STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	**1104 HWY 12 HETTINGER, ND 58639**

(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 The complaint survey started on July 12, 2021 and was completed on July 13, 2021. A partial extended survey subsequent to the complaint survey was completed on July 20, 2021.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		8/11/21

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

Electronically Signed | 08/04/2021

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, and staff interview, the facility failed to ensure the resident representative received notification for 1 of 1 sampled resident (Resident #1) who experienced a fall from a mechanical lift (Hoyer). Failure to ensure the resident's representative received notification of the fall after onset of pain and difficulty breathing limits their ability to make informed decisions regarding medical assessment and treatment for possible injury. Findings include: Information provided by the complainant indicated the facility failed to notify the resident's representative of Resident #1's fall from Hoyer (full body lift) lift after the onset of persistent pain	F 580	1.) The corrective action accomplished related to notifying the resident representative of a fall is that an attempt to immediately contact Resident #1□s POA and subsequent message to call the facility for an update occurred on 07/01/21. The POA was also notified on 07/05/21 regarding Resident #1□s current status and updated after his clinic appointment. In addition, a care conference was held with the POA on 07/10/21 to further review the incident and answer any additional questions. 2.) The facility recognizes that all residents whom fall have the potential to be affected by the same practice. 3.) Measures put into place to ensure this practice will not reoccur are that	

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F 580	Continued From page 2 and breathing difficulty. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) affecting the right side and aphasia (difficulty speaking). The current care plan stated, "[Resident's nickname] requires extensive assistance with adls [activities of daily living] . . . Assist with transfers using the Hoyer lift and 2 persons. . . . Falls: [Resident's nickname] is at risk for falls . . . If a fall occurs notify family . . . COGNITION: The resident has impaired cognitive function . . . BIMS [Brief Interview for Mental Status] is a 2 [Severe cognitive impairment]." Resident #1's nurses' notes identified the following: * 07/01/21 at 9:34 a.m. "This nurse was called to resident room by staff. This nurse observed resident on the floor. 2 staff members where [sic] in the room with the resident and the Hoyer lift. Per staff reports, one of the handles that they hook the resident sling in tilted downwards and the clamps to assist with keeping the lift slings in place while lifting the the [sic] resident allowed the sling to come off the left [sic] causing the the [sic] resident to fall out of the Mechanical lift. Resident assessed immediately, denies pain, PROM [passive range of motion] to all extremities, no deformities noted. Skin intact. Assisted resident to his wheel chair 3 person assist with another Hoyer lift . . . Family [sic] member [name] contacted and a VM [voice message] left to contact the facility." * 07/01/21 at 11:26 p.m. "Fall f/u: [follow up] resident lying in bed in supine position, HOB [head of bed] elevated, denies pain when asked	F 580	nursing staff were reeducated on 08/10/21 at an in-service by the co-Directors of Nursing Services on the facilities policy entitled, Falls and Fall Prevention. Emphasis will be put on the need to ensure all attempts to notify the POA are clearly documented within the medical record. 4.) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator/designee to monitor by using random audits that resident representatives are notified following a fall per facility policy. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 08/08/21. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5.) Corrective action will be completed by 08/11/21.	

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F 580	Continued From page 3 by this nurse, however CNAs [certified nursing assistants] reported grimacing when placing resident in bed . . . appeared to have difficulty breathing. Tylenol PRN [as needed] given as ordered. Resident refused 02 [oxygen]. . . ." Review of Resident #1's July 2021 Medication Administration Record (MAR) showed from July 2-6 pain levels documented ranged from 4-7 (pain scale defined 0 as no pain and 10 as worst pain) on 11 occasions when Tylenol PRN 650 milligrams administered. The medical record lacked evidence of further attempts to notify the resident's representative regarding Resident #1's fall from the lift after initial onset of pain including difficulty breathing. During an interview on the afternoon of 07/12/21 an administrative nurse (#1) stated she would expect staff to keep calling the resident representative to notify them of a fall.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not	F 609		8/11/21

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F 609	Continued From page 4 involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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: Based on record review, review of State Survey Agency reports, review of facility policy, and staff interview, the facility failed to report to the State Survey Agency a potential incident of neglect for 1 of 1 sampled resident (Resident #1) who experienced a fall from a mechanical lift. Failure to report all alleged incidents of neglect placed all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 07/12/21. This policy, revised 09/13/19, stated, ". . . Ensure that all alleged violations involving abuse, neglect, . . . are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not	F 609	1.) The corrective action accomplished related to reporting all alleged incidents of neglect is that Resident #1□s fall from the Hoyer lift was reported to the State Survey Agency on 07/07/21. 2.) The facility recognizes that all residents have the potential to be affected by the same practice. 3.) Measures put into place to ensure this practice will not reoccur are that nursing staff were reeducated on 08/10/21 at an in-service by the co-Directors of Nursing Services on the facilities policy entitled, Abuse, neglect, and exploitation. Emphasis will be put on the need to immediately report any potential incidents of abuse or neglect to administration for subsequent review and determination on appropriate timeframes for reporting to the State Survey Agency. 4.) The facility plans to monitor its	

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F 609	Continued From page 5 involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including State Survey Agency. . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) affecting the right side, aphasia (difficulty speaking) and shortness of breath. The current care plan stated, "[Resident's nickname] requires extensive assistance with adls [activities of daily living] . . . Assist with transfers using the Hoyer [total body lift] lift and 2 persons. . . ." Resident #1's nurses notes identified the following: * 07/01/21 at 9:34 a.m. "This nurse was called to resident room by staff. This nurse observed resident on the floor. 2 staff members where [sic] in the room with the resident and the Hoyer lift. Per staff reports, one of the handles that they hook the resident sling in tilted downwards and the clamps to assist with keeping the lift slings in place while lifting the the [sic] resident allowed the sling to come off the left [sic] causing the the [sic] resident to fall out of the Mechanical lift. . . ." Review of the facility FRI (Facility Reported Incident) identified Resident #1 had a fall from the Hoyer lift on 07/01/21. The facility reported the fall on 07/07/21 (six days later). The facility failed to report the incident to the State Survey Agency within 24 hours. During an interview on the afternoon of 07/07/21, an administrative nurse (#1) stated the facility reported the incident on 07/07/21 after receiving the x-ray results.	F 609	performance to make sure solutions are sustained by assigning the QA Coordinator/designee to monitor by using audits that any potential incidents of abuse or neglect are reported to the State Survey Agency per facility policy. These audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 08/08/21. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5.) Corrective action will be completed by 08/11/21.	

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F 609	Continued From page 6 See F689	F 609		
F 689 SS=J	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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON 03/17/21 Based on observations, record review, information from the complainant, review of facility policy, review of the mechanical lift operator's manual, review of facility's fall investigation report, and staff and service technician interviews, the facility failed to provide appropriate and sufficient supervision to prevent accidents for 1 of 1 sampled resident (Resident #1). Failure to safely utilize/maintain a mechanical lift with a sling resulted in a fall with injury for Resident #1. Failure to complete a thorough investigation and immediately educate nursing staff on safe mechanical lift procedures placed all residents requiring this type of transfer at risk for accidents and/or injury. During the complaint survey on July 12, 2021, the team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential	F 689	1.) The corrective action accomplished related to educating nursing staff on the use of mechanical lifts and removing the lift from service is that the Vanderlift II B 450 Vancare lift was immediately taken out of service following the incident on 07/01/21 and remained out-of-service until formal evaluation occurred by Northland staff on 07/06/21. In addition, the Vanderlift II B 450 Vancare lift was retired from use on 07/12/21. 2.) The facility recognizes that no additional residents have the potential to be affected by the same practice since the Vanderlift II B 450 Vancare lift was taken out of service. 3.) Measures put into place to ensure this practice will not reoccur are that nursing staff begin reeducation on the Vanderlift II B 450 Vancare lift following inspection by Northland staff on 07/06/21. In addition, nursing staff were educated on the facilities new Volaro lifts prior to	8/11/21

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F 689	Continued From page 7 resulted from observation of the mechanical lift, review of Resident #1's medical record regarding a fall with injury, the facility fall investigation, staff training records, and staff interview. These findings placed residents in immediate danger due to a need for education on the use of the safety clips on the Hoyer (full body mechanical lift) lift and the importance of staff not physically altering the rubber safety clips to prevent additional serious injury as the lift remained in service. * 07/12/21 at 2:52 p.m. - The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. * 07/12/21 at 4:35 p.m. - The survey team notified the Co-Director of Nursing [DON] of the IJ situation and requested they develop a plan for abatement of the immediate jeopardy. * 07/13/21 at 9:19 a.m. - The facility provided a written plan (via email) of correction for the IJ. * 07/13/21 at 9:50 a.m. - The survey team reviewed and accepted the facility's written plan. * 07/13/21 at 1:00 p.m. - The survey team determined the IJ situation at a scope/severity of J was abated and reduced to a scope and severity of G. * 07/13/21 afternoon - The SSA notified the regional office of the immediate jeopardy situation. Findings include:	F 689	their next scheduled shift beginning on 07/13/21 and underwent a competency based skills evaluation. All new facility contract or core staff will be educated on the safe use of lifts during the facilities established orientation process. At an in-service by the co-Directors of Nursing Services on 08/10/21, emphasis was put to immediately remove any malfunctioning lifts from service and report any noted alterations on lifts to maintenance staff. Finally, The Director of Environmental Services reeducated his staff regarding the need to complete lift inspections in accordance with the manufacturer□s guidelines on 08/10/21. 4.) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator/designee to monitor by using audits that new nursing staff receive education on mechanical lifts. An additional audit will be performed to ensure that lift inspections are occurring per manufacturer□s guidelines. These random audits will be done weekly x 8, monthly x 4, and then for one quarter beginning the week of 08/08/21. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5.) Corrective action will be completed by 08/11/21.	

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F 689	Continued From page 8 Review of the facility policy titled "Lifting Machine, Using a Portable" occurred on 07/12/21. This undated policy stated, ". . . To transfer a resident from the bed to a chair . . . 5. Attach the hooks to the sling. Be sure the hooks are placed so that they are facing away from resident. 7. Attach the sling to the lift . . ." Review of the facility's Vancare (Vanderlift II) mechanical lift operator's manual occurred on 07/13/21. This manual stated ". . . It is also required that qualified maintenance staff inspect the lift at least monthly for missing parts and excessive wear that might cause the lift to fail. A permanent record of each of these inspections and repairs made should be kept by the facility . . ." The facility failed to provide records of monthly inspections and operator's instructions addressing the use/maintenance of the rubber safety clips. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (stroke) affecting the right side and aphasia (difficulty speaking). The current care plan stated, "[Resident's nickname] requires extensive assistance with adls [activities of daily living] . . . Assist with transfers using the Hoyer lift and 2 persons . . . COGNITION: The resident has impaired cognitive function . . . BIMS [Brief Interview for Mental Status] is a 2 [Severe cognitive impairment]." Resident #1's nurses' notes identified the following: * 07/01/21 at 9:34 a.m. "This nurse was called to resident room by staff. This nurse observed	F 689		

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F 689	Continued From page 9 resident on the floor. 2 staff members where [sic] in the room with the resident and the Hoyer lift. Per staff reports, one of the handles that they hook the resident sling in tilted downwards and the clamps to assist with keeping the lift slings in place while lifting the [sic] resident allowed the sling to come off the left [sic] causing the [sic] resident to fall out of the Mechanical lift. Resident assessed immediately, denies pain, PROM [passive range of motion] to all extremities, no deformities noted. Skin intact. Assisted resident to his wheel chair 3 person assist with another Hoyer lift Immediately [sic] removed the malfunctioning lift out of use to be looked at by maintenance. immediately [sic] checked all lifts in facility for functionality. MD [Medical Doctor] notified via fax communication, Family [sic] member [name] contacted and a VM [voice message] left to contact the facility." * 07/01/21 at 11:26 p.m. "Fall f/u: [follow up] resident lying in bed in supine position, HOB [head of bed] elevated, denies pain when asked by this nurse, however CNAs [certified nursing assistants] reported grimacing when placing resident in bed, CNAs also reported that resident appeared to have difficulty breathing. Tylenol PRN [as needed] given as ordered. Resident refused O2 [oxygen] via NC [nasal cannula]." *07/02/21 10:11 a.m. "The resident is being monitored status post fall day # 1. He has generalized pain to the abdominal area. No bruising noted. He was medicated with Tylenol which was helpful. Also received back the faxed communication to MD that they are aware of this Fall [sic]." At 10:57 p.m. ". . . fall day #2. He has generalized pain in the abdominal area. The resident wants the HOB elevated . . . medicated with Tylenol this evening for pain."	F 689		

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F 689	Continued From page 10 * 07/04/21 at 4:10 a.m. "The resident is being monitored for a fall on 7/1/2021, fall day #3. He continues to C/O [complain of] generalized pain in the abdominal area, the pain [sic]. The resident wants the HOB elevated and had O2 on at 2 L [liters]. No bruising noted. He was medicated with Tylenol this evening and night for pain." * 07/05/21 at 8:35 a.m. (Restorative Program Note) "Resident seen today for restorative nursing services. Resident propelled self down to therapy room in his w/c [wheelchair]. Resident completed AROM [active range of motion]/PROM exercises, and refused walking. Resident did wince when performing ROM on his R [right] UE [upper extremity] and is leaning to the left while sitting in his w/c. Resident did cough, and did have an expression of pain on his face with this, and grabbed for his ribs. Charge Nurse [nurse initials] was notified." * 07/05/21 at 8:54 a.m. "Resident winces during exercises with CPTA [certified physical therapy assistant], CPTA asked resident where did it hurt, . . . pointed to his ribs. CPTA notified the nurse, and the nurse asked the resident did his ribs hurt, resident nodded yes. No wincing observed while the resident is breathing. No labored respirations noted. No bruising observed during the assessment. Notified MD via fax, awaiting a response." * 07/05/21 at 10:22 a.m. "CMA [certified medication aide] reported that while residents [sic] was being toleilting [sic], he was wincing and facial grimacing and was hollowing [sic]. Nurse called [name] Clinic Nurse [name] and gave her an status update regarding resident complaining about pain in the rib region, getting a possible x-ray then possibility of him being seen also. Clinic nurse stated that she will speak to [name]	F 689		

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F 689	Continued From page 11 FNP [Family Nurse Practitioner] to [sic] Residents PCP [Primary Care Physician]." * 07/05/21 at 12:16 p.m. "Received a phone call back from [clinic nurse] stating that [name] FNP would like him seen by one of the residents [doctor in training] today in the clinic. Clinic appointment scheduled for 1400 [2:00 p.m.]. Transportation is being provided by the facility and he will have a staff escort. Called and spoke to [name of power of attorney (POA)] about residents status and the appointment scheduling. She voiced understanding." * 07/06/21 at 13:12 "CPTA alerted nurse that resident is wincing and having a lot of pain on his right side. Called and left a message for [MD name] inquiring about some more pain medication other that Tylenol." * 07/06/21 at 1:29 p.m. "[MD name] returned phone message and instructed nurse to give Motrin 400mg [milligrams] Alternating [sic] from [sic] Tylenol PRN Q [every] 4-6 hours to a max [maximum] of 2400 mg/day. Incentive Spirometer Q30 mins [minutes] 2 deep breaths. MD informed nurse that resident has a liner [sic] rib fx [fracture] and a possible stress leg fx. Called and left a message for [Name of POA] to call the facility." A fall investigation report, dated 07/01/21, stated, "The Nurse was called to [Resident name] room by staff. The Nurse observed the resident on the floor. Two staff members were in the room with the resident and the hoyer lift. One of the handles that they hook the resident sling in was slightly tilted downwards and the clamp to assist with keeping the lift slings in place while lifting the resident allowed the sling to come off the lift causing the resident to fall out of the mechanical lift. The nurse assessed the resident	F 689		

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	355042	A. BUILDING _____ B. WING _____	C 07/20/2021

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F 689	Continued From page 12	F 689		

immediately. [Resident name] denied pain, PROM to all extremities. No deformities noted. Skin intact. Three staff members assisted resident to his wheelchair with another hoyer lift. The hoyer lift that was used when the fall occurred was immediately taken out of service. All lifts were immediately checked for functionality. MD was notified regarding fall. POA was notified by phone with a voice message to contact the facility. 7/2/21 [Resident name] c/o generalized pain in abdominal area when he coughed . . . 7/5/21 [Resident name] c/o increased pain in right abdominal area. Practitioner was notified and x-rays were ordered. Clinic appointment on 7/5/21. Linear right rib fracture and possible stress fx to right leg noted. Motrin alternating with APAP [acetaminophen] was ordered. Incentive spirometer was also ordered. . . ."

Resident #1's clinic report dated 07/05/21 stated, "The patient . . . presents with complaints of pain. The pain is described as being located in the right side ribs and right arm. The onset of pain has been acute and had been occurring in a persistent pattern for 4 days. The course has been increasing. The pain is described as moderate . . . CNA states that hoyer lift tipped over on patient causing patient to fall to ground . . . The chest pain has been occurring for 4 days in a persistent pattern. The course has been constant. The level of severity is moderate. . . There has been associated trauma. . . . Pain was precipitated by a fall in the nursing home, pt [patient] was being moved by the halter-swing, and the machine tipped over a [sic] dropped him on his right side [This report conflicted with the nursing facility's fall investigation report, dated

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F 689	Continued From page 13 07/01/21]. Pain is worse with inspiration . . . Assessment and Plan . . . Pt had a fall at the NH [nursing home] while using the transfer lift. Pt was dropped, likely on the Rt [right] side. . . . Tylenol 500mg q4-6 hours as needed for pain control . . . Ibuprofen 400mg q4-6 hours as needed for pain control. . . ." Review of Resident #1's Medication Administration Record (MAR) for July 1-12, 2021 identified the following: * 07/01/21 Acetaminophen 650 mg by mouth every 4 hours as needed for pain for 7 days. Resident #1 received 12 doses of prn acetaminophen from 07/02/21 through 07/07/21. * 07/06/21 Ibuprofen 400 mg by mouth every 4 hours as needed for pain control alternate acetaminophen and ibuprofen. Resident #1 received 4 doses of ibuprofen from 07/07/21 thru 07/09/21. Review of Resident #1's chest x-ray report, completed on 07/05/21, identified ". . . suspicious for nondisplaced right eighth rib fracture." Observations on the morning and afternoon of 07/12/21 showed the Vancare (Vanderlift II) lift used to transfer residents and had a thick glue around the top of the rubber safety clip. Interviews on the morning and afternoon of 07/12/21 identified three of four CNAs (#3, #6, and #7) interviewed lacked education on the Vancare (Vanderlift II) lift including the importance of not altering the safety clips after Resident #1 experienced a fall from the mechanical lift.	F 689		

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F 689	Continued From page 14 During an interview on 07/12/21 at 2:01 p.m., when asked if he/she has ever turned a rubber safety clip or observed the clips turned the CNA staff member (#3) stated, "I have not turned them, but I have observed them turned and I notified maintenance." During an interview on 07/12/21 at 2:12 p.m., a CNA (#5) identified by the facility as a CNA trainer, stated the rubber safety clips move in all directions and are not safe to use when they are turned. During an interview on 07/12/21 at 2:42 p.m. with a maintenance staff member (#2) and an administrative nurse (#1) the staff member (#2) stated he/she provided maintenance repair on the Vancare (Vanderlift II) mechanical lift after Resident #1's fall from the lift. He/she reported two of the safety clips, one on each side of the lift, were turned outward. When asked how this happened, he/she stated nursing staff turn these rubber safety clips outward as it easier for the staff to use the lift. He/she then replaces the safety clips or re-glues them. He/she used rubber safety clips designed for the sit to stand lift in place of the original metal clips. When asked how often facility staff perform routine maintenance on the mechanical lifts, he/she stated only when staff have an issue with the lift. During a phone interview on 07/12/21 at 3:57 p.m., a mechanical lift service technician (#4) stated, "I have not seen rubber safety clips used at other places as I don't usually service Vancare (Vanderlift II) lifts. The rubber safety clips are a bad design and the facility said they are ordering upgraded spring safety clips. I complete annual	F 689		

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F 689	Continued From page 15	F 689		

lift inspections and additional inspections when the facility requests them, but the operator manual does recommend the facility complete a monthly inspection." When asked if he/she completes monthly inspections the technician (#4) stated he/she did not.

The facility placed the Vanderlift II back into service for staff utilization of resident transfers on 07/07/21 after the inspection completed by the service technician (#4) on 07/06/21. A letter from the technician's service company, dated 07/20/21, stated, "The performance test did not present evidence of problems on asset [Vanderlift II] . . . and 'passed' the annual inspection . . . there are rubber clips available for safety purposes that are not necessary but an additional safety feature. . . ." The review/letter failed to note any mechanical problem noted in the facility's Fall Investigation Report, dated 07/01/21.

Review of staff education showed five Vander-Lift, Vander-Lift II & Vango Skills Observation Assessment sheets completed by staff from 07/07/21 through 07/12/21.

The facility failed to immediately educate nursing staff after Resident #1's fall and injury from a mechanical lift on 07/01/21. Lack of staff education to ensure competency regarding proper utilization of a mechanical lift and the importance of not physically altering the rubber safety clips placed other residents at risk for injury during transfer with a mechanical lift. The facility failed to complete a thorough investigation regarding a mechanical failure and/or possible operator failure including a clinic report, dated

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F 689	Continued From page 16 07/05/21, documenting the lift "tipping over" versus the Fall Investigation documenting the sling came off the lift causing the resident to fall. The facility failed to complete monthly lift inspections as required/stated in the Vanderlift II Operating Manual and failed to ensure operating instructions included the utilization of the rubber safety clips and appropriate/safe process for gluing/maintenance of the safety clips on the mechanical lift.	F 689		