STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 10/21/20 and concluded on 10/26/20.	F 000		
F 580 SS=G	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 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	F 580		12/4/20

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

Electronically Signed | 11/25/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 580	Continued From page 1 (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 record review, facility investigation, review of facility policy, and staff interview, the facility failed to immediately inform the physician and the resident's family/representative of a significant change in the resident's physical condition for 1 of 1 resident (Resident #1) with an injury of unknown origin. Failure to notify the physician of a significant change resulted in the resident experiencing pain and a delay in treatment of a right femur fracture and left tibia/fibula fractures. Findings include: Review of the facility policy, "Physician Notification" occurred on 10/26/20. This policy, dated September 2020, stated, "Policy: Physicians will be notified in a timely manner regarding resident change in condition or an injury. Purpose: To insure (sic) that residents are assessed for changes or injuries that need to	F 580	1. As of 10/19/20 all staff involved in said incident were placed on suspension. As of 10/26/2020 staff night nurse #4 involved in the incident was terminated. 2. Facility has identified that all residents with in the facility have the potential to be affected by this practice. 3. Re-Education will be provided to all nursing staff: When residents with physical, mental or psychosocial status change or accident involving injury are thoroughly assessed for significant change and require physician intervention the physician and family members are to be notified immediately. The need of staff immediately reporting changes in condition of resident to staff nurse, administrative staff, physician and family to prevent the delay in treatment to resident. Physician notification policy and procedure reviewed and revised.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 580	Continued From page 2 have Physician notification and interventions put into place. Procedure: 1. The nurse who first observes an injury or significant change in a resident's condition will be responsible to assess the resident and use their professional judgement to determine if the change in condition or injury requires the Physician to be contacted immediately. If the resident needs immediate attention, they will be sent over to the clinic or Emergency room. (ex. [example] . . . accident with major injury . . . ." Review of Resident #1's medical record occurred on October 21-22, 2020. Resident #1's medical diagnoses include Alzheimer's disease, age-related osteoporosis without current pathological fracture, history of compression fracture to spine, and primary generalized osteoarthritis. The quarterly Minimum Data Set (MDS), dated 09/10/20, identified severe cognitive impairment, and total dependence on two or more staff members for bed mobility and transfers. Resident #1's current care plan identified the following: " . . . I have Potential for Pain. *Osteoporosis and arthritis *Hx of compression fx's [fractures] to spine. . . . monitor resident for c/o [complaint of] pain or discomfort. If pain noted or change noted notify MD [medical doctor] PRN [as needed] . . . I am at risk for falls r/t [related to] Unaware of safety needs. *I rarely make positional changes per self. . . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t Dementia. . . . Transfer/Mobility: Hoyer Lift assist of two with all transfers. . . . CRA [certified resident assistant (certified nursing assistant)] for	F 580	4. The facility has implemented a systemic change. When triggered, Nursing staff will fill out a significant change in status assessment to help determine the status of a resident and assist with notifying the physician in a timely manner. 5. An audit tool has been developed to ensure significant change status assessments are completed on significant change in status and injury requiring physician interventions and that notification of physician and family was timely. Audit tool will be completed by Director of Nursing or designee weekly for one month, 1 X a week for two months, and then quarterly for one year. 6. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. 7. Compliance will occur on or before December 4th, 2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 580	Continued From page 3 all mobility. . . . Bed Mobility: The resident requires extensive to total assist to turn and reposition. Needs assistance to make repositional (sic) changes . . . Skin: I require skin inspection Q [every] shift. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. . . ." Review of Resident #1's nurses notes identified the following: * 10/19/20 at 8:15 a.m. - "Med-aid [medication assistant] asked this author [Nurse #9 (day shift nurse)] to come look at resident's left foot this morning. When author uncovered residents left foot, residents left foot was visibly longer than her right foot. Residents L) [left] foot was in the pressure relieving booty and pressed into the mattress. Color of Left foot was pale in color and dark in areas and cool to touch. Author palpated for pedal pulse on left foot and was absent. Resident did yell out in pain when author touched the top of her foot. Author did not move resident foot and something was visibly wrong. Then called nurse manager and DON [director of nursing] to assess. . . ." *10/19/20 at 8:26 a.m. - (Note written by night nurse #4) ". . . Health status and vitals: Resident was more uncomfortable during the night, but discomfort did not seem to be originating from infection. Run (sic) from a deep tissue wound over the left outer malleolus. Entire red area was 8.5 cm [centimeter] X 1.5 cm. Skin over malleolus appeared thinner, with fluid present underneath, and very purple, blanched when pressure applied, but resident's pain response was very evident when palpated. Applied a loose Kerlex dressing over area. . . . Family . . . updated: Aware. . . ."	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 580	Continued From page 4 *10/19/20 at 8:39 am - (Note written by night nurse #4) "Skin note. Observation: Resident has a large deep tissue injury over left outer malleolus of ankle. Area is red, but pressure is applied, painful with palpation. Area the time of observation was not open, but skin over area is fragile. . . . Placed telfa, and loose kerlex drsg [dressing] to protect wound, so dressing should not stick to area if it did open. . . . Sent note to skin nurse to observe on rounds." *10/19/20 at 9:14 a.m. - (Note written by night nurse #4) "Spoke to daughter [name of daughter] and informed he (sic) that resident has a broken ankle. Drgr [daughter] asked how this happened and told her we had discovered this during the noc [night]. . . . Resident's dtgr was very aware how osteoporosis and bone dimeiniearilization (sic) from non-use occurs. Informed her that resident would be sent to ER for evaluation." *10/19/20 at 10:44 a.m. - (Note written by nurse manager # 10) "8:30 a.m. CRA [certified resident assistant] was doing cares and noticed that residents L) foot was deformed, CRA went and got [Nurse #9] to observe and upon seeing foot [Nurse #9] had [Nurse #8] and this nurse [Nurse #10] come in to assess it. L) foot and ankle has severe deformity noted, appears to be fractured. Call placed to DON to come over to observe and assess while this nurse called [name of physician] for orders to send to [name of local hospital] ER [emergency room] by ambulance . . . . Nursing assessment: Resident screams out in pain with any movement or touching of ankle... No pedal pulses present, foot and toes were cold to touch and gray in appearance. Foot supported with soft boot while waiting for the ambulance to arrive. . . . [Name of physician] informed of deformity, lack of pedal pulses, discoloration and	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 580	Continued From page 5 pain when called. . . . order received to send to ER by ambulance. Ambulance called for transfer to [name of hospital] ER . . . 8:50 am Ambulance here to get resident and upon getting resident ready for transfer onto gurney it was noted that R) leg had deformity as well. Ambulance crew and this nurse unsure if it was a femur injury or an injury to her R) knee. Large amount of bruising noted to the back of her R) knee that was deep purple in color. Resident in pain with any movement of this leg as well. Assisted ambulance crew with placing immobilizer/air splint on both legs and then carefully transferring her onto the gurney for transfer to ER. . . . family informed by . . . night nurse prior to hospital transfer." *10/21/20 at 10:17 a.m. - Author called . . . [name of hospital] for an update on resident. [Name of hospital nurse] explained that the resident has a left tibia and fibia (sic) fracture and right femur fracture and is not a candidate for surgery so the bones have been set and splinted. . . ." Review of the facility investigation/interview with the night CRA (#6) identified the CRA (#6)thought Resident #1's foot 'looked bad' when she did her first rounds of the night and notified the nurse (#4) to come and check her foot. The CRA (#6) stated the nurse didn't come to the room until 1:00 or 2:00 a.m., and she told the nurse she thought it was broke. The CRA (#6) stated the nurse said it was a deep tissue injury, measured the area, and then left the room. The CRA (#6) stated the resident did not look in distress at that time. The CRA (#6) did rounds again at 4:30 a.m. and insisted the nurse (#4) come and look at the foot because it was "bad" and something needed to be done. The CRA (#6) said the nurse (#4)	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 580	Continued From page 6	F 580		

dressed the area and said she would contact the wound nurse.

Review of the facility investigation/interview with the night nurse (#4) identified the nurse said that around 1-2 a.m. a CRA (#6) asked her to look at Resident #1's foot. The nurse (#4) said she thought the area was a deep tissue bruise because it was purple with fluid under it. When she looked at it again with the CRA (#6) around 5:00 a.m., she felt Resident #1's foot and the 'bones felt like there were misplaced' and she thought it was broken. The nurse said she did not want to overreact, so told the CRA she would notify the wound nurse. The nurse (#4) denied Resident #1 had any facial grimacing or indications of pain or discomfort, but later stated the resident had been more vocal this night than the past night. The nurse confirmed she did not call the nurse manager, director of nursing, or the physician about Resident #1's foot.

During an interview on 10/22/20 at 8:00 a.m., an administrative nurse (#1) stated she was not satisfied with the nurse's [Nurse #4] assessment/actions regarding Resident #1's leg and placed her on suspension. During an interview on 10/26/20 at 11:00 a.m., the administrative nurse (#1) stated that after completion of the investigation, the facility terminated the nurse (#4) and confirmed the nurse should have notified the physician of Resident #1's injury.

The facility staff failed to notify the physician and the resident's family/representative of Resident #1's suspected fracture, discomfort, bruise/tissue injury when assessed at 5:00 a.m. on 10/19/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 580	Continued From page 7 Failure to notify the physician immediately when a fracture was suspected resulted in the resident experiencing pain and a delay in treatment for a fractured right femur and fractures of the left tibia/fibula of unknown source.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on information from the complainant, record review, review of facility policies/procedures, review of the facility's investigation reports, and staff interviews, the facility failed to ensure residents have the right to remain free from possible physical abuse/neglect for 1 of 1 resident (Resident #1) with fractures of unknown source while residing in the facility. Failure to provide necessary services to protect residents from physical harm resulted in Resident #1 sustaining fractures from an unknown source to her right femur and left tibia/fibula.	F 600	1. As of 10/19/20 all staff involved in said incident were placed on suspension, CRA #2, CRA #3, NOC nurse #4. As of 10/26/2020 staff night nurse #4 involved in the incident was terminated, CRA #3 resigned without notice, Nurse #19 resigned without notice. CRA#2 completed suspension and was reinstated on the floor after education provided on Hoyer lift policies and procedures and Abuse and Neglect responsibility of CRAs. ALL CRAs have been re-educated on Hoyer use policy and procedures. As	12/4/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 8 Findings include: Review of the facility policy, "Abuse Policy" occurred on 10/21/20. This policy, revised June 2020, stated, "Purpose: All residents at Sheyenne Care Center have a right to be free from mistreatment, neglect . . . All staff will be educated as to specific types of abuse . . . Staff will also be educated as to their responsibility to report any and all suspected and observed incidents of abuse, neglect . . . All alleged violations involving mistreatment; neglect or abuse, including injuries of unknown source . . . will be reported immediately to the administrator and to other officials in accordance with State law . . . Appropriate corrective action will be taken if the alleged violation was (sic) been verified. Abuse or neglect means the non-accidental physical injury or condition, . . . or negligent treatment of a resident under circumstances, which indicate that the resident's health, welfare and safety are harmed. . . . I. Procedure/Intervention(s): . . . Education/Training 1. As a part of orientation, staff and volunteers will receive training . . . on Abuse/Neglect of residents along with definitions to assist them in recognizing Abuse and their responsibility. 2. Ongoing education on Abuse will be offered no less than yearly. . . Identification/Injuries of Unknown Origin: 1. Staff will report all resident injuries, of both known and unknown origin immediately to the Nurse Manager or Charge Nurse. The reported injuries are to include bruises, skin tears, fractures, and suspicious injuries. 2. The Nurse Manager or Charge Nurse will complete an Injury of Unknown Origin Investigation Form . . . assure the immediate safety and mental well being of the resident,	F 600	of December 4th, all staff will have been reeducated on Abuse and Neglect policy and procedure and responsibility of reporting immediately 2. Facility has identified that all residents with in the facility have the potential to be affected by this practice. 3. Re-Education will be provided to all nursing staff: When residents with physical, mental or psychosocial status change or accident involving injury are thoroughly assessed for significant change and require physician intervention the physician and family members are to be notified immediately. The need of staff immediately reporting changes in condition of resident to staff nurse, administrative staff, physician and family to prevent the delay in treatment to resident and investigation of incident. The significance of treating residents□ pain. Physician Notification Policy and Procedure reviewed and revised. Fall Prevention policy and procedure reviewed and revised. Standard of Cares of policy and procedure reviewed and revised. Abuse Policy reviewed and re-education given. 4. All CRAs were re-educated on the Abuse and Neglect Policy, remaining staff will be re-educated by December 4th, 2020. 5. The facility has implemented a systemic change. When triggered, Nursing staff will fill out a significant change in status assessment in EHR, to help determine the status of a resident and assist with notifying the physician in a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 9 investigate the extent of harm to the resident . . . 3. If the Nurse Manager or Charge Nurse's conclusion is that suspected or actual mistreatment, abuse or neglect has taken place, the NSA [nursing service administrator] or Administrator is contacted . . . 8. If it is an employee who is being suspected for abuse, the employee is informed and suspended while the NSA [nursing service administrator] or designee conducts investigation. The investigation will include interviews with the resident reported to have been abused: . . . anyone witnessing the abuse; the persons suspected of committing the abuse; or other pertinent persons. . . ." Review of the facility policy, "Lifts and transfers" occurred on 10/26/20. This policy, dated May 2020, stated, ". . . Purpose: Residents will be moved and/or repositioned in a manner that will ensure resident comfort and reduce risk of injury to resident and/or staff. Procedure: Guidelines for moving, positioning, lifting and transferring residents: 1. Verify care plan and/or with nurse before attempting to move, lift or transfer resident. 2. Have second CNA [certified nursing assistant] assist if required. . . . Mechanical Lifts: . . . 2. When a mechanical lift is determined as necessary it will be placed on resident's care plan by nurse . . . 3. Mechanical lift (Hoyer) requires two people to be present during all transfers. . . ." Review of the facility policy, "Walking Rounds" occurred on 10/26/20. This policy, dated July 2020, stated, "Policy: CRA [certified resident assistant] will report to oncoming CRAs at the beginning and end of each shift any special information that occurred during their shift regarding resident. Procedure: CNA reporting to	F 600	timely manner. All nursing staff will perform annual skills review for competency on assessing resident for significant changes or injuries requiring physician interventions. 6. An audit tool has been developed to ensure significant change status assessments are completed when significant change in status and injury requiring physician interventions occur and that notification of nursing staff, administrative staff, physician and family was timely. Audit tool will be completed by Director of Nursing or designee 2x weekly for one month, 1 X a week for two months, and then quarterly for one year. 7. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance is maintained. Injury of unknown origin have been added to the IDT to review weekly. 8. Compliance will occur on or before December 4th, 2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 600	Continued From page 10	F 600		

oncoming CNA is a simple transfer of information between certified nursing assistants at shift change. This will empower CNAs to not only complete tasks but to inform the next shift of care, issues, treatments or any special information that occurred during their shift to report to the CNA beginning the next shift. . . ."

- Review of Resident #1's medical record occurred on October 21-22, 2020. Resident #1's medical diagnoses included Alzheimer's disease, age-related osteoporosis without current pathological fracture, history of compression fracture to spine, and primary generalized osteoarthritis. The quarterly Minimum Data Set (MDS), dated 09/10/20, identified severe cognitive impairment, extensive assistance required from one staff for dressing and toilet use, total dependence on two or more staff members for bed mobility and transfers, total dependence on one staff for personal hygiene, locomotion on/off the unit, and daily scheduled medications for pain.

Resident #1's current care plan identified the following:
- ". . . I have Potential for Pain. *Osteoporosis and arthritis *Hx [history] of compression fx's [fractures] to spine. . . . monitor resident for c/o [complaint of] pain or discomfort. If pain noted or change noted notify MD [medical doctor] PRN [as needed] . . ."
- ". . . I am at risk for falls r/t [related to] Unaware of safety needs. *I rarely make positional changes per self. . . ."
- ". . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t Dementia. . . . Toilet Use: I require total assist of 1. . . . I am checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 11	F 600		

and changed routinely. I currently have a Foley [urinary] catheter. . . . Hoyer Lift assist of two with all transfers. . . . The resident requires extensive to total assist to turn and reposition. Needs assistance to make repositional (sic) changes . . . reposition every 2-3 hours. . . .
- ". . . I require skin inspection Q [every] shift. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. . . ."

Review of Resident #1's nurse's notes identified the following:
*10/18/20 at 2:24 p.m. - "Res [resident] alert. Res not using call light at any time. Res yells out loudly and grinds teeth when staff try to repo [reposition], move, give meds, etc. Res rests well when in bed not moving. . . . Res has contractures to arm and legs, knees are bent up to chest and arms are pulled up to chest. . . . "
*10/19/20 at 8:15 a.m. - "Med-aid [Medication Assistant (MA)] asked this author [Nurse #9] to come look at resident's left foot this morning. When author uncovered residents left foot, residents left foot was visibly longer than her right foot. Residents L) [left] foot was in the pressure relieving booty and pressed into the mattress. Color of Left foot was pale in color and dark in areas and cool to touch. Author palpated for pedal pulse on left foot and was absent. Resident did yell out in pain when author touched the top of her foot. Author did not move resident foot and something was visibly wrong. Then called nurse manager and DON [director of nursing] to assess. . . ."
*10/19/20 at 8:26 a.m. - (Note written by night shift nurse #4) ". . . Resident was more uncomfortable during the night, but discomfort

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 12	F 600		

did not seem to be originating from infection. Run (sic) from a deep tissue wound over the left outer malleolus. Entire red area was 8.5 cm [centimeter] X 1.5 cm. Skin over malleolus appeared thinner, with fluid present underneath, and very purple, blanched when pressure applied, but resident's pain response was very evident when palpated. Applied a loose Kerlex dressing over area. . . . Family/POA [power of attorney] updated: Aware. . . ."
*10/19/20 at 8:39 am - (note written by night shift nurse #4) "Skin note. Observation: Resident has a large deep tissue injury over left outer malleolus of ankle. Area is red, but pressure is applied, painful with palpation. Area the time of observation was not open, but skin over area is fragile. . . . Placed telfa, and loose kerlex drsg [dressing] to protect wound, so dressing should not stick to area if it did open. . . . Sent note to skin nurse to observe on rounds."
*10/19/20 at 9:14 a.m. - (note written by night shift nurse #4) "Spoke to daughter [name of daughter] and informed he (sic) that resident has a broken ankle. Drgr [daughter] asked how this happened and told her we had discovered this during the noc [night]. . . . Resident's dtgr was very aware how osteoporosis and bone dimeiniearilization (sic) from non-use occurs. Informed her that resident would be sent to ER [emergency room] for evaluation."
*10/19/20 at 10:44 a.m. - (Note written by day shift nurse #10) "8:30 a.m. CRA was doing cares and noticed that residents L) foot was deformed, CRA went and got [Nurse #9] to observe and upon seeing foot [Nurse #9] had [Nurse #8] and this nurse [Nurse #10] come in to assess it. L) foot and ankle has severe deformity noted, appears to be fractured. Call placed to DON to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 13	F 600		

come over to observe and assess while this nurse called [name of physician] for orders to send to [name of local hospital] ER by ambulance . . . Nursing assessment: Resident screams out in pain with any movement or touching of ankle . . . No pedal pulses present, foot and toes were cold to touch and gray in appearance. foot (sic) supported with soft boot while waiting for the ambulance to arrive. . . . [Name of physician] informed of deformity, lack of pedal pulses, discoloration and pain . . . order received to send to ER by ambulance. . . . 8:50 am Ambulance here to get resident and upon getting resident ready for transfer onto gurney it was noted that R) leg had deformity as well. Ambulance crew and this nurse unsure if it was a femur injury or an injury to her R) knee. Large amount of bruising noted to the back of her R) knee that was deep purple in color. Resident in pain with any movement of this leg as well. Assisted ambulance crew with placing immobilizer/air splint on both legs and then carefully transferring her onto the gurney for transfer . . . family informed by . . . night nurse prior to hospital transfer."
*10/21/20 at 10:17 a.m. - "Author called . . . [name of hospital] for an update on resident. . . . has a left tibia and fibia (sic) fracture and right femur fracture and is not a candidate for surgery so the bones have been set and splinted. . . ."

An interview with an administrative nurse (#1) occurred on 10/22/20 at 8:00 a.m. The administrative nurse (#1) indicated she found out about the incident involving Resident #1 the morning of 10/19/20 and is starting day three of the investigation. The administrative nurse (#1) stated no staff members have reported and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 600	Continued From page 14	F 600		

admitted knowledge regarding the cause of Resident #1's leg fractures. After staff interviews, the administrative nurse (#1) stated she narrowed the time frame of the incident to the afternoon/evening of 10/18/20.

- The administrative nurse (#1) stated that during her interview with the CRA (#2) who transferred Resident #1 from the chair to the bed around 2:00 p.m. on 10/18/20, the CRA (#2) admitted transferring the resident without assistance, but denied anything happened during the transfer. The administrative nurse (#1) placed the CRA (#2) on suspension during the on-going investigation, but stated she felt the CRA (#2) was very honest and detailed with his/her story.

- The administrative nurse (#1) stated she interviewed another CRA (#3) twice, because his/her story did not match the information provided by other staff. The CRA (#3) transferred Resident #1 into her chair around 4:00 p.m. with the help of another CRA (#7) and proceeded to transfer her back to bed after the nurse (#5) told him/her "not to get the resident up." The CRA (#3) admitted he/she noticed something was wrong with the resident's foot at 8:00 p.m. rounds but insisted nothing happened during the transfer. The CRA (#3) told her he/she took responsibility for not doing safety rounds [walking rounds] with the day shift CRA (#2) and not reporting to the nurse about Resident #1's foot. The administrative nurse (#1) said the CRA (#3) became very argumentative and defensive, wanted to "blame" others, and refused to answer questions during the second interview. The administrative nurse (#1) placed the CRA (#3) on suspension during the on-going investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 15 - The administrative nurse (#1) stated the night shift CRA (#6) had reported his/her concerns regarding Resident #1's left ankle to the night nurse (#4). The night nurse (#4) assessed the resident's ankle as a "deep tissue injury" and did not notify the physician, as he/she thought it could wait until the morning. The administrative nurse (#1) indicated she was not satisfied with the nurse's assessment/actions of not reporting the injury. She placed the nurse (#4) on suspension during the on-going investigation. Additional information from the facility's investigative report identified the following: * The ER physician called the facility and described Resident #1 as having a "right smashed distal femur and fracture to tibia, fibula of left leg" and "these types of injury (sic) are caused by great force." * A nurse (#5) and a MA (#13) described Resident #1 as resting comfortably in the commons area at 2:00 p.m. on 10/18/20 with no injuries observed. * The CRA (#7) who was identified as assisting CRA (#3) transfer Resident #1 in the Hoyer lift to the chair at 4:00 p.m. on 10/18/20 denied helping CRA (#3) with the transfer. * The nurse (#5) who was identified as instructing the CRA (#3) to transfer Resident #1 back to bed around 4:00 p.m. on 10/18/20 denied telling this to the CRA (3#). * When the administrative nurse (#1) alleged the CRA (#3) transferred the resident by herself, the CRA (#3) responded with an angry tone, 'If I did that, the lift would fly back and break both of her legs!' * The night shift (10/19/20) CRA (#6) stated	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 600	Continued From page 16	F 600		

he/she and the evening shift (10/18/20) CRA (#3) did "verbal" rounds at shift change and the CRA (#3) told her "everyone is good."
* The night shift CRA (#6) noticed something was wrong with Resident #1's foot when he/she checked her on first rounds of the night and reported it to the nurse (#4). The CRA (#6) stated the nurse (#4) didn't assess Resident #1's foot until 1:00 a.m.-2:00 a.m., at which time the nurse thought the resident had a deep tissue injury. At 4:30 a.m. rounds, the CRA (#6) insisted the nurse (#4) look at Resident #1's foot as it looked "bad" and "you need to do something." The nurse dressed the ankle with gauze.
* The night shift (10/19/20) nurse (#4) reported she thought Resident #1 had a deep tissue injury on her initial assessment. Later, after being asked by the CRA (#6) to look at Resident #1's foot again, the nurse (#4) stated that at her 5:00 a.m. assessment, "the bones felt like they were displaced" and she thought it was broke. The nurse (#4) initially denied Resident #1 showed any signs/symptoms of pain, but later described the resident as being "more vocal." The nurse (#4) reported asking the wound nurse to assess Resident #1's leg, as she felt it was broken. The wound nurse (#17) denied being told the leg may be broken, so planned to look at the wound the next day.
* A MA (#12) observed Resident #1's leg at 8:30 a.m. on 10/19/20 and described it as "white/green in color and curved." She reported the night nurse (#4) described the leg as "bruised, but not broke" during rounds. The MA (#12) reported another nurse (#19) examined Resident #1's ankle and determined it was not broken, described the situation as a non-emergency, and stated she would deal with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 600	Continued From page 17 it after she finished passing medications. The MA (#12) reported the nurse (#19) told her she used to be a paramedic and therefore knew the leg was not broken. The nurse (#19) acknowledged briefly looking at Resident #1's leg and stated she "would come back after passing medications" to assess the leg. * A MA (#12) and a CRA (#14) stated a CRA (#3) told them he/she described "[trying] to put [Resident #1's] foot back together, her bones." The facility failed to protect the resident from abuse, which resulted in a severe injury of unknown origin. The facility staff failed to immediately report changes in the resident's condition to the nurse, complete a prompt, thorough assessment of the resident to determine the extent of injury, treat pain experienced by the resident, and report these findings to the physician, family, and administrative staff. These events resulted in delay of investigation, notification, and treatment of these injuries for an estimated 12 hours.	F 600		
F 689 SS=D	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, review of facility policies/procedures, review of the facility's	F 689	1. As of 10/20/2020 Staff involved in incident have been re-educated about the	12/4/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 689	Continued From page 18 investigation reports, and staff interviews, the facility failed to ensure 1 of 2 residents (Resident #5) received appropriate assessment and assistance following a fall resulting in a fractured leg. Failure of staff to assess for injuries after the fall and ensure sufficient staff utilized a Hoyer lift (full body mechanical lift) for transfer has the potential for additional injuries/pain for all residents experiencing a fall with major injury. Findings include: Review of the facility policy, "Fall prevention" occurred on 10/26/20. This policy, revised August 2020, stated, ". . . PURPOSE: To strive to prevent falls from occurring by . . . assessing after falls for immediate action . . . PROCEDURE: . . . ALL residents will be lifted off the floor post fall with a hoyer lift. . . ." Review of Resident #5's medical record occurred on October 21-22, 2020. Resident #5's medical diagnoses include anxiety, osteoarthritis, and bilateral wrist fractures and right hip fracture. The admission Minimum Data Set (MDS), dated 09/16/20, identified intact cognition, extensive assistance from one staff member required for most activities of daily living (ADLs), and a history of falls with injury. The current care plan identified the following: * "I have an ADL Self Care Performance Deficit r/t [related to] Musculoskeletal impairment post fall and recent fractures . . . TOILET USE: I require limited assist of 1 staff participation to use toilet . . . TRANSFER/MOBILITY: I require extensive assist of 1 staff and gait belt for pivot transfers. I depend on a wheelchair propelled by staff for	F 689	importance of not moving a resident after a fall and waiting for the nurse to assess resident for injury. 2. The facility has identified that all residents in the facility have the potential to be affected by this practice. 3. As of 11/27/2020 all CRA staff have been re-educated in regards to Fall policy and procedure and Standard of Cares involving falls/injury of resident. Standard of Cares policy and procedure reviewed and revised. Fall Prevention policy and procedure reviewed and revised. 4. An audit tool has been developed to ensure all falls are reviewed and staff followed policy and procedures after fall regarding moving of resident. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, 1 X week for 3 months and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. b. Falls will be reviewed weekly at IDT 5. Compliance will occur on or before December 4th,2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 689	Continued From page 19 mobility . . . * I have a history of falls r/t unsteady gait . . . Be sure my call light is within reach and encourage me to use it for assistance . . . Encourage/remind me to put on light to ask for assist when needing the toilet . . . Educate resident/caregivers about safety reminders and what to do if a fall occurs . . . Follow facility fall protocol . . ." The progress notes, dated 10/18/20 at [4:57 p.m.], identified, ". . . Res [Resident #5] fell in bathroom at [4:20 p.m.] Res [Daughter #1] in room at the time of fall, [Daughter #2] . . . on phone via Facetime at the time of fall. [Daughter #2] reports hearing fall on phone, [Daughter #2] called for help. Res did not lose consciousness . . . Res ambulated per self with walker to bathroom. Res fell onto R) [right] side in bathroom. Res did not put call light on for assist, but res daughter was in room and another daughter on Facetime. Res assisted off floor with assist of 2, gait belt, walker. Once on toilet res was very shaky which [Daughter #2] reports as normal. Res reports pain in R) hip. No bruising at this time to R) hip. Res has 10/10 pain to R) hip. Res assisted into w/c [wheelchair] from toilet with 2 assist. Once in w/c res transferred to bed for evaluation of R) hip. This writer observed R) hip to rotated outward and shorter than L) [left] leg. Res is also in lots of pain with any movement to R) hip. Res is agreeable to being sent in to [Hospital] ER [emergency room] for x-ray/evaluation. [Daughter #2] also agreeable . . ." The emergency room report, dated 10/18/20, identified, ". . . Fracture of unspecified part of neck of right femur . . ."	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 689	Continued From page 20	F 689		

During an interview on 10/22/20 at 10:30 a.m., an administrative nurse (#1) stated, "I know the progress note says [Resident #5] was transferred by 2 people. It was not a 2-person transfer. MA [Medication Aide] (#13) heard [Resident #5] fall and told CRA [Certified Resident Aide] (#3) to wait while she called Nurse (#5). When she came back [Resident #5] was already on the toilet."

The MA (#13) provided a written statement which identified the following, ". . . [Resident #5] had fallen. [Resident #5's daughter] came out in hallway stating her mother had fallen. [CRA (#3)] had went running to [Resident #5]'s room. I told her I would call [Nurse (#5)]. I went to [Resident #5]'s room by the time I got to room [Resident #5] was up on toilet. I asked CRA (#3) if she picked her up, she stated yes put her on toilet."

The administrative nurse (#1) provided a copy of the notes taken while interviewing [Nurse (#5)]. The notes identified, ". . . [Nurse (#5)] stated that [CRA (#3)] had picked [Resident #5] up off the floor and placed her on the toilet after a fall in the bathroom and did not wait for the nurse to assess resident. [Nurse (#5)] stated that after completing her assessment and getting resident off to the ER for evaluation that she educated [CRA (#3)] on importance of not moving resident and waiting for nurse . . ."

During interviews on 10/22/20 at 11:00 a.m. and 12:00 p.m., a [Nurse (#5)] stated, "I found out later [Resident #5] fell to the floor. The initial pick up from the floor to the toilet was just [CRA (#3)]. I found out later that [CRA (#3)] had transferred [Resident #5] by herself. I thought the [MA (#13)]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	**979 CENTRAL AVE N VALLEY CITY, ND 58072**

(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 689	Continued From page 21 had helped her prior to coming to get me." The CRA (#3) failed to wait for the nurse to assess Resident #5 for any injuries prior to transferring him/her from the bathroom floor onto the toilet and failed to utilize a Hoyer lift with staff assistance.	F 689		