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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 11/28/23-11/29/23 with additional information obtained remotely on 11/30/23-12/1/23. Onsite validation of the corrective action plan was completed on 12/4/23. Therefore, the exit date was changed to 12/4/23. Event ID #U8LH11. The following intake was investigated NC00210122. 1 of 1 complaint allegation resulted in deficiency. Intake NC00210122 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.25 at tag F689 at scope and severity (J) The tag F689 constituted Substandard Quality of Care. Non-compliance began on 10/31/23. The facility came back into compliance effective 11/2/23. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and Physician interviews, the facility failed to provide a	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/06/2023

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.

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safe transfer when the Transportation Aide did not ensure a resident's lower extremities were raised during a transfer onto the wheelchair lift platform of the facility van for 1 of 1 resident reviewed for supervision to prevent accidents (Resident #1). During a facility van transport on 10/31/23, Resident #1 was assisted onto the wheelchair lift platform by the facility Transportation Aide when she fell forward from the wheelchair resulting in a laceration to the head, fractures of cervical (neck) 1 and 2 vertebrae, fractures of the right tibia and fibula (bones of the lower leg), and fracture of the femur (hip). Resident #1 was sent to the emergency room for evaluation and treatment and required transfer via life flight to a second hospital on 10/31/23 for acute trauma care. Resident #1 had surgical closure of the laceration of the scalp and repair of the open fractures of the tibia and fibula. She demonstrated decline in her overall condition with decreased cognition and ability to swallow necessitating feeding tube placement while hospitalized. She was transferred to an inpatient hospice on 11/9/23 where she passed away on 11/10/23 with cause of death listed as complications of multiple blunt force injuries.

Findings included:

Resident #1 was admitted to the facility on 2/1/22 with diagnoses which included, in part: history of stroke with ataxia (impaired balance and coordination), muscle weakness and osteoporosis.

Review of Resident #1's care plan revealed a 6/23/23 focus of at risk for falls related to confusion, gait, and balance problems and unaware of safety needs. The goal indicated

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Resident #1 would be free of falls resulting in major injury. The mobility interventions indicated Resident #1 used a wheelchair for locomotion, required supportive care and assistance with mobility, and staff were to anticipate and meet resident's needs.

Review of Resident #1's 9/18/23 quarterly Minimum Data Set (MDS) assessment indicated resident was cognitively intact and demonstrated no behaviors. Resident #1 required extensive assistance with transfers, had impaired balance and required a wheelchair for mobility.

Review of the 10/30/23 physical therapy progress note indicated Resident #1 had significant impairments in the bilateral lower extremities and core strength, transfers, functional mobility, and was at risk for falls.

An interview was conducted on the facility van on 11/28/23 at 1:40 PM with the Transportation Aide with the Administrator present. Observation of the facility van revealed a wheelchair accessible van with the wheelchair lift mechanism on the side. The wheelchair lift mechanism included a threshold plate which bridged the gap between the lift platform and the vehicle floor and the metal grating surface upon which the wheelchair was positioned for entering and exiting the van. The floor of the interior of the van had a rubberized flooring material. The Transportation Aide stated when offloading a resident from the van, with the lift platform level with the vehicle floor in the fully raised position he backed the wheelchair up and then turned the chair to the right pushing the chair forward onto the lift platform located on the side of the van. The outer end of the lift platform had a metal raised

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outboard roll stop barrier that must be in place prior to lowering the lift platform to the ground. The Transportation Aide stated he stood on the lift platform behind the wheelchair as he lowered the lift platform to the ground. The Transportation Aide stated on 10/31/23 he had Resident #1 in her wheelchair and had turned the chair to the right and was attempting to get her wheelchair onto the lift platform. The Transportation Aide stated he was rolling the chair forward onto the lift platform when Resident #1 put both her feet down and tilted forward and she hit the corner of the metal outboard stop barrier at the end of the lift and went down on her knees. The Transportation Aide stated he lowered the lift platform down to the ground level and went to the therapy room to call for assistance. The Transportation Aide revealed he was trained in the use of the wheelchair van lift when the facility obtained the van about 12 or 13 years ago. The Transportation Aide stated he was trained that according to the lift manufacturer instructions he could position the resident in the wheelchair facing outboard (toward the outside of the van) or inboard (toward the interior of the van) when he raised and lowered the lift platform for entering and exiting the vehicle.

On 11/29/23 at 9:30 AM a reenactment of the incident on 10/31/23 involving Resident #1 was completed with the Transportation Aide on the facility van using a standard wheelchair without leg rests. The Administrator was present for the reenactment. The reenactment also included an interview with the Transportation Aide for clarification of the information presented. The reenactment began as the Transportation Aide raised the wheelchair lift platform (located on the side of the vehicle) to the high position flush with

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F 689	Continued From page 4 the floor of the vehicle. The Transportation Aide then demonstrated that on 10/31/23, Resident #1 was sitting in the wheelchair without leg rests present when he released the locking hooks and lap/shoulder strap, unlocked her wheelchair brakes, and backed her wheelchair up to the back of the van in preparation to turn the wheelchair to the right to proceed to the lift platform. The Transportation Aide stated Resident #1 had her legs straight out in front of her initially. The Transportation Aide demonstrated that he then turned her wheelchair to the right and began pushing the wheelchair forward toward the lift platform. At this time, the Transportation Aide noted Resident #1 no longer had her legs straight out in front of her. The Transportation Aide indicated he did not provide Resident #1 with verbal instructions to lift her feet or to hold her feet up as he was pushing her wheelchair and getting her onto the lift platform. The Transportation Aide indicated Resident #1 had been on the transport van multiple times before, and he thought she knew what he was doing and what was required of her. The Administrator interjected that there was no need to provide instructions to Resident #1 regarding keeping her feet elevated when being moved in the wheelchair as she initially lifted her feet and she had been transported on the van many times previously. The Transportation Aide further stated he did not always provide instructions to the residents regarding the procedure of getting onto the lift platform or keeping their feet up. The Transportation Aide stated that he provided instructions regarding the procedure of being moved in the wheelchair onto the lift platform to the residents on an as needed basis. The Transportation Aide indicated he was not rushed or in a hurry when he was getting Resident #1 off	F 689		

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F 689	Continued From page 5 the van. He explained that he had another transport scheduled for later that day and there were no other residents on the van with Resident #1. The Transportation Aide demonstrated he was behind Resident #1's wheelchair pushing her onto the lift platform as she put her feet down causing the wheelchair to stop. The Transportation Aide indicated Resident #1 went forward out of the wheelchair hitting her head on the left corner of the raised edge at the end of the lift platform and landing on her knees. The Transportation Aide demonstrated Resident #1 laying on the lift platform with her head at the outside end and her feet towards the van. The Transportation Aide demonstrated he stepped onto the lift platform with Resident #1 lying on the platform, lowered the platform to the ground and quickly went to the entrance of the building to summon help. The Transportation Aide indicated he did not move the resident and that the nurses and nursing assistants quickly responded and began administering first aid. An interview was conducted on 11/28/23 at 2:40 PM with the MDS Nurse. The MDS Nurse stated she responded to the overhead page for nursing STAT (respond immediately, without delay) to therapy on 10/31/23. When she arrived, the facility van was outside the therapy room and the MDS Nurse stated she observed Resident #1 lying on her back on the lift platform with her head at the outside edge of the platform and her feet towards the inside of the van. The MDS Nurse stated Resident #1 was bleeding from the top of her head with a large amount of blood dripping onto the ground, had a large laceration and blood bruise to her right leg and was in a lot of pain. The MDS Nurse stated she was instructed by the Administrator to ask Resident #1 why she put her	F 689		

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feet down. The MDS Nurse indicated Resident #1 responded she did not know how she fell.

An interview on 11/28/23 at 2:09 PM with Nursing Assistant (NA) #2 revealed she was familiar with Resident #1's care as she was assigned to her regularly since she started working at the facility 3 months ago. NA #2 indicated Resident #1 was alert and oriented, required assistance with toileting and transfers and was able to put her feet up when instructed to do so when pushed in the wheelchair. NA #2 stated on 10/31/23 she responded to the overhead page for nursing stat to therapy. NA #2 stated she observed Resident #1 lying on her back on the lift platform with her head at the end of the platform and her feet towards the van. NA #2 stated Resident #1 was bleeding from her head and her knee and kept repeating her head was hurting. NA #2 stated she observed Resident #1 was in a lot of pain from her head and leg, so she tried to comfort her and keep her calm until Emergency Medical Services (EMS) arrived.

An interview was conducted on 11/28/23 at 2:20 PM with the Unit Manager. The Unit Manager revealed she responded to the overhead page for nursing stat to therapy on 10/31/23 and observed Resident #1 lying on the lift platform with a large amount of bleeding from her head. The Unit Manager stated she went to obtain medical supplies, returned, and observed Resident #1 crying complaining of severe pain to her head and her right leg. The Unit Manager observed bleeding from Resident # 1's right leg.

An interview was conducted with the Staff Development Coordinator (SDC) nurse on 11/29/23 at 12:50 PM. The SDC nurse indicated

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she responded to the overhead page for nursing stat to therapy on the morning of 10/31/23. The SDC nurse indicated when she arrived at the area outside therapy, she observed Resident #1 lying on the lift platform with a significant amount of bleeding from her head and a laceration to her right leg. The SDC nurse stated Resident #1 was in a lot of pain. The SDC nurse indicated she assisted with emergency care to Resident #1 until EMS arrived.

An interview was conducted with the Director of Nursing (DON) on 11/28/23 at 4:53 PM. The DON stated she responded to the overhead page for nursing stat to therapy on 10/31/23. The DON stated the other nurses were already providing emergency care to Resident #1's lacerations to the head and leg when she arrived outside to the wheelchair van. The DON stated she instructed Nurse #2 to call 911, obtain paperwork and notify the physician and the family.

An interview was conducted with Nurse #2 on 11/29/23 at 1:00 PM. Nurse #2 stated she was familiar with Resident #1, was assigned to her care frequently and was assigned to her on 10/31/23 7:00 AM to 7:00 PM shift. Nurse #2 stated Resident #1 required assistance with mobility, had weakness in her legs and at times required reminders to lift her feet up during locomotion. Nurse #2 indicated on 10/31/23 she heard the overhead page for nursing stat to therapy and responded. Nurse #2 stated when she arrived, she observed Resident #1 lying on her back on the lift platform. Nurse #2 stated she was informed by a staff member, although she could not recall which one, that the Transportation Aide was pushing Resident #1 off the van when her legs dropped, and she tipped over. Nurse #2

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stated she quickly left the scene of the incident called 911, prepared transfer paperwork and made phone calls.

Review of Resident #1's medical record revealed a transfer to the hospital form dated 10/31/23 at 4:00 PM was completed by the Director of Nursing (DON). The transfer form indicated Resident #1 was transferred to the hospital due to a fall resulting in a scalp laceration, right lower leg laceration and a laceration to the palm of the right hand.

Review of a 10/31/23 nursing post fall progress note written by Nurse #2 at 4:28 PM indicated Resident #1 wearing shoes at the time of the fall.

Review of the hospital #1 emergency department note on 10/31/23 revealed Resident #1 presented at 11:11 AM in a cervical collar with a v shaped laceration of the head and obvious deformity of the right shin with a laceration over the deformity after a fall from a wheelchair. X rays and Computerized Tomography (CT) scans were completed with the following results: CT of the cervical spine revealed a non-displaced fracture of cervical vertebra 1, type 2 Dens fracture (an unstable break of the second bone of the neck), CT scan of the head revealed a large superficial left sided soft tissue hematoma, x ray of the right tibia fibula revealed comminuted and displaced fractures of the tibia and fibula. The note indicated Resident #1 received intravenous fluids, intravenous antibiotic cefazolin 2 grams for open fractures, and narcotic fentanyl 50 micrograms intravenous for severe pain. The emergency department note indicated at 1:56 PM Resident #1 was transferred via life flight to hospital #2 for further management and the need for more

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advanced care.

Review of the 11/9/23 discharge summary from hospital #2 revealed Resident presented on 10/31/23 at 2:51 PM as a trauma transfer from hospital #1. Resident #1 was unable to recall what happened. Resident #1 presented at hospital #2 with pain in her right lower leg, head, and neck and a blood pressure of 77/36. Resident #1 underwent surgical closure of the laceration of the scalp and repair of the open fractures of the tibia and fibula. The discharge summary indicated Resident #1 demonstrated decline in her overall condition with decreased cognition and ability to swallow necessitating feeding tube placement while hospitalized. Hospice was consulted and Resident #1's family opted for comfort care. Resident #1 was transferred to the hospice care center on 11/9/23 for end-of-life care. Resident #1's discharge diagnoses included cervical vertebra 1 and 2 fractures, right tibia and fibula fractures, left femur fracture, scalp laceration with acute blood loss anemia and atrial fibrillation with rapid ventricular response.

Review of a death certificate dated 11/10/23 revealed Resident #1 was pronounced dead on 11/10/23 at the inpatient hospice center with the cause of death listed as complications of multiple blunt force injuries sustained on 10/31/23 at the nursing facility.

Review of a typed statement written and signed by the facility Administrator dated 11/27/23 revealed he heard an announcement for nursing stat to therapy over the overhead paging system on 10/31/23 around 10 AM. The statement indicated he walked to the therapy gym where the

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F 689	Continued From page 10 Unit Manager asked him to obtain towels which he did. The statement indicated he then walked back to the therapy gym and saw multiple staff members outside under the breezeway. When he walked outside, the statement indicated the Administrator saw the MDS Nurse providing care to Resident #1's head. The statement indicated the Administrator asked the Van Driver [Transportation Aide] what happened and was told Resident #1 put her feet down as the Van Driver [Transportation Aide] was pushing her onto the lift and she fell forward onto the lift. The statement indicated the Administrator instructed the MDS Nurse to ask Resident #1 "Why did you put your feet down? Resident #1 replied to the MDS Nurse "I don't know." The statement concluded staff stayed with Resident #1 until emergency medical services (EMS) arrived shortly after. During an interview with the Administrator on 11/29/23 at 2:15 PM he indicated the Transportation Aide reported the following when he (Administrator) interviewed him (Transportation Aide) about the 10/31/23 incident: he (Transportation Aide) observed Resident #1 with her legs lifted prior to moving the wheelchair, the resident put her feet down onto the lift platform, and he stopped pushing the wheelchair when she put her feet down. The Administrator stressed that instructions regarding keeping her feet up when the wheelchair was moved were not necessary as Resident #1 initially lifted her legs and had been on the facility wheelchair van in the past. The Administrator requested this surveyor re-interview the Transportation Aide to verify the events that occurred on 10/31/23 with Resident #1.	F 689		

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A follow up interview was conducted with the Transportation Aide with the Administrator present on 11/29/23 at 2:20 PM. The 10/31/23 incident with Resident #1 that occurred on the facility van was again reviewed. The Transportation Aide reported the same information from the previous interviews and reenactment. The Transportation Aide stressed that he stopped pushing Resident #1 onto the lift platform when the resident put her feet down.

An interview on 11/28/23 at 1:10 PM with NA #1 revealed she was assigned to Resident #1 on 10/31/23 on the 7:00 AM to 3:00 PM shift. NA #1 indicated on the morning of 10/31/23 she assisted Resident #1with her personal care prior to her leaving on the facility van for her doctor's appointment. NA #1 stated Resident #1 was normally alert, oriented, and able to follow directions. NA #1 stated Resident #1 had weakness in her lower extremities and required assistance with transfers and mobility using the wheelchair. NA #1 stated she instructed Resident #1 to hold her legs up when pushing her into the bathroom for toileting and she was able to do this. NA #1 stated Resident #1 did not normally use leg rests on her wheelchair.

An interview on 11/28/23 at 11:30 AM with Physical Therapy Assistant (PTA) revealed she worked with Resident #1 frequently and was familiar with her care. The PTA indicated Resident #1 was alert, cooperative with care and able to follow directions. The PTA stated Resident #1 had weakness in both her lower legs, was fearful of falling and was working with therapy staff on transfers and wheelchair mobility. The PTA stated the resident required moderate assistance with transfers.

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An interview was conducted with the Physician via phone on 11/29/23 at 10:17 AM. The Physician stated he was familiar with Resident #1. The Physician stated Resident #1 was cognitively intact, however at her age, periods of forgetfulness could occur. The Physician stated residents can change what they do and how they do things daily. The Physician stated Resident #1 was alert, had weakness in her lower extremities and required a wheelchair at baseline. The Physician further indicated Resident #1 had diagnosis of osteoporosis and osteopenia and at her age was at increased risk of fractures. The Physician indicated with a diagnosis of osteoporosis and osteopenia, multiple fractures could occur from a fall on to a hard surface and could lead to terminal decline.

An interview was conducted with the Payroll Specialist on 11/29/23 at 1:20 PM. The Payroll Specialist stated she transported residents to doctors' appointments using the facility wheelchair van at times. The Medical Records/Payroll Specialist indicated she was trained to operate the wheelchair lift but could not recall when she received training. The Payroll Specialist indicated when she offloaded a resident from the van, she explained the procedure, instructed the resident to keep their feet up off the floor and backed the wheelchair onto the lift platform. The Payroll Specialist explained she then locked the brakes of the wheelchair and lowered the lift platform to the ground. The Payroll Specialist indicated some residents had leg rests on their wheelchairs if they had weakness or were not able to keep their feet up off the ground. The Payroll Specialist indicated she received in service training

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	345194	A. BUILDING ______ B. WING ______	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

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following the incident on 10/31/23 regarding the procedure for loading and offloading residents from the van. The in-service training indicated to explain the procedure to the resident, instruct the resident to lift their feet off the floor and then proceed with assisting them onto the lift platform. The Payroll Specialist did not recall if she had transported Resident #1 on the facility van.

An interview was conducted on 11/29/23 at 3:05 PM with the Activity Director. The Activity Director stated she transported residents to doctors' appointments and outings using the facility wheelchair accessible van. The Activity Director stated she was trained to operate the wheelchair lift but could not recall when the training occurred. The Activity Director stated wheelchair leg rests were used if the resident had any trouble lifting their legs. The Activity Director indicated when offloading a resident from the wheelchair van, she first explained the procedure including reminding the resident to lift their feet to move the wheelchair onto the lift platform. The Activity Director stated she slowly moved the resident backward onto the lift platform while observing their feet and arms for safety. The Activity Director stated she attended a recent in-service training regarding safe loading and offloading of residents on the wheelchair van including ensuring leg rests were on the wheelchair and instructing the resident on the procedure. The Activity Director did not recall if she had transported Resident #1 to an appointment or on an outing.

An interview was conducted on 11/28/23 at 4:20 PM with the facility Administrator. The Administrator stated competencies and annual retraining of the Transportation Aide and other

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staff that transported residents in the facility wheelchair van were not completed since he was in the position of Administrator at the facility for the past 4 years. The Administrator stated the incident that occurred on 10/31/23 was discussed and a root cause was not determined. The Administrator further indicated the incident was used as an opportunity to provide education and conduct audits.

The Administrator was notified of the Immediate Jeopardy on 11/29/23 at 1:35 PM.

The facility provided the following corrective action plan with a completion date of 11/2/23.

1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
On 10/31/2023, the resident was immediately assessed by Hall Nurse and Minimum Data Set Nurse. The facility called 911 and the resident was taken to the hospital for further evaluation. The Administrator notified the resident's responsible party regarding the incident on 10/31/2023.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
All residents needing transportation services have the potential to be affected. It is the new practice that leg rests will be in place on all wheelchairs for vehicle transports. The Transportation Aide was observed by the Administrator on 10/31/23 for the last appointment of the day; the Transportation Aide ensured leg rests were applied to the wheelchair and the resident's legs were positioned on the leg rests while the

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F 689	Continued From page 15 wheelchair was moved. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/31/2023, the Director of Nursing immediately in-serviced the Transportation Aide on the process applying leg rests to wheelchairs prior to resident being transported to an appointment. All teammates who do transportation which includes the Transportation Aide, Activities Director, Payroll Specialist, Treatment Aide, and a 3rd shift Certified Nursing Assistant for residents were in serviced by the Administrator and Director of Nursing on 10/31/2023. The education on 10/31/2023 included the new procedure of ensuring leg rests are applied to resident's wheelchair prior to resident being transported to an appointment and ensuring resident's legs remain on leg rests while the wheelchair is being moved. The facility Driver will be responsible for ensuring leg rests are applied to the resident's wheelchair prior to completing any transportations. The Administrator was responsible for making sure teammates not in serviced on 10/31/23 were in serviced prior to completing any facility transportations. If the resident chooses not to have or refuses leg rests, the resident will be educated by the Director of Nursing on the benefit of using leg rests, and their preference will be care planned. The Facility Driver will notify the Director of Nursing if a resident refuses to have leg rests. If a resident refuses leg rests, the transportation will not occur. It is standard practice at our facility to notify the Director of Nursing any time a resident deviate from their care plan or facility policy.	F 689		

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F 689	Continued From page 16 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The decision to conduct monitoring audits and decision to take to Quality Assurance Performance Improvement committee were made on 11/1/2023. On 11/6/2023, the Administrator or Staff Development Coordinator began auditing 5 transports each week (if less than 5 scheduled, all will be observed at time resident loads onto or off the bus) ensuring leg rests are applied to the wheelchair. The audit also includes ensuring the resident's legs remain on the leg rests during loading or offloading while the wheelchair is being moved; after four weeks the audit will continue for 10 transports per month for a quarter. Any identified issues will be immediately corrected. The Administrator will present the findings of the audit to the Quality Assurance Performance Improvement committee during the quarterly Quality Assurance Performance Improvement meetings for the next two quarterly meetings. Alleged date of compliance: 11/2/2023 The corrective action plan was validated onsite on 12/04/23. Record review verified education was completed with staff who provide transportation related to the new procedure to ensure leg rests were applied to residents' wheelchairs prior to loading/unloading from the facility vehicle. Education included ensuring the resident's legs remain on leg rests while the wheelchair was being moved. Interviews with the Transportation Aide, Activities Director and Payroll Specialist showed they had been in-serviced on the process of applying leg rests to wheelchairs prior to resident being	F 689		

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F 689	Continued From page 17 loaded/unloaded from the facility vehicle and ensuring resident's legs remain on leg rests while the wheelchair was being moved. Staff indicated they would notify the DON if a resident refused leg rests. During an interview with the DON, she indicated if the resident chose not to have leg rests or refused leg rests, the resident would be educated on the benefit of using leg rests and it will be care planned. Transportation would not occur if leg rests were refused. A resident observation verified the resident's leg rests were on a wheelchair prior transport to an appointment. The Transportation Aide confirmed the resident's legs were resting on the leg rests before moving the resident in and out of the facility's vehicle. The facility's corrective action plan was validated to be completed as of 11/2/23.	F 689		