STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	**1515 2ND AVE WEST WILLISTON, ND 58801**

(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 completed on February 7, 2024. During the report investigation the facility was found noncompliant with regulatory requirements.	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 record review, review of facility investigation, review of the facility policies, and staff interviews, the facility failed to ensure adequate supervision and assistance for 1 of 3 sampled residents (Resident #3) who required staff assistance and sit to stand mechanical lift transfers. Failure to provide adequate assistance as care planned for transfers may have resulted in Resident #3's fracture and placed all residents requiring assistance for transfers at risk for injuries. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 02/07/24. This undated policy, stated, ". . . It is the policy of [Facility Name] to develop and implement a comprehensive person-centered	F 689	1) Nursing staff, including RN's, LPN's, CNA's and Therapy staff were educated on the importance of ensuring adequate supervision and assistance for residents who require a sit to stand mechanical lift transfer. THis education was for resident#3 and any other resident who requires a lift transfer. 2) All residents who require a lift devicee to be transferred have the potential to be affected. 3) Mandatory all staff education will be held on March 5th & 6th, 2024 @2pm each day to educate on the importance of Lift Training. Will review policy/procedure titled "Comprehensive Care Plans" and "Nursing Practice Guidelines - Nursing	3/7/24

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

Electronically Signed | 02/29/2024

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F 689	Continued From page 1 care plan for each resident, . . . to meet a resident's medical, nursing, and mental . . . needs . . . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. . . . f. Resident specific interventions that reflect the resident's needs . . . 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made." Review of the facility policy titled "Nursing Practice Guidelines - Nursing Service Department" occurred on 02/07/24. This undated policy, stated, ". . . II. Activity of each resident will be maintained at a maximal level. a. Ambulation of residents will be carried out: 1. According to individual needs . . . 2. Using proper . . . transfer techniques. . . . 3. Assisting residents to use adaptive equipment . . . XI. Other Therapy. a. Provisions should be made to insure [sic] safe and proper therapeutic use of equipment such as: mechanical lifts . . . ." Review of Resident #3's medical record occurred on 02/06/24. The current care plan stated, ". . .TRANSFER: PAL [mechanical sit to stand lift] LIFT TRANSFER . . . revision on 01/25/24 . . . " A nursing progress note, dated 02/01/24 at 4:20 a.m., stated, ". . . PAL lift in the bathroom during transfer with 2 assist . . . Once toileting complete she was being lifted in PAL lift and she removed her left hand from the left handle. She was easily redirected by staff to place hand back to handle,	F 689	Service Department". All nursing and CN staff have access to resident electronic charts which have all the residents information in it, including the way the resident transfers. The CNA paper assignment sheet is not part of the facility's mode of communication for any resident ADL care. All staff, including CNA's are to us the Kardex and the care plan that is available in the electronic resident chart per facility policy and training. 4) DON or designee will monitor to ensure residents are being transferred with adequate supervision and assistance according to care plan. Monitoring will start March 7th, 2024 and will be weekly x4, monthly x3, then quarterly there aftere. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the Quarterly QA committee meeting. 5) 3/7/2024	

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F 689	Continued From page 2 removed x2 [two times] during transfer. Yelling out with transfer and nothing heard or seen by staff during transfer . . . CNA [certified nurse aide] [name] noticed that left hand was uneven and called the nurse. Upon assessment, noted resident in pain upon movement of left arm. Pain scale 10/10 upon movement. Limited ROM [range of motion] left arm. Noted swelling on left upper arm. Left arm looks uneven. . . . Informed on-call [administrative nurse] . . . Informed on-call doctor . . . and got an order to send resident to ED [emergency department] for evaluation . . . Transferred resident to her wheelchair using hoyer [full body mechanical lift] with 4 assist. Maintained support on left arm. . . . Resident was brought to ED per wheelchair in stable condition with arm sling on left arm, accompanied by CNA . . ." An emergency room physician's progress note, dated 02/01/24 at 5:38 a.m., stated ". . . presents to emergency department with left arm deformity . . . Very obvious fracture on her x-ray . . ." Review of the facility's investigation of the incident identified the following: * Resident #3's care plan revised for transfers on 01/25/24 * The change was communicated through report and placed in the communication book * The facility staff failed to update the CNA paper assignment sheet with the change in Resident #3's transfer status * The facility conducted interviews with staff working 01/31/24 and 02/01/24 The facility's investigation report stated, ". . . It was noted in [CNA #2's name] statement she had	F 689		

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F 689	Continued From page 3 transferred the resident earlier in the evening in the shower room bathroom with assist of 1, gait belt, and grab bar. Then got the resident toileted and ready for bed, placed back to the lounge for a bit . . . she used a two person PAL lift assist to transfer the resident to bed at bedtime, but did the transfer herself in the shower room to assist the resident with toileting and bedtime cares. . . . In review of all information, it is likely the injury was more likely to have occurred during that assist of 1 transfer in the shower room bathroom with the resident standing with the grab bar, turning and putting herself backwards to the toilet by still holding the grab bar to her right. Placing that left arm in a twisted, akward [sic] position, across her body, with the weight of her body going back and down. . . ." During an interview on 02/06/24 at 1:39 p.m., the CNA (#2) confirmed she transferred Resident #3 with a gait belt and assist of 1 on the evening of 01/31/24. She stated she was unaware of the care plan change for Resident #3 to PAL lift for all transfers, did not review care plans on a routine basis, and relied on the paper CNA assignment sheet for transfer status. During an interview on 02/06/24 at 2:45 p.m., an administrative nurse (#1) stated she expected staff to be aware of resident care plans and changes to them. She confirmed the facility staff failed to update the paper CNA assignment sheet with the change to Resident #3's transfer status, and the CNA (#2) failed to follow Resident #3's care plan for transfers that likely resulted in Resident #3 sustaining a fractured left arm.	F 689		