STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER POINTE A PROSPERA CO	3500 21ST ST SE MANDAN, ND 58554

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F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on September 19, 2024. During the report investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 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	F 609		10/24/24

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

Electronically Signed | 10/03/2024

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F 609	Continued From page 1 by: Based on review of the facility reported incident, review of facility policy, and record review, the facility failed to report an incident of potential neglect to the State Survey Agency (SA) for 1 of 1 sampled resident (Resident #1) who fell out of a mechanical lift. Failure to report an event of potential neglect in the required time frame does not comply with regulations established to protect residents. Findings include: Review of the facility policy, "Abuse and Neglect," occurred on 09/19/24. This policy, dated 07/22/24, stated, "PURPOSE: * To ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location . . .* To ensure that all identified incidents of alleged or suspected abuse/neglect . . . are promptly reported and investigated. . . . PROCEDURE: . . . 4. Notification procedures: a. Alleged or suspected violations involving any mistreatment, neglect . . . will be reported immediately to the administrator. b. In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.). . . Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. ii. If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made." Review of the facility reported incident, received by the SA on 09/13/24, indicated Resident #1 fell	F 609	F-609: Reporting of alleged violations It is the intent of this facility to remain in compliance with F-609 and report alleged violations as written in the policy. Resident #1 had previously had the potential violation reported on 9/13/24. All residents who sustain a fall have the potential to be affected by this deficient practice. The policy entitled Abuse and Neglect-Rehab/Skilled, Therapy & Rehab was reviewed and remains in place unchanged. Education was initiated with all staff which includes review of the policy entitled Abuse and Neglect-Rehab/Skilled, Therapy & Rehab beginning 10/1/24. QI Monitoring using the audit tool entitled Validation Checklist – Reporting Alleged Violations will begin the week of 10/24/24. All falls will be audited for compliance x 12 weeks. QI monitoring will be completed by the QI coordinator and/or her designee. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined	

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F 609	Continued From page 2 from a full body lift on 09/11/24. Review of the final investigation report, dated 09/17/24, stated, "[name of resident] fell in his room witnessed while being transferred in a total lift by 2 staff. Staff did not loop sling on lower left side and hook to lift appropriately. . . . Assessment completed and nurse noted right knee was swollen and indent noted. . . ." Review of the facility reported incident identified the facility reported Resident #1's fall out of a mechanical lift on 09/13/24, two days after the incident occurred. Facility staff failed to report an incident of potential neglect within the required timeline of 24 hours. Refer to F689.	F 609	based on these findings.	
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 record review, policy review, review of staff education, review of facility reported incident, and resident interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #1) who fell out of a mechanical lift. Failure to safely use the mechanical lift resulted in a fall	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 3	F 689		

with injury for Resident #1. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident.

Findings include:

The surveyor determined a deficient practice existed on 09/11/24. The facility immediately implemented corrective action and completed corrective action on 09/16/24.

Review of the facility policy, "Safe Resident Handling Program Overview" occurred on 09/17/24. This policy, dated 02/28/24, stated, ". . . Policy: . . . goal is to maintain a safe living . . . environment for residents . . . All caregivers . . . must receive thorough, documented training prior to conducting mobilization . . . Care givers will perform a TIME OUT safety stop while the resident is in a sling or harness and still over the surface of the bed or chair to ensure that all straps are secure before moving away from the surface. This is to be competed once the straps are taut, but before the resident leaves a surface. . . ."

Review of final investigation of the facility reported incident, dated 09/17/24, stated, "[name of resident] fell in his room witnessed while being transferred in a total lift by 2 staff. Staff did not loop sling on lower left side and hook to lift appropriately. . . . Assessment completed and nurse noted right knee was swollen and indent noted. . . . Resident was immediately seen by floor nurse post fall and assessment completed. Resident alert and orientated post fall. No concerns of abuse or neglect noted. Staff

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F 689	Continued From page 4	F 689		

members that were involved with transfer were immediately interviewed and education provided. Competency completed by registered nurse on 2 staff post incident. Administration reviewed all staff meeting competency and education reviewed at that time. Discussed lift education with those due for annual education. . . Resident did not have any concerns and did not want to be seen by a provider until his primary was due to round 9/13/2024. On provider visit she discussed getting an Xray and he finally agreed. Preliminary showed fractures of right tibia and fibula. Results of Investigation: Resident was transferred with total lift by 2 staff. One staff member did not loop sling bottom appropriately which resulted in resident falling out of lift. Resident had seen orthopedics and has immobilizer . . . Final Action Taken: No indication of abuse or neglect. Staff education completed and competency done with 2 staff involved incident immediately."

During an interview with Resident #1 on 09/17/24 at 9:00 a.m. regarding the fall from the mechanical lift, the resident stated, "it was just an accident, one strap wasn't hooked up right." The resident stated his leg "bent behind" him, but he didn't have any pain because of his paraplegia. Resident #1 stated he didn't go to the emergency room (ER) right after it happened because "there wasn't anything they could do about it anyway."

Review of Resident #1's medical record occurred on the morning of 09/17/24. The record identified Resident #1 as cognitively intact and able to make decisions.

Review of nursing progress notes identified the following:

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F 689	Continued From page 5 * 09/11/24 at 12:49 p.m., "This nurse was called to residents' room. Resident was on the ground with one strap attached to the Hoyer lift and the left strap was not attached. CNA [certified nursing aide] stated that the strap was not looped into the other strap on the left side. Resident uses a multipurpose sling. Resident was being transferred from his w/c [wheelchair] back into his bed. Resident stated his leg got bent back when he fell to the floor. Residents right knee was slightly swollen and had a small indent on it under the knee. Resident did not bump his head. Resident denied any pain. Resident is a paraplegic. This nurse did ROM [range of motion] on residents left knee. Resident was Hoyer [mechanical lift device] lifted back to bed and vitals were took which were WDL's [within normal limits] for resident. This nurse assessed resident and found no bruising on resident. . . . This nurse had therapy assess residents' knee while back in bed. A note was left for provider and resident will be seen on Friday as resident would like to see [name of provider] PA-C [Physician's Assistant - Certified]. This nurse called residents wife and explained thoroughly everything noted." * 09/12/24 at 3:55 p.m., "Fall team met to discuss recent fall, education has been completed including competency with staff present during fall, all staff competency and education reviewed and discussed with those due for annual education." * 09/13/24 at 5:43 p.m., ". . . Resident returned from his x-ray. Resident has 2 fractures in his right knee and was sent to ER. Resident denied surgery and has a splint on his right knee. Resident is suppose [sic] to see ortho in a week but at this time is going to think on it since he is being discharged next week. Resident had no	F 689		

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F 689	Continued From page 6 other new orders noted. . . . Residents' wife is aware of all the new orders listed and resident's wife was at ER with resident." Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions as follows: * The employees involved in the incident were immediately re-educated on Safe Resident Handling and use of the mechanical lift and slings. * Provider and family notified of the fall and follow up care and treatment provided. * Education provided to all staff members on Safe Resident Handling, including use of various lift devices, types and sizes of slings, and mechanical lift scenarios.	F 689		