extremely rigid, it may work better to bring the left wing under the right thigh and the right wing under the left thigh instead of going between the resident's legs.

Interventions the facility implemented immediately after the fall include the following:

- The AP was immediately removed from the floor and the work schedule. The facility immediately re-trained the AP, and all the staff working at the time of the fall and the two shifts after the fall, on the safe use of the EZ lift.
- All staff is required to be re-trained on the safe use of the EZ lift before they can use the lift. As of 06/09/2009, all but three NAs have been trained on the safe use of the EZ lift. Memos were sent to the three NAs noting that, prior to their next shift, they must see their supervisor to be re-trained on the safe use of the EZ lift.
- Nurses will audit and document the safe use of the EZ lift, daily for two weeks, weekly for three weeks and randomly for two months.
- Staff will be educated on the safe use of the EZ lift at staff meetings and during each shift report, for the next 30 days.
- Care plans for residents using the EZ lifts have been revised to clearly state that two staff are to be present when using the EZ lift. Staff have been re-educated on how to read the care plan.
- An addendum to EZ lift instructions reflects that there is to be two staff members present when using the EZ lift. The EZ lift instructions and the lift policy have been attached to each EZ lift.
- In April 2009, the facility developed a new employee orientation program which covers the equipment more efficiently and implements a NA competency check list the preceptor and the new employee must sign. The check list is then reviewed by the Director of Nursing.
- Additional, the facility plans to implement, by the end of 2009, an annual skills and competency day for staff, which will include the safe use of the EZ lift.

Conclusion:

As defined by federal regulatory requirements at 42 CFR 483.13(b), and the current statutory definition specified within Minnesota Statutes §626.5572, the preponderance of evidence indicates that **neglect did occur** in connection with the allegation that resident #1's fall was a result of the AP not using the EZ lift with the assistance of two staff persons as noted in resident #1's care plan, and per the usual facility practice. There was no evidence to indicate that the facility had provided adequate training to the AP on the proper use of the EZ lift.

The "mitigating factors" in Minnesota Statutes, §626.557, subdivision 9c (c) were considered and it was determined that the facility is responsible for the neglect because the facility failed to train the AP on the use of the EZ lift. The facility will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

Prior to this visit, the facility implemented corrective measures; therefore no federal deficiencies or state licensing orders will be issued.

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Saint Louis County Medical Examiners
St. Louis County Sheriff
St. Louis County Attorney

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

PRINTED: 06/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245469	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2009
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NAME OF PROVIDER OR SUPPLIER WHITE COMMUNITY HOSPITAL C&NC	STREET ADDRESS, CITY, STATE, ZIP CODE 5211 HIGHWAY 110 AURORA, MN 55705
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey was conducted to investigate complaint H5469007. No deficiencies are issued.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.