STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTZ LIVING CENTER	**555 LAKE AVE E NAPOLEON, ND 58561**

(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 started on May 29, 2024, and concluded on May 30, 2024. During the report investigation the facility was found noncompliant with regulatory requirements. Based on the results of the investigation survey, an extended survey was conducted on May 30, 2024.	F 000		
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: Based on observation, record review, review of the facility reported incident (FRI) report, facility policy review, and staff interviews, the facility failed to prevent accidents for 1 of 1 sampled resident (Resident #1) who sustained a fall with fractures. Failure to use the appropriate sling sized during a full body mechanical lift transfer resulted in an avoidable fall and fractures for Resident #1 and places all residents at risk for falls and/or injuries. During the investigation survey, the team consulted the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 05/29/24 at 3:00 p.m. The IJ resulted from a failure by the facility to assess residents	F 689	Wentz Living Center (WLC) staff will ensure residents environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident no. 1 is currently bed bound. When she is medically cleared to be transferred she will be assessed by nursing or therapy for appropriate sling size for the dependent mechanical lift. 2. All residents will be assessed by nursing or therapy for appropriate sling size with dependent mechanical lift transfers, referencing the updated policy. 3. WLC has 1 resident with current	6/21/24

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

Electronically Signed | 06/16/2024

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F 689	Continued From page 1 for the proper sized sling for use during a full body mechanical lift transfer. This failure resulted in a resident sustaining a fall and fractures. *05/29/24 at 4:00 p.m. The survey team notified the administrator and director of nursing of the IJ situation, provided them with the IJ template, and requested a plan for removal of the immediate jeopardy. * 05/29/24 at 6:30 p.m., The facility provided (via email) an IJ removal plan. The removal plan contained the following: * Therapy or nursing will assess sling size per policy developed * Therapy or nursing staff will communicate to the charge nurse of appropriate sling size, a comment order will be entered into provider orders, it will be care planned in the activities of daily living section and sent to the Kardex for easy certified nurse aides (CNAs) viewing. * Education will be provided to all nursing/CNA staff working the evening and night shift of 5/29/24 and day shift 5/30/24. Each CNA or nurse upon their first shift since this survey will be educated by reviewing the policy, care plan, Kardex and signing the education form. *05/30/24 at 10:00 a.m., the survey team accepted the IJ removal plan. The survey team verified the implementation of the plan and removed the IJ as of 05/29/24. The deficient practice remained at a scope and severity of a "G" after removal of the IJ. Findings included:	F 689	orders to be transferred with the dependent mechanical lift. She was assessed for proper sling size on 5/29/24 the size determined was put on the residents orders, care planned and on the CNA kardex. All orders received to use mechanical lifts will include proper assessment of sling size by nursing or therapy. Policy on sling sizing for mechanical lifts was developed on 5/29/24 and education was provided to nursing and CNA's on staff that pm shift. Education continued for the night shift, day shift on 5/30/24 then each aide or nurse on their first shift back from the survey date forward was educated and signed attendance. June 10 and 11, 2024 monthly nursing, CMA, and CNA staff meetings were held which also included a review of the new sling sizing policy, care planning and kardex. 4. WLC will monitor our 1 resident who has current orders to use a dependent mechanical dependent lift monthly starting in June, and if any additional residents receive transfer orders to use a dependent mechanical lift for transfers they will be added to our sample - monthly x 3, then quarterly by an office nurse or QA coordinator. The data will be reviewed by the QA committee and board of directors monthly x3 then quarterly. DON reviews the QA data at monthly staff meetings and re-educates as needed.	

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F 689	Continued From page 2	F 689		

Review of the facility policy titled "Mechanical Dependent Lift" occurred on 05/29/24. This policy, dated December 2019, failed to include assessments for the proper sling size for resident's dependent on mechanical lifts for transfers.

Review of the facility's initial incident report, submitted to the state agency on 05/28/24, identified Resident #1 slipped out of the sling and onto the floor.

Review of Resident #1 medical record occurred on 05/29/24. The care plan identified, ". . .The resident has an ADL [Activities of Daily Living] selfcare performance deficit . . . requires dependent Mechanical lift . . ." A nursing progress note, dated 05/28/24 at 1:54 p.m., identified the following: ". . . resident is laying on floor . . . They [CNAs] [certified nursing aides] stated she fell out of sling."

During an interview on 05/29/24 at 10:40 a.m., a staff member (#2) stated, "We grabbed the Hoyer lift [full body mechanical lift] and used the sling that was with the lift." During the transfer the resident shifted in the sling and fell to the floor. Observation of Resident #1's room during this interview showed a small sling in the resident's bathroom.

During a telephone interview on 05/29/24 at 11:13 a.m., a staff member (#3) stated, we placed the resident in the sling, which was a medium.

During an interview with a staff member (#4) on 05/29/24 at 1:13 p.m., the staff member

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F 689	Continued From page 3 confirmed the CNAs used a medium sized sling. During an interview on 05/30/24 at 3:33 p.m., an administrative nurse (#1) agreed residents should have been assessed for sling sizes. The facility failed to assess Resident (#1) for the appropriate device (transfer sling) for a full body mechanical lift and provide staff with the information and education regarding transfers. This resulted in a fall with major injury for Resident #1.	F 689		