F 000

INITIAL COMMENTS

Surveyor: 32355
A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/15/19 through 5/16/19. Areas surveyed included: proper use of mechanical transfer lifts, investigations, staff education, policy review, competencies, nursing services, and maintenance services. Bowdle Healthcare Center was found not in compliance with the following requirements:
F610, F689, F835, F842, and F908.

F 610
Investigate/Prevent/Correct Alleged Violation

CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Surveyor: 32355
Based on record review, interview, and policy review, the provider failed to appropriately

This deficiency has the potential to affect all residents. Resident 1 is unable to be reviewed as resident 1 no longer resides in the facility as of 5.15.19. Education was provided to employee C on 5.15.19 by Employee J and to all staff at the beginning of each shift starting evening shift on 5.16.19 in regards to what transfer each residents uses, if any, and that all lifts require a minimum of 2 certified personnel. This is posted by the CNA charting area for staff to readily reference.

The Abuse Prevention and Reporting policy has been revised on 6/6/19. The policy has been revised to include the multidisciplinary team in all investigation that includes DON, Administrator/designee, Medical Director, SS/SSD, and any other personnel necessary to conduct a thorough investigation. Starting immediately all investigations conducted will be audited weekly that the required personnel are in attendance. This will be audited by ADM/Designee or DON and reported to QA committee initially weekly for the first month, and then monthly thereafter until the committee recommends discontinuing.

Addendum 6.12.19 LR,DK
F 610 Continued From page 1
investigate a major injury after a fall for one of
one sampled resident (1) who was dependent on
staff to meet her mobility needs and required a
mechanical lift for all transfers. Findings include:

1. Review of the provider’s 5/14/19 final incident
report and investigation submitted to the South
Dakota Department of Health for (SD DOH)
resident 1 revealed:
*She was in the process of being transferred on
5/6/19 at 7:55 a.m. by certified nursing assistant
(CNA) C.
*The CNA was transferring the resident with a
Sara 3,000 mechanical stand aide.
*Conclusionary summary statement of facility
investigation:
"CNA reported: "I started to lift up resident in the
sit to stand (Sara) lift. Resident let go of handle
on the right side of the lift. She swung her right
arm so fast. It knocked off the sling on (R) [right]
side. It caused resident to fall forward. The other
side of the sling also came unhooked. Resident
collapsed to the floor. I couldn’t stop resident from falling
to the floor. It happened so fast. I reported
resident’s fall to CNA B and registered nurse
(RN) F. CNA B came to the resident’s room and
RN F came in also with the vital [sign] machine.
They examined resident. Resident complained of
burning in her (R) elbow area. She had a skin
tear on her (R) elbow. RN F and CNA E
transferred resident to her wheelchair."
*She had complained of right elbow burning from
the skin tear and was able to move it without
difficulty.
*She remained in the facility and was monitored
by the staff until the morning of 5/7/19.
*On 5/7/19 she had:
-Gone to the clinic to see physician assistant [PA]
-M to have her toes checked.
Continued From page 2

- Been complaining of pain in her (R) elbow, PA M examined it, and ordered an x-ray of that area.

Interview on 5/16/19 at 9:25 a.m. with the director of nursing (DON) revealed:
  * She confirmed:
    - The fall with major injury for resident 1 on 5/6/19.
    - The investigation of that incident with resident 1 and the changes that had occurred from that fall.
  * She:
    - Was not aware the investigation had not supported that a full root cause analysis had been completed.
    - Would have supported and assisted the social service designee (SSD) in the investigation process for reportable and incorporeal events.
  - Agreed:
    -- The SSD did not have a nursing degree and should have had support from the nursing department when completing those incidents and investigations.
    -- There should have been a full review on the investigation for resident 1 and the fall from a mechanical lift.
  * She agreed the investigation for resident 1 was incomplete and should have included:
    - How many staff members had been involved with the transfer.
    - Education with CNA C and all the other staff regarding the proper use of the mechanical transfer aides.
    - Competencies completed on the CNAs to ensure they were knowledgeable on the proper use of the mechanical lifts.
    - A review of all the residents and their current type of transfer to ensure it was appropriate for them and their safety.
    - The review of the mechanical lifts by the maintenance department to ensure they had
F 610 Continued From page 3
been working properly and safely.
-Support from the nursing department and
administration to ensure the investigation was
completed in a manner to ensure the safety of all
the residents had occurred.

Interview on 5/16/19 at 10:00 a.m. with the SSD
revealed she had:
*Completed:
-The initial and investigative report from 5/6/19 to
include interviews from the staff on resident 1.
-That investigation without support from
administration or the nursing department.
*Informed the administrator and DON of the
incident involving resident 1 and that it had
required a full investigative report submitted to
the SD DOH.
*Placed a copy of the report on the DON's desk
for review.
*Not been aware the report did not support a full
investigation of the incident with the resident.
*After a review of the above observations,
interviews, and record reviews she agreed it was
incomplete.
*There was no documentation to support the
continued safety for all the other residents had
occurred.
*Always completed the investigations and reports
without support from the other departments.
-She agreed there should have been support
from them.

Review of the provider's undated Reporting
Abuse policy revealed the SSD was to have
completed the investigation without the support of
the other administrative departments. The DON
and administrator would have completed an
investigation and submitted it to the SD DOH only
under the absence of the SSD.
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<td>Refer to F689, findings 1, 2, 3, 4, 5, and 6. Refer to F635, finding 1. Refer to 908, finding 1.</td>
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<td>F 689</td>
<td>SS=G</td>
<td>Free of Accident Hazards/Supervision/Devices CCR(s): 483.25(d)(1)(2)</td>
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<td>§483.25(d) Accidents. The facility must ensure that:</td>
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<td>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</td>
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<td>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</td>
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<td>Surveyor: 32355 Based on record review, observation, interview, record review, policy review, and job description review, the provider failed to ensure:</td>
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<td>*One of one sampled resident (1) was transferred safely with the use of a Sara 3,000 mechanical stand aide by one of one certified nursing assistant (CNA) (C).</td>
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<td>*All thirty-six residents who resided in their facility had initial and on-going transfer assessments completed for their safety.</td>
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<td>*A transfer assessment policy was in place for the professional staff to use when determining a transfer type for a resident.</td>
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<td>*A process was in place to educate, monitor, and assess the unlicensed staff on a routine basis to ensure they were knowledgeable on the safe and proper use of the mechanical lifts.</td>
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<td>*The staff had followed: -Their policy and procedure on safe lifting and movement of the residents.</td>
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F 669 This deficiency has the potential to affect all residents. A Transfer Assessment tool was written 5.23.19 and reviewed by medical director on 5.29.19. The Transfer Assessment tool was implemented to use with Sara Lift/Harness policy and EZ Lift/Harness policy. The transfer Assessment tool will be completed by nursing on all admissions/readmissions, quarterly, and as needed on all residents. Resident 1 is unable to be reviewed as resident 1 no longer resides in the facility as of 5.15.19. All other residents had a transfer assessment completed by nursing on 5.23.19 and reviewed by medical director on 5.29.19. 1-5 residents will be audited by DON weekly and reported to QA committee monthly until the committee recommends discontinuing.

05/28/19 Staff education was provided to employee C on 5.15.19 by Employee J and to all staff at the beginning of each shift starting evening shift on 5.16.19 in regards to what transfer each residents uses, if any, and that all lifts require a minimum of 2 certified personnel. This is posted by the CNA charting area for staff to readily reference. Staff education was assigned per Healthstream online learning center on Safe Patient Handling, Lifting and to be completed by 6/15/19. Lift competencies were completed on all nursing staff by 5/30/19 by DON/designee. These competencies will be completed on 5-10 employees weekly for the first quarter and then at a frequency determined by the QA committee. Completed competencies will be reviewed monthly at QA committee meeting.
Continued from page 5

- The manufacturer's recommendations for the use of the Sara 3,000 mechanical stand-aide on four of five observed resident transfers (3, 4, 5, and 6).
  - Four of four mechanical transfer lifts had been placed on a preventative maintenance program and checked on a routine basis per the manufacturer's instructions and the safety of fifteen residents who had required their use.
  - The administrative staff had been involved and supported the social services designee (SSD) with the investigations of all reportable and non-reportable incidents.
  - Findings include:
    - 1. Review of the provider's 5/14/19 final incident report and investigation submitted to the South Dakota Department of Health (SD DOH) for resident 1 revealed:
      - She was in the process of being transferred on 5/6/19 at 7:56 a.m. by CNA C.
      - The CNA was transferring the resident with a Sara 3,000 mechanical stand aide.
      - Conclusionary summary statement of facility investigation:
        - "CNA reported: "I started to lift up resident in the sit to stand (Sara) lift. Resident let go of handle on the right side of the lift. She swung her right arm so fast. It knocked off the sling on (R) [right] side. It caused resident to fall forward. The other side of the sling also came unhooked. Resident fell to the floor. I couldn't stop resident from falling to the floor. It happened so fast. I reported resident's fall to CNA B and registered nurse (RN) F. CNA B came to the resident's room and RN F came in also with the vital [sign] machine. They examined resident. Resident complained of burning in her (R) elbow area. She had a skin tear on her (R) elbow. RN F and CNA E
Continued From page 6

transferred resident to her wheelchair."  
*She had complained of right elbow burning from the skin tear and was able to move it without difficulty. 
*She remained in the facility and was monitored by the staff until the morning of 5/7/19.  
*On 5/7/19 she: 
- Had gone to the clinic to see physician assistant [PA] M to have her toes checked.  
- Had been complaining of pain in her (R) elbow, PA M examined it, and ordered an x-ray of that area. 
*The investigation did not support a full root cause analysis to determine:  
- How many staff members were present and assisting the resident with the transfer when the fall occurred.  
- When education for CNA C and the other direct caregivers had occurred to ensure the continued safety for the other residents during the transferring process.  
- How the director of nursing (DON) had determined resident 1 could no longer use the Sara 3,000 mechanical stand-aide.  
- What the administration had done to ensure the continued safety for all thirty-six residents after resident 1 had fallen from the mechanical lift.  
- If there was an inspection completed on the mechanical lifts to ensure they had been working properly and safely.

Review of resident 1's 5/7/19 physician's orders and progress notes revealed:  
*She had an x-ray completed of her right elbow.  
The x-ray results had revealed a displaced olecranon fracture (fx) of her right elbow.  
*The family had refused to have surgery and fixation of that right elbow due to (d/t) her age and multiple co-morbidities.

Addendum 6.12.19 LR, DK
Continued From page 7

*PA M had completed a closed reduction and splinting of that arm in the emergency room per the direction of an orthopedic surgeon.

Review of resident 1's complete medical record revealed:
*She was ninety years old and was admitted to the facility on 3/6/16.
*Her diagnoses included: history of mental and behavioral disorder, disorientation, bursitis to the right elbow, osteoarthritis, anxiety, syncope and collapse, and weakness.
*Her memory recall had been moderately impaired.
*She had required the staff to assist her with activities of daily living (ADL).
-Those activities included bed mobility, transfers, toileting, and personal hygiene.
*She had:
- A history of falls and required the use of a wheelchair (w/c) for mobility.
- Been on an antidepressant, antianxiety, and diuretic medication.
- Acquired a major injury from a fall during a transfer with the Sara lift on 5/6/19.
*There was no documentation to support a transfer assessment had been completed:
- On a regular basis with her facility assessments.
- As needed with health status changes.
- From the time she had been admitted through 5/16/19.
- To support the need of a mechanical lift for all transfers.
*There was no documentation to support how the staff had assessed her and determined the type of transfer method that was the safest for her.

Review of resident 1's 5/4/19 mood and behavior documentation revealed she had refused to hold...
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| F 689 | | Continued From page 8 onto the mechanical lift.  
- She had kept her arms down during a transfer off the toilet with two staff members.  

Review of resident 1's 3/7/19 comprehensive care plan revealed:  
* She had required the use of a sit-to-stand mechanical lift for transfers.  
* Those transfers:  
- Required two staff assistance.  
- Were changed on 5/6/19 to a Hoyer total body transfer mechanical lift and two staff assistance after a fall that day.  
* No documentation to support when the sit-to-stand mechanical lift had been initiated.  

Observation on 5/15/19 at 11:05 a.m. of CNAs A, B, and D with resident 1 revealed:  
* They had prepared to assist the resident with personal care and repositioning.  
* She:  
- Was laying in bed and had been incontinent of bowel movement.  
- Had a splint on her right arm up past her elbow that was held in place with an Ace wrap.  
- Did not open her eyes nor respond when spoken to by the staff during the entire personal care process.  
- Had occasionally lifted her left arm up over her head and mumbled softly.  
* They had repositioned her onto her right side and left the room.  

Interview on 5/15/19 at the time of the above observation with CNAs A and B regarding resident 1 confirmed:  
* The resident had recently fallen out of a lift while a CNA attempted to transfer her with it.  
* She had fractured her right elbow and was
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<td>Continued From page 9 possibly being admitted to Hospice services. The health had been declining prior to the fall, and she currently had an urinary tract infection (UTI). Attempted interview on 5/15/19 at 11:17 a.m. with resident 1 revealed she had: *Not been capable of participating in an interview with the surveyor. Remained silent with her eyes shut as observed above with the staff. 2. Random observations and interviews on 5/15/19 from 11:20 a.m. through 12:50 p.m. of CNAs A, B, C, D, and E with six mechanical lift transfers with residents 2, 3, 4, 5, and 6 revealed: *They had used two staff members with both the Sara 3,000 stand-aide and Hoyer mechanical lifts. *Five of those transfers had required the use of the Sara 3,000 mechanical stand-aide. -The staff had not placed the safety strap around the resident's legs to ensure safety had occurred for all five of those transfers. -Those safety straps remained draped over a ledge attached to the mechanical pole on the lift for all the transfers. *Resident 3 had required cueing to leave his feet on the stand-aide base during the transferring process. *They were to have used two staff members when a resident required a mechanical lift to assist them with their transfers. Chart reviews for residents 2, 3, 4, 5, and 6 from 2/1/19 through 5/15/19 revealed: *They had all required the use of a mechanical lift to assist them with transfers from one surface to another.</td>
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*There was no documentation to support initial and routine transfer assessments had been completed on them to support:
-How those transfers had been determined.
- The continued safety of the residents had occurred with transfers from the use of a mechanical lift.

Interview on 5/15/19 at 1:20 p.m. with RN F regarding resident 1 revealed:
*She had been charge nurse the day the resident fell from the Sara mechanical stand-aide.
*The resident had:
- Been experiencing a decline in her health prior to the fall.
- Episodes of increased anxiety and could be very demanding.
- Her ditropan medication to relax the bladder had been decreased per pharmacy recommendations, and she was not tolerating that well.
*She stated:
- "Apparently during the transfer she lifted her right arm, knocked the sling off, fell forward, and the other side came unhooked to."
- "She just complained of burning where she had skin tears from the fall."
- "She never really complained of pain and she moved it just fine."
- "So I was surprised when they said she broke it."
*She confirmed the staff:
-Were to have used two CNAs when transferring the residents with a mechanical lift.
-Should have been using the safety strap to secure the resident's legs in place when using the Sara 3,000.
-Used the care plans as a guide to help them with the residents' care.
*She had not been aware:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
BOWDLE NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**
6001 W 5TH STREET POST OFFICE BOX 656
BOWDLE, SD 57428

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- The staff were not using the safety strap on the resident's legs when transferring with the stand-aide. 
- How the residents were assessed for the appropriate transfer type.  
  *She never completed a transfer assessment on a resident to guide her with determining a transfer.*  
  *Stated:*  
  - "I'm sure they involve the physical therapist to help decide transfers, actually I know they do."  
  - "Typically a CNA will tell us when a resident has changed or not feeling well and what they did."  
  - "We will just tell the next shift."  
  - "No I wouldn't necessarily document that, because later that day or the next day the resident might be fine and back to their normal self."  
  - "We have great and seasoned staff here so, they know the residents well, and I trust them to decide what transfers to use."  
  - "Yes, the CNAs can determine that and yes, I'm comfortable with them deciding what to do."  
  - "Actually [resident name] at any given time can be a stand pivot transfer or maybe the Sara lift or Hoyer."  
  - "It depends on his mood and behaviors, and the girls know when he is being bad to use the lifts."  
  - "No I don't document those transfer changes as they might be short lived and the resident might be feeling better later."  
  *There had been no staff education after resident 1 had fallen from the Sara lift to ensure transfers were being completed in a safe manner.*  
  *She had not been aware of any staff competencies having been done to ensure the mechanical lifts had been used properly before or after the fall with the mechanical lift.*  
  *To her knowledge no residents had been
Continued From page 12

re-assessed for the proper transfer type to ensure their safety had occurred.
"She stated: "We are a no lift facility you know, we can't lift their arms to transfer them."

Interview on 5/15/19 at 2:00 p.m. with CNAs B and C regarding resident 1 revealed:
"They confirmed:
-Resident 1 had acquired a fracture to her right elbow after a fall from the Sara 3,000 mechanical stand-aide lift.
-Two staff members were to assist all residents with transfers that had required the use of a mechanical lift.
-Both of them had been working when she had fallen from that mechanical lift.
*CNA C:
-Confirmed she had assisted the resident with the transfer when she fell from the mechanical lift and fractured her right elbow.
-Had completed that transfer by herself and without the assistance from another staff member.
-Supported the above investigation review and interview that had been submitted to the SD DOH.
-Stated:
-"I know we are supposed to use two people with the lifts, but I was in a hurry and did it by myself."
-"There are no excuses we were just busy, busy, and she stands well so I did it by myself."
-"She really didn't have much pain, just kept complaining of a burning sensation where the skin tears were, she even moved it ok."
-Had not been interviewed or re-educated on the proper use of the mechanical lifts after the resident had fallen.
-Was not asked how she completed that transfer during the investigative process.
F 689 Continued From page 13

*They were not sure how the transfers were
determined for the residents.
*The resident required reminding to hold onto the
lift with transfers.
*They stated:
"But we can't decide that [types of transfers], the
nurses do and the therapy department does."
"We are told we can always go up [such as from
a stand-aide to a total body lift] with a transfer but
never back down. The nurses have to okay that
process. And of course, we have to tell them
when this happens."
*The resident had been changed to a Hoyer [total
body] mechanical lift after her fall.
--The DON made that change.
*There had not been:
-Staff education on mechanical lifts and the
required process for resident safety after she had
fallen.
-Competency reviews completed on the staff
when assisting the residents with a transfer.
*They:
-Had never been reviewed and watched to ensure
transfers with the residents were completed
safely and as directed.
-Had not been educated on the proper use of
those lifts.
-Agreed they should have been reviewed for
competent and proper use of those lifts for the
resident's safety.

3. Interview on 5/15/19 at 2:30 p.m. with CNAs A
and G revealed they:
*Confirmed two staff members had been required
to assist residents who used a mechanical lift for
transfers.
*Did not have the capability of determining the
transfer types for the residents.
*Could have gone to a higher level of transfer for
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<td>&quot;We can't do whatever we want to [regarding transfers].&quot;</td>
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<td>and yes he needs reminding to keep his feet in</td>
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|     |        |     | place."
|     |        |     | "Were unaware of how the nurses' determined what |
|     |        |     | type of transfer was the safest for the |
|     |        |     | residents to use. |
|     |        |     | "Had never been watched or monitored by the |
|     |        |     | administrative department to ensure they had |
|     |        |     | used the mechanical lifts properly and in a safe |
|     |        |     | manner. |
|     |        |     | "Were aware of the safety strap for the legs on |
|     |        |     | the Sara 3,000 mechanical stand-aide. |
|     |        |     | "Stated:                        |
|     |        |     | -"I'm not sure if we are supposed to use it." |
|     |        |     | -"I guess it would make it safer for the residents, |
|     |        |     | but we've never been told to use it." |
|     |        |     | "CNA G stated: "Have you seen the Sara lifts? |
|     |        |     | There is one that the arms are uneven."

|     |        |     | 4. Observation and interview on 5/15/19 at 2:50 |
|     |        |     | p.m. with CNAs A and G of the Sara 3,000 |
|     |        |     | mechanical lift in question revealed: |
|     |        |     | "It had been located on the same wing as |
|     |        |     | resident 1's room. |
|     |        |     | "The arms used to attach the transfer sling were |
|     |        |     | not even. |
|     |        |     | -The right arm was approximately three to four |
|     |        |     | inches higher in height than the left arm. |
Continued From page 15

"CNA G stated:

-"The other Sara lift was like that but just not as bad. They fixed that one."
-"We've told maintenance about this one, so I know they know."
-"There is a book that we put our concerns in and they check it."
-They:

-Could not confirm that mechanical lift had been used on resident 1.
-Stated: "There are only two of them and they get moved back and forth between the two wings."

Observation and interview on 5/15/19 at 3:00 p.m. with maintenance director L revealed he:

-Confirmed:

-There was a concern with one of the Sara lifts, and he had fixed that one.
-There was a book the staff wrote their concerns in for them to check."

-Had not been aware of a concern with the other Sara lift and the arms not even.

-After observation of that lift with the surveyor he confirmed there was a safety risk for the residents who used that lift.

"Did not have the mechanical lifts on a preventative maintenance program and would have checked them only upon request from the staff.

-Had not been asked to check the mechanical lifts after resident 1 had fallen from one.

-He agreed he should have been to ensure the continued safety of the residents who required their use for transfers.

Review on 5/15/19 at 3:10 p.m. from 2/1/19 through 5/15/19 of the maintenance work order book revealed no documentation to support a request and concern with the two Sara 3,000
Continued from page 16 mechanical stand-aides by the direct caregivers.

5. Interview on 3/15/19 at 3:20 p.m. with resident 1's daughter revealed she had no complaints on the care her mother had received. She had been aware of the fall, the injury, and decline in condition. She stated: "My mother has been declining for some time now so that part is no surprise. No, I can't say she was in a lot of pain, I saw her, and she was moving that arm. All is good with us and her."

Interview on 5/15/19 at 3:30 p.m. with physical therapist (PT) H revealed:
*On occasion she would have been asked to assess a resident to determine the type of transfer that was safest for them.
-Those assessments had been informal and not documented on.
*All of her recommendations for the residents had been verbal and not documented.
*She:
-Agreed if it was not documented on it did not support those recommendations and reviews had occurred.
-Stated: "My assessments and recommendations are conservative to make sure the residents are safe."
-Was not aware if the residents had been assessed on a routine basis to support what type of transfer they had required.
-The staff had asked her about resident 1 and the concern of her not holding onto the lift with transfers.
*She:
-Stated: "Rule of thumb, is if they don't hang onto the lift and continue to not be safe they should be a Hoyer lift."
-Was not aware of any competencies or reviews.
F 689 Continued From page 17
completed on the CNAs with transfers to ensure the residents' safety.
-Agreed there should be competency reviews completed on the direct care givers.
-Was not a part of the staff education after they were hired and completed their orientation process.
*Her education had been on safety and the proper body mechanics to use when they transferred or took care of a resident to prevent injury to themselves.
*She:
-Did not support the use of the safety strap for the resident's legs with a transfer using the stand-aide.
-Stated: "I consider that a restraint, because they can't move their legs."
-Thought the CNAs were competent and knew the residents well enough to decide what type of transfer they had required without professional staff involvement.

Chart review for resident 1 from 2/1/19 through 5/15/19 revealed:
*She had all required the use of a mechanical lift to assist her with transfers from one surface to another.
*There was no documentation to support initial and routine transfer assessments had been completed on her to support:
-How those transfers had been determined.
-The continued safety of the resident had occurred with transfers from the use of a mechanical lift.

5. Interview on 5/15/19 at 4:25 p.m. with RNs J and K revealed they:
*Had not been aware of all the issues and concerns identified above through:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LG I.D IDENTIFYING INFORMATION)</th>
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<td>-Observations.</td>
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<td>-Interviews.</td>
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<td>-Limited record review.</td>
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<td>*Confirmed there was no:</td>
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<td>-Formal transfer assessment policy in place for the staff to follow to ensure the continued safety of their residents through that process had occurred.</td>
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<td>-Transfer assessments completed upon admission, as needed with health condition changes, and with their routine assessments.</td>
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<td>-Documentation to support the PT assessments and recommendations made from their requests.</td>
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<td>*Were not aware:</td>
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<td>-There was a concern with both of the Sara 3,000 mechanical stand aides.</td>
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<td>--They confirmed the process the maintenance department had in place for them to use to inform him of any identified concerns for him to check.</td>
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<td>-The investigation for resident 1 and her fall from a mechanical lift had not been complete.</td>
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<td>-There had not been any initial or ongoing competencies and reviews of the CNAs while using the mechanical transfer lifts to ensure the residents' safety.</td>
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<td>*Agreed their processes above had placed the residents at risk for potential injury while being transferred with the mechanical lifts.</td>
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<td>Interview on 5/16/19 at 6:30 a.m. with PA M revealed regarding resident 1 revealed he.</td>
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<td>*Had been aware of her major injury from a fall during a transfer with a mechanical lift.</td>
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<td>*Had been working in the clinic on 5/7/19 when she had an appointment to have her toenails checked.</td>
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<td>*Confirmed the staff had informed him of the fall, and he had assessed her for injuries.</td>
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|     | *Confirmed he had been informed of the skin
Continued From page 19

ears on her right elbow and that she had complained of a burning sensation to that area.
"Stated:
"-But it was so confusing, because she used it like it was not broke."
"-Plus she had a lot of arthritis too."
"-When she came for her appointment they had asked me to check her arm."
"-She had a lot of bruising there and complained of some pain, so I decided to X-ray it."
"Confirmed the above review of his progress note and the closed reduction completed on her right
elbow.
"Was not aware how the staff determined the type of transfer she required or for the other
residents in the facility.
"Agreed the administrative staff should have completed a full review of the situation to ensure
the safety of the other residents had occurred.
"Stated:
"-There should have been a re-evaluation of that situation with education to the staff."
"-We need to make sure the others [residents] are safe and that the current process is ok.
"-They should have followed their policies and the manufacturer's recommendations on the lifts."

Interview on 5/16/19 at 9:25 a.m. with the DON revealed:
"She confirmed:
-The fall with major injury for resident 1 on 5/6/19.
The investigation of that incident with resident 1, and the changes that had occurred from that fall.
"She:
-Was not aware the investigation had not supported that a full root cause analysis had been
completed.
-Would not have supported and assisted the SSD in the investigation process for reportable and
**F 669 Continued From page 20**

incorporate events.

- Agreed:
  -- The SSD did not have a nursing degree and should have had support from the nursing department when completing those incidents and investigations.
  -- There should have been a full review on the investigation for resident 1 and the fall from a mechanical lift.
  *She confirmed:
  - The staff were to have used two staff members at all times when transferring the residents with the mechanical lifts.
  - There was not a formal transfer assessment completed on resident 1 after her fall from the mechanical lift and should have been to support the continued use of a total body transfer.
  - There was no formal process in place and documentation to support the involvement of the PT department and her assessments and recommendations.
  - There were no competency reviews and education completed with the staff while using the mechanical lifts on a routine basis.
  *She had been assisting the staff on the floor with the residents frequently and would have completed a visual assessment of the residents when doing a transfer with them.
  - There was no documentation to support those visual assessments.
  *She stated:
  - "I have seasoned staff working here, and I am ok with them making a decision with a transfer."
  - "Yes, they should report that change to the nurse, so they check into it."
  - "No, the CNAs cannot go back down to a lesser type transfer on their own but can always go up to a higher level of a transfer."
  *She was not aware:
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<th>(X4) ID PREFIX TAG</th>
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<th>(X5) COMPLETION DATE</th>
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<td>F 699</td>
<td>Continued From page 21</td>
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<td>-RN K had not completed transfer assessments upon admission and routinely with their MDS assessments.</td>
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<td>-There was a problem with both of the Sara mechanical stand aids.</td>
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<td>*It would have depended on the resident and their cognition status on whether it was safe to use the safety strap with a transfer or not.</td>
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<td>*She agreed the investigation for resident 1 was incomplete and should have included:</td>
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<td>-How many staff members had been involved with the transfer.</td>
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<td>-Education with CNA C and all the other staff regarding the proper use of the mechanical transfer aids.</td>
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<td>-Competencies completed on the CNAs to ensure they were knowledgeable on the proper use of the mechanical lifts.</td>
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<td>-A review of all the residents and their current type of transfer to ensure it was appropriate for them and their safety.</td>
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<td>-The review of the mechanical lifts by the maintenance department to ensure they had been working properly and safely.</td>
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<td>-Support from the nursing department and administration to ensure the investigation was completed in a manner to ensure the safety of all the residents had occurred.</td>
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<td>Interview on 5/16/19 at 10:00 a.m. with the SSD revealed she had:</td>
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<td>*Completed:</td>
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<td>-The initial and investigative report to include interviews from the staff on resident 1.</td>
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<td>-That investigation without support from administration or the nursing department.</td>
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<td>*Informed the administrator and DON of the incident involving resident 1, and that it had required a full investigative report submitted to</td>
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**F 689** Continued From page 22

the SD DOH.

*Placed a copy of the report on the DON's desk for review.

*Not been aware the report did not support a full investigation of the incident with the resident.

*After a review of the above observations, interviews, and record reviews she agreed they were incomplete.

*There was no documentation to support the continued safety for all the other residents had occurred.

*Always completed the investigations and reports without support from the other departments.

*She agreed there should have been support from them.

Review of CNAs B, C, and F's employee files revealed no documentation to support:

*Education had been provided on the proper use of the mechanical lifts.

*There was no documentation:

  - Of training, instruction, or competency performed on the mechanical lifts.

  - Review on the process for use of those lifts had been completed after resident 1's fall with a major injury from the Sara 3,000 mechanical transfer aide on 5/6/19.

Refer to 610, finding 1.
Refer to F835, finding 1.
Refer to 908, finding 1.

6. Review of the provider's July 2017 Safe Lifting and Movement of Residents policy revealed:

**In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.**

**Resident safety, dignity, comfort, and medical**
Continued From page 23

F 689 Condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.

"Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis."

"Staff will document resident transferring and lifting needs in the care plan."

"Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents."

"Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques."

"Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order."

"Safe lifting and movement of residents is part of an overall facility employee health and safety program, which:

- Provides training on safety, ergonomics, and proper use of equipment."

Review of the provider's July 2017 Lifting Machine, Using a Mechanical Lift policy revealed:

"At least two nursing assistants are needed to safely move a resident with a mechanical lift."

"Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility."

"Before using a lifting device, assess the resident's current condition including:

- Can the resident assist with transfer?
- Can the resident understand and follow instructions?
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<tr>
<td>F 689</td>
<td>Continued From page 24</td>
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<td>-Does the resident express fear or appear anxious about the use of a lift?</td>
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<td>-Is the resident agitated, resistant, or combative?</td>
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<td><strong>&quot;Make sure that all necessary equipment is on hand and in good condition.&quot;</strong></td>
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<td>Review of the provider's 6/1/15 Director of Nursing Job Description revealed:</td>
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<td>&quot;Supervises planning and administration of all nursing care, to provide and maintain high quality resident care.&quot;</td>
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<td>&quot;Responsible for the organization, management, guidance, and supervision of Nursing Service Department and nursing facility guidance and supervision and assist with administrative decisions in the absence of the administrator.&quot;</td>
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<td>&quot;Have knowledge and support of the philosophy, policies, and standards of the nursing home and assume responsibility for the development and maintenance of all policies and standards of the nursing department including providing means to assure their explanation and implementation.&quot;</td>
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<tr>
<td>F 689</td>
<td>Continued From page 25 about the issue.</td>
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<td>*Revealed no documentation to support the maintaining safety for the residents.</td>
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**F 835**

**SS=G**

§483.70 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:

- Surveyor: 32355
- Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure the facility was operated in a manner that ensured the safety and overall well-being for all residents by ensuring:
  - A formal process was in place for determining and supporting any resident transfer from one surface to another.
  - All staff were trained and regularly monitored in the safe use of the mechanical lifts per manufacturer's recommendations.
  - Investigations for all incidents whether reportable or not reportable to the South Dakota Department of Health (SD DOH) had been completed thoroughly and involved the assistance from the appropriate departments involved in the incident. Findings include:
- 1. Interview on 5/16/19 at 11:03 a.m. with the administrator revealed she had:
  - Not been aware:
    - There were no formal assessments, documentation, and policy to follow for

This deficiency has the potential to affect all residents. Resident 1 is unable to be reviewed as resident 1 no longer resides in the facility as of 5.15.19. Education was provided to employee C on 5.15.19 by Employee J and to all staff at the beginning of each shift starting on 5.16.19 in regards to what transfer each residents uses, if any, and that all lifts require at a minimum of 2 certified personnel. This is posted by CNA charting area for staff to readily reference. A formal process utilizing the Transfer Assessment Tool has been completed on all other residents on 5.23.19 and will continue to be completed on all admissions/readmissions, quarterly, and as needed. **1-5 residents will be audited by DON/designee weekly and reported to QA committee monthly** until the committee recommends discontinuing.

Those that are newly hired for RN/LPN and CNA positions will be trained by certified CNA trainer on how to properly use Sara lift, EZ lift, and pivot transfers. Lift competencies and Safe Patient Handling, Lifting Healthstream online learning center education will be completed within two weeks of hire date. This will be audited by DON/designee monthly and reported to QA committee until QA Committee recommends discontinuing.

**Addendum 6.12.19. LR, DK**
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<tr>
<td>F 835</td>
<td>Continued From page 28 determining and supporting any of the transfers including transfers using lifts.</td>
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<td>05/16/2019</td>
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<td>-Who assessed, monitored, and approved the changes on transfers for all of the residents in the facility.</td>
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<td>-The nursing staff had not been properly trained to use the mechanical lifts according to the manufacturer's recommendations.</td>
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<td>-There were no competencies completed on the use to ensure the proper use of the mechanical lifts had occurred.</td>
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<td>&quot;Not been involved in the investigation of any incidents involving the residents to ensure their safety and over-all well being had occurred.</td>
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<td>-She agreed she should have been.</td>
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<td>&quot;Not been aware:</td>
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<td>-The social services designee (SSD) had completed any and all of the incident investigations with no support from the other departments.</td>
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<td>-The investigation on resident 1 after she fell from a mechanical lift and acquired a major injury was completed to support:</td>
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<td>--A root cause analysis had been reviewed to ensure the safety of the other residents.</td>
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<td>--Staff education had occurred on the proper use of the mechanical lifts.</td>
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<td>--The certified nursing assistant (CNA) C involved in the transfer had been educated and monitored to ensure she was knowledgeable on the proper use of the mechanical lifts.</td>
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<td>--All the residents had been re-assessed for the appropriate transfer type and the support needed during a transfer.</td>
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<td>--The mechanical lifts had been assessed by the maintenance department to ensure they had been working properly.</td>
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<td>--The mechanical lifts were on a preventative maintenance program per their manufacturer's</td>
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recommendations and monitored routinely for safe use.

"She stated:

"-Typically the [social services designee name]
will tell me about it [incidents and investigations]
and whether she had to report it or not to the state [SD DOH]."

"-But no, I don't help with the investigations and
should be."

"She agreed the process above had created the potential for further falls with injuries to have occurred from the use of the mechanical lifts.

Refer to 610, finding 1.
Refer to 689, finding 1, 2, 3, 4, 5, and 6.
Refer to 842, finding 1.
Refer to 908, finding 1.

Review of the provider's undated Administrator
Job Description revealed the following duties and responsibilities:

"Transmitting, interpreting, and implementing policies, rules, and regulations affecting all facility activities, and personnel."

"Establishing procedures for systematic performance of nursing duties and coordinating activities of all departments."

"The executive department had primary responsibility for the safety and protection of patients [residents]."

"Formulating sound personnel policies and disseminating these policies to all employees, developing an organizational structure with clearly defined lines of authority and areas of responsibility which will enable the employees to work together toward common objectives, selecting and training qualified department heads, coordinating all department activities, and establishing lines of communication between
<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 835</td>
<td>Continued From page 28 administrative and line employees.&quot;</td>
<td>F 835</td>
<td>This deficiency has the potential to affect all residents. Resident 1 is unable to be reviewed as resident 1 no longer resides in the facility as of 5.15.19. Education was provided to employee C on 5.15.19 by Employee J and to all staff at the beginning of each shift starting evening shift on 5.16.19 in regards to what transfer each residents uses, if any, and that all lifts require at a minimum of 2 certified personnel. This is posted by CNA charting area for staff to readily reference. Investigation reports that are submitted to DOH will be printed and placed in medical chart. This will be audited by DON/designee monthly and reported to QA committee monthly until QA committee recommends discontinuing.</td>
<td>05/23/19</td>
</tr>
<tr>
<td>F 842</td>
<td>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</td>
<td>F 842</td>
<td>A Transfer Assessment tool was written 5.23.19 and reviewed by medical director on 5.29.19. The Transfer Assessment tool was implemented to use with Sara Lift/Harness policy and EZ Lift/Harness policy. The transfer Assessment tool will be completed by nursing on all admissions/readmissions, quarterly, and as needed on all residents. All residents had a transfer assessment completed by nursing on 5.23.19 and reviewed by medical director on 5.29.29. 1-5 residents will be audited by DON/designee weekly and reported to QA committee monthly until the committee recommends discontinuing.</td>
<td>05/23/19</td>
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<td>SS=E</td>
<td>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</td>
<td></td>
<td>All resident related assessment/tools/ investigations will be entered into resident medical record electronically or manually per Charting and Documentation Policy. This will be audited by DON monthly and reported to QA committee until QA committee recommends discontinuing.</td>
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<td>§483.70(i)(1) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</td>
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<td>Addendum 6.12.19 LR, DK</td>
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<td>§483.70(i)(2) The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.505; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation</td>
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<td>(X4) ID PRERIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<tr>
<td>F 842</td>
<td>Continued From page 29 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</td>
<td>F 842</td>
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§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

This REQUIREMENT is not met as evidenced by:
Surveyor: 32355
Based on observation, interview, record review, and policy review, the provider failed to ensure six of six sampled residents (1, 2, 3, 4, 5, and 6) had documentation to support complete documentation in their medical records. Findings include:
### Summary Statement of Deficiencies

**F 842** Continued From page 30

1. Review of resident 1's medical record revealed incomplete or missing documentation related to:
   - *A complete and thorough investigation after a fall with major injury from a mechanical lift.*
   - *Transfer assessments to support how the staff had determined which type of transfer including the use of a mechanical lift had been the safest for her.*
   - Refer to F689, finding 1, 2, 3, 4, 5, and 6.
   - Refer to F610, finding 1.

2. Review of residents 2, 3, 4, and 5 revealed incomplete or missing documentation to support the completion of transfer assessments including the use of a mechanical lift to support:
   - *How the staff had determined which type of transfer had been the safest for them.*
   - *Initial and ongoing transfer assessments had been completed for them on a routine basis with their Minimum Data Set assessments.*
   - Refer to F689, finding 2.

3. Review of the provider's Charting and Documentation policy revealed:
   - "*All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.*"
   - "*The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.*"

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**F 908** Essential Equipment, Safe Operating Condition

**CFR(s):** 483.90(d)(2)

- §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating conditions.
| F 908 | Continued From page 31 condition. This REQUIREMENT is not met as evidenced by:
   Surveyor: 32355
   Based on observation, interview, record review, manufacturer's guidelines review, and policy review, the provider failed to ensure four of four mechanical transfer aids were on a preventative maintenance program and checked routinely according to the manufacturer's instructions for safe use for:
   *One of one sampled resident (1) who had a fall with major injury from one of two Sara 3,000 mechanical stand-aides.
   *Fifteen of thirty-six residents who had required the use of a mechanical lift for transfers.
   Findings include:

   1. Review of the provider's 5/14/19 final incident report and investigation submitted to the South Dakota Department of Health (SD DOH) for resident 1 revealed:
   *The investigation did not support a full root cause analysis to support there was an inspection completed on the mechanical lifts to ensure they had been working properly and safely.

   Review on 5/15/19 of the maintenance work order book at 3:10 p.m. from 2/1/19 through 5/15/19 revealed no documentation to support a request and concern with the two Sara 3,000 mechanical stand-aides by the direct caregivers.

   Interview on 5/16/19 at 11:03 a.m. with maintenance director L revealed:
   *There was no policy in place for him to follow to ensure the maintenance and upkeep of the lifts had occurred.
   *He had created his own that day after review of

| F 908 | This deficiency has the potential to affect all residents. All mechanical lifts have been placed on a preventative maintenance program that follows the manufacturer's recommendations. Sara lifts are checked weekly and every 12 months and the Hoyer lift is checked monthly, as these are the manufacturer's recommendations. The preventative maintenance check for all lifts will be completed by the Maintenance Department. The Sara lift that had bent arms was taken out of use as of 5/16/19 and new bar was ordered. The new bar was installed on 5.29.2019, maintenance check was done on 5.29.2019 and it was put back in use on 5.29.2019. A Hoyer lift was taken out of use on 5/16/2019 due to a pin being replaced by a bolt. A replacement Hoyer was ordered on 5.19.2019. The new replacement Hoyer lift will be inspected per manufacturer's recommendation prior to being placed into service. All maintenance checks will be completed by Maintenance department and will be brought to QA committee. The checks will be audited by Administrator/designee and reported to the QA Committee initially weekly effective 6.13.19 for the first month then monthly thereafter until the QA Committee recommends discontinuing.

The Abuse Prevention and Reporting policy has been revised on 6.6.19. The policy has been revised to include the multidisciplinary team in all investigations that includes DON, Administrator/designee, Medical Director, SS/SSD, and any other personnel necessary to conduct a thorough investigation. Starting immediately all investigations conducted will be audited weekly that the required personnel are in attendance. This will be audited by ADM/Designee or DON and reported to QA committee initially weekly for the first month, and then monthly thereafter until the committee recommends discontinuing.
F 908
Continued From page 32
the manufacturer's instructions for them.
"He agreed:
- They should have been reviewed to ensure he
had checked them according to their
recommendations and to ensure the safety of the
residents.
- They should have had routine maintenance by
the company representatives to ensure they had
been operating safely.

Review of the provider's November 2014
Manufacturer's Sara 3,000 Mechanical Stand
Aide instructions revealed:
"On page 8: "Lower leg straps: Accessory used to
ensure that the lower parts of the resident's legs
stay close to the knee support."
"On page 8: Warning:
- "An assessment must be made for each
individual resident being raised by the Sara 3,000
by a medically qualified person as to whether the
resident requires the lower leg straps when using
the standing sling."
- "Use if necessary, e.g. with unruly residents,
residents with spasms, etc., that were assess as
suitable to be raised with it."
"On page 20: Maintenance: "Periodic testing, to
be carried out at weekly intervals."

Refer to F699, findings 1, 2, 3, 4, 5, and 6.

F 908
Policies ensuring maintenance and upkeep of
lifts have been implemented by maintenance on
5.16.19 and reviewed by medical director on
6.3.19. Preventative maintenance for sara lifts
are checked weekly and every 12 months and
as stated in the policy. The hoyer lift is
checked monthly and as needed as stated in
the policy as these are the manufacturers'
recommendations. Preventative
maintenance records will be audited by
Administration/designee and reported to QA
committee initially weekly effective 6/13/2019
for the first month then monthly until QA
committee recommends discontinuing.

Addendum 6.12.19 LR, DK