STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	1001 S Egan Ave Madison, SD 57042

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. 50015 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, interview, and manufacturer's reference guide review the provider failed to ensure the safety of one of one sampled resident (1) who fell from a mechanical lift (a lift and sling used to lift a person's body) that was not used by staff as the manufacturer directed and received skin injuries to her scalp and her elbow. Findings include: 1. Review of the provider's 10/18/24 SD DOH FRI regarding resident 1 revealed: *On 10/17/24 at 7:05 p.m. she fell out of a mechanical lift sling while being transferred by staff while using the lift. *Her Brief Interview for Mental Status (BIMS) assessment score was 2 which indicated she had severe cognitive impairment. *She is a bilateral lower amputee. *After supper resident was taken to room and was yelling out due to pain from sore on [her] bottom. *Vital signs and neuros were initiated and were stable. *The sling and Arjo [mechanical lift] got caught and resident slipped thru sling onto floor. *Superficial abrasion found on back of head. -Ice applied to abrasion on her head. *Skin tear on her left elbow 0.2 cm x 0.1 cm. -Skin tear cleansed and steri strips (a closure device) were applied. *Family was notified. -They declined an emergency room 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	*Physician was notified. *Staff were educated: -To plan transfer to ensure smooth transitions. -Educated on safety awareness related to using mechanical lifts. -Proper positioning of the lift sling. -Educated on notifying the nurse of pain to treat it before transferring. *A double amputee sling will be ordered. 2. Review of resident 1's electronic medical record (EMR) revealed: *She had diagnoses of: -Left below knee amputation. -Right above knee amputation. -Dementia with behavioral disturbances. -Pressure ulcer of sacral region (bone area at the base of the spine), stage four. -Spinal stenosis (narrowing of spaces in the spine) of the lumbar region (lower back). -Cerebral vascular accident (stroke) with left-side hemiplegia/hemiparesis (paralysis). *Her weight on 11/3/24 was 63 pounds. *Her current care plan revealed: -She was dependent on two staff for all transfers using the Arjo (mechanical lift). -Small Arjo sling. -May use medium sling as needed [PRN]. -Staff to be aware to use safe transfer techniques due to bilateral lower extremity (LE) amputations. -She was on hospice services. -She was non-weight bearing. -She required frequent turning and positioning as directed in care plan and hospice orders. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Observation on 11/6/24 at 11:02 a.m. with certified nursing assistant (CNA) D and E while transferring resident 1 with mechanical lift revealed: *CNA D and CNA E placed a lift sling under her, crossed the lower straps, and rolled the resident onto the sling. *CNA D attached the upper strap clips to the mechanical lift to the top lugs. *CNA D attached the lower strap clips to the lift bottom lugs from the outside of her legs, not between her legs. *The catheter bag was clipped to the lower part of the lift during the transfer. *She was placed over her Rock and Go wheelchair (rocking wheelchair with a tiltable seat) and lowered onto the cushion. *CNA D unclipped the sling from the lift. *CNA D combed resident 1's hair and put her glasses on. *She was pushed in her wheelchair by CNA D out to the dining room for lunch. 4. Interview on 11/5/24 at 2:25 p.m. with CNA C revealed: *She had transferred resident 1 on 10/17/24 with CNA F and had used the mechanical lift. *She had boosted her in her wheelchair earlier in the evening. -That caused the sling to have moved closer to her buttocks area. *Resident 1 was to be assisted with eating and then placed back in bed after she finished eating due to the sore on her bottom. *She was controlling the lift remote and wanted to get her into bed quickly. *CNA F moved the catheter bag and the wheelchair. *She did not position the lift high enough to clear the wheelchair. -The sling caught on the wheelchair which she felt caused an opening in the sling and resident 1 slid out of the sling onto the floor. *Resident 1's head landed on the leg of the lift and that caused a cut on her head that bled. *She went and notified registered nurse (RN) G. *Two staff were needed to use the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*Sling sizes were listed on a sheet in the west hallway closet and resident 1's care plan. 5. Interview on 11/5/24 at 4:25 p.m. with RN G regarding the incident that involved resident 1 revealed: *She worked the evening on 10/17/24 when resident 1 fell out of the lift. *CNA C notified her of the incident. *Neuro assessment and vitals were started and were documented. *Resident 1's family was notified. -They declined emergency room evaluation of resident 1. *The physician was notified. *RN G documented resident 1's abrasion to her head and the skin tear to her left elbow in a progress note. -She applied pressure to the abrasion on her head to attempt to stop the bleeding. -She cleansed the skin tear and applied Steri-strips (adhesive suture strips). 6. Interview on 11/6/24 at 8:25 a.m. with CNA F regarding the above 10/17/24 incident revealed: *Resident 1 was hollering out after dinner. *She and CNA C attached the sling to the lugs on the lift. *Due to resident 1's amputations We cross the leg straps under her butt and then hook it to the Arjo lift. *CNA C was operating the lift and raised resident 1 from the wheelchair. *She grabbed the catheter bag, and the wheelchair got stuck on the leg of the lift. *She tried to move it out of the way. *The sling got caught on the wheelchair and resident 1 slid through the sling butt first onto the floor. *Resident 1's head hit the leg of the lift or the floor, she was not sure which one. *Resident 1 had a cut on her head that was bleeding and a skin tear on her left elbow. *CNA C went to get the nurse. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*CNA F stayed with resident 1. *She observed RN G take resident 1's blood pressure and looked at her head. -RN G then told them to get resident 1 into bed. *She had never used an Arjo lift before working at this facility. *During her first shift a nurse showed her how to use the Arjo lift. 7. Interview on 11/6/24 at 12:55 p.m. and again at 3:07 p.m. with RN B revealed: *She updated resident 1's care plan on 11/5/24 to include staff were to use a medium sling and a large PRN (as needed). *On 10/24/24 she completed a Safe Resident Handling and Movement assessment of resident 1. *She provided the CNA training and competencies (skills testing) with staff. *CNA C completed competencies for the Arjo lift when she was in the CNA class on 3/14/24. *She was unsure how agency staff were trained for use of the lifts. *She had verbalized reminders to CNA C about how to boost a resident who uses a sling and a lift. *She had not given any education to CNA F following resident 1's incident above. 8. Interview on 11/6/24 at 2:15 p.m. with director of nursing (DON) H revealed: *RN B completed the training of staff. *During class they would watch videos and practice using the lifts on each other. *Competencies were completed yearly at skills fair. *Competencies were completed by the employing agency for the temporary staff employees. *She had asked RN B to investigate the incident and make sure the staff was properly trained. *She was on vacation at the time of the incident. *She planned to create a policy for reporting incidents and following through. *Administrator A has ordered a new sling and they were awaiting the delivery of the sling. *Additional training was planned to be completed when the new sling arrived. 9. Interview on 11/6/24 at 3:22 p.m. with administrator A revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*The provider for the agency staff would send them competencies verifications for the agency staff they would hire. *He agreed there is a difference between types of lifts. *When new agency staff start at the facility, assistant director of nursing (ADON) I would do the walk-through and show them where things are located. *He had ordered a new sling to use for resident 1 and supplied an email confirmation of the order. 10. Interview on 11/6/24 at 3:40 p.m. with ADON I revealed: *She completed the orientation walk-through with CNA F on 9/25/24. *CNA F was then sent to train with another CNA during her first shift. *She did not show CNA F how to use the Arjo lift. *CNA F should have been shown how to use the lift by the training CNA. 11. Review of the Arjo Maxi Move Quick Reference Guide dated 5/2020 revealed: *Pull each leg strap from under the thigh so that it emerges on the inside of the thigh. *Move the lift away from the chair. The angle of recline can be adjusted to increase comfort for restless patients. The lift can now be directed towards the next transfer point. *To lift from a bed: -Press down on the positioning handle until the sling leg sections can be connected. Connect the leg sections under the thighs by lifting one leg at a time.