STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALCESTER CARE AND REHAB CENTER, INC	**101 CHURCH STREET ALCESTER, SD 57001**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** Based on observation, interview, record review, policy review, manufacturer's review, in-service training review, and personnel file review, the provider failed to ensure a thorough investigation had been completed and documented for:*One of one sampled resident (1) who received a head injury during a transfer with a mechanical lift by two of two certified nursing assistants (CNA) (D and E). *One of one sampled resident (2) was safely transferred from the bed to a wheelchair (w/c) with the use of a mechanical lift by two of two CNAs (F and G). Findings include: 1. Review of the 2/28/20 Facility Self-Reporting Form submitted to the South Dakota Department of Health (SD DOH) regarding resident 1 revealed: *The incident had occurred on 2/28/20 at 7:00 p.m. *The initial report revealed she .was in a sit-to-stand machine being transferred off the commode into her wheelchair. The machine upended and the resident fell backwards with the lift following. The lift struck the resident in the forehead and causing an open gash. Injury noted to the head and needed stitches. Transferred to the (hospital name) at 1950 (7:30) after using the hoyer lift to get her off the floor and back into the wheelchair. *The final report revealed: -CNA D had indicated that the white strap of the sling was used for this resident and the Administrator assumed the green strap would have been used. The green strap is a tighter and snugger fit than the white strap, but unable to determine if this was the sole factor causing the lift to fall over. *The director of nursing (DON) had interviewed CNAs D and E. -They stated that the leg strap was utilized, but it was not tightened/snug against the Resident's legs. -They also reported that the legs of the stand were used correctly to help give the lift balance. *Administrator took the sit-to-stand away from use for this resident and other residents until it can be concluded the integrity of the machine is not malfunctioning. It was replaced by a spare EZ Way, different manufacture and model machine. 2. Review of the 3/3/19 initial Facility Self-Reporting Form submitted to the SD DOH regarding resident 2 revealed: *Resident had a witnessed fall in her room. -Resident was being transferred from her bed to her w/c via Hoyer lift and CNA x2. -Hoyer began to tip over, and CNA G, placed himself between the Resident and the floor and gently lower the Resident to the ground. -Resident was found on the floor on her back with the Hoyer lift still connected to her sling. -Lift noted to not have legs open during the transfer (CNAs educated real time to always have the legs spread on the lift while transferring residents). -Assist of 4 with hoyer lift to w/c. -When lifting Resident with Hoyer, it was noted to be unsteady. -Hoyer lift was taken off the floor and immediately evaluated further by the Maintenance Director, Administrator, and DON. -When attempting to lift stationary item (Facility trailer), it was noted that one of the legs was not staying locked open/wide. -This was causing the lift to be unsteady and tip when weight was applied to the lift arm. -Maintenance staff took the lift apart, and noted that the primary bolt in the leg had come loose. -Upon further assessment, the threads that the bolt attaches to had stripped out causing the leg to be unsteady. Refer to F657, findings 1, 2, and 3. Refer to F689, findings 1, 2, and 3. Refer to F726, finding 1. Refer to F865, findings 1, 2, and 3.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (1 and 2) had a revised and updated care plan to reflect their current needs. Findings include: 1. Review of the 2/28/20 Facility Self-Reporting Form submitted to the South Dakota Department of Health (SD DOH) regarding resident 1 revealed: *The incident had occurred on 2/28/20 at 7:00 p.m. *The initial report revealed she .was in a sit-to-stand machine being transferred off the commode into her wheelchair (w/c). The machine upended and the resident fell backwards with the lift following. The lift struck the resident in the forehead and causing an open gash. Injury noted to the head and needed stitches. Transferred to the (hospital name) at 1950 (1750) after using the hoyer lift to get her off the floor and back into the wheelchair. *The final report revealed: -Certified nursing assistant (CNA) D had .indicated that the white strap of the sling was used for this resident and the Administrator assumed the green strap would have been used. The green strap is a tighter and snugger fit than the white strap, but unable to determine if this was the sole factor causing the lift to fall over. *The director of nursing (DON) had interviewed CNAs D and E. -They stated that the leg strap was utilized, but it was not tightened/snug against the Resident's legs. -They also reported that the legs of the stand were used correctly to help give the lift balance. *Administrator took the sit-to-stand away from use for this resident and other residents until it can be concluded the integrity of the machine is not malfunctioning. It was replaced by a spare EZ Way, different manufacture and model machine. Review of resident 1's medical record revealed: *[DIAGNOSES REDACTED]. *The [DATE], five day Minimum Data Set (MDS) assessment revealed she: -Scored fifteen on the Brief Interview for Mental Status (BIMS) examination indicating she was cognitive. -Required total assistance of two staff for transfers and toilet use. -Was unsteady moving from a seated to a standing position, moving on and off the toilet, and transferring between a bed and chair or w/c. *The 2/24/20 Morse Fall Scale score was sixty indicating a high fall risk. *There was no assessment completed by the nursing staff or the therapy department regarding which lift to use or what sling was to be used prior to the 2/28/20 incident. *The DON had completed a Volaro Lift/Transfer Assessment Form for her on 3/5/20. Review of the following 12/31/19 through 1/22/20 occupational therapist progress notes regarding resident 1 revealed there was no documentation to use a mechanical lift. Review of the 2/21/20 hospital occupational therapist progress notes regarding resident 1 revealed: *She had been admitted to the hospital. *Prior to two weeks ago patient was up with 1 to commode. *Pt is dependent on dressing. *For the past two weeks patient has been using the EZ stand. Review of resident 1's 9/2/18 care plan revealed: *Focus: -Is at risk for falls r/t (related to) deconditioning. -[DATE]8/18: Sometimes refuses to allow nursing staff to use a gait belt during transfers. *Interventions: -9/2: Fall in room during transfer: 2A (two assist) with gaitbelt or EZ stand with transfers. --There was no documentation of what size sling to use. Review of the 12/11/19 CNA pocket care plan for resident 1 indicated she transferred with two staff with the EZ stand. It had not included what size sling to use. Interview on [DATE] at 9:07 a.m. with DON B regarding resident 1 revealed: *He was not sure who had made the decision on what sling to use with the EZ stand. *There was no documentation from the nursing department on what sling to use. -He wanted to trust that the nurses made correct decisions. Review of the provider's [DATE]7/10 E-Z Stand policy and procedure revealed: *Preparation: -Check care plan for equipment use on resident. *Procedure: -5. Apply belt around legs and snap buckle. Tighten buckle. Review of the PA800 Operator's Manual manufacturer's instructions for the EZ lift used for resident 1 on 2/28/20 revealed: *Attaching Sling to Lift: -Adjust the shin rest up or down. -Locate the top of the shin rest two inches below the knee cap. -At this point you can lock the brakes on the lift to prevent the person from pushing the lift away from them. -The shin rest has a built-in safety support strap. -The strap helps those who need the added security and support. -This will keep their shins and feet securely in place. -It is not necessary to use the strap on everyone. 2. Observation on 3/9/20 at 1:45 p.m. in resident 2's room with CNAs F and L revealed: *They had resident 2 attached to the

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

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) mechanical EZ lift. *CNA F walked over to the w/c that had been positioned in the middle of the room. *CNA L pulled the EZ lift with the resident in the sling out from the bed and pushed it to the w/c. -The legs of the EZ lift were not in a widened position. *When CNA L got the EZ lift to the w/c she looked at CNA F and asked what to do next. *CNA F told her to open the legs to the EZ lift. *CNA L opened the legs to the EZ lift and then pushed it, so it was surrounding the w/c. -Lowered resident 2 into the w/c. Interview on 3/9/20 at 1:55 p.m. with CNA F revealed: *She had been employed with the facility since June 2018. *She had worked at different nursing homes prior to her employment here. *She confirmed the EZ lift could have been used with the legs closed or opened. *Usually placed the lift between the w/c with the legs closed. *She had received education on the proper use of the EZ stand (sit-to-stand) following the incident on 2/28/20 with resident 1. -She had not received education on the proper use of the EZ lift. *She had demonstrated back to the DON with a verbal response on how to properly use the EZ stand. -She had not completed any physical demonstration of the EZ stand. *She had received some type of training on the mechanical lift after she had started but had not received any further training. Review of the 3/3/19 initial Facility Self-Reporting Form submitted to the SD DOH regarding resident 2 revealed: *Resident had a witnessed fall in her room. -Resident was being transferred from her bed to her w/c via Hoyer lift and CNA x2. -Hoyer began to tip over, and CNA G, placed himself between the Resident and the floor and gently lower the Resident to the ground. -Resident was found on the floor on her back with the Hoyer lift still connected to her sling. -Lift noted to not have legs open during the transfer (CNAs educated real time to always have the legs spread on the lift while transferring residents). -Assist of 4 with hoyer lift to w/c. -When lifting Resident with Hoyer, it was noted to be unsteady. -Hoyer lift was taken off the floor and immediately evaluated further by the Maintenance Director, Administrator, and DON. -When attempting to lift stationary item (Facility trailer), it was noted that one of the legs was not staying locked open/wide. -This was causing the lift to be unsteady and tip when weight was applied to the lift arm. -Maintenance staff took the lift apart, and noted that the primary bolt in the leg had come loose. -Upon further assessment, the threads that the bolt attaches to had stripped out causing the leg to be unsteady. Review of resident 2's medical record revealed: *[DIAGNOSES REDACTED]. *The 2/16/20 quarterly MDS assessment revealed: -A BIMS score of nine indicating she was cognitively impaired. -Required total assistance of two staff with transfer, dressing, and toilet use. *The Morse Fall Scale had a score of seventy-five indicating she was a high risk for falls. *She had multiple falls. Review of the 10/2/19 occupational therapy plan of care (evaluation only) for resident 2 revealed: *Is referred to therapy due to poor wheelchair positioning noted by some staff members and question if current chair is too large. -Patient (resident) is also occasionally not positioned appropriately in chair by staff members which places her at risk for skin issue or postural abnormality. -Education has been provided to facility staff and they have expressed understanding of recommendations. *'Precautions: -Hoyer lift for all transfers. *There was no documentation provided to staff on the appropriate use of the mechanical EZ lift or which sling to use. Review of resident 2's 6/27/19 care plan revealed: *Focus: -The resident has an ADL (activities of daily living) self-care performance. *Interventions: -Transfer: --The resident is totally dependent on 2 staff & Hoyer for transfers. *There was no documentation indicating what size sling to use. *There was no focus, goal, or interventions listed for falls. Review of resident 2's 12/11/19 CNA pocket care plan revealed: *2 assist w/Hoyer. *There was no documentation indicating what size sling to use. Review of the provider's [DATE]7/10 E-Z Lift policy and procedure revealed: *Preparation: -Check care plan for equipment use on resident. *Procedure: -8. Check that base legs are spread wide. Review of the manufacturer's EZ lift operating instructions revealed: *Adjust lift legs. -Using the spreader bar, adjust the legs of the lift to go around the wheel chair. 3. Interview on 3/9/20 at 2:10 p.m. with CNA O and nursing assistant P regarding the use of care plans and CNA pocket care plans revealed: *CNA O: -Would know how to care for the resident by using the CNA pocket care plan. -Did not know where to find the main care plan for each resident. *Nursing assistant P was unsure where to find the resident care plans or the CNA pocket care plan. Interview on [DATE] at 10:10 a.m. with registered nurse (RN)/assistant DON/MDS coordinator C regarding care plans revealed: *She had been in the role as the MDS coordinator for one week. *All nurses had been educated to update the care plans. *Her role was to oversee the care plans. *The CNA pocket care plan had recently been reinstated. -It was a work in progress. -They were not sure who would be responsible to update the CNA pocket care plan. -It was considered an extension of the care plan. *Everyone had access to the care plan that was located on the computer. *Her expectations would have been for: -All staff to know where the care plan was located. -The care plan and CNA pocket care plan to include what size sling to be used with each mechanical lift used on individual residents. *Resident 1 had been a two person transfer before a recent hospitalization . -Physical therapy had wanted her to be an EZ stand with assist of two staff. -That should have been updated on her care plan. *Resident 2 should have had falls addressed on her care plan. Interview on [DATE] at 4:35 p.m. with CNA D regarding care plans and CNA pocket care plan revealed: *The CNA pocket care plans were kept at the nurses station. *She had not kept the CNA pocket care plan on herself. -It had been left at the desk while she was on duty. -She had referred to it if she needed to know something. *She thought the care plans were: -Kept in the pink books on the shelf behind the nurses station. -For the nurses to use and not the CNAs. *The pink books were paper medical charts for each resident. -They had not included the care plan. Interview on [DATE] at 4:45 p.m. with administrator A and DON B regarding care plans and CNA pocket care plans revealed: *Their expectations would have been for the care plan to have been updated and reflected each resident's current needs. *The care plan guided the care of each resident. *The CNA pocket care plan was considered an extension of the care plan. -There was not a separate CNA pocket care plan policy and procedure. Review of the provider's 9/18/19 Care Plan policy and procedure revealed: *Care plans:-Will be developed by an interdisciplinary team. -Include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care. Refer to F610, findings 1 and 2. Refer to F689, findings 1, 2, and 3. Refer to F726, finding 1. Refer to F865, findings 1, 2, 3, and 4.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, manufacturer's review, in-service review, personnel file review, policy review, and job description review, the provider failed to ensure: *One of one sampled resident (1) was safely transferred with the use of a mechanical EZ Stand lift by two of two certified nursing assistants (CNA) (D and E) that resulted in a head injury. *One of one sampled resident (2) was safely transferred from the bed to a wheelchair (w/c) with the use of a mechanical EZ Lift lift by two of two certified nursing assistants (F and G). *Ongoing assessment and documentation had been completed for two of two sampled residents (1 and 2) who required the use of a mechanical lift. *All staff were competent who utilized all mechanical lifts. Findings include: 1. Review of the 2/28/20 Facility Self-Reporting Form submitted to the South Dakota Department of Health (SD DOH) regarding resident 1 revealed:*The incident had occurred on 2/28/20 at 7:00 p.m. *The initial report revealed she .was in a sit-to-stand machine being transferred off the commode into her wheelchair. The machine upended and the resident fell backwards with the lift following. The lift struck the resident in the forehead and causing an open gash. Injury noted to the head and needed stitches. Transferred to the (hospital name) at 1950 (7:50) after using the hoyer lift to get her off the floor and back into the wheelchair. *The final report revealed: -CNA D had .indicated that the white strap of the sling was used for this resident and the Administrator assumed the green strap would have been used. The green strap is a tighter and snugger fit than the white strap, but unable to determine if this was the sole factor causing the lift to fall over. *The director of nursing (DON) had interviewed CNAs D and E. -They stated that the leg strap was utilized, but it was not tightened/snug against the Resident's legs. -They also reported that the legs of the stand were used correctly to help give the lift balance. *Administrator took the sit-to-stand away from use for this resident and other residents until it can be concluded the integrity of the machine is not malfunctioning. It was replaced by a spare EZ Way, different manufacture and model machine. Interview on 3/9/20 at 5:00 p.m. with resident 1 regarding the above incident revealed: *She had been sitting in her room on the commode with the lid closed. *She had been taking a break from sitting in her w/c. *She had just transferred from her w/c to the commode. *The EZ stand had been sitting in front of her. -She was not connected with a sling to the lift. *One CNA had been sitting beside her. *She looked up and saw the lift coming towards her. *She looked down, and the lift hit her on the top of her head. *She had not fallen to the floor. *They used the same lift to transfer her from the commode back to her w/c. *She could not recall if anyone had checked the lift prior to transferring her with it back to her w/c. *She went to the

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) hospital emergency department and received stitches to the top of her head. Review of resident 1's medical record revealed: *[DIAGNOSES REDACTED]. *The [DATE] five day Minimum Data Set (MDS) assessment revealed she:-Scored fifteen on the Brief Interview for Mental Status (BIMS) examination indicating she was cognitive. -Required total assistance of two staff for transfers and toilet use. -Was unsteady moving from a seated to a standing position, moving on and off the toilet, and transferring between a bed and chair or w/c. *The 2/24/20 Morse Fall Scale score was sixty indicating a high fall risk. *There was no assessment completed by the nursing staff or the therapy department regarding which mechanical lift to use or what sling was to be used prior to the 2/28/20 incident. *The DON had completed a Volaro Lift/Transfer Assessment Form for her on 3/5/20. Review of the following 12/31/19 through 1/22/20 occupational therapist progress notes regarding resident 1 revealed there was no documentation to use a mechanical lift. Review of the 2/21/20 hospital occupational therapist progress notes regarding resident 1 revealed: *She had been admitted to the hospital. *Prior to two weeks ago patient was up with 1 to commode. *Pt (resident) is dependent on dressing. *For the past two weeks patient has been using the EZ stand. Review of resident 1's 9/2/18 care plan revealed:*Focus: -Is at risk for falls r/t (related to) deconditioning. -[DATE]8/18: Sometimes refuses to allow nursing staff to use a gait belt during transfers. *Interventions: -9/2: Fall in room during transfer: 2A (two assist) with gaitbelt or EZ stand with transfers. --There was no documentation of what size sling to use. Review of the 12/11/19 pocket care plan for resident 1 indicated she transferred with two staff with the EZ stand. There was no documentation found regarding what size of sling was to be used. Review of resident 1's 2/28/20 incident report revealed: *At about 7 p.m, CNAs came and got writer on fall. CNA stated that they were using the EZ stand and the stand tipped forward without warning/happened fast. When writer came in, the EZ stand was upright again. Resident was sitting upright on floor. Injury noted to top of forehead, middle. Laceration about an inch in length. Bleeding did stop, open gash. Needed stitches. Resident was taken to hospital. Review of resident 1's 2/28/20 at 8:47 p.m. physician's emergency department report revealed: *Brought in for evaluation of a laceration of the scalp after a fall. -Patient was in a device designed to allow standing when she was left unattended and it apparently fell over. -She either struck her head on the frame or on the floor. -She was also noted here to have an abrasion to the back of her head. *Plan: -After confirmation of the anesthesia 5 staples were used to close the wound without difficulty. -Dressing would be used on the abrasion to the occiput. -The abrasion measured 2 cm in the laceration 3 cm. -Staples will be removed in 1 week. Interview and record review on 3/9/20 at 2:50 p.m. with maintenance director K regarding the EZ stand lift revealed: *He had documented with the date and his initials that he had completed monthly inspections for proper functioning of all mechanical lifts. -There was no further documentation on what he had inspected with the mechanical lifts. *He had not seen any issues with any of the mechanical lifts during the monthly inspections. Interview on [DATE] at 8:20 a.m. with DON B regarding resident 1 revealed: *The type of mechanical lift to use was decided by the nurse. -If a resident was on a therapy case load then the therapist would decide. *He was unaware of the manufacturer's guidelines on which sling to use for the mechanical lifts. *He confirmed they had used the correct sling for resident 1. *They used different brands of mechanical lifts. Interview on [DATE] at 9:07 a.m. with DON B regarding resident 1 revealed: *He was not sure who had made the decision on what sling to use with the mechanical EZ stand. *There was no documentation from the nursing department on what sling to use. -He wanted to trust that the nurses made correct decisions. Interview on [DATE] at 1:10 p.m. with physical therapy assistant H regarding lift training revealed she had: *Been working as a contracted employee since 2/1/20. *Not done any mechanical lift training with the staff. Interview on [DATE] at 3:10 p.m. with licensed practical nurse (LPN) J regarding resident 1 revealed she: *Had previously assessed resident 1 for the use of the mechanical EZ stand. *Was not sure on what sling to use with the mechanical EZ stand. -Would use the smaller of the two slings that had been available. Interview on [DATE] at 3:25 p.m. with occupational therapist I regarding mechanical lift training revealed: *She had been the former director of therapy until 1/31/20. -They were a contracted service. *She was at the facility weekly. -It depended how many residents she had on case-load regarding to how many days she would be in the facility. *She had not been involved with the mechanical lifts for staff training. -If they had a specific resident they had been working with who was going to use a mechanical lift they would do specific training with the CNAs for that specific resident. -They always did the sit-to-stand lift and not the total lift. -They had no involvement in care plans. -They might make recommendations. Interview on [DATE] at 4:35 p.m. with CNA D regarding resident 1 revealed she: *Had assisted with the transfer for resident 1 on 2/28/20. *Was unable to confirm if the strap had been secured around the resident's back leg since CNA E had done that. *She had just assumed the strap had been secured around the resident's back leg. *CNA E was unavailable for interview during the survey. Review of the provider's [DATE]7/10 E-Z Stand policy and procedure revealed: *Preparation: -Check care plan for equipment use on resident. *Procedure: -5. Apply belt around legs and snap buckle. Tighten buckle. Review of the PA800 Operator's Manual manufacturer's instructions for the EZ lift used for resident 1 on 2/28/20 revealed: *Attaching Sling to Lift: -Adjust the shin rest up or down. -Locate the top of the shin rest two inches below the knee cap. -At this point you can lock the brakes on the lift to prevent the person from pushing the lift away from them. -The shin rest has a built-in safety support strap. -The strap helps those who need the added security and support. -This will keep their shins and feet securely in place. -It is not necessary to use the strap on everyone. 2. Observation on 3/9/20 at 1:45 p.m. in resident 2's room with CNAs F and L revealed: *They had resident 2 attached to the mechanical EZ lift. *CNA F walked over to the w/c that had been positioned in the middle of the room. *CNA L pulled the EZ lift with the resident in the sling out from the bed and pushed it to the w/c. -The legs of the EZ lift were not in a widened position. *When CNA L got the EZ lift to the w/c she looked at CNA F and asked what to do next. *CNA F told her to open the legs to the EZ lift. *CNA L opened the legs to the EZ lift, and then pushed it, so it was surrounding the w/c. -Lowered resident 2 into the w/c. Interview on 3/9/20 at 1:55 p.m. with CNA F revealed: *She had been employed with the facility since June 2018. *She had worked at different nursing homes prior to her employment here. *She confirmed the EZ lift could have been used with the mechanical lift legs closed or opened. *Usually placed the lift between the w/c with the legs closed. *She had received education on the proper use of the EZ stand following the incident on 2/28/20 with resident 1. -She had not received education on the proper use of the EZ lift. *She demonstrated back to DON B with a verbal response on how to properly use the EZ stand. -She had not completed any return demonstration of the EZ stand. *She had received some type of training on the mechanical lift after she had started but had not received any further training. Review of the 3/3/19 initial Facility Self-Reporting Form submitted to the SD DOH regarding resident 2 revealed: *Resident had a witnessed fall in her room. -Resident was being transferred from her bed to her w/c via Hoyer lift and CNA x2. -Hoyer began to tip over, and CNA G, placed himself between the Resident and the floor and gently lower the Resident to the ground. -Resident was found on the floor on her back with the Hoyer lift still connected to her sling. -Lift noted to not have legs open during the transfer (CNAs educated real time to always have the legs spread on the lift while transferring residents). -Assist of 4 with hoyer lift to w/c. -When lifting Resident with Hoyer, it was noted to be unsteady. -Hoyer lift was taken off the floor and immediately evaluated further by the Maintenance Director, Administrator, and DON. -When attempting to lift stationary item (Facility trailer), it was noted that one of the legs was not staying locked open/wide. -This was causing the lift to be unsteady and tip when weight was applied to the lift arm. -Maintenance staff took the lift apart, and noted that the primary bolt in the leg had come loose. -Upon further assessment, the threads that the bolt attaches to had stripped out causing the leg to be unsteady. Review of resident 2's medical record revealed: *[DIAGNOSES REDACTED]. *The 2/16/20 quarterly MDS assessment revealed: -A BIMS score of nine indicating she was cognitively impaired. -Required total assistance of two staff with transfer, dressing, and toilet use. *The Morse Fall Scale had a score of seventy-five indicating she was a high fall risk. Review of the 10/2/19 occupational therapy plan of care (evaluation only) for resident 2 revealed: *Is referred to therapy due to poor wheelchair positioning noted by some staff members and question if current chair is too large. -Patient is also occasionally not positioned appropriately in chair by staff members which places her at risk for skin issue or postural abnormality. -Education has been provided to facility staff and they have expressed understanding of recommendations. *'Precautions: -Hoyer lift for all transfers. *There was no documentation provided to staff on the appropriate use of the mechanical EZ lift or which sling to use. Review of resident 2's 3/3/20 at 3:13 p.m. nursing progress notes documented by registered nurse (RN) Q revealed: *Called to residents room per DON and ADON (assistant director of nursing), resident lying supine on the floor. -DON states that the CNAs were transferring the resident with the hoyer lift and the lift tipped over. -DON stated that when he entered residents room the lift was on top of the resident on its left side. -Lift noted to not have the legs spread during the transfer (CNAs educated to all ways have the legs spread on the lift while transferring residents). Review of resident 2's 6/27/19 care plan revealed: *Focus: -The resident has an ADL (activities of daily living) self-care performance. *Interventions: -Transfer: --The resident is totally dependent on 2 staff & Hoyer for transfers. *There was no documentation indicating what size of sling to use. Review of the 12/11/19 CNA pocket care plan

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ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH STREET ALCESTER, SD 57001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) revealed: *2 assist w/Hoyer. *There was no documentation indicating what size of sling to use. Interview on 3/9/20 at 1:55 p.m. with CNA F regarding resident 2 revealed: *She had assisted with the EZ lift transfer of her on 3/3/20. *CNA G and her had completed checking and changing her. *They transferred her with the EZ lift from the bed to the w/c. *The base of the legs had not been opened to a wide position. *CNA G went between the w/c with the legs closed. *Before CNA G could lower her into the w/c, he turned the Hoyer lift, and it started to tip towards the window. *The entire lift went on the floor on it's side with the resident still attached to it. *She confirmed the mechanical lift could be used with the legs open or closed. Interview on 3/9/20 at 2:45 p.m. with DON B regarding resident 2 revealed: *Following the 3/3/20 incident with her the administrator, maintenance director, and himself took the Hoyer lift outside. *They determined the cause of the above incident was due to equipment failure. *They had not provided any follow-up training for the staff regarding of the above incident. *Their policy stated to have the base of the legs open during transfers. *He had been told after the incident the base of the legs had not been opened wide during the transfer. Interview on [DATE] at 2:05 p.m. with CNA G regarding resident 2 revealed: *He had assisted with the EZ lift transfer of her on 3/3/20. *They had hooked her up to the lift, lifted her up in to the air, began to pull the EZ lift from under the bed, it had got stuck, began to pull the EZ lift from under the bed again. -Once the EZ lift was out from under the bed he started to turn the lift, it began to tip, and then went onto the floor with her still attached. *He confirmed the legs to the base of the mechanical EZ lift had not been open. 3. Review of the provider's [DATE]7/10 E-Z Lift policy and procedure revealed: *Preparation: -Check care plan for equipment use on resident. *Procedure: -8. Check that base legs are spread wide. Review of the manufacturer's EZ lift operating instructions revealed: *Adjust lift legs. -Using the spreader bar, adjust the legs of the lift to go around the wheel chair. Review of the provider's 2/1/15 Resident Accident Prevention policy and procedures revealed: *To ensure the resident's environment remains as free as possible of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents. *Procedure:-1) All facility staff will continuously monitored for unsafe/hazardous conditions and corrections will be made promptly when area of concern is identified to ensure a well maintained and safe environment for residents. -7) All residents are assessed quarterly for their risk of accidents and fall, and receive individualized care planning related to their individualized needs. -10) Members of the management team review all incidents and changes will be made to plan of care as needed. Review of the provider's 3/9/20 initial Preventative Maintenance policy revealed:*Policy: -To provide for early detection of potential maintenance problems as well as proper care and routine maintenance of all equipment in possession of (facility name). *Procedure: -4. Procedure: --a. The list will include a description of the equipment, location, type of service due, date of last service, and a place to sign off indicating the work completed. Review of the undated provider's Administrator job description revealed: *Coordinates and integrates the total overall program of the facility. *Interprets and transmits policies of the governing board/management to the medical staff and personnel of the facility to assure compliance with polices. -Make sure residents are meeting their highest level of professional care needed. *Develops and monitors all department within the facility to meet the standards put forth by the governing board, management, and state and federal regulations. Review of the undated Director of Nursing job description revealed: *Essential Duties: -Monitors the job performance of the nursing staff by use of performance evaluations and completes performance evaluations of all nursing department staff. --Staff performance evaluations will be brought to the Administrator for review. -Develops and directs nursing services objectives, policies and procedures. -Develops in-service educational programs geared to the specialized needs of geriatric individuals and meets regulatory annual requirements. Review of the undated Nursing Assistant job description revealed: *Works under the supervision of the charge nurse and performs routine resident care duties and procedures. -Assist residents with mobility: --Turn and position residents, transfer residents to chair/bed. --Use appropriate gait belts, equipment, body mechanics per resident care plan. -Assist residents in promoting safety. Review of the provider's undated Maintenance Supervisor job description revealed: *Essential Duties: -Overall maintenance of the entire facility. -Preventative maintenance and repair to assure efficient operating equipment. Refer to F610, findings 1 and 2. Refer to F657, findings 1, 2, and 3. Refer to F726, finding 1. Refer to F865, findings 1, 2, 3, and 4.
F 0726 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on observation, interview, employee personnel files review, in-service record training review, manufacturer's recommendations review, and policy review, the provider failed to ensure all employees were competent who utilized the mechanical lifts. That failure created a situation of immediate jeopardy that had the potential for causing harm to all of the residents who utilized a mechanical lift. NOTICE: Notice of immediate jeopardy was given verbally to the administrator and director of nursing (DON) on 3/9/20 at 4:10 p.m. The administrator was asked for an immediate plan of correction (POC) to ensure all staff who utilized the mechanical lifts received education and demonstrated competencies for the use of the mechanical lifts and overall safety review and documentation of the mechanical lifts being utilized. PLAN: On 3/9/20 at 9:39 p.m. administrator provided the surveyor with an email that included the written (POC). The written POC dated 3/9/20 was accepted by the surveyor on [DATE] at 8:08 a.m. That immediate POC included: Immediate Jeopardy Action Plan: DON, Administrator, and interdisciplinary team reviewed and revised as necessary the policy and procedure for resident accident and prevention, proper mechanical lift transfers for the three types of mechanical lifts which include the manufacture guidelines for competency checks. Policy and procedure for each lift will be reviewed and revised to include proper positioning of the lift legs. DON or licensed nurse or a licensed therapist will provide immediate re-education for all staff and each staff member's competency relating to each of the three make/model mechanical lifts. Before each staff member with job duties relating to mechanical lift transfers are able to work their scheduled shift, mandatory competency training will be performed until 100% of the staff responsible for mechanical lift transfers are in compliance. Staff members will be taken off their scheduled shift(s) until training is completed first. Administrator re-educated the Maintenance Director on policy and procedure for monthly preventative maintenance checks relating to lifts. A step-by-step guideline by the manufacture's recommendation will also be signed off to indicate that each part was visibly and specifically checked. Maintenance director will complete preventative maintenance checks on the three make/model mechanical lifts by [DATE] and perform checks on all other mechanical lifts. Additional instruction provided to the administrator and the director of nursing included completing a thorough investigation with resident 2's 3/3/20 incident and continue to set-up frequent monitoring of the mechanical lifts. During the survey on [DATE] at 8:08 a.m. the surveyor confirmed removal of the immediate jeopardy situation. Findings include: 1. Observation on 3/9/20 at 1:45 p.m. in resident 2's room with certified nursing assistants (CNA) F and L revealed: *They had resident 2 attached to the mechanical EZ lift (total lift). *CNA F walked over to wheelchair (w/c) that had been positioned in the middle of the room. *CNA L pulled the EZ lift with the resident in the sling out from the bed and pushed it to the w/c. -The legs of the EZ lift were not in a widened position. *When CNA L got the EZ lift to the w/c she looked at CNA F and asked what to do next. *CNA F told her to open the legs to the EZ lift. *CNA L opened the legs to the EZ lift, and then pushed it, so it was surrounding the w/c. -Lowered resident 2 into the w/c. Interview on 3/9/20 at 1:55 p.m. with CNA F revealed: *She had been employed with the facility since June 2018. *She had worked at different nursing homes prior to her employment here. *She confirmed the EZ lift could have been used with the legs closed or opened. *Usually placed the lift between the w/c with the legs closed. *She had received education on the proper use of the EZ stand (sit-to-stand) following the incident on 2/28/20 with resident 1. -She had not received education on the proper use of the EZ lift. *She demonstrated back to the director of nursing (DON) with a verbal response on how to properly use the EZ stand. -She had not completed any physical operation of the EZ stand. *She had received some type of training on the mechanical lift after she had started but had not received any further training. Review of CNA F's personnel file had no documentation that training or competencies had been completed for the use of all mechanical lifts. Interview on 3/9/20 at 2:00 p.m. with CNA L revealed: *She had been working as a CNA for five years. *She usually worked the day shift. *She had been trained a long time ago on both types of lifts. *She had been retrained last week on the EZ stand but not the EZ lift. *She had not competed a verbal demonstration or a physical demonstration on how to use the EZ stand lift following the retraining last week. Interview on 3/9/20 at 2:10 p.m. with CNA O revealed: *She had been hired in November 2019. *She had completed her certified nursing assistant training from the provider. *She had received some training on the use of the mechanical lifts and had completed return demonstrations on how to use them. *She had received training on the EZ stand last week but not on the EZ lift. -She had not completed a demonstration on the EZ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) stand. Interview on 3/9/20 at 2:20 p.m. with administrator A and DON B regarding the mechanical lifts revealed: *They had done retraining and reeducation with staff on the EZ stand but not the EZ lift. *They had done a demonstration on the EZ stand and provided a sheet for the employee's to read. *The staff were given the opportunity to ask questions and have a dialogue regarding the mechanical lifts. *The staff then signed a document they had read the information. *CNA E was the only employee who had completed a return demonstration on the EZ stand. *Registered nurse M and CNA N had worked at the facility following the incidents on 2/28/20 and 3/3/20 without being retrained prior to operating any mechanical lifts. *They had made an attempt to get as many employees retrained on the EZ stand before their next scheduled work shift. *The company that provided the mechanical lifts offered additional services. -They would complete annual maintenance checks. *Lift training was provided by physical therapy and occupational therapy. Interview and document review on 3/9/20 at 2:40 p.m. with administrator A regarding the mechanical lift training revealed : *It had been done last on 8/20/18. *There had been no staff competencies completed. Interview on [DATE] at 1:10 p.m. with physical therapy assistant H regarding mechanical lift training revealed she had: *Been working as a contracted employee since 2/1/20. *Not done any mechanical lift training with the staff. Interview on [DATE] at 2:05 p.m. with CNA G regarding lift training revealed: *He had worked at the facility five or six years. *He had received training on the mechanical lifts two years ago. *The DON had shown him a few days ago how to use the EZ stand but not the EZ lift. *He had not completed a return demonstration. Interview on [DATE] at 3:25 p.m. with occupational therapist I regarding mechanical lift training revealed: *She had been the former director of therapy until 1/31/20. -They were a contracted service. *She was at the facility weekly. -It depended how many residents she had on case-load regarding how many days she would be in the facility. *She had not been involved with the mechanical lifts for staff training. -If they had a specific resident they had been working with who was going to use a mechanical lift they would do specific training with the CNAs for that specific resident. -They always did the sit-to-stand lift and not the total lift. -They had no involvement in care plans. -They might make recommendations. Interview on [DATE] at 4:35 p.m. with CNA D regarding the mechanical lift training revealed she had: *Worked at the facility for a year. *Completed her CNA training at the facility. *Received training on the mechanical lifts. *Done a return demonstration on the EZ stand during the testing phase of her CNA training. *Not completed a return demonstration on the EZ lift during the testing phase of her CNA training. Review of the following CNAs employee files revealed: *CNA D:-Hired on 3/25/19. -There was no documentation she had completed or demonstrated appropriate use of the mechanical lifts. *CNA E:-Hired on [DATE]/19. -There was no documentation she had completed or demonstrated appropriate use of the mechanical lifts. *CNA G: -Hired on [DATE]0/15. -There was no documentation he had completed or demonstrated appropriate use of the mechanical lifts. Interview on 3/9/20 at 3:20 p.m. with administrator A revealed he could not verify if training had been done as there was no documentation of competencies in CNA D, E, and G's personnel files. Review of the provider's reviewed and revised [DATE] In-Service Training policy revealed: *Every staff member is required to attend to be reeducate. -If a staff member is unable to make it to the meeting, handouts and/or competency checks will be required. -These topics include the following subjects: --(11) Use of mechanical lift(s) training to be conducted on an annual or PRN (as needed) schedule to include the sit-to-stand and hoyer lifts. Refer to F610, findings 1 and 2. Refer to F657, findings 1, 2, and 3. Refer to F689, findings 1, 2, and 3. Refer to F865, findings 1, 2, 3, and 4.
F 0865 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on observation, interview, record review, policy review, manufacturer's review, and in-service training review, the provider failed to ensure performance improvement projects (PIP) had been implemented for falls, staff education, and use of mechanical lifts for continued interventions and evaluations for an effective quality assurance performance improvement program. Findings include: 1. Review of the fall incidents from 2/9/20 through 3/7/20 revealed they had:*Ten residents who had falls. -Of those ten residents five had two or more falls. 2. Review of resident 1's medical record revealed she had a fall with a head injury involving a mechanical lift on 2/28/20. 3. Review of resident 2's medical record revealed she had a fall with a mechanical lift on 3/3/20. 4. Interview on [DATE] at 4:45 p.m. with administrator A and director of nursing B regarding their quality assurance performance improvement (QAPI) program revealed: *They met quarterly as a QAPI group. *There was no documentation on the 2/19/20 falls PIP. *They had not addressed falls or falls with the use of mechanical lifts prior to the fall events on 2/28/20 with resident 1 and on 3/3/20 with resident 2. Review of the provider's 12/1/17 QAPI Plan revealed: *The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. *Overall PIP Plan: -Performance Improvement Projects will be concentrated effort on a particular problem in one area of the nursing center or on a facility-wide basis. -The nursing center will conduct PIPs to examine and improve care or services in areas that the nursing center identifies as needing attention. *PIP Determination Process: -Areas for improvement are identified by routinely and systematically assessing quality of care and service, and include high risk, high volume, and problem prone areas. Refer to F610, findings 1 and 2. Refer to F657, findings 1, 2, and 3. Refer to F689, findings 1, 2, and 3. Refer to F726, finding 1.