STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355066	A. BUILDING _____ B. WING _____	C 08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK LIVING CENTER	**400 S 4TH ST WISHEK, ND 58495**

(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
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on August 11, 2021. The sample included three (3) sampled residents and two (2) closed records for focused review.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of resident's record, the facility's investigation into the incident, and facility policy, and staff interview, the facility failed to provide appropriate and sufficient supervision to prevent accidents for 1 of 1 resident (Resident #4) discharged from the facility who fell during a full body mechanical lift transfer. Failure to safely utilize a mechanical lift resulted in Resident #4 falling from the lift and sustaining a serious injury and placed all residents requiring this type of transfer at risk for falls and/or injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: - Review of Resident #4's medical record occurred on 08/11/21. Diagnoses included transient cerebral ischemic attacks (TIAs),	F 689	Past noncompliance: no plan of correction required.	9/2/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2021

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F 689	Continued From page 1	F 689		

cerebrovascular accident (CVA), osteoarthritis, osteoporosis, and fracture of the left orbital floor. The quarterly Minimum Data Set (MDS), dated 06/05/21, identified dependance on two or more staff members for transfers.

The care plan identified, ". . . Resident requires extensive assist to complete ADL [activities of daily living] tasks . . . total lift assist of 2 for all transfers. . . . Resident at risk for falls secondary to diagnosis, meds [medications], and occasional incontinence. . . . dizziness due to BP [blood pressure], confusion at times. . . . decreased physical functioning. . . ."

An incident report, dated 08/03/21 at 7:31 a.m., identified, ". . . Called to resident's room at 7:35 [a.m.] d/t [due] to resident having a fall out of transfer sling during a transfer with total lift from bed to w/c [wheelchair]. Entered room and resident laying on her back on floor and was alert. CNA [certified nursing assistant] supporting residents head and neck. 2 CNA staff were assisting with the transfer and report that the sling came out of the hook causing the sling to open and resident to fall onto floor. CNA staff reported that the resident did not lose consciousness. Observed right eye to have a laceration on eyelid and broken tooth. Nose and upper lip was [sic] bleeding. No rotation to bilateral LEs [lower extremities]. Resident was moving and anxious on floor. No apparent injury to neck. Resident was supported and lifted with sling to bed for comfort. A skin tear is observed to her right elbow and a left anterior shin. Ice was applied to right side of face. Resident's daughter [name] notified of fall and consents to ER [emergency room] for further assessment. 911

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F 689	Continued From page 2 called and arrived at 7:50 a.m." A hospital emergency room report, dated 08/03/21, identified, ". . . The patient [was] brought in by ambulance. The history says that she fell from 2 to 3 feet high after a lift failed. She fell face first on her right side. She was actually bleeding from her face and mouth and was taken by ambulance to the emergency room. . . . She has a small laceration on her forehead deep enough to be sutured, measuring 2 cm [centimeters] in length. Another 2 small ones parallel, also bleeding but this is mostly a fissure. The right eye is completely shut by hematoma. . . . She had abrasions on both elbows and right knee. Legs have + [plus] 1 pitting edema below knees. She moves both legs to command laying down. . . . Neck and head CT [cat scan] was negative for fracture or bleeding, but showed multiple facial fractures on the right side. . . . Right hip x-ray showed fracture right iliac bone. . . ." The facility's "Final Investigation Report" identified, ". . . We are unable to say for sure what exactly happened or how it happened. We can speculate that [Resident #4] may have been positioned just slightly too low in the sling and sat up and fell out of the side. We have educated the CNAs and will also work with the nurses at the next meeting to ensure they also know the protocol for total lift transfers. We have the lift that was used in the transfer put aside until the EZ Way technician can check it over and the sling was taken out as well. We will continue to do ongoing training with staff regarding total lift transfers to ensure this does not occur again in the future."	F 689		

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F 689	Continued From page 3 During an interview on 08/11/21 at 5:00 p.m., an administrative nurse (#1) reported she added the following information to the policy after Resident #1 fell from the lift, "Effective immediately the following steps must be followed during all total transfers: Two persons must be in the room. One to operate the lift and one to have the hands-on approach during the lift. Both team members must stop and call a time out once the straps have been placed. Both persons will check the straps to ensure proper placement. 8/4/2021." Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient practice by: * Completing an investigation with interviews of staff who assisted with the transfer on 08/03/21, * Determining staff likely positioned Resident #4 slightly to the side or too high in the sling resulting in her fall from the Hoyer lift and serious injury, and * Updating the facility's policy to include a hands-on approach and time out procedure to ensure proper placement. The facility put measures in place to ensure the deficient practice does not recur by: * Providing education to all CNA staff on August 3 and 4, 2021 ensuring a hands-on approach and time out procedure to ensure proper placement, * Auditing Hoyer lift transfers starting on 08/10/21. The survey team determined a deficient practice existed on 08/03/21. The facility implemented	F 689		

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F 689	Continued From page 4 corrective action on 08/03/21, provided staff education on August 3-4, 2021, and audited Hoyer lift transfers through 08/10/21.	F 689		