



SF/JR

*Protecting, Maintaining and Improving the Health of Minnesotans*

Office of Health Facility Complaints Investigative Report  
PUBLIC

**Facility:**

St Therese Home  
8000 Bass Lake Road  
New Hope, MN 55428  
Hennepin County

Report: H5518050

Date: 08/11/2009

Date of Visit: 6/23/2009

Time of Visit: 1:00 PM

By: Deb Neuberger, 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: On June 20, 2009, neglect occurred when resident #1 fell out of a mechanical lift while being transferred by two staff members, AP #1 and AP #2. The resident was transported to an area hospital and later died.

**Investigative Findings:**

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

Investigative activities included medical record reviews of resident #1 and the 2 other residents who utilize EZ lifts, observations of transfers with EZ lifts, interviews with staff, residents and families, training record review, staffing review of the date resident #1 fell until the on-site investigation, internal investigation review, policy and procedure review of VAA and policies related to transferring residents with a lift, incident report review for April and May, 2009, 24 hour log review, photographs and testing of the lift and sling in question, and personnel file review including training review of the 2 employees who transferred resident #1.

**Medical Record:** Resident #1's medical record was reviewed and revealed the following information:

- Resident #1 was admitted to the facility on 12/19/2006.
- Resident #1's diagnoses included Traumatic Brain Injury, seizure disorder and quadriplegia.
- Resident #1 Minimum Data Set (MDS) assessment dated 3/31/2009 indicated:
  - He was totally dependent on two staff for transfers.
  - He was able to recall staff names and faces.
  - He had moderately impaired cognitive skills for daily decision making.

- He did not resist care or exhibit other behavioral symptoms; and
- He had partial loss of range of motion to one hand and both arms and legs.
- Resident #1's care plan most recently dated 5/25/2009 indicated he required two + person physical assist for transfers, used the Hoyer lift for all transfers, and staff were to explain the procedure to the resident before transferring.
- The falls risk assessment dated 3/30/2009 indicated resident #1 had experienced no falls in the last year.
- On 6/20/2009 he was being transferred at approximately 1:00 PM from his wheelchair into his bed by 2 nursing assistants with an EZ lift.
- According to the nursing notes written by employee (F) LPN and dated 6/20/2009 at 2:30 PM, she "...was called into resident's (#1) room by NAR (nursing assistant). A loud thud was heard prior. Writer was summoned to room and on entering resident (#1) was noted on the floor. Two NAR's were in the process of transferring resident from wheelchair to bed. Hoyer lift was still in up position, the hooks on the left were tilted and few straps have come undone. Resident was laying on his back head towards bed and feet facing doorway and draped over base of lift."
- According to the physician telephone order dated 6/20/2009 and written by employee (F), resident #1 was sent to the hospital on 6/20/2009 for evaluation "post fall with injury on upper back and hitting head."

Cause of death on the death certificate was listed as "blunt force craniocerebral injuries due to fall."

Although the allegation indicated a Hoyer lift was involved in the fall, the lift actually involved in the fall was an "EZ lift." The EZ lift is similar to a Hoyer lift in that it is a mechanical lift that utilizes a sling with loops to attach to the hooks on the lift in order to lift a resident from a bed, floor, wheelchair or toilet. The sling is placed under a resident from shoulders to under the knees and then the loops are attached to the hooks on mechanical lift. The resident is then lifted slowly utilizing the mechanical lift. Hoyer is a generic term used for these types of lifts in many healthcare facilities.

**Internal Investigation:** The internal investigation review revealed the following:

- Employee (B) indicated she was conducting the ongoing internal investigation.
- Employee (B) indicated that staff members gave varied descriptions of the events.
- AP#2 indicated she did not remember what happened. AP#2 indicated in her written statement, dated 6/20/2009, resident #1 slipped from the lift to the floor.
- AP#1 indicated she had her back to the resident and did not see what happened. AP#1 indicated in her written statement dated 6/20/2009 that she was moving the wheelchair and heard a thud. She stated she turned and saw resident #1's trunk and head on the floor and the bottom half of his body hanging in the sling. She saw 2 straps on both sides of the sling off. Straps for the leg/hip area were still hooked to the bottom hooks. She did not remember who hooked up which straps.
- Employee (F) was the first to enter the room after the fall. She indicated that when she entered the room she saw resident #1's head was on the floor, and his feet were draped over the base of the lift. The sling on the right side of the lift was still attached to the lift and the left side was not attached. She indicated in her written statement that she questioned if the sling was attached wrong when she entered the room. When she assessed resident #1 he did not respond as usual.
- Employee (G) indicated in her statement dated 6/20/2009 that when she entered the room right after Employee (F), she noted resident #1 was on the floor with his head and trunk of his body on the floor and his feet/legs were in the sling dangling from the lift.

- According to employee (B) the lift and sling were found to be in normal working order.

**Interviews:**

Employee (F) was interviewed on 6/24/2009 at 11:45 AM and revealed the following:

- She was near resident #1's room on 6/20/2009 and heard a loud thud like someone fell.
- A nursing assistant came out to get her.
- When she got into resident #1's room the straps on the lift were still attached to the lift on resident #1's right side, but off the left side of the lift.
- Resident #1's head was on the floor and feet were draped over the base of the lift.
- He was facing AP #2, the person operating the lift.
- His eyes were fixed and unresponsive when she checked him. This was not a normal baseline for resident #1.
- His left arm had some range of motion prior to the fall and it was flaccid when she lifted it after the fall.
- The lift was not tilted when she entered.
- They used the same lift and sling to get resident #1 into bed after the fall, and it functioned properly.
- She called the physician and family and transferred him to the hospital.
- She has experience transferring residents with a mechanical lift and had full training from the facility.
- When using a mechanical lift, both staff members are responsible for checking that the sling loops are securely in the hooks before fully lifting the resident.
- Staff members should hook it up, lift it a little to be sure it is secure, then lift the rest of the way.
- She and AP #2 used that same lift in the morning to transfer resident #1 with no problems.
- She has never experienced problems using a lift.
- Resident #1 did not move around during transfers.

Employee (G) was interviewed on 6/24/2009 at 12:05 PM and stated the following:

- She was sitting near the nursing station on 6/20/2009 and the TMA (Trained Medication Assistant) nearby said she heard something.
- When she entered resident #1's room the privacy curtain was drawn.
- When she pushed the curtain back she saw resident #1 on his back on the floor.
- His feet were in the sling.
- The base of the lift was expanded.
- On her right side (the non battery side of the lift) the sling was still attached to the lift.
- On her left side (the battery side of the lift) the sling was not attached to the lift.
- Resident #1 was on his back, with his head on the floor, his legs were still both up in the sling on the non battery side of the lift.
- She could not tell if the sling was crossed over at the legs, as was normal practice.
- All staff members who use a lift for transferring residents should be checking that the loops of the sling are securely in the hooks before and during a transfer of a resident and that is how staff members are trained.
- She had used that lift before with no problems.
- Training on the lifts takes place during orientation for nursing staff.

Employee (C) was interviewed on 6/23/2009 at 3:00 PM and stated the following:

- She received a page to call resident #1's unit at approximately 1:00 PM on 6/20/2009.
- She arrived at resident #1's room at about 1:05 PM.
- She was not able to immediately open the door, as they said they were moving the lift.
- When she entered the room resident #1 was on the floor with his feet facing the door.
- Staff indicated resident #1 fell out of the lift.
- The sling was no longer hooked to the lift.
- The staff members used the same lift to get him back to bed after the fall without incident.
- While in resident #1's room AP#2 told her that she said "wait, wait" when AP#1 was moving the wheelchair before the incident.
- She looked at the lift and noted nothing wrong with it.
- She could not get a clear picture of what happened from AP #1 and AP #2.
- The staff members have training on lifts during nursing assistant orientation and whenever new equipment arrives.

On 6/23/2009 at 2:50 PM AP#1 was interviewed and stated the following:

- On 6/20/2009 AP#2 asked for help with resident #1.
- She went into the room and both staff members hooked up the EZ lift.
- She indicated she hooked the sling to the lift according to the procedure.
- Both staff participated in hooking up the sling, and she believes she hooked up the left side of the sling.
- She checked to be sure all of the straps were all the way down in the hooks and stable before removing the wheel chair.
- AP #2 went to the controls of the lift.
- When they raised the lift, she moved the wheelchair to the bathroom.
- She had her back to resident #1 when resident #1 fell and she did not see resident #1 fall.
- When she turned around the two shoulder straps were no longer connected and resident #1 was on the floor.
- AP #1 said "What happened?" and AP#2 said "I don't know."
- She had no idea how the fall happened.
- She stated there was nothing wrong with the sling or lift.
- She stated there was nothing wrong with the wheelchair.
- She stated they were not short of staff.
- Resident #1 was not moving during the transfer.
- AP #1 had used this lift before and had never seen a sling become unhooked before.
- She denied AP #2 stated "wait, wait" before the incident occurred.
- She indicated both staff members involved in using a lift are responsible for watching and monitoring the resident to be sure the straps are securely in the hooks while raising up the lift.

On 6/23/2009 at 3:30 PM AP#2 was interviewed and stated the following:

- She was planning to get resident #1 to bed before feeding the other residents lunch.
- She got the lift, opened the base and she and AP #1 hooked resident #1 up to the lift together.
- She had used this lift before with no problems.
- She does not remember the lift/sling having anything wrong with it.
- She and AP#1 hooked up the straps to the lift together.
- She checked the straps to be sure they were secure as she was lifting resident #1.

- She was facing resident #1 who was in the sling and the sling was hooked to the lift.
- She was operating the lift when resident #1 fell.
- She does not remember what happened.
- She does not remember what he hit.
- She and AP#1 both yelled "he's coming down" together when resident #1 fell.
- He was not anxious or moving around before the lift was performed.
- As soon as the wheelchair was moved she did not know what happened but he was on the floor.
- She denied that she said "wait, wait" just before resident #1 fell.
- After the fall the straps on resident #1's right side were off and the straps on his left side were still hooked to the lift and his left leg was still in the sling.
- They were not short staffed.
- Both staff members involved in lifting a resident are responsible for watching the resident and loops in the hooks to be sure they are secure before and during the lifting of a resident.

Employees (K), (H), (P) and (N) were interviewed on 6/24/2009 between 12:00 PM and 3:00 PM during observations and indicated the following:

- They had used the EZ lift involved in resident #1's fall before and had never had a problem with the lift.
- Both staff members involved in transferring a resident are responsible to be watching and checking the loops of the sling to be sure they are securely attached to the hooks of the lift during a transfer.

Employee (L) and (J) were interviewed on 6/24/2009 at 1:00 PM during observations and indicated the following:

- They each received training on the lift at orientation.
- Both staff members involved in transferring a resident are responsible to be watching and checking the loops of the sling to be sure they are securely attached to the hooks of the lift during a transfer.

Employee (R), (S) and (Q) were interviewed on 6/23/2009 between 4:15 PM and 4:30 PM during observations and indicated the following:

- They each received training on the lift at orientation.

Employee (M) was interviewed on 6/24/2009 at 2:05 PM and indicated the following:

- Staff members on the units get yearly evaluations.
- The facility performs observations of NA staff doing their work in order to fill out the evaluations.
- Both staff members involved in transferring a resident are responsible to be watching and checking the loops of the sling to be sure they are securely attached to the hooks of the lift during a transfer.
- Resident #1 had not experienced other incidents like this during his stay at the facility.

Employee (O) was interviewed on 6/24/2009 at 12:30 PM and indicated the following:

- She provides training to staff members on how to transfer residents with lifts during orientation.
- She uses videos and demonstration/participation to train the staff.
- When transferring with a lift, the staff members are taught to check that the loops of the sling are securely in the hooks of the lift before and during the transfer of a resident.

- The lift elevates very slowly, and during that time staff members should be observing the lift and resident safety.
- When NAs are taught no one is taught to take responsibility for any certain side of the resident to secure the loops of the sling to the hooks of the lift.
- The staff members are taught to keep monitoring the resident all the time.
- They should be monitoring the feet position and body position of the resident as they lift.

Resident #2 was interviewed on 6/23/2009 at 4:30 PM and indicated the following:

- She uses an EZ lift for transfers and has for a long time.
- The staff members transferring her have always known how to transfer her.
- The staff members transferring her have always transferred her safely.
- The staff members transferring her have always used two people.
- She does not have to tell them what to do, they know the procedures.
- She always feels safe during transfers.

The lift was tested on 6/24/2009 at 12:50 PM with a volunteer staff member being transferred from a wheelchair to bed.

- The EZ lift and sling used was the same lift used when resident #1 fell.
- The transfer was accomplished without any problems.
- The lift functioned as usual.
- The sling was in working order with no frayed or worn areas noted.
- The lift raised very slowly.
- The staff members involved in transferring the volunteer employee were able to visualize the volunteer, the lift and the sling during the transfer without difficulty.
- The lift's maintenance log indicated it had last been checked on 10/1/2008 and passed a mechanical inspection and operational checklist.

***Personnel Files:***

The personnel file for AP#1 was reviewed and provided the following information:

- She was hired 10/9/2006.
- Her most recent performance evaluation was on 11/21/2008 with no problems noted and a meets or exceeds requirements rating.
- She was counseled on 11/27/2007 for leaving a resident bed elevated after transferring the resident to bed and the resident fell from the bed.
- The required background check was completed by the facility dated 10/2/2006 and indicated that AP#1 may provide direct contact services.
- She signed a document that verified that she received training on mechanical lifts on 10/10/2006.

The personnel file for Employee E/NA (AP#2) was reviewed and revealed the following:

- She was hired 3/11/2002.
- Her most recent performance evaluation was dated 3/11/2009 with no problems noted and a meets or exceeds requirements rating.
- The required background check was completed by the facility dated 4/3/2002 and indicated that AP#2 may provide direct contact services.
- She signed a document that verified that she received training on mechanical lifts on 3/12/2002.

***Policies/Procedures:*** Policies provided by the facility were reviewed and provided the following information:

On the EZ lift operating instructions for use, attachment A (undated), the following is stated:

Lifting the patient:

- 1) Push "UP" button on hand control. Lift the patient until there is tension on the wings of the sling, making sure all the loops on the sling are securely hooked on the sling hanger. Then smooth the sling wings under the patient's thighs with a slight pull on the outside seam of wings.
- 2) Lift the patient to the desired height (usually 3-4 inches above the chair.)

**Conclusion:**

As defined by federal regulatory requirements at 42 CFR 483.13(c), and the current statutory definitions specified within Minnesota Statutes, §626.5572, the preponderance of evidence indicates that **neglect did occur** when during a transfer on June 20, 2009, resident #1 fell out of a mechanical lift while being transferred by two staff members. The resident was transported to an area hospital and later died from injuries sustained in the fall.

Evidence exists that:

- Resident #1 did not have a history of moving during transfers.
- According to the policy and procedure provided, staff are to watch and monitor the loops to be sure they are secure during transfer.
- The mechanical lift and sling were not malfunctioning and had been used before and after the fall.
- Both AP's verified they were trained on the use of mechanical lifts and were required to monitor residents for safety during the lifting procedure.
- AP#1 turned her back to resident #1 during the transfer.
- Although AP#2 was operating the lift and facing resident #1 she does not remember what happened.
- If AP#1 and AP#2 had been following the procedure and monitoring resident #1 as the lift was raised, and checking the loops and hooks to be sure they were secure before removing the wheelchair, they would have been able to describe what occurred.
- The statements made by the AP's are incongruous with what happened in resident #1's room and the policies they indicated they were following.

During the course of the investigation staff verified they were given appropriate training on the lifts used in the facility and had never had a problem using the lift in question or any other lift in the facility. Also during the course of the investigation transfers were observed and residents interviewed. No problems with transfers, with the lift involved nor any other EZ lifts were noted. The facility immediately suspended the use of the lift until the investigation could be completed. Therefore the facility was found in compliance with Federal and state regulations at the time of the investigation. No deficiencies will be issued.

The "mitigating factors" in Minnesota Statutes, §626.557, subdivision 9c (c) were considered and it was determined that the perpetrators, AP#1 and AP#2, are responsible for neglect. AP#1 and AP#2 will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

According to Minnesota Statutes, section 245C, a nursing assistant who has been found responsible for serious maltreatment of a vulnerable adult will be disqualified from providing direct care services in any facility licensed by the Minnesota Department of Health. This individual may appeal the disqualification through a reconsideration process which includes a fair hearing. At the completion of the appeal process if the maltreatment and disqualification decisions are upheld, the nursing assistant will be disqualified from providing direct care services for up to 7 years and a maltreatment finding will be entered onto the Nurse Aide Registry.

xc: Division of Compliance Monitoring - Licensing & Certification  
Hennepin County Medical Examiners  
New Hope City Police Department  
Hennepin County Attorney  
New Hope City Attorney

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245518</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/20/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST THERESE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8000 BASS LAKE ROAD</b> <b>NEW HOPE, MN 55428</b>
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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><b>INITIAL COMMENTS</b></p> <p>An abbreviated standard survey was conducted to investigate complaints H5518050 and H5518051. No deficiencies are issued.</p>	F 000		
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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.