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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 12/2/24 through 12/3/24 with additional information received remotely on 12/4/24 to 12/5/24. Onsite validation of the immediate jeopardy removal plans was conducted on 12/9/24. Therefore the exit date was 12/9/24. Event ID#2YM311. The following intakes were investigated NC00220682 and NC00224589. 1 of the 4 complaint allegations resulted in deficiency. Intake NC00224589 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) Immediate Jeopardy for F689 began on 11/15/24 and was removed on 11/18/24. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) Immediate Jeopardy for F684 began on 11/15/24 and was removed on 12/5/24. The tags F684 and F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		12/9/24

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

Electronically Signed | 12/24/2024

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F 684	Continued From page 1 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, Physician, Surgical Technician, and staff interviews, the facility failed to leave Resident #4 in place to be assessed by a medical professional following a fall in the facility ' s transportation van. Resident #4 was transported to a medical appointment in the facility transport van and when Transporter #1 arrived at the appointment site and parked, Resident #4 stated he was sliding from his wheelchair. Transporter #1 was not trained for transferring residents and went to back of van and transferred Resident #4 from the floor of the van back into his wheelchair. Transporter #1 did not inform the facility about the fall until he returned Resident #4 to the facility from his follow up appointment with the surgeon for a left leg above the knee amputation completed on 10/12/24. Resident #4 ' s right hand became swollen and painful later in the day and x-ray results were negative. There was a high likelihood of a serious adverse outcome including further injury when moving a resident after a fall prior to being assessed by a licensed medical professional. This occurred for 1 of 3 residents reviewed for falls (Resident #4). Immediate jeopardy began on 11/15/24 when Transporter #1 lifted Resident #4 from the floor of the transportation van without being assessed by	F 684	1. Resident #4 was assessed immediately after returning to the facility on 11/15/24 when Transporter #1 notified the nurse on duty of the incident by the licensed nurse. Upon initial assessment the resident #4 denied any type of pain or injury. The facility nurse practitioner was notified of the fall by the nurse on duty, later the same day Resident #4 hand was reddened, swollen and painful. An x-ray was ordered and obtained the same day. Resident #4 complained of pain 3 out of 10 and was administered one dose hydrocode-acetaminophen 5-325 at 3:49 PM which was documented as effective at 6:36 PM. Results of the x-ray showed no acute fracture or dislocation, mild osteopenia, and osteoarthritis. Resident #4 was assessed by physician on 11/18/24 and per the physician note Resident #4 was found to have mild swelling and Resident #4 stated that his symptoms were improved. 2. Any resident experiencing a fall may have the potential to be affected. On 12/03/2024, the Unit Manager and Assistant Director of Nursing reviewed facility falls for the previous 30 days to	

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F 684	Continued From page 2 a medical professional. Immediate jeopardy was removed when 12/5/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensuring monitoring systems put into place for resident assessment following a fall. The findings included: Resident # 4 was admitted to the facility on 9/24/24 with a most recent readmission on 10/21/24. His diagnoses included type 2 diabetes mellitus, right leg below the knee amputation and left leg above the knee amputation (10/12/24). A care plan initiated 10/4/24 revealed a focus that Resident #4 required assistance with ADL (activities of daily living) related to: cognition, muscle weakness, bilateral BKA (below the knee amputation). The interventions included transfer with one-person physical assistance and reposition with one-person physical assistance as needed. Review of a physician ' s order dated 10/21/24 revealed an order for Hydrocodone 5mg-Acetaminophen 325 mg (milligrams)- Take 1 tablet by mouth every 6 hours as needed for pain. The Admission Assessment Minimum Data Set (MDS) dated 10/1/24 indicated Resident #4 had moderate cognitive impairment. He required extensive assistance plus one-person physical	F 684	ensure proper assessment, trained staff transferring, proper notification and intervention prior to moving resident. No issues were found. 3. On 12/3/24, The Administrator, Assistant Director of Nursing, and Unit Manager provided education to staff that should a resident experience a fall, they must not be moved before being assessed by a nurse or physician. On 12/03/2024 staff were also educated by the Administrator that only staff who are trained to transfer a resident may do so. On 12/03/2024 education by the Administrator that following a fall, facility staff who are qualified to perform clinical assessments for injury must be notified, if none are present at the time of the fall. Education was also conducted by the Regional Corporate Nurse on 12/03/2024 to the facility Director of Nursing, Assistant Director of Nursing and Unit Managers on the facility fall related policies, how to properly assess a resident prior to being mobilized after a fall. Moving forward, only a Certified Nursing Assistant (CNA) will be present on transportations provided by the facility. Should the driver of the facility van not be a certified or licensed medical professional, a CNA or Nurse will accompany the resident and transport driver for the appointment. On 11/14/2024, The transport coordinator was educated about this change and has been responsible for ensuring a CNA or a Nurse is present on all transports. The Regional Director of Compliance provided	

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F 684	Continued From page 3 assistance for transfers and bed mobility. Resident #4 had functional limitation of range of motion to both lower extremities and used a wheelchair as a mobility device. Resident #4 weighed 114 pounds. Review of a statement by Transporter #1 dated 11/15/24 revealed he had taken Resident #4 to a medical appointment in the transportation van. When he got to the destination, Resident #4 stated he was sliding. Transporter #1 reported he went to the back of the van and put his arm in front of the resident to support him. The note said the transport driver removed the van shoulder belt and Resident #4 slid down slowly off his wheelchair. The note said the transport driver was right beside Resident #4 and partially supporting him. The note said Transporter #1 instructed Resident #4 to put his arms around his neck and he assisted him back into the chair by lifting him up by the waist of his pants. An interview was conducted with Transporter #1 on 12/2/24 at 2:22 PM. Transporter #1 reported that on the morning of 11/15/24, Resident #4 wasn ' t ready when it was time to leave, so he was sent without his prosthesis. Transporter #1 stated when he arrived at the medical appointment and stopped the van, Resident #4 stated he was starting to slip. Transporter #1 indicated he went to the resident and unbuckled the seatbelt securement system, and the resident was assisted to the floor of the van. Transporter #1 stated Resident #4 ' s buttocks were almost at the very edge of the wheelchair seat when he went to assist, and he felt that Resident #4 would have continued to slide if the seatbelt securement system had not been removed. Transporter #1 stated he had one arm in front of the resident and	F 684	1:1 education with the Transport Coordinator that all facility transports will be accompanied by a C.N.A or Nurse was completed on 12/4/24. Moving forward, should a resident experience a fall outside of the facility while under the care of facility staff, if a license nurse is not present, if not in imminent danger, 911 will be activated to assess the resident prior to transferring/mobilizing. If a licensed nurse qualified for clinical assessment is present, the nurse will assess the resident and determine the need to call 911 and/or performing transfer of resident. 4. The administrator/designee will monitor transportation schedule 5 x weekly x4 weeks, 3 x weekly x 4 weeks then weekly thereafter to ensure that a CNA or nurse is present for transportations. Additionally, administrator/designee to interview 5 staff members weekly to assess for proper knowledge of process/practices related to not moving residents until clinically assessed by a qualified professional. 5. Audits will be reviewed by the Quality Improvement Committee monthly and discussion to ensure substantial compliance. Once the Quality Improvement Committee determines consistent substantial compliance audits will be done on a random basis.	

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was standing to the side and he slowly assisted him to the floor of the van. Transporter #1 described he instructed Resident #4 to put his arms around his neck and he picked up resident by his belt loops to lift him back up into the wheelchair. Transporter #1 stated Resident #4 had no complaints of pain at that time and the surgeon ' s office staff came out and pushed the resident inside. Transporter #1 picked the resident up after the appointment and returned to the facility. Transporter #1 stated he would have called back to the facility if the resident was hurt but since the resident stated he was not hurt he reported the fall to Nurse #1 when he returned to the facility. Transporter #1 confirmed he had no training in transferring residents.

An interview was conducted with Surgical Technician #1 and Surgical Technician #2 on 12/3/24 at 12:52 PM. Surgical Technician #1 stated 12/3/24 she was asked to go the Resident #4 ' s medical exam room to assist with repositioning him and Surgical Technician #2 assisted. Surgical Technician #2 stated Resident #4 mentioned he had slipped from his chair to the floor in the transportation van. Surgical Technician #2 stated she did not assess Resident #4 for injury because that was outside of her scope of practice.

A review of Transporter #1 ' s education completion history revealed no module for safe transfer of residents. Transporter #1 completed the online Falls training required for all staff on 1/21/24 which included residents were to be assessed by a nurse before moving the resident. Transporter #1 completed online training titled Provide Safe Transportation on 12/14/23. Review

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of the videos revealed there was no content regarding not moving the resident if there was a fall or accident or calling the facility if there was an accident or incident immediately.

A nurse ' s note written by Nurse #1 dated 11/15/24 at 11:02 AM indicated Resident #4 was on the transport van and slid out of wheelchair onto the floor. Resident #4 did not complain of pain and had no

injury at that time. The transport driver reported Resident #4 had not hit his head and the resident was unable to keep his balance in chair.

A nurse ' s note written by Nurse#1 dated 11/15/24 at 4:21 PM indicated Resident #4 ' s right hand was swollen, warm to touch and painful. Resident #4 was unable to recall if he had hurt his hand when he slid out of the wheelchair in the transport van. The on-call health provider was notified and an order a new order for a stat (urgent order) x-ray was given. Resident #4 received as needed pain medication which was effective.

An interview was conducted with Nurse #1 on 12/3/24 at 9:00 AM. Nurse #1 stated she was working on Unit 3 on 11/15/24 and she spoke with Transporter #1 when he returned with Resident #4. Nurse #1 stated she was informed Resident #4 had slid out of the wheelchair when Transporter #1 stopped at the appointment. Nurse #1 stated Resident #4 reported that he was sliding when Transporter #1 went to assist him. Resident #4 reported Transporter #1 unbuckled the seat belt and assisted the resident to slide to the floor. Resident #4 reported he did not hit his head. Nurse #1 indicated she assessed Resident

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#4 and did not find any injury. Nurse #1 reported at 4:30 PM on 11/15/24 Medication Aide #1 reported Resident #4 ' s right hand was warm and swollen. Nurse #1 stated she asked Resident #4 if he had hurt his hand while on the van and the resident could not remember being on the van at that time. Nurse #1 stated she notified the physician and received an order for an x-ray.

Review of an on-call physician ' s service Triage Note dated 11/15/24 revealed Resident #4 was seen due to a fall injury that happened on 11/15/24. The note indicated Resident #4 ' s right hand was swollen and warm to the touch. Orders were given for stat x-ray of right hand and prn (as needed) hydrocodone (a narcotic pain medication). Resident #4 was to be seen by his primary physician for follow up.

Review of a physician order dated 11/15/24 revealed an order for a stat x-ray to be completed on Resident #4 ' s right hand. The x-ray results dated 11/15/24 revealed no acute fracture or dislocation. There was mild osteopenia and a mild degree of osteoarthritis.

An interview was conducted with Resident #4 on 12/2/24 at 1:56 PM. Resident #4 stated he had a fall on the transportation van on the way to the surgeon ' s office a few weeks ago. He reported he was strapped in his wheelchair when he began to slide out of the wheelchair. Resident #4 recalled calling out to Transporter #1 he was sliding. Resident #4 stated he slid onto his buttocks onto the transport van floor. Resident #4 stated the transport driver assisted him back up

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into the wheelchair. Resident #4 recalled he did not have any pain at that time, but his hand became swollen and painful a few hours later. Resident #4 stated during previous transports he felt himself sliding in the wheelchair but was able to reposition himself back up using his prosthetic leg. The interview further revealed Transporter #1 was a different driver, not the "ladies" that usually took him to appointments.

Review of a physician progress note dated 11/18/24 revealed Resident #4 was evaluated with concerns of pain and swelling in the right hand. The note indicated Resident #4 was complaining of pain and swelling on the dorsum (the back or the top of the hand) of his right hand but stated his symptoms were better. Resident # 4 reported he had an x-ray and was told the results came back negative. Resident #4 stated the pain, and swelling had improved a lot but had not completely resolved. The note further indicated Resident #4 was on hydrocodone for pain as needed.

An interview was conducted with the Physician on 12/4/24 at 1:11PM. The Physician stated residents should always be assessed after a fall by a licensed medical professional prior to moving them. The Physician stated the resident could have experienced additional injury without a clinical assessment prior to being moved. The Physician further stated he did not feel that Resident #4 ' s fall would have been prevented with his prosthetic leg in place.

An interview was conducted with the Administrator on 12/3/24 at 3:51PM. The

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Administrator stated he was not made aware of the fall until the next day (11/16/24) and he went to see Resident #4 on Monday 11/18/24. The Administrator stated Resident #4 indicated he did not have his prosthetic leg on, so he fell once he got to his appointment. Resident #4 reported that he did not get hurt when he fell. The Administrator stated Resident #4 reported the transport driver took off his seatbelt and had to catch him. The Administrator stated Transporter #1 had not been trained in transferring residents. The Administrator further stated Resident #4 was assessed by the nurse when he arrived back at the facility, and he had no known injury at that time. The Administrator stated all three transporters had received education on falls, providing safe transportation and viewed the manufacturer ' s videos on use of the van ' s securement system prior to transporting any residents. The Administrator indicated the falls training included residents being assessed for injury by the nurse/MD before moving them. The Administrator stated Transporter #1 had asked the resident if he was hurt prior to moving him and the transporter did what any other person would have done. He felt that the resident was alright because he went to his appointment and back to the facility without any complaints of pain or injury.

The facility Administrator was notified of immediate jeopardy on 12/3/24 at 12:04 PM.

The facility provided the following Immediate Jeopardy removal plan.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

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o Resident #4 slid from his wheelchair on 11/15/24 while being transported to an outside physician appointment. Resident was noted to be sliding down in his wheelchair and when Transporter #1 removed the securement device, he was assisted to the floor of the van by Transporter #1. When he complained of no distress or injury, Transporter #1 assisted him to his chair by instructing Resident #4 to place both arms around Transporter #1 ' s neck and then Transporter #1 grabbed Resident #4 ' s pant belt loops to lift him back up into the wheelchair. After returning Resident #4 to his chair Transporter #1 proceeded into the physician ' s office. Resident #4 was assisted with repositioning in his chair by two surgical techs in the physician ' s office. Transporter #1 is not a medical professional and does not have specific training on transferring or assessing a resident. After returning to the facility, Transporter #1 notified the nurse on duty of the incident and the resident was immediately assessed by the licensed nurse

on duty. Upon initial assessment the resident denied any type of pain or injury. The facility nurse practitioner was notified of the fall by the nurse on duty, later the same day when the nurse was notified by the CNA that the resident ' s hand was reddened, swollen and painful. An x-ray was ordered and obtained that same day. Resident #4 complained of pain 3 out of 10 and was administered one dose of hydrocode-acetaminophen 5-325 at 3:49 PM which was documented as effective at 6:36 PM. Results of the x-ray showed no acute fracture or dislocation, mild osteopenia and osteoarthritis. The resident was assessed in person by the physician on 11/18/24 and per the physician note

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Resident #4 was found to have mild swelling and Resident #4 stated that his symptoms were better.

o Residents experiencing a fall have potential to be affected.

o Unit Manager and Assistant Director of Nursing reviewed facility falls for the previous 30 days to ensure proper assessment, trained staff transferring, proper notification and intervention prior to moving resident. No issues were found. (12/3/24)

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

· Direct 1:1 education was provided by the Administrator to staff currently working in the facility that should a resident experience a fall, they must not be moved before being assessed by a nurse or physician. Those not currently on shift shall be educated prior to the start of their next shift. (Completed 12/3/24)

· Current staff, including agency staff, were educated by the Administrator that only staff who are trained to transfer a resident may do so. Those not currently working will be educated prior to the start of their next shift. (12/3/24)

· Current staff, including agency staff, were educated by the Administrator that following a fall, facility staff who are qualified to perform clinical assessments for injury must be notified, if none are present at the time of the fall. Those not

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currently working will be educated prior to the start of their next shift. (12/3/24)

· New hire staff will be educated on the process for staff notification of falls, safely transferring residents, and qualifications of clinical assessment through online education platform learning and 1:1 education by the Administrator during orientation.

· The Corporate Nurse/Consultant Nurse then educated Director of Nursing, Assistant Director of Nursing and Unit Managers on the facility fall related policies, how to properly assess a resident prior to being mobilized after a fall. (Completed 12/3/24)

· Moving forward, a Certified Nursing Assistant (CNA) or nurse will be present on transportations provided by the facility. Should the driver of the facility van not be a certified or licensed medical professional, a CNA or Nurse will accompany the resident and transport driver for the appointment. All staff including agency staff were notified of this change through the proprietary software system as well as in person education provided to transport staff by the Administrator. The transport coordinator will be responsible for ensuring a CNA or a nurse is present on all transports. (Completed 11/14/24)

· The Regional Director of Clinical Compliance provided 1:1 education with the Transport Coordinator that all facility transports will be accompanied by a CNA or nurse. (12/4/24)

· In the event of a new hire transport coordinator, the Administrator will be responsible

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for 1:1 education regarding the responsibility to ensure a CNA/nurse is present on all transports. This will be completed in orientation.

· Moving forward, should a resident experience a fall outside of the facility while under the care of facility staff, if a licensed nurse is not present, the resident will be made safe. If not in imminent danger, 911 will be activated to assess the resident prior to transferring/mobilizing. If a licensed nurse qualified for clinical assessment is present, that nurse will assess the resident and determine the need to call 911. All staff, including agency staff were educated on this through in person education by the Assistant Director of Nursing. (Completed 12/3/24). The Director of Nursing/designee will be responsible for providing this education to new hire transport staff.

· The Administrator/designee will track and provide education to those staff not present prior to their next shift to ensure completion.

Alleged date of IJ removal: 12/05/24

The IJ removal plan was validated on 12/9/24 and it concluded the facility had implemented an acceptable corrective action plan on 12/05/24. Review of staff education materials and sign-in sheets for the education were reviewed to determine that education was provided to all transportation staff including Transporter #1, nursing and nursing assistant staff that a resident who experiences fall must not be moved without being assessed by a nurse, physician or a licensed medical professional. The education also included only staff trained to transfer residents may do so and if there is no one

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F 684	Continued From page 13 qualified to perform a clinical assessment when a resident has a fall outside the facility, then 911will be activated to assess the resident prior to transferring/mobilization. Review of the facility documents revealed audits were done per the facility ' s plan of correction. Interviews were conducted with the nursing staff and nurse aides who confirmed they received education regarding a licensed medical professional needing to assess a resident prior to transferring them after a fall and call 911 if the fall happens outside of the facility before moving	F 684		
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 observation, record review, and resident, staff and physician interviews, the facility failed to ensure Resident #4 was safely secured in the transportation van. During transport on 11/15/24 Resident #4 reported to the driver, Transporter #1, he felt like he was sliding out of his wheelchair. Transporter #1 had arrived at the resident's doctor's office and came to a complete stop at the front entrance to the appointment location at the time the resident reported this to him. Transporter #1 got into the back of the van and removed the seatbelt securement system. Resident #4 continued to slide down from	F 689	Past noncompliance: no plan of correction required.	

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wheelchair and onto the floor of the van with Transporter #1's assistance. Transporter #1 stated Resident #4 was almost at the very edge of the wheelchair when he went to assist, and he felt that Resident #4 would have continued to slide if the seatbelt had not been removed. Transporter #1 stated he secured the resident the same way on the return trip to the facility. Later that day, Resident #4's right hand was swollen, warm to touch, and painful requiring narcotic pain medication. There was a high likelihood of serious harm, injury, or death from unsafe securement in the transportation van. This deficient practice affected 1 of 3 residents reviewed for accidents.

The findings included:

The manufacturer's instructional video indicated to Pull the seat belt over the occupants' chest and buckle seat belt to removable pelvic belt. Adjust the seat belt height so that belt rest on occupant's shoulder.

Resident # 4 was admitted to the facility on 9/24/24 with a most recent readmission on 10/21/24. His diagnoses included type 2 diabetes mellitus, right leg below the knee amputation and left leg above the knee amputation (10/12/14).

The Admission Assessment Minimum Data Set (MDS) dated 10/1/24 indicated Resident #4 had moderate cognitive impairment. He required extensive assistance plus one-person physical assistance for transfers and bed mobility. Resident #4 had functional limitation of range of motion to both lower extremities and used a wheelchair as a mobility device. Resident #4 weighed 114 lbs.

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A nurse's note written by Nurse #1 dated 11/15/24 at 11:02 AM indicated Resident #4 was on the transport van and slid out of wheelchair onto the floor. Resident #4 did not complain of pain and had no injury at that time. The transport driver reported Resident #4 had not hit his head and the resident was unable to keep his balance in chair.

A nurse's note written by Nurse #1 dated 11/15/24 at 11:40 AM indicated Resident #4 returned from his follow up appointment related to his left above the knee amputation (AKA) with no new orders. The note further indicated the surgical wound had satisfactory healing.

A nurse's note written by Nurse#1 dated 11/15/24 at 4:21 PM indicated Resident #4's right hand was swollen, warm to touch and painful. Resident #4 was unable to recall if he had hurt his hand when he slid out of the wheelchair in the transport van. The on-call health provider was notified and an order a new order for a stat (urgent order) x-ray was given. Resident #4 received as needed pain medication which was effective.

Review of a Fall Note dated 11/15/24 at 5:01 PM indicated Resident #4 was on transport van and Resident # 4 slid out of wheelchair to floor. Resident #4 was buckled in but continued to slide. Resident #4 did not complain of pain. There was no apparent injury noted at that time. The transport driver noted Resident #4 did not hit his head. Resident could not keep balance in chair. The fall interventions that were in place at the time of the fall was the wheelchair was to be locked. The immediate intervention to prevent recurrence was to transport Resident #4 with 2 staff.

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Review of a statement by Transporter #1 dated 11/15/24 revealed he had taken Resident #4 to a medical appointment in the transportation van. When he got to the destination, Resident #4 stated he was sliding. Transporter #1 reported he went to the back of the van and put his arm in front of the resident to support him. The note said the transport driver removed the van seat belt and Resident #4 slid down slowly off his wheelchair. The note said the transport driver was right beside Resident #4 and partially supporting him. The note said Transporter #1 instructed Resident #4 to put his arms around his neck and he assisted him back into the chair by lifting him.

An interview was conducted with Transporter #1 on 12/2/24 at 2:22 PM. Transporter #1 reported that on the morning of 11/15/24, Resident #4 wasn't ready when it was time to leave, so he was sent without his prosthesis. Transporter #1 stated when he arrived at the medical appointment and stopped the van, Resident #4 stated he was starting to slip. Transporter #1 indicated he went to the resident and unbuckled the seatbelt securement system, and the resident was assisted to the floor of the van. Transporter #1 stated Resident #4's buttocks was almost at the very edge of the wheelchair when he went to assist, and he felt that Resident #4 would have continued to slide if the securement belt had not been removed. Transporter #1 stated he had one arm in front of the resident and was standing to the side and he slowly assisted him to the floor. Transporter #1 described he instructed Resident #4 to put his arms around his neck and picked up resident by his belt loops to lift him back up into the wheelchair. Transporter #1 stated Resident

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#4 had no complaints of pain at that time. Transporter #1 stated when he got back to the facility, he reported the fall to Nurse #1.

An interview was conducted with Resident #4 on 12/2/24 at 1:56 PM. Resident #4 stated he had a fall on the transportation van on the way to the surgeon's office a few weeks ago. He reported he was strapped in his wheelchair when he began to slide out of wheelchair. Resident #4 recalled calling out to Transporter #1 he was sliding. Resident #4 stated he slid onto his buttocks onto the transport van floor. Resident #4 stated the transport driver assisted him back up into the wheelchair. Resident #4 recalled he did not have any pain at that time, but his hand became swollen a painful a few hours later. Resident #4 stated during previous transports he felt himself sliding in the wheelchair but was able to reposition himself back up using his prosthetic leg.

An interview was conducted with Resident #4 on 12/3/24 at 12:45 PM. Resident #4 stated he did not touch the seat belt because he knew it was there for his safety.

Review of a statement by Medication Aide #1 dated 11/15/24 revealed Resident #4 went out to an appointment, and they did not have time to get his prosthetic leg on as he was already late for his appointment. Medication Aide #1 reported when Resident #4 came back she went to check his blood sugar and noticed his right hand was swollen. Medication Aide #1 notified the nurse immediately.

An interview was conducted with Medication Aide #1 on 12/2/24 at 3:14 PM. Medication Aide #1

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stated she was asked by Transporter #1 if Resident #4 was ready for his appointment. Medication Aide #1 stated she was being rushed and she had not looked at the appointment log that morning. She reported the nurse assistant that was assisting Resident #4 was new, so she went in and assisted her. Medication Aide #1 stated they were having difficulty getting Resident #4's prosthetic leg in place that morning and she did not want him to be late or miss his appointment. Medication Aide #1 stated she decided to send Resident #4 without his prosthetic leg.

Nurse Aide #1 that assisted with getting Resident #4 ready on 11/15/24 was not available for interview.

An interview was conducted with Nurse #1 on 12/3/24 at 9:00 AM. Nurse #1 stated she was working on Unit 3 and Medication Aide #1 was working on Unit 4. Nurse #1 stated she was not notified that the aides were having difficulty placing Resident #4's prosthetic leg until after he had left the building. Nurse #1 stated she spoke with Transporter #1 when resident returned. Nurse #1 stated she was informed Resident #4 had slid out of the wheelchair when he stopped and at the appointment. Nurse #1 stated Resident #4 reported that he was sliding when Transporter #1 went to assist him. Transporter #1 unbuckled the restraint and assisted the resident to slide to the floor. Resident #4 reported he did not hit his head. When Resident #4 came back to the facility, she assessed him and he stated he was not hurt. Nurse #1 reported at 4:30PM on 11/15/24 Medication Aide #1 reported Resident #4's right hand was warm and swollen. Nurse #1 stated she asked Resident #4 if he had hurt his

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hand while on the van and the resident could not remember being on the van at that time. Nurse #1 stated she notified the physician and received an order for an x-ray.

A review of the x-ray results dated 11/15/24 revealed no evidence of fracture or dislocation. Mild osteopenia and mild degree of osteoarthritis.

Review of a statement by the Administrator dated 11/18/24 revealed Resident #4 had a fall from his wheelchair and the transport driver was there to help him. Resident #4 indicated he did not have his prosthetic leg on, so he fell once he got there. Resident #4 reported that he did not get hurt and did not hit the ground when he fell. Resident #4 reported the transport driver took off his belt and had to catch him. Resident #4 stated he did not know what happened to his hand. Resident #4 was unable to state whether he hurt his hand when he slid out of the chair.

An interview was conducted with the Administrator on 12/3/24 at 3:51PM. The Administrator stated he was not made aware of the fall until the next day 11/16/24. The Administrator stated he prompted the former Director of Nursing on the steps that she needed to take to complete the fall investigation. The Administrator stated the facility had put a full plan of correction in place related to the resident's fall.

An interview was conducted with the physician that followed up with Resident #4 on 12/4/24 at 1:11PM. The physician stated he saw Resident #4 on 11/18/24 and he reported that his hand was better. The physician stated Resident #4 was unable to state what had happened to his hand. The physician further stated he did not feel that

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Resident #4's fall would have been prevented with his prosthetic leg in place.

The Administrator was notified of immediate jeopardy on 12/3/24 at 12:07PM

The facility provided the following corrective action plan with a completion date of 11/19/24.

Address how corrective action will be accomplished for those residents found to have been affected the deficient practice.

On 11/15/24 Transporter #1 failed to safely secure Resident #4 in his wheelchair in the facility transport van. During the transport, Resident #4 reported to Transporter #1 that he felt like he was sliding out of his wheelchair. When arriving to the appointment location, Transporter #1 got into the back of the van and removed the securement system. Resident #4 continued to slide down from the wheelchair and Transporter #1 assisted him to the floor of the van. After returning to the facility, Transporter #1 notified the nurse on duty of the incident and the resident was immediately assessed by the licensed nurse on duty. Upon initial assessment resident denied any type of pain or injury. The facility nurse practitioner was notified of the fall by the nurse on duty, later the same day when the nurse was notified by the CNA that the resident's hand was reddened, swollen and painful. An x-ray was ordered and obtained that same day. Resident #4 complained of pain 3 out of 10 and was administered one dose of hydrocode-acetaminophen 5-325 at 3:49 PM which was documented as effective at 6:36 PM. Results of the x-ray showed no acute fracture or dislocation, mild osteopenia and osteoarthritis. The resident was assessed in

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person by the physician on 11/18/24 and per the physician note Resident #4 was found to have mild swelling and Resident #4 stated that his symptoms were better.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice

All residents who are transported by the facility have the potential to be affected.

An audit of all transports for the last 30 days was completed by the Administrator and the Transport Coordinator. No deficient practice was identified (Completed 11/18/24)

Address what measure will be put into place or systemic changes made to ensure that the deficient

The Maintenance Director inspected all securement devices in facilities transport buses. All were found to be in proper working order. (11/15/24)

All policies and procedures specific to resident transports were reviewed by Regional Director of Clinical Services to ensure compliance with manufacturer's recommendations and guidelines. No revisions were warranted. (11/18/24)

The Administrator facilitated transport staff education through a manufacturer's video on the use of the bus securement system, return demonstration and a validation checklist. The Transport Coordinator, the Maintenance Director, and Maintenance Assistants were included in this education. (11/18/24).

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F 689	Continued From page 22 Prior to transports, all residents' securements will be checked by 2 separate staff who have current transportation skills validation checklist completed with return demonstration. This may include transport staff, Transport Coordinator, Maintenance Director, Maintenance Assistants, and Administrator. Transport staff will have a competency completed upon hire and annually to ensure knowledge of proper procedures. This will include the manufacturer's video on the bus's securement system, return demonstration, and validation check off sheet. The Maintenance Director will be responsible for observing return demonstration and validation check off sheets. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Plan of correction was reviewed and discussed by the Quality Assurance (QA) committee. In attendance were the Administrator, Assistant Director of Nursing/Infection Prevention Coordinator, Unit Managers (2), Maintenance Director, Human Resources, Activities Director, MDS Coordinator, Dietary Manager and Director of Rehab. The Medical Director was notified of the plan of correction via phone conversation. (11/18/24) The Maintenance Director/Designee will inspect each transport vehicle ' s securement system monthly to ensure proper functioning. Five residents will be observed weekly by Administrator or Transport Coordinator to ensure	F 689		

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proper securement prior to leaving facility x 4 weeks then the plan of correction will be reassessed by the Administrator to determine if further monitoring is required.

The results will be reported to the QA Committee by the Administrator monthly for review and discussion.

Alleged date of IJ removal: 11/19/24

The correction date of 11/19/24 was validated on 12/9/24. Review of staff education materials and sign in sheets for the education were reviewed to determine that education was provided to Maintenance staff and Transportation drivers, and a return demonstration and validation check off had been conducted. Review of the facility documents revealed audits were done per the facility's plan of correction. Interviews were conducted with the transport drivers who confirmed they received education regarding the proper use of the facility bus seatbelt system and that 2 separate staff would check the resident's securement system prior to transport. Observations were conducted of transport staff connecting the securement system and properly securing a resident in a wheelchair. The 11/19/24 completion date for the corrective action plan was validated.