STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435105	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatcrest Hills Healthcare Center	1311 Vander Horck St Britton, SD 57430

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43021 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, interview, policy review, and manufacturer's instructions review, the provider failed to ensure the safety of one of one sampled resident (1) who sustained an injury when staff did not use the full-body mechanical lift (a mechanical device and sling used to lift a person's body) as directed in the manufacturer's instructions, facility policy, and the resident's care plan. Failure to use the mechanical lift as instructed contributed to the resident 1's injury. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of provider's 10/22/24 SD DOH FRI revealed: *On 10/20/24 at 5:41 p.m. resident 1 was being transferred into her wheelchair by certified nursing assistant (CNA) G who used the full-body mechanical lift on her own. *When unhooking the sling from the lift's sling hangers the metal sling hanger bar swung back and hit resident 1, causing a laceration to her forehead. *The on-call physician's assistant was called and orders were received to send resident 1 to the emergency department for evaluation. *Resident 1 was sent by ambulance to the nearby hospital's emergency department. *Resident 1 returned to the facility that evening with surgical staples to her forehead and physician orders to: -Keep [the wound] clean and dry. -Wash gently with soap and water BID [twice a day]. -Apply an antibiotic cream. -The [surgical] staples can come out in 5-7 days. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Wheatcrest Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 Vander Horck St Britton, SD 57430	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*CNA G stated she was aware she should have had another staff person assist with the full-body mechanical lift transfer. *CNA G was suspended until the incident's investigation was completed. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted to the facility on [DATE] *She had diagnoses that included diabetes mellitus, type 2; acute kidney failure; non-pressure chronic ulcer of right heel and midfoot with unspecified severity; polyneuropathy (nerve damage that causes pain); and depression. *She had a recent Brief Interview for Mental Status score of 12 which indicated she was moderately cognitively impaired. *A 9/4/24 device evaluation identified she used a full-body mechanical lift with a large sling for her transfers. *Licensed practical nurse (LPN) H had completed a nursing progress note on 10/20/24 at 6:03 p.m. which stated Nurse [LPN H] called to resident's room. CNA was transferring resident into W/C [wheelchair] with the hoyer [a full-body mechanical lift brand name] lift. Resident was already in W/C and CNA was unhooking the lift sheet [sling] from the hoyer bar when the bar came back and hit resident in the forehead. Assessed forehead area, bleeding. Cleansed area and measures 4.5 cm [centimeters] x 0.5 cm with 0.6 cm depth. Applied normal saline to 4x4 gauze and wrapped head. Notified on-call provider, DON [director of nursing], and ED [executive director]. RCVD [received] orders to send to ER [emergency room] for further eval via ambulance. Notified husband of transfer. *Her current care plan that was printed on 10/30/24 indicated: -She required the use of the total [full-body mechanical] lift with [a] large sling and [the assistance of] 2 staff [members] for transfers which had been initiated on 7/12/24. -A problem area was added to her care plan on 10/21/24 that indicated I have a laceration on my forehead with staples. --The goal for that problem area indicated I would like my skin to heal appropriately. --Interventions for that problem area included Nurse to provide wound cares as ordered and Nursing to monitor healing process. --The problem area was revised on 10/29/24 with staples removed 10/24/24. 3. Interview on 10/30/24 at 8:53 a.m. with executive director (ED) A and director of nursing (DON) B revealed: *ED A had worked at the facility for [AGE] years and had been the DON, but had accepted the ED position recently. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*DON B had worked at the facility for [AGE] years and had accepted the DON position at the beginning of October 2024. *ED A stated the provider did not have a policy for the mechanical lifts but used the lift manufacturer's instructions as their policy. *ED A stated that nursing staff sign a lift agreement upon hire. 4. Review of Total (Hoyer) Lift acknowledgment and interview with ED A on 10/30/24 at 9:00 a.m. revealed: *The Total (Hoyer) Lift acknowledgment was the lift agreement staff signed upon hire. *The acknowledgment stated It is best practice to have 2 staff present when using the Total (Hoyer) lift. [Provider's name] will enforce this. We understand that at times there may be an emergency when this is not possible. *The form included: -Three corrective actions that would be taken for violations of the acknowledgment. -Signature lines for: --The employee. --The DON. --The ED. -A line for the date the acknowledgment was signed. *When asked about the statement We understand that at times there may be an emergency when this is not possible. ED A clarified the 'emergency' as a facility fire stating When you do what you need to do to get residents out of harm's way. *She provided and confirmed the [Brand Name] Smart Lift with 500, 600, & 1,000 lb. [pound] Capacities Operator's Instructions was their policy. 5. Observation and interview on 10/30/24 at 11:23 a.m. with CNA C, CNA/certified medication aide (CMA) D and CNA/CMA E while they assisted resident 1 to transfer from her bed to her wheelchair revealed: *CNA C hooked the large sling's four hook straps to the full-body mechanical lift's metal sling hanger. *CNA/CMA E held the resident's two wound vacuums, one wound vacuum to each of her lower legs, that were placed during her 10/21/24 skin graft surgery. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*CNA/CMA D operated the lift and lifted resident 1 from her bed. *CNA C held the resident's legs during the transfer and stated [Resident's first name] watch your head while maneuvering the resident over her wheelchair. *CNA/CMA D operated the lift to lower the resident into her wheelchair. *After the resident was seated in her wheelchair, CNA/CMA E placed the wound vacuums to hang, one wound vacuum from each of the handles of the wheelchair. *CNA C unhooked the four hook straps from the lift's metal sling hanger bar and tucked the straps into the wheelchair, underneath resident 1. *No concerns were noted during this transfer. *CNA C had worked at the facility for one year and stated: -Two staff are required when using the total (full-body mechanical) lift. -For me, I use three staff for [resident 1's first name] transfers due to her wound vacuums. 6. Observation and interview on 10/30/24 at 11:34 a.m. with resident 1 in her room after she had been transferred to her wheelchair revealed she: *Had sustained an injury to the top right of her head, within her hairline. *Recalled being injured during a transfer recently, but could not remember when or the staff member's name that caused her injury. *Stated she felt safe with her transfers. *Stated she recently had surgery to clear up the sores on her legs. *Stated the staff responded promptly to her call light and she felt there was enough staff on duty to take care of her needs. 7. Interview on 10/30/24 at 1:17 p.m. with CNA F revealed: *He had worked at the facility for four years. *He was working at the facility on Sunday, 10/20/24, when resident 1's incident above occurred. -There were two CNAs on duty when that the incident occurred. -He was working on the east hallway and was informed about the incident by LPN H that evening. -He thought CNA G was sent home around 5:45 p.m. that evening. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Another staff member was called to come in that evening to assist with the residents' care needs. *He had attended a staff meeting last week during which education was provided on the use of mechanical lifts. -Two staff were required when using the full-body mechanical lifts. -He had signed a form regarding the full-body mechanical lifts. *He had never transferred a resident with a full-body mechanical lift alone. *He stated CNA G had returned to work at the facility. 8. Interview on 10/30/24 at 4:17 p.m. with ED A revealed: *She had called the facility on 10/20/24 after LPN H had notified her of resident 1's incident with injury and had placed CNA G on leave pending investigation. *She had completed the incident's investigation on Monday, 10/21/24. *CNA G returned to the facility on Tuesday, 10/22/24 at 1:00 p.m., to complete education regarding the need to have two staff assist with a full-body mechanical lift. *CNA G returned to work on 10/22/24 after completing that education and signing the Total (Hoyer) Lift acknowledgment form. 9. Interview on 10/30/24 at 4:39 p.m. with CNA G revealed she worked: *At the facility for [AGE] years as a CNA. *The evening shift from 2:00 p.m. to 10:00 p.m. and was a full-time employee. *The evening shift on 10/20/24 as she was scheduled for that shift. -She stated there were three CNAs scheduled for that shift, but one of the CNAs scheduled had called off, leaving two CNAs, her and CNA F on duty as the CNAs working that shift. -She had assisted resident 1 transferring from her bed to her wheelchair before supper that evening. -She had looked for CNA F to assist her with the full-body mechanical lift as she knew two staff were needed. -When she could not find CNA F, she decided to transfer resident 1 by herself using the full-body mechanical lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-After she transferred resident 1 to her wheelchair, she was unhooking the sling from the full-body mechanical lift's metal sling hanger and the free end of the hanger swung around and hit resident 1 in the face. -After the incident, she went and got LPN H as resident 1's face was bleeding and she took care of the wound. -She left around 5:30 p.m. that evening as she was dismissed after a phone call from ED A confirming she should not have completed resident 1's transfer by herself and she was being placed on leave until the investigation of the incident was completed. -ED A called her on Monday and told her to return to the facility on Tuesday, 10/22/24 at 1:00 p.m. for training and work at 2:00 p.m. -On 10/22/24 at 1:00 p.m. she met with ED A in the ED's office to review the requirement for two staff to be involved in full-body mechanical lift transfers and that the second person could be another CNA, CMA, or the nurse-on-duty. ED A had her sign an Education/Coaching Documentation form that stated: --The Employee has been educated or coached on the following topics: You are to use 2 [staff members] assist for the total body lift at all times No exceptions. You can ask the nurse or med aide to assist you if it is a weekend. --Describe the action plan for improvement: Will use 2 [staff members] assist for the total body lift immediately. -She then met with DON B in the DON's office to review the requirements for full-body mechanical lift transfers, complete the CNA Competency form for Mechanical lift transfer, and the Total (Hoyer) Lift acknowledgment. -CNA G confirmed that she should not have completed a full-body mechanical lift by herself but should have had another staff person's assistance. 10. Interview on 10/30/24 at 5:00 p.m. with DON B regarding resident 1's 10/20/24 incident revealed: *LPN H had called her that evening and informed her that resident 1 had to have stitches as she was hit with the mechanical lift's sling hanger bar. *LPN H told her that the incident gets worse as CNA G was doing resident 1's full-body mechanical lift transfer alone. *DON B had responded by stating CNA G would need to be placed on suspension and sent home. *DON B stated she then called ED A and discussed how to proceed. *DON B stated after that phone call, ED A called CNA G and placed her on leave pending investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*DON B stated this was CNA G's first violation of the Total (Hoyer) Lift acknowledgment which resulted in CNA G completing an education form. *The next day, 10/21/24, the provider held an all-staff meeting at 2:00 p.m. during which they discussed the requirement of two staff involved with residents using the full-body mechanical lift for transfers. -ED A led the all-staff meeting. -The steps for completing a mechanical lift transfer were discussed using the CNA Competency Mechanical lift transfer form. -Staff signed the Total (Hoyer) Lift acknowledgment form. -The all-staff meeting lasted for 45 minutes. 11. Interview on 10/30/24 at 5:25 p.m. with ED A revealed: *On Monday, 10/21/24, at 2:00 p.m. she held an all-staff meeting. *During the 45-minute meeting, she talked through the full-body mechanical lift process and procedure using the CNA Competency Mechanical lift transfer form. *She reviewed with staff members the Total (Hoyer) Lift acknowledgment form and had staff members sign the form. *On Tuesday, 10/22/24, she met with CNA G at 1:00 p.m. and completed the Education/Coaching Documentation Form with her and had her sign the form. *DON B then met with CNA G and provided her the education presented at the all-staff meeting including the full-body mechanical lift process and procedure and the Total (Hoyer) Lift acknowledgment form. *DON B had CNA G sign the Total (Hoyer) Lift acknowledgment form. 12. Review of the provider's documentation after resident 1's full-body mechanical lift incident with a head wound performed by only one staff person revealed the actions the provider took included: *The DNS or designee will re-train all nurses and nurse aides on the use of the [Brand name] hoyer (total) Lift. -DON B was responsible for providing that training. -The completion date was 10/21/24 to 10/22/24 or before next working shift. -The provider's education sign-in form revealed 36 staff members' signatures. ED A stated on 10/30/24 at 2:30 p.m. that five staff members who worked occasionally as needed had yet to complete the education and would not be able to work until they had completed the education. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*The ED or designee reviewed the care plan for every resident who requires the use of a mechanical lift to ensure resident-specific interventions were present. Lift sling size identified and listed. -ED A was responsible and completed this review on 10/21/24. *Mechanical lift training will continue to be completed by DON or designee during orientation for new nurses and nurse aides. *Mechanical lift training will continue to be included in yearly competencies . completed by DON or designee. -Review of completed CNA Competency Mechanical lift transfer forms revealed 36 staff members had completed this form between 10/21/24 and 10/28/24. *All Nursing staff will sign agreement [Total (Hoyer) Lift acknowledgment] that they are aware of the use of two staff with a total [full-body] mechanical lift. -Review of signed Total (Hoyer) Lift acknowledgments revealed 36 staff members had signed individual acknowledgments between 10/20/24 to 10/28/24. *DON or designee will audit 3 total lift residents weekly for 4 weeks and monthly for two months for utilization of two staff with total lift transfers. The DON or designee will bring the results of the audits to the monthly QAPI [Quality Assurance Performance Improvement] committee for review and recommendations to continue or discontinue the audits. *DON or designee will audit walkie talkies to make sure CNAs have them on their person weekly for 4 weeks and monthly for two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for review and recommendations to continue or discontinue the audits. 13. Review of CNA G's personnel file revealed she: *Was hired on 6/13/07. *Had signed a Total (Hoyer) Lift acknowledgment one year prior to the 10/20/24 incident on 10/18/23. *Worked 10/20/24 from 1:55 p.m. to 5:47 p.m. *Did not work 10/21/24. *Worked 10/22/24 from 12:58 p.m. to 10:05 p.m. *Received education and coaching on 10/22/24 and signed an Education/Coaching Documentation Form regarding the use of two staff members for the total (full-body mechanical) lift at all times. *Had completed a CNA Competency Mechanical lift transfer form with ED A on 10/22/24. *Signed a Total (Hoyer) Lift acknowledgment on 10/22/24. That was also signed by DON B and ED A. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	14. Review of the provider's 6/14/23 (Brand name) Smart Lift with 500, 600, & 1,000 lb. (pound)Capacities Operator's Instructions revealed: *A Safety Note that stated The [brand name] Smart Lift TM [Trade Mark] was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary. *ED A and DON B had signed the back page of the operator's instructions on 10/21/24. The provider implemented action on 10/21/24 to ensure the deficient practice does not recur and was confirmed on 10/30/24 after record review revealed the facility had followed their quality assurance process, education was provided to all direct care staff regarding mechanical lift safety and following residents' care plans, observations and interviews revealed staff understood how to correctly operate mechanical lifts according to each resident's individualized care plan, review of the appropriate sling sizes for each resident's mechanical lift needs, care plans were reviewed to ensure the resident's correct sling size, and verification of certified nurse aide (CNA) competencies and audits were being performed. Based on the above information, non-compliance at F689 occurred on 10/20/24, and based on the provider's implemented corrective actions completed on 10/22/24 for the deficient practice confirmed on 10/30/24, the non-compliance is considered past non-compliance.