STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	C 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

(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 and concluded on 10/25/21.	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 information received from the complainant, record review, and staff interview, the facility failed to provide the necessary assistance to prevent an injury for 1 of 1 discharged resident (Resident #2) whose wheelchair tipped backwards while being transported in the facility van. Failure of the facility to ensure staff properly secured Resident #2's wheelchair in the van resulted in the resident experiencing a widening of a C1 [cervical vertebra near base of skull] anterior arch fracture and the development of a posterior arch fracture. Findings include: The complainant alleged the facility failed to properly secure a resident in the facility van which resulted in a fall with injury during transport. The facility failed to provide copies of their policy regarding transporting residents via the facility	F 689	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. R2 choose not to return to facility after admission to hospital. Any resident using the facility van has the potential to be affected. To protect	11/5/21

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

Electronically Signed | 11/11/2021

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F 689	Continued From page 1 van and/or the manufacturer's recommendations for the van's seatbelt/locking mechanism as requested. Review of Resident #2's medical record on 10/25/21 identified diagnoses including dementia and a cervical vertebra fracture. The progress notes identified the following: * 09/14/21 at 5:46 a.m., "Resident left with staff for . . . appointment will meet [family] and then will go . . . to [health care facility] . . ." * 09/14/21 at 7:55 p.m., "Resident returned with [family] from . . . appointment . . ." * 09/14/21 at 8:05 p.m., "Phone call recieved [sic] from . . . MD [medical doctor] who has talked with radiologist who reviewed x-rays taken this am he noted an Acute neck Fx [fracture] of C1 - calling it a Jefferson unstable fracture [a more severe injury that occur when the transverse ligament is also ruptured secondary to the extent of spread of the CI arch] and wants to have resident transferred by ambulance following C-spine [cervical-spine] precautions to . . . ER [emergency room] - he relates that resident has had a previous neck fracture and is unsure if what they are noting is a [sic] old or new fracture but doen't [sic] want to take a chance of having it be an issue not further followed up immediately. . . ." * 09/14/21 at 8:10 p.m., "Resident denies pain in upper back or neck relates it as a 'crackling noise with turning head' - in talking about pain scale he then is calling it a '4 to base of skull' . . . He is aware that he will be going back to [ER] . . . by ambulance for evaluation and is tearful . . ." * 09/14/21 at 10:30 p.m., "[Hospital] ambulance service is here and . . . aware to . . . follow	F 689	residents from a similar situation, Administrator and Activity Director completed a competency verification on 9/14/21 with activity assistant/CAN #6. On 10/22/2021 DNS educated nursing staff on proper notification of ADM/DNS of any incidents including those that occur during transportation of residents. On 10/27/2021, all van personnel had a competency validation to ensure capability to safely load, secure, transport, and unload residents, along with completed a pre/post transfer check. To ensure deficient practice will not recur, (1) Administrator/Activity Director will conduct weekly competencies checks on all van personnel weekly for a month, then 2x a month for 3 months, then yearly. Any new staff assigned transport residents will receive training in safely loading, securing, transporting, and unloading residents, along with expectation for notifying administrator if there is an incident or unusual occurrence. Competency will be verified before transferring residents independently, (2) a safety checklist and pre/post transport report will be completed for all resident transports and turned into the Administrator or designee, (3) during shift change, nurses will follow standard report form to ensure all incidents or unusual occurrences are reported to the oncoming shift, (4) Director of nursing or designee will monitor shift change reports during morning clinical meetings to ensure any	

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F 689	Continued From page 2 C-spine precautions and transport to [ER]. . . ." * 09/14/21 at 1:07 a.m., "Spoke to [ER] . . . resident was admitted by [MD] at this time they have no admitting diagnosis as resident is still in MRI [magnetic resonance imaging] . . ." The hospital reports identified the following: * 09/14/21 at 11:48 p.m., ". . . The patient . . . was at the [appointment] earlier today when he fell backwards in his wheelchair while in their van. He hit his head but denies any LOC [loss of consciousness]. No changes in vision or hearing. No headache, light headedness or dizziness. He did have some neck pain although it is feeling OK now. . . . He had a CT [computed tomography] head/neck there that saw C1 fx prompting admission here. . . . He also has a hx [history] of cervical spine surgery in the past. . . ." * 09/15/21 at 9:32 a.m., ". . . Patient has known anterior arch C1 fracture from July 2021. Call . . . to neurosurgery for review of images, with recommendation to wear Vista collar [neck brace] when out of bed, get MRI cervical spine and follow up in Neurosurgery clinic, which had not happened. Patient did not wear collar. New cervical CT scan 9/14/21 shows widening of C1 anterior arch fracture, and interval development of left posterior arch fracture. . . . neck tender at dorsal midline . . ." The incident report, dated 09/15/21, identified, ". . . Strap on w/c [wheelchair] in van not fastened tight enough [and] shifted off of stabalizer [sic] bar while driving. . . . Employee . . . re-instruction . . . [CNA (certified nursing assistant) (#6)] states she has been fully trained in van use [and] was comfortable [with] transfers. . . ."	F 689	incidents have been properly reported and addressed. To monitor performance, Administrator or designee will audit to ensure (1) competency check where completed per schedule and retraining was completed if indicated, (2) transportation reports are completed, (3) nurses are using standard shift change report and reporting incidents and unusual occurrence to the next shift (4) shift change reports are reviewed and morning meeting and proper action taken. Audits will occur weekly x4 weeks and every other week for 12 weeks. Administrator or designee will report findings the QAPI committee monthly for review and further recommendations as indicated. Substantial compliance achieved on 11/5/2021.	

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F 689	Continued From page 3	F 689		

An activity assistant/CNA (#6), who transported Resident #2 to the [appointment], submitted an undated, handwritten statement regarding the incident. It read, ". . . We were on our way to . . . meet up with [Resident #2's family]. [Resident #2] said he fell backwards and his bottom of neck landed on the ramp. I stop [sic] the van and went to check on resident and help him up. I notice [sic] one of the straps were [sic] loose. I double check the straps before we left again . . . I told his family of the incident and also when I came back to nursing home I reported it to the nurse."

On 09/15/21, an administrative staff member (#2) also submitted a handwritten statement regarding the incident. It read, ". . . [Activity Assistant/CNA (#6)] says she feels the straps were in correctly. . . . She is unsure what caused the strap to loosen. Inservice training/reeducation was provided by her supervisor. . . . [Activity Assistant/CNA (#6)] says there was a red mark across resident's shoulders. She does not feel [at] any time that he hit [at] the base of his skull (C1 area). Resident said 'he hurt a little' but was not in any sort of visible pain . . . [Activity Assistant/CNA (#6)] placed chair back into position, strapped him back in [and] drove the remaining distance. . . ."

During an interview on 10/25/21 at 2:05 p.m., a nurse (#3), who was on duty at the time Resident #2 returned from his . . . appointment, reported being unaware Resident #2's wheelchair had tipped backwards in the van. The nurse (#3) stated she was taken aback when the doctor phoned the facility later that evening and told her about the incident. She indicated the previous nurse had failed to update her regarding the incident during report.

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F 689	Continued From page 4 During an interview on 10/25/21 at 2:38 p.m., when asked how Resident #2's wheelchair tipped backwards during transport, an administrative staff member (#1) and the supervisory staff member (#4) stated, "Basically it was due to operator error. This was [Activity Assistant/CNA (#6)] first transfer out of town. She forgot to put the buttons down, so they [the straps] were not locked. [Resident #2] didn't fall out of the wheelchair. He fell backwards in the wheelchair. He hit the [folded metal loading] ramp. [Activity Assistant/CNA (#6)] told staff of the incident when she got back from dropping him off with [family]." Although the supervisory staff member (#4) reported educating [Activity Assistant/CNA (#6)] prior to the incident, she failed to provide documentation showing the education she provided her staff. The facility failed to ensure Resident #2 received the care and services necessary to attain the highest degree of safety possible while staff transported him in the facility van. The facility failed to ensure: * transport staff received education on securing residents in the van per the manufacturer's recommendations, * transport staff properly secured Resident #2's wheelchair in the van, * transport staff promptly notified the nurse on duty of the incident limiting her ability to make informed decisions regarding Resident #2's medical care, and * nursing staff informed the on-coming shift regarding the incident to ensure continuity of care.	F 689		