STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minot Health and Rehab, LLC	600 S Main St Minot, ND 58701

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** 27221 Based on observation, review of facility reported incident (FRI) reports, review of medical records and facility policies, and resident and staff interviews, the facility failed to provide appropriate supervision and/or assistance to prevent an accident for 1 of 1 resident (Resident #3) who fell during van transport. Failure to utilize chest and lap seatbelts to restrain a resident in the facility van resulted in Resident #3's fall from his tilt-in-space wheelchair, serious injury, and placed all residents transported via the facility van at risk for falls and/or injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include: A Initial Allegation of Mistreatment, Abuse, Neglect or Theft and Facility Reported Incidents Reporting Form, dated 08/24/22, stated, . [Resident #3] was being transported by [staff member #2] in the facility vehicle. At a stop sign [Resident #3] slid out of the wheelchair and fell on to the floor. Resident was helped by two EMS [emergency medical services] personnel and [staff member #2] back into his wheelchair. Resident was found to have bilateral broken femurs. Review of the facility policy titled Facility Van occurred on 09/07/22. This policy, revised 02/02/18, stated, . Training to include vehicle specific operations, lift use and safety . Residents . must be restrained with seatbelts and tie downs prior to driving. One of the most important safety tips when operating a vehicle is to make sure every passenger is buckled up at all times. Random observations September 6-7, 2022 showed Resident #3 lying in bed with both legs in immobilizers. During an interview on 09/06/22 at 2:56 p.m., Resident #3 stated, I think my care has been pretty [profanity] poor. I have two broken legs. It was [staff member #2]. As soon as he [staff member #2] slammed on the brakes, I went flying. He didn't strap me in at all. Yep, I had pain, between an 8 & a 10 [on a 1-10 point pain scale, with 10 being severe]. Review of Resident #3's medical record occurred on September 6-7, 2022. Diagnoses included fractures to bilateral femur bones. The quarterly Minimum Data Set (MDS), dated [DATE], identified intact cognition and extensive assistance of two or more staff members required for transfers. The current physician's orders identified, . Immobilizer on at all times to BLE [bilateral lower extremities] except for routine wash ups and skin checks. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minot Health and Rehab, LLC	600 S Main St Minot, ND 58701

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The current care plan identified, . Alteration in musculoskeletal r/t [related to] to [sic] bilateral broken femurs 8/24/22. Non ambulatory. Assess CMS [circulatory, motor, sensory] and skin every shift to bilateral legs . Assess for pain every shift . Bilateral leg immobilizers on at all times except with skin checks and bathing. ADL [activities of daily living] self care deficit . [tilt-in-space wheel]chair . Transfer with [full body lift] x [times] 2 [two staff members] . The progress notes, dated 08/24/22, identified the following: * At 2:30 p.m., identified, Resident had a fall in the transportation vehicle while going to [medical center] for a lab draw. Resident was sitting in his [tilt-in-space wheel]chair and slid forward onto the foot rests and touched the floor. Driver called dispatch for assistance and resident was assisted by two staff to get back into his [tilt-in-space wheel]chair. Resident was brought to his appointment and back to the [nursing home] facility. Resident stated that he did not have injuries. Guardian and physician aware of the incident. * At 3:30 p.m., At 1530 [3:30 p.m.] 08-24-2022, resident came back from his appointment, was reported he fell from the facility van on the way going to his lab appointment but an ambulance helped him getting back to his wheelchair and he went to his lab appointment. Nurse assessment done per protocol. Resident stated he did not hit his head. ROM [range of motion] on his BUE [bilateral upper extremities] and BLE was [at] his baseline. He was then transferred to his bed x 2, using a mechanical lift. When asked about his pain, he stated it was 5/10. This is his baseline. He had abrasions on the inner aspect of the left leg and 3rd digit left toe about less than 1 cm [centimeter] in diameter. 1730 [5:30 p.m.] Reassessed post fall. Noticed swelling with deformity and crepitus [a grating sound or sensation produced by friction between bone and cartilage or the fractured parts of a bone] on his knees. Placed a [sic] pillows on the side while stabilizing legs. Asked him about the pain and he stated 5/10 again. This nurse explained pain scale and he said 7/10. Tylenol 500 mg [milligrams] was given PRN [as needed] for pain per MAR [medication administration record]. On call MD [medical doctor] [physician's name] called orders to send resident to ED [emergency department] obtained. * At 6:44 p.m., Spoke to residents guardian, [guardian's name], updated her on the incident. Ok to send to ER [emergency room] for evaluation and treatment . A ETC [early total care] Physician's Note, dated 08/24/22 at 9:51 p.m., identified, . Patient presents following fall . Was not adequately secured and so fell out of his wheelchair inside the transportation van. after his lab tests he went back to the nursing home where they decided to send him to the emergency room for evaluation of possible left knee injury. Radiology results: . Bilateral distal femur fractures. During an interview on 09/07/22 at 10:00 a.m., an administrative staff member (#1) reported, [Staff member #2] signed off on the [facility van] education. [Staff member #2] said he wanted more training after [Resident #3] fell . He didn't ask for addition training prior to the fall. The resident [should have been] strapped to the wheelchair with two seatbelts, one running across his waist and another across his left shoulder to right waist. (continued on next page)

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Minot Health and Rehab, LLC	600 S Main St Minot, ND 58701

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[Staff member #2] submitted a handwritten note, dated 08/24/22, which stated, Backed up and parked facility vehicle at main entrance. [Resident #3] was secured in van with all hooks on [tild-in-space wheelchair] at 1:15 p.m. I failed to put shoulder and lap seat belt on. At first stop sign [Resident #3] slid forward out of chair to the floor of the van. Called dispatch at 1:21 p.m. for assistance getting [Resident #3] back in his chair and properly secured. A Facility Van Training form, signed by [staff member #2] on 06/02/22, identified, . I have read and understand the attached . Facility Van Training and have been oriented on specific manufacturer guidelines for wheelchair lift systems, wheelchair restraint systems . and other safety features systems of the facility van. An administrative staff member co-signed the form, indicating I have observed this employee demonstrating the functions on specific manufacturer guidelines for wheelchair lift systems, wheelchair restraint systems . and other safety features systems of the facility van. The [Nursing Home] Incident Investigation, dated 08/30/22, identified, . Interviewed . staff . [and] residents . [staff member #2] was placed on suspension prior to the start of his shift on 8/25/22 and removed from his position on 8/30/22. Van taken out of use on 8/24/22, staff reeducation of proper van use policy titled, 'Facility Van Policy' started 8/26/22, and an automotive shop reviewed the vehicle on 08/29/22 for safety needs of the van. Quality Assurance review of event occurred on 08/25/22 with an action and audit plan created. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for the resident affected by the deficient practice by: * Completing an investigation on 08/30/22, including an interview with [staff member #2] who transported Resident #3 via the facility van, * Determining [staff member #2] failed to adequately secure Resident #3 in his [tilt-in-space] wheelchair in the facility van during transport resulting in a fall with serious injury. The facility also put measures in place to ensure the deficient practice does not recur by: * Suspending [staff member #2] on 08/25/22 and removing him from his position on 08/30/22, * Having an automotive shop review the facility van for safety issues, * Providing education to all staff members who transport residents with the facility van on 08/26/22, ensuring a return demonstration to ensure proper placement of the chest and lap seatbelts, and * Completing quality assurance audits to ensure resident safety during facility van transport. The survey team determined a deficient practice existed on 08/24/22. The facility implemented various corrective actions on August 24-30, 2022, immediately suspending and later removing [staff member #2] from his position, assessing the facility van for safety issues, re-educating all staff members who transport residents in the facility van, and completing quality assurance audits.