STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smp Health - St Catherine North	1351 N Broadway Fargo, ND 58102

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46259 Based on record review, review of facility investigation, review of the facility policy, and staff interview, the facility failed to ensure adequate supervision and assistance for 1 of 1 closed records (Resident #1) reviewed for an accident with subsequent injury. Failure to provide adequate assistance with a full-body mechanical lift transfer resulted in Resident #1's injury and placed all residents requiring full-body mechanical lifts at risk for injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Review of the facility policy titled Safe Resident Handling/Transfers occurred on 05/21/24. This policy, revised 05/10/24, stated, . It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action . Review of the Validation Checklist-Mechanical Lift occurred on 05/21/24. This document, dated 2024, stated, Purpose: To determine if the individual performs transfers with mechanical lifts in accordance with professional standards of practice and as per manufacturer's instructions for use. Attached the sling straps to the desires settings and ensured the straps were secure. Gently raised the resident minimally away from the bed surface and ensured that straps were still secure. Moved and positioned the lift over the respective chair, with the assistance of the second staff member, and gently lowered the resident into the chair . Review of Resident #1's medical record occurred on 05/21/24. The care plan stated, . TRANSFER: I require assist of 2 with hoyer [full-body mechanical lift] for transfers. Review of Resident #1's progress notes identified the following: * 05/09/24 at 10:39 a.m., [Resident #1] fell out of hoyer sling during transfer this morning. Pupils reactive and equal in size. Unable to assess strengths bilaterally. Resident guarding right hip and grimacing. Notification: Call placed to [provider name]. Send resident to . ER [emergency room] for further evaluation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* 05/09/24 at 12:38 p.m., . Resident returns to facility from . ER. Neuros [neurological assessments] are as follows: Pupils are equal and brisk to react. Resident remains aphasic (baseline for her). Able to do ROM [range of motion] on all 4 extremities with some guarding during motion of her leg. * 05/10/24 at 11:40 a.m., . Resident was very sleepy during brunch. She kept placing her hand near her head and looking down. Ice pack applied for 15 mins [minutes] and Tylenol provided for comfort. Neuros have remained unchanged this shift and continue to be assessed every 2 hrs [hours]. She has a large area of bruising to the back of skull, with further bruising running down the left & [and] right neck into the collar bone region. Her scalp has a small area with dried blood on it. * 05/11/24 at 7:03 a.m., . Resident slept comfortably all shift with no s/s [signs/symptoms] of pain/infection. Back of head stopped oozing this shift. Hematoma [pool of blood or bruise] still present to back of head with edema. Neuro checks completed and are running her baseline at this time. * 05/11/24 at 1:17 p.m., . Resident slept all morning/early afternoon and was unable to be arose. Did not receive medication or any food. Resident had 75 second seizure at 1300 [1:00 p.m.] today. on-call provider . was called . Send resident in to . ER and hold bed. The facility's investigation report, dated 05/13/24, stated, . based on the demonstration of how the fall occurred and reporting of staff who witnessed the fall, investigation indicates that [certified nurse aide (#2)] did not follow the proper steps for a safe transfer by ensuring that the sling was securely hooked to the lift, having equipment in the appropriate position, and keeping her hands on the resident for guidance and/or support during the transfer . During an interview on the afternoon of 05/21/24 an administrative staff member (#1) confirmed staff failed to properly transfer Resident #1 which led to the injuries. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for the deficient practice by: * Completing an investigation with interviews of staff that determined the cause of the incident. * Providing immediate staff education on 05/09/24 to staff via e-mail regarding proper transferring with Hoyer lifts. * Completing competency validations of safe transfers for all nursing staff beginning 05/09/24. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: * Implemented weekly Hoyer transfer audits to ensure staff on all units are performing safe and appropriate transfers using mechanical lifts * Implemented weekly care plan audits to ensure Hoyer sling sizes are on each resident care plan. * On 05/10/24 all mechanical lifts were inspected to ensure they were working properly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The surveyor determined a deficient practice existed on 05/09/24. The facility implemented corrective action and completed all staff education on 05/20/24.