

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

PRINTED: 02/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355084		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2024	
NAME OF PROVIDER OR SUPPLIER LUTHERAN SUNSET HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 333 EASTERN AVE GRAFTON, ND 58237			
(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			F 000			
F 689 SS=G	An unannounced onsite investigation survey regarding a facility reported incident was completed on May, 21, 2024. During the report investigation the facility was found non-compliant with regulatory regulations. 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: 1. Based on record review, resident and staff interviews, and review of a facility reported incident, the facility failed to prevent accidents for 1 of 1 sampled resident (Resident #1) reviewed for an accident with subsequent injury. Failure to follow facility policy for proper use of a stand-lift resulted in injury. Findings include: Review of Resident #1's medical record identified diagnoses of osteoarthritis and abnormalities of gait (walking). The care plan identified, ". . . Self-care deficit with mobility related to decreased mobility, . . . and other risk factors. . . . Assist of 1 with stand aid lift for all transfers. . . ." Record review occurred on 05/21/24. The nurse's			F 689	1) Staff member that was involved in the incident was removed from the schedule and has not returned to the facility. The mechanical lift and sling that were used in the resident transfer were checked for proper functioning by rehab manager on 4/30/24 and determined to be functioning appropriately. Resident's injuries were assessed by nursing staff and monitored. Resident pain was monitored and controlled by nursing staff. Physician was made aware of the incident. 2) Facility Incident Log was reviewed for the month of April on 6/10/24 to determine if there were any patterns related to transfers or with the staff member that was involved in the incident. 3) Mechanical lift policy and procedure		6/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/14/2024

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.

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F 689	Continued From page 1 notes identified the following: 4/30/24 4:08 p.m. ". . . CNA [certified nurse aide] called nurse into resident's room @ [at] 6:30 AM. Showed nurse resident's bruise to right rib area and right breast area. Nurse assessed and measured bruise. Resident was being transferred from chair to bed with stand aid lift when bruise occurred. Resident denied pain @ this time. Assessed and measured resident [bruised area]. 18 cm (L) [centimeters in length] X 26 cm (W) [centimeters in width] dark purple bruise to right rib area and right breast area. Reported to . . . Nurse Manager . . . COTA [certified occupational therapy assistant] . . . checked lift for proper functioning. Machine cleared. Pain assessment completed. Resident denied pain throughout shift. . . ." During an interview with Resident #1 on 05/21/24 at 11:00 a.m., the resident stated she has been a resident at the facility for eight years. When asked about the incident that caused the bruises she described, "I was all bruised along my chest and down my leg. She [CNA] had that lift backwards. It was so painful, and I told her it was wrong, and I was hurting but she ignored me." The resident explained she had never had that happen to her before or since the episode on 4/28/24. The resident acknowledged the bruises did not show up until a couple of days later and "the two nurses that came to check on me were so upset and said, 'what in the world happened here?' So, I told them . . ." During an interview with a staff member (#8) on 05/21/24 at 1:00 p.m., the staff member stated she observed bruises on the resident's chest area while assisting the resident on the morning			F 689	was reviewed on 5/28/24. No changes were made to the policy at this time. Mandatory staff in-services occurred on 5/28, 5/29, and 5/30 for all nursing staff. Staff were educated on proper mechanical lift policies and procedures and were required to demonstrate proper lift usage. 4) Director of nursing, or designee, will perform routine audits of nursing staff operating the mechanical lifts to proper procedures are performed. These audits will be completed twice per week for a period of three months and then will be reduced to weekly for a period of three months. Audits will then be reduced to monthly for at least six months or until compliance has been achieved and sustained. Results of these audits will be shared with the facility QA committee on a quarterly basis.		

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F 689	Continued From page 2 of 04/30/24. The staff member said she was stunned to see the bruising and wondered what happened. She immediately reported it to the charge nurse. The staff member said the resident often talks about being "scared" now when being lifted and she had not expressed that fear before. Review of the Facility Reported Incident investigation identified, "... It was noted on 4-30-24 during AM [morning] cares that [resident] has a very large bruise to her right breast mid nipple line and down and to the side area that is black /blue in color. Bruised area measures 18 x 26 cm. When [resident] was asked about the bruise, [resident] stated that two evenings ago (04/28/24) she kept telling the "new" CNA that the lift was hurting her, but the CNA wouldn't listen to her and kept talking over her as she proceeded with the transfer despite [resident's] continued complaints of pain. . . ." During an interview on 05/21/24 at 2:45 p.m., two administrative staff members (#1 and #2) confirmed they expected staff to follow the proper procedure for stand lift transfers. The facility failed to ensure staff followed appropriate procedure for a transfer with a sit to stand lift. 2. Based on record review, staff interviews, review of facility policy, and review of a facility reported incident, the facility failed to prevent accidents for 1 of 1 sampled resident (Resident #3) reviewed for an accident with subsequent injury. Failure to follow facility policy for proper use of a maxi-lift (mechanical full body lift) resulted in injury.	F 689			

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F 689	Continued From page 3 Findings include: Review of the facility policy titled "Mechanical Lift - Total Lift" occurred on 05/21/24. This policy, revised December 2022, stated, "Purpose: A mechanical lift is used appropriately to facilitate transfer of residents. *The mechanical lift is used by nursing staff. *Two persons are needed to use mechanical lift unless indicated by resident's care plan. Procedure: 3. Place lift sling under the resident; position lift over resident. 4. Attach sling clips to lift, making sure they are attached snugly. . . ." Review of Resident #3's medical record identified diagnoses of dementia and muscle weakness. The current care plan identified, ". . . Self-care deficit related to osteoarthritis, . . . and other risk factors. . . . Assist X 2 [two staff people] with maxi lift for all transfers. . . ." Record review occurred on 05/21/24. The nurse's notes identified the following: *02/23/24 at 10:32 a.m. "CNA's states [sic] while lifting resident in maxi lift didn't realize straps were not properly attached causing resident to fall back and hit her head on the floor causing laceration [cut] 1 cm [centimeter] x 0.1 cm. Assist x 2 to lift resident up off floor back into her wheelchair. Writer and treatment nurse assessed resident's laceration, cleansed with NS [normal saline] applied steri strips [a type of band aid used to hold wound edges together]. . . . Writer called [providers office] spoke to Nurse [name] states to monitor, neuro [neurological] checks every two hours and call if any other concerns. . . . Education given to staff in prevention of future			F 689			

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F 689	Continued From page 4 falls, to assure maxi lift sling is properly in place when attempting to lift resident. . . ." *2/27/24 11:00 a.m. "f/u [follow up] to fall on 2/23/24: 2 CNAs were assisting [resident] to use the commode per maxi lift. Lift sling was properly connected between [resident's] legs, but the top hooks were not connected; neither CNA confirmed correct placement prior to lifting [resident] into the air and as she was being lift [sic], [resident's] body weight shifted her backward on her w/c [wheelchair], causing her to fall back and hit her head on the floor. [Resident] sustained a 1 cm x 0.1 cm laceration to the back of her scalp . . ." During an interview on 05/21/24 at 1:15 p.m., a staff member (#4) stated she thought the other CNA in the room said, "I hooked the back clips," but instead she said, "you need to hook the back clips." She said they miscommunicated. Review of the Facility Reported Incident investigation identified, ". . . [Resident] was being transferred from her wheelchair with the use of the maxi lift. CNA used the remote on the maxi lift to lift [resident] up in the maxi lift while [other] CNA was elsewhere in the room. Bottom lift sling clips were clipped, but upper lift sling clips were not clipped causing [resident's] wheelchair to tip backward and [resident] to fall backward and hit head on the floor. [resident] sustained a 0.1 x 1 cm laceration to the back of head. During an interview on 5/21/24 at 2:45 PM, two administrative staff members (#1 and #2) confirmed they expected staff to follow the proper procedure for mechanical full body lift transfers.	F 689			

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F 689	Continued From page 5 The facility failed to ensure staff followed mechanical lift procedures which resulted in injury. 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 02/23/24. *Determining staff failed to follow the Maxi-lift policy and resulted in a resident's fall with injury. *Providing 1 on 1 education immediately after the incident with involved staff regarding proper use of Maxi-lift and sling with return demonstration to the rehabilitation manager. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: *Providing education to all nursing staff on proper mechanical lift transfers on 04/09/24. The survey team determined a deficient practice existed on 02/23/24. The facility implemented corrective action on 02/23/24 and completed nursing education on 04/09/24.			F 689			