STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355039	A. BUILDING ______ B. WING ______	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRIGGS COUNTY CARE CENTER	**107 12TH ST S COOPERSTOWN, ND 58425**

(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 investigation survey regarding a facility reported incident was completed on 11/29/23. During the report investigation the facility was found noncompliant with regulatory requirements.	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 observation, record review, review of the facility reported investigation, review of facility policy, stand lift Operator's Instructions, resident interview, and staff interview, the facility failed to provide appropriate safety/supervision to prevent accidents for 1 of 1 sampled resident (Resident #1) who sustained a major injury during an EZ stand lift (mechanical sit-to-stand lift). Failure to follow the facility policy for EZ stand transfers and safety interventions resulted in a fracture of Resident #1's left arm. Findings include: Review of the facility policy titled, "EZ Stand Lift" occurred on 11/29/23. This policy, revised 02/13/18, stated, ". . . Purpose: To lift and transfer resident/patient safely with as little physical effort as possible. . . . Position the EZ	F 689	GCCC Plan of Correction F689: 1. Immediate action(s) taken for the resident(s) found to have been affected include: In coordination with the Director of Nursing, Resident Care Coordinator, and primary physician/healthcare provider, resident #1 orders were changed on 11/22/2023: D/C E-Z stand transfers. To be transferred via Hoyer lift with assist x2 for all transfers. Appropriate revisions were made to the resident□s care plan to reflect new transfer orders. The revised care plan was reviewed with staff involved in the care of resident #1. 2. Identification of other residents having	12/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/28/2023

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F 689	Continued From page 1	F 689		

stand in front of the resident/patient. . . . Have the resident/patient place his feet (or help as needed) on platform and position his shins into the shin forms. Place leg strap around legs, buckle, and pull the strap to tighten. . . ."

The EZ Way Smart Stand Operator's Instructions, page 6, stated, ". . . Use of Shin Pad Strap: If a caregiver deems it necessary to keep a patient's shins or feet on the foot plate, secure the shin strap around the patient's legs. . . ."

Review of Resident #1's medical record occurred on 11/29/23. Diagnoses included paralytic syndrome (weakness/paralysis) following cerebral infarction (stroke) affecting left non-dominant side and contractures of the left hand and left shoulder muscle. A quarterly Minimum Data Set (MDS), dated 09/28/23, identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition.

The care plan at the time of the incident indicated EZ stand transfers with one assist.

The facility reported a fall incident to the state agency on 11/22/23 and immediately started an investigation. The facility's final investigation report stated, on 11/22/23 at 9:00 a.m., ". . . Resident was being transferred via E-Z stand lift. While transferring, resident's knees gave out and went to the side and her arms 'chicken winged' and started to slide out of the lift. A chair placed under the resident and she was assisted via Hoyer lift. Resident later complained of pain to the left shoulder. She was taken to the emergency department and diagnosed with a closed displaced fracture of the left humerus

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the potential to be affected was accomplished by: All residents who require the use of the EZ stand lift for transfers have the potential to be affected. The nursing management team reviewed the MDS assessments for all residents who have been identified as having a potential risk for safety related concerns regarding transferring with an EZ Stand Lift to help ensure appropriate interventions are in place. This review was done on 12/18/2023. Safety risk assessments were found to be complete and interventions were found to be currently in place, reflecting appropriate plans of care.

3. Actions taken/systems put into place to reduce the risk of future occurrence include: No changes to facility policies were needed, as policies already included use of leg straps to encourage an added layer of safety while transferring residents. All licensed nursing staff attended an In-Service Training on EZ Way Stands and Safe Transfers on the following dates; 11/30/2023, 12/1/2023, and 12/4/2023. During this In-Service the EZ Stand Lift and EZ Hoyer Lift policies were reviewed. Staff then demonstrated proper use of the lift, completed a competency quiz, and completed competency forms verbalizing understanding of the training.

On 12/8/2023, labels were placed on each EZ Stand Lift stating Chest and leg straps must be used with all transfers.

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F 689	Continued From page 2 bone received. . . . Resident to not be lifted all the way up in the lift . . . may have been lifted too high in the lift which caused her left arm to slip out. . . ." During an interview on 11/29/23 at 2:58 p.m., when asked about the events that occurred on 11/22/23, Resident #1 confirmed two staff were present during the EZ stand lift transfer, and stated, "They [the CNAs] didn't have my feet on the platform properly before they started to stand me up." When asked if staff used the leg straps during the transfer, she stated "no" and further stated "they never do." During an interview on 11/29/23 at 4:11 p.m., the CNA (#1) stated Resident #1's legs went to the side (indicating to the left) as they began to lift the resident. When asked if she used the leg straps during Resident #1's transfer on 11/22/23, the CNA (#1) stated, "No". During an interview on 11/29/23 at 4:34 p.m., two physical therapy staff members (#4 and #5) stated they would expect staff to use the EZ stand as ordered and use the leg straps per facility policy. The facility staff failed to strap Resident #1's legs into the EZ stand lift and ensure the resident was not lifted too high during a transfer which resulted in a fracture.	F 689	All resident incidents will be reviewed daily by the nursing management team to ensure appropriate implementation/use of safety interventions, including updating the plan of care as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The nursing management team or designee will review/investigate each incident immediately upon occurrence to ensure appropriate interventions were utilized during the incident, as well as to check to see if care plans were updated, as needed. The Quality Assurance Performance Improvement (QAPI) Nurse initiated random transfer audits on 12/6/2023, which were completed daily for one week. Then starting on 12/18/2023, random transfer audits were being completed twice weekly for two consecutive weeks. Starting 1/4/2023, audits will continue weekly for three consecutive weeks and then will be completed monthly at random starting on 2/1/2024. Any problems found will be reported immediately to the Director of Nursing to determine if disciplinary action is required. Results of all monitoring will be reported to the Quality Assurance Performance Improvement (QAPI) Committee at its	

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F 689	Continued From page 3	F 689	regularly scheduled meetings where decisions for further monitoring will be made. The Director of Nursing and QAPI Nurse will continue to review all incidents to ensure that appropriate interventions have been put in place to reduce the risk of resident accidents and that care plans have been updated to reflect interventions needed. 5. 12/28/2023	