STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 Sarazin Street Shakopee, MN 55379

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to report an injury of unknown origin to the State Agency (SA) immediately, but not later than two hours after the allegation is made for 1 of 3 residents assessed. Staff assisted R1 with a transfer using a sit-to-stand lift (a device that assists people with limited mobility to move from a seated position to a standing position) for toileting. R1's legs became weak, she needed to be sat down, and was lowered to the toilet. Approximately six hours later R1 woke-up in extreme pain, was sent to the emergency department (ED) and an x-ray revealed a fractured clavicle (one of the bones at the base of the neck, collar bone). Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMs) score was a 15 indicating R1 was cognitively intact. R1 was dependent on staff for all transferring. R1's pertinent diagnoses were congestive heart failure, end stage renal disease, malnutrition, respiratory failure, and morbid obesity. R1's facility observation detail list report dated 11/6/24 at 12:45 a.m. indicated R1 had voluntarily transferred from the facility to the emergency department. The document indicated R1's transfer was necessary for R1's welfare and needs could not be met at the facility. R1 was transferred immediately for urgent medical needs. The document did not indicate R1's allegations of sliding in the mechanical lift, R1's pain level or location of pain. The document was unsigned. R1's nursing progress note dated 11/6/24 at 1:16 a.m. indicated R1 reported pain in her left shoulder. She reported her legs gave out early and she slide off the EZ sit-to-stand device and was seated on the toilet. Staff then used the ceiling lift to transfer R1 back from the toilet to the bed. R1's on-call provider was called, and an order was given for oxycodone (a narcotic medication for pain) and an x-ray of the shoulder/upper arm. No prior nursing notes were documented regarding any incident of R1 sliding in the in the lift or the use of a ceiling lift. R1's ED after visit summary dated 11/6/24 at 2:40 a.m. indicated R1 was seen for an arm injury and diagnosed with a displaced fracture of acromial end of left clavicle. R1 was given an arm sling to use and referred to Orthopedics. She was discharge back to the facility. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 11/13/24 at 12:01 p.m. registered nurse (RN)-C stated she was on-call and received a call at approximately 2:00 a.m. from RN-B, the night nurse reporting R1 had been transferred to the emergency department due to excruciating pain. RN-B told her R1 had slid in the sit-to-stand lift earlier in the evening because her knees buckled. She stated RN-A the evening nurse told her R1 was having pain, weakness, and nausea all evening, and refused her p.m. mediations. RN-C stated she assumed something happened with the sling during the transfer, however, was not certain of a root cause. Upon observation and interview on 11/13/24 at 12:18 p.m. R1 was in the upright position in her bed, attempting to eat lunch. She had a sling on her left arm. She took many breaks while speaking due to pain. She stated on 11/5/24 in the early evening she was taken to the bathroom by NA-A and NA-B using the sit-to-stand lift. She stated when she got to the bathroom, she started screaming that her legs were weak, she was going to fall, they needed to sit her down. She stated she felt like she slipped in the lift. When she was seated on the toilet NA-A left to get the nurse because R1 requested the use of the ceiling lift to get her back to bed due to weakness, nausea, and fear of falling. R1 was transferred back to bed without difficulty. About an hour later around 7:30 p.m. RN-A came into give R1 her bedtime medications and R1 refused due to nausea. R1 could not recall her pain level at that time. She stated in the middle of the night, uncertain of time she woke-up in severe pain and called for a nurse stating she needed to go the hospital. R1 stated she did not recall bumping her arm in either of the transfers earlier in the evening nor did she recall any incidents in bed such as rolling over on her arm. Upon interview on 11/13/24 at 1:29 p.m. registered nurse (RN)-A stated on the evening on 11/5/24 (NA)-A asked RN-A if the staff could use the ceiling lift on R1 instead of the sit-to-stand because R1 was weak and not feeling well. RN-A stated she assessed R1 and allowed the use of the ceiling lift due to R1's fear of falling. A bit later checked on R1 and R1 denied any pain and refused her p.m. medications due to nausea. She stated she was still at work after 1:00 a.m. and was told by RN-B, the night nurse that R1 was having severe shoulder pain and wanted to go to the hospital. RN-A told RN-B that during the evening shift R1 was weak and requested the ceiling lift, however her vital signs were stable, and she was not complaining of any pain. Upon interview on 11/13/24 at 1:48 p.m. NA-B stated she was assisting NA-A on the evening of 11/5/24 at around 6 p.m. R1 was transferred to the toilet. She stated R1 looked weak, so the aides set her on the toilet. NA-B did not recall if R1 said anything during the transfer. She stated R1 was holding the sit-to-stand appropriately on the bar the entire time of the transfer and did not slide or bump her body during the transfer. She stated when R1 was seated on the toilet she told NA-A and NA-B she was too weak and nauseated to use the stand again and requested the ceiling lift be used. NA-B stayed with R1 until NA-A got permission from RN-B to use the ceiling lift. Another unidentified NA came to assist when the ceiling lift was used and R1 was safely transferred back to her bed. Upon interview on 11/13/24 at 2:27 p.m. RN-B stated she was the night nurse on 11/06/24 and around 1:30 a.m. R1 called her to her room crying saying she needed to go to the hospital because she was in excruciating pain. RN-B stated she attempted to assess R1 and all R1 could say was the pain was in her left shoulder and earlier that evening she slipped in the lift. RN-B called the on-call provider and sent R1 to the emergency department. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 11/13/24 at 2:48 p.m. the assistant director nursing (ADON) stated she was aware of R1's incident. She heard during a transfer with the sit-to-stand lift R1's knee's buckled and she slid to the toilet. She stated the facility did not fill out a fall report upon interviews with the NA's R1 did not slide. She stated she assumed R1 had her arms up when she was being lowered and that jolted her arms and that is when the fracture occurred. She then stated the lift goes very slowly so there should not be any sort of force when the residents are seated. Upon interview on 11/13/24 at 3:09 p.m. NA-A stated on the evening of 11/5/24 at around 6:30 p.m. Her and NA-B transferred R1 from her bed to the bathroom using the sit-to-stand lift. She stated when they got to the bathroom R1 started screaming that her legs were giving out on her, and she needed to sit. The NA's lowered R1 to the toilet. R1 was breathing heavily, sat on the toilet a few minutes and told the NA's that she did not feel well and that she wanted to use the ceiling lift to go back to bed. NA-A left to get the nurse. When she came back R1 appeared to be fine, just continuing to refuse the sit-to-stand lift. NA-A stated with the assistance of another aid they transferred R1 back to bed without difficulty. She stated the rest of the shift R1 was on her telephone and then went to sleep. She stated R1 did not complain of pain the rest of the p.m. shift. Upon interview on 11/13/24 at 4:08 p.m. the facility's Medical Director stated due to R1's end stage renal disease she had severe osteoporosis leaving her vulnerable to fractures with even a slight movement of the arm. He stated she could have hit her arm on the sit-to-stand lift. Just lifting her arm over her head or a side-to-side motion could have enough pressure to cause a fracture in someone of her stature. In addition, due to her weight an attempt to move her body in bed or roll could have caused the fracture. He stated the cause of the injury was unknown. Upon interview on 11/13/24 at 4:15 p.m. the Administrator stated that to her knowledge R1 fractured her clavicle when she was lowered to the seat of the toilet because it took the aids about 15-30 seconds, and R1 could have had her arms up and caused the fracture. She stated upon her interviews with staff R1 was having minimal pain when the transfer began and was when she was lowered to the toilet with a complete proper transfer. R1 needed to catch her breath and was requesting the ceiling lift. R1 was not complaining of pain at that time. She stated it could reasonably be explained that R1 did fracture her clavicle during the transfer, however R1 always had pain so it was difficult to say exactly where the pain was coming from. The Administrator was not certain why R1 did not complain of pain from approximately 7 p.m. after she got back into bed following the transfers until about 2:00 a.m. when she woke-up in excruciating pain. The Administrator was aware that injury of unknown origin is to be reported to the SA within 24 hours, but she felt it was reasonable that R1 obtained the fracture during the lift. A facility policy titled Abuse Prevention Policy dated 2017 indicated the community is responsible for reporting serious bodily injury the individual is to report the event immediately, but no later than 2 hours. If the event does not involve abuse and does not result in bodily injury the individual is required to report no later than 24 hours. In addition, an injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained; and the injury is suspicious because the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incident of injuries over time.