STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 5/5/25 to conduct a complaint investigation. The survey was conducted onsite on 5/5/25 and 5/6/25 with additional information obtained remotely on 5/7/25. On 5/8/25 the survey team returned to the facility to conduct onsite validation of the immediate jeopardy removal plans. Therefore, the exit date was 5/8/25. Event ID# 8UDP11. The following intakes were investigated: NC00226025, NC00228700, and NC00230033. Intake NC00230033 resulted in immediate jeopardy. 3 of the 5 complaint allegations resulted in deficient practice. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tags F600, F684, and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/25/25 and was removed for F600 on 5/8/25 and for F684 and F689 on 5/7/25. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		5/22/25

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

Electronically Signed | 05/27/2025

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F 600	Continued From page 1 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, resident, Contracted Transportation Company, and the Physician, the facility failed to protect Resident #1's right to be free of neglect for 1 of 3 residents reviewed for accidents. On 4/25/25 at approximately 4:30 PM during transportation back to the facility from a medical appointment in the contracted transport van the resident's wheelchair flipped backwards landing horizontal on the floor of the van. Resident #1's head hit the van floor and her back sustained impact when the wheelchair backrest (the support structure for the user's back) hit the floor. The Contracted Transport Driver was not qualified to complete a clinical assessment of injury. He asked the resident if she was okay, set the wheelchair upright, secured the wheelchair in the van, and continued the trip back to the facility. The resident reported during the entire ride back to the facility the Contracted Transport Driver repeatedly stated that he was going to be fired for what happened. Upon return to the facility, the Contracted Transport Driver notified facility staff the resident was complaining of pain in her back, but	F 600	" Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Upon return from her appointment on 4/25/25 Resident #1 was evaluated by the Nurse at the facility, was provided Tramadol due to resident reports of pain. The Nurse contacted the Medical Doctor (MD) related to the resident reports of pain and obtained an order to transport the resident to the Emergency Department for additional evaluation. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility had 22 residents who had falls between 4/1/25 and 5/6/25. The Director of Nursing (DON) reviewed documentation to ensure that each resident was assessed by a licensed	

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F 600	Continued From page 2 deliberately withheld information about the resident suffering a fall. After the Contracted Transport Driver left the facility, the resident informed staff of the fall and complained of pain rated a 10 out of 10 (with 10 being the worst pain possible) in her neck, shoulders, and back. Staff reported they had never seen Resident #1 in pain like that before and that she was moaning and crying out. Opioid pain medication was administered but it was not effective to relieve the pain. The resident was transferred to the hospital where she was evaluated in the Emergency Department (ED) at approximately 7:32 PM. The resident was identified with a fracture at the superior endplate (flat surface at the top of each vertebra) of the L1 (lumbar spine region, first vertebra). Disregarding the need for Resident #1 to be clinically assessed for injury prior to moving the resident had a high likelihood of resulting in further injury. The Contracted Transport Driver's decision to withhold information essential for the staff to be notified of in order for a clinical assessment to be completed to determine the necessary care the resident required delayed care and extended the time period the resident suffered severe pain without treatment. These deliberate actions taken by the Contracted Transport Driver constituted neglect. Immediate Jeopardy began on 4/25/25 when the Contracted Transport Driver neglected to have Resident #1 assessed for injury by a medical professional prior to being moved following a fall in the contracted transport van. Immediate jeopardy was removed on 5/08/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with	F 600	nurse for injury following a fall, and non-medical staff notified staff who were qualified to perform clinical assessment prior to the resident being moved, discrepancies were corrected during the audit on 5/6/25. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All facility staff members were re-educated regarding the policy and procedure for identification and prevention of abuse, neglect and misappropriation; including examples of what constitutes neglect, by each Department Supervisor, or designee on 5/6/25. Staff who did not receive this education on 5/6/25 received the training prior to working their next shift, by their respective Supervisor. This education has been added to the General Orientation of any newly hired staff members. All facility staff members received education on the facility policy to not move the resident after a fall until he/she has been examined by a licensed nurse for possible injuries, by each Department Supervisor, or designee, on 5/6/25. Staff who did not receive this education on 5/6/25 received the training prior to working their next shift, by their respective Supervisor. This education has been added to the General Orientation of any newly hired staff members.	

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F 600	Continued From page 3 potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: The tag is cross-referenced to: F684: Based on record review, interviews with staff, resident, Contracted Transportation Company, and the Physician, the Contracted Transport Driver failed to have Resident #1 assessed for injury by a qualified professional prior to moving the resident following a fall in the transportation van and to notify the facility nursing staff of the fall in order for the resident to be clinically assessed for injuries from the fall. Resident #1 returned to the facility on 4/25/25 at approximately 5:30 pm and notified staff that her wheelchair had flipped backwards while being transported back to the facility and the Contracted Transport Driver lifted her and her wheelchair up from the floor and returned her to the facility. Resident #1 suffered pain rated a 10 out of 10 (with 10 being the worst pain possible) in her neck, shoulders, and back. The resident was transferred to the hospital where she was identified with a fracture at the superior endplate (flat surface at the top of each vertebra) of the L1 (lumbar spine region, first vertebra). There was a high likelihood of further injury from moving a resident after a fall prior to a clinical assessment of injury and not informing staff of the fall delayed treatment for the resident. This deficient practice affected one of three residents reviewed for accidents (Resident #1). An initial report completed by the Administrator	F 600	On 5/6/25 100% of the facility□s Transport Drivers received training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility Transport Driver will notify the facility of any fall that occurs during transport. The facility□s Transport Driver training was provided by the facility Maintenance Director on 5/6/25. Newly hired facility Transportation Drivers will be provided training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility Transport Driver will notify the facility of any fall that occurs during transport, provided by the Maintenance Director. Drivers for the vendor who is providing contracted transportation services received training related to assessing the resident for injury prior to moving the resident, by notifying 911 so a qualified professional will assess the resident and notifying the facility of falls by calling the facility after calling 911. Vendor training also included examples of what constitutes abuse and neglect. The	

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F 600	Continued From page 4 was submitted to the State Agency on 5/01/25 for an allegation of neglect. The Contracted Transport Driver was noted as the accused individual. The report indicated on 4/25/25 Resident #1 was transported from dialysis back to the facility by the Contracted Transport Driver and after Resident #1 returned she reported she had fallen in the van and had back pain. The Contracted Transport Driver returned Resident #1's paperwork to the nurse and made no report of an incident during transport. The resident was sent to the ED for evaluation. On 5/01/25 the facility was notified that Resident #1 sustained an acute fracture related to the fall during transport on 4/25/25. During an interview with Nurse #2 on 5/05/25 at 1:05 pm she stated that after she was notified of Resident #1's fall on 4/25/25 by Nurse Aide #1 she immediately went to assess the resident. She revealed that Resident #1 appeared to be panicked, "like talking all over the place and rambling". She indicated the resident seemed hesitant to report what happened, "almost nervous like not looking at her [Nurse #2]" when she asked her about what happened on the ride back from dialysis. An interview was conducted on 5/08/25 at 9:01 am with Resident #1 who revealed that during the entire ride back to the facility after the fall on 4/25/25 the Contracted Transport Driver kept saying he was going to be fired for what happened. The initial report submitted on 5/1/25 for an allegation of neglect related to the 4/25/25 fall for Resident #1 was reviewed with the Administrator on 5/05/25 at 2:29 pm. The Administrator was	F 600	vendor provided documentation to the NHA on 5/7/25. Newly hired contract transport drivers for this vendor will be provided this training, by the contracted transportation company owner, or designee, prior to being assigned transportation trips for the facility residents. The Maintenance Director, or designee, will audit 10 instances when a resident is secured in a transport van at the facility to ensure the resident chair is securely fastened in the transport vehicle weekly, for 12 weeks. The facility will address any concerns that are identified during audits and take appropriate follow up action. Weekly transportation audits for securely fastening resident chairs in the transport vehicle will continue after 3 months, to ensure ongoing compliance. The DON, or designee, will audit 10 falls per month, to ensure that the resident was assessed for fall by a qualified professional prior to the resident being moved, for 3 months. The facility will address any concerns that are identified during audits and take appropriate follow up action. Monthly audits will continue after 3 months, to ensure ongoing compliance. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Maintenance Director will present the analysis of the transportation	

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F 600	Continued From page 5 unable to state why she completed and submitted the initial report for neglect but she stated it was not neglect on the role of the facility. She stated the facility confirmed Resident #1's fall and injury had occurred but she did not feel the facility was responsible for the actions of the Contracted Transport Driver. The Administrator further stated that she did not identify anything, on their end, that the facility would have done differently. On 5/05/25 at 4:51 pm the Administrator was notified of immediate jeopardy. The facility provided the following Immediate Jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: On 4/25/25 Resident #1 had a fall in the Contracted Transportation Van and the Contracted Transport Driver moved the resident prior to having the resident assessed for injuries by a qualified professional. Upon return to the facility the Contracted Transport Driver informed the staff the resident wanted to go to bed and did not feel good but he failed to notify the facility nursing staff of the fall in order for the resident to be clinically assessed for injuries from the fall. On 4/25/25 at 5:30 p.m., Resident #1 reported to Nurse #2 that her back was hurting and stated that her wheelchair flipped back in the contracted transportation van, the driver forgot to lock her wheelchair down, and she bumped her head. Nurse #2 went directly to evaluate Resident #1 and identified that the resident was tearful and reported pain.	F 600	safety/fastening audit compliance percentage to the Nursing Home Administrator (NHA) at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The Maintenance Director is responsible for implementing and maintaining the acceptable plan of correction related to transportation safety/fastening. The DON will present the analysis of the fall assessment audit compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The DON is responsible for implementing and maintaining the acceptable plan of correction related to fall assessment and documentation. 1. Completion Date: 5/22/25	

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F 600	Continued From page 6	F 600		

Nurse #2 completed a neurological assessment of Resident #1, which was normal. Resident #1 was given Tramadol for pain at 5:45 p.m. for pain.

Nurse #2 contacted the primary Medical Doctor (MD) for Resident #1 to report the resident complained of pain in her back, neck and shoulder. The MD provided an order to transport Resident #1 to the Emergency Department (ED) for evaluation. Nurse #2 called Emergency Medical Services (EMS) for transportation to the ED and Resident #1 left for the ED at 6:45 p.m. Nurse #2 contacted the Responsible Party (RP) to report the incident that occurred in the contracted van, the resident report of pain and the MD order to transport the resident to the ED.

Resident #1 remained in the Hospital undergoing a Cat Scan on 4/25/25 with negative results for acute diagnosis. Due to continued complaints of pain at the Hospital, the Hospital completed an MRI on 4/29/25 which identified a lumbar 1 fracture.

The Health Information Management (HIM) Director contacted the Contracted Transportation Company Owner on 4/25/25 at approximately 5:45pm to report Resident #1's allegation that Resident #1 stated her wheelchair flipped back and she hit her head. On 4/25/25 the Contracted Transportation Company Owner provided a statement to the Facility in an email from the Contracted Transportation Company Owner. The email from the Contracted Transportation Company Owner described an interview that the Contracted Transportation Company Owner had with the Contracted Transport Driver following the incident on 4/25/25 with Resident #1. Per the

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F 600	Continued From page 7	F 600		

Contracted Transportation Company Owner, the Contracted Transport Driver reported that Resident #1's wheelchair tilted backwards causing her to fall and hitting her head and back. The Contracted Driver reported he immediately stopped, asked Resident #1 if she was OK, sat her chair upright and returned her to the facility. The Contracted Transport Driver stated Resident #1 reported to him that she was OK. Per the Contracted Transportation Company Owner, the Contracted Transport Driver did not follow the policy by notifying 911 to assess the resident for injury prior to moving the resident and not notifying the facility of the fall. The Contracted Transportation Company Owner reported that the Contracted Transport Driver was terminated due to gross negligence and is ineligible for rehire.

The Director of Nursing (DON) will review all facility falls within the last 30 days to verify that all residents were assessed by a licensed nurse for injury following a fall and non-medical staff notified staff who were qualified to perform clinical assessments prior to the resident being moved. The facility will complete an investigation for any concerns that are identified and take appropriate follow-up action based upon the results of the investigation. The Administrator will assume responsibility to ensure the investigation and follow-up are completed.

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:

The facility will have effective systems in place to provide the necessary care and services to all resident and to protect all residents from neglect.

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F 600	Continued From page 8	F 600		

The Administrator spoke with the Contracted Transportation Company Owner regarding the need for education and documentation on 5/6/25. The Transportation Vendor who will be utilized for appointment transportation will provide training for all contract transport drivers who transport residents from the facility starting on 5/6/25. Training will be provided by the Contract Transportation Vendor Supervisors and will include notifying 911 to assess the resident for injury prior to moving the resident and the requirement to notifying the facility of falls by calling the facility at the time of the fall after calling 911. On 5/7/25 the Contract Transportation Vendor Supervisors will complete training on identifying and reporting neglect, including examples of what constitutes neglect. Effective 5/6/25 all contract transport drivers this Transportation Vendor sends to the facility will have this training completed prior to being assigned transportation trips for the facility residents. Training documentation will be provided to the Administrator by the Contracted Transportation Company Owner or Designee to be maintained at the facility. Newly hired contract transport drivers for this vendor will be provided this training by the Contracted Transportation Company Owner or Designee prior to being assigned transportation trips for the facility residents.

On 5/6/25 100% of facility staff received re-education regarding the facility policy for Abuse Identification, including indicators of neglect, and reporting neglect, including examples of what constitutes neglect. Department Supervisors will provide this education for their respective staff on 5/6/25. All staff who did not complete this training

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F 600	Continued From page 9	F 600		

on 5/6/25 will have the training provided prior to working their next shift, provided by their respective Department Supervisor. The Clinical Competency Coordinator will be responsible for tracking to ensure that 100% of staff receive the training. This training will be provided during general orientation for all newly hired staff after 5/6/25.

On 5/6/25 100% of facility staff received re-education provided by the Administrator regarding the facility policy not to move the resident after a fall until he/she has been examined by a licensed nurse for possible injuries. Department Supervisors will provide this education for their respective staff on 5/6/25. All staff who did not complete this training on 5/6/25 will have the training provided prior to working their next shift, provided by their respective Department Supervisor. The Clinical Competency Coordinator will be responsible for tracking to ensure that 100% of staff receive the training. This training will be provided during general orientation for all newly hired staff after 5/6/25.

On 5/6/25 100% of the facility's transport drivers will receive training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility transport driver will notify the facility of any fall that occurs during transport. The facility's Transport Driver training was provided by the facility Maintenance Director on 5/6/25.

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F 600	Continued From page 10	F 600		

Newly hired facility transportation drivers will be provided training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility transport driver will notify the facility of any fall that occurs during transport provided by the Maintenance Director.

Alleged date of immediate jeopardy removal: 5/08/25

Onsite validation of the immediate jeopardy removal plan was completed as follows:

The Administrator verified that effective 5/05/25 the facility ceased use of the vendor for the company that provided transportation for Resident #1 on 4/25/25.

A review of the facility provided documentation revealed an audit of falls within the last 30 days was completed by the Director of Nursing as outlined in their removal plan. The audits included review for documentation that a licensed nurse assessed the resident for injury following a fall and that non-medical staff notified qualified staff to perform a clinical assessment prior to the resident being moved. There were no concerns identified.

Review of the contracted transportation company's education documentation revealed all staff had completed education on 5/06/25 regarding the notification of 911 to assess the resident for injury prior to moving, and to notify

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F 600	Continued From page 11	F 600		

the facility of any van related incident after calling 911. Further review of the education documentation revealed the contracted transportation company completed education on 5/07/25 on identification of neglect and reporting of neglect. The education included examples of neglect. The education was verified by sign-in sheets from both service locations. Newly hired contract transport drivers for this vendor will be provided this training by the Contracted Transportation Company Owner or Designee prior to being assigned transportation trips for the facility residents.

The Administrator confirmed this was the only contracted transportation company the facility currently used for transportation effective 5/05/25.

Review of the facility education materials and sign-in sheets were reviewed and confirmed that education was provided to all facility staff, which included transportation staff, was completed on the facility policy for Abuse Identification which included how to identify neglect, reporting neglect, and examples of neglect. The staff sign-in sheets were reviewed and were completed by all facility staff in all departments, which included contracted staff. The Clinical Competency Coordinator will be responsible for tracking to ensure that 100% of staff receive the training. This training will be provided during general orientation for all newly hired staff after 5/6/25.

A review of the facility education was conducted regarding the facility policy related to falls, with focus to not move a resident after a fall until examined by a licensed nurse for possible injury. Staff sign-in sheets were reviewed and completed

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by all facility staff including contracted staff. The Clinical Competency Coordinator will be responsible for tracking to ensure that 100% of staff receive the training. This training will be provided during general orientation for all newly hired staff after 5/6/25.

Review of the education materials and sign-in sheets for the facility transportation staff were reviewed regarding the procedure if a fall should occur during transport. The education included that the resident was to be assessed by a qualified professional before moving a resident, to move the transportation vehicle to a safe location and call 911. The education further noted that facility transportation staff were to notify the facility of any falls that occur during transports. Newly hired facility transportation drivers will be provided training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility transport driver will notify the facility of any fall that occurs during transport provided by the Maintenance Director.

Interviews were conducted on 5/08/25 with facility staff and contracted facility staff to confirm that education was received regarding abuse and neglect education which included definitions and examples, and reporting of resident neglect.

Interviews were conducted on 5/08/25 with the facility transportation staff who confirmed education was completed regarding management of resident falls during transports including not

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F 600	Continued From page 13 moving a resident without being assessed by medical professional, reporting incidents to the facility, and abuse and neglect which included examples of neglect. The facility's immediate jeopardy removal date of 5/08/25 was validated.	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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, interviews with staff, resident, Contracted Transportation Company, and the Physician, the Contracted Transport Driver failed to have Resident #1 assessed for injury by a qualified professional prior to moving the resident following a fall in the transportation van and to notify the facility nursing staff of the fall in order for the resident to be clinically assessed for injuries from the fall. Resident #1 returned to the facility on 4/25/25 at approximately 5:30 pm and notified staff that her wheelchair had flipped backwards while being transported back to the facility and the Contracted Transport Driver lifted her and her wheelchair up from the floor and returned her to the facility. Resident #1 suffered pain rated a 10 out of 10 (with 10 being the worst pain possible) in her neck, shoulders, and back.	F 684	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Upon return from her appointment on 4/25/25 Resident #1 was evaluated by the Nurse at the facility, was provided Tramadol due to resident reports of pain. The Nurse contacted the Medical Director (MD) related to the resident reports of pain and obtained an order to transport the resident to the Emergency Department for additional evaluation. " Address how the facility will identify other residents having the potential to be	5/22/25

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F 684	Continued From page 14 The resident was transferred to the hospital where she was identified with a fracture at the superior endplate (flat surface at the top of each vertebra) of the L1 (lumbar spine region, first vertebra). There was a high likelihood of further injury from moving a resident after a fall prior to a clinical assessment of injury and not informing staff of the fall delayed treatment for the resident. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1). Immediate Jeopardy began on 4/25/25 when Resident #1 was not assessed by a medical professional for injury prior to being moved following a fall in the contracted transport van. Immediate jeopardy was removed on 5/07/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 3/24/22 with diagnoses which included a left above the knee amputation, right below the knee amputation, and dependence on dialysis. The Minimum Data Set (MDS) quarterly assessment dated 1/29/25 revealed Resident #1 had severe cognitive impairment. Resident #1 was dependent upon staff for transfers and used a wheelchair for mobility. Resident #1 was not coded for pain or for the use of opioid pain medication.	F 684	affected by the same deficient practice: The facility had 22 residents who had falls between 4/1/25 and 5/6/25. The Director of Nursing (DON) reviewed documentation to ensure that each resident was assessed by a licensed nurse for injury following a fall, and non-medical staff notified staff who were qualified to perform clinical assessment prior to the resident being moved, discrepancies were corrected at the time of the audit, which was conducted on 5/6/25. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All facility staff members received education on the facility policy to not move the resident after a fall until he/she has been examined by a licensed nurse for possible injuries, provided by each Department Supervisor, or designee, on 5/6/25. Staff who did not receive this education on 5/6/25 received the training prior to working their next shift, by their respective Supervisor. This education has been added to the General Orientation of any newly hired staff members. On 5/6/25 100% of the facility□s Transport Drivers received training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to	

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F 684	Continued From page 15 The nursing progress note written by Nurse #2 dated 4/25/25 at 6:54 pm revealed Resident #1 returned from her dialysis appointment at approximately 5:30 pm and the Contracted Transport Driver reported that Resident #1's back was hurting and she wanted to go to bed. Nurse #2 noted that staff entered the room to assist Resident #1 to bed and she started moaning and crying out that her back hurt. Resident #1 explained that her wheelchair flipped backwards while being transported back to the facility because the Contracted Transport Driver forgot to lock the wheelchair down. Nurse #2 noted that Resident #1 reported a pain score of 10 out of 10 for her back from top of neck all the way down the back, neck, and shoulders and was administered the as needed (PRN) tramadol (opioid pain medication) at 5:45 pm. Nurse #2 noted the Medical Doctor was notified and she received an order to send Resident #1 to the emergency department for evaluation. Nurse #2 noted that EMS (emergency medical services) was called and arrived at the facility within ten minutes. The nursing progress note further reported that Resident #1 continued to yell out in pain while Nurse #2 prepared the paperwork and notified her Responsible Party. Nurse #2 reported that Resident #1 was transferred to the hospital at 6:45 pm. Review of the Controlled Drug Record revealed Nurse #2 administered 2 tramadol 50 milligram (mg) tablets for pain to Resident #1 on 4/25/25 at 5:45 pm. A telephone interview was conducted on 5/05/25 at 1:05 pm with Nurse #2 who was assigned to Resident #1 on 4/25/25 when she returned from	F 684	moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility Transport Driver will notify the facility of any fall that occurs during transport. The facility□s Transport Driver training was provided by the facility Maintenance Director on 5/6/25. Newly hired facility Transportation Drivers will be provided training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility Transport Driver will notify the facility of any fall that occurs during transport, provided by the Maintenance Director. Drivers for the vendor who is providing contracted transportation services received training related to assessing the resident for injury prior to moving the resident, by notifying 911 so a qualified professional will assess the resident and notifying the facility of falls by calling the facility after calling 911. The vendor provided documentation to the NHA on 5/7/25. Newly hired contract transport drivers for this vendor will be provided this training, by the contracted transportation company owner, or designee, prior to being assigned transportation trips for the facility residents.	

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F 684	Continued From page 16 the dialysis appointment. Nurse #2 stated she was at the nursing station when the Contracted Transport Driver approached the desk with Resident #1 and the dialysis communication book and reported that Resident #1's back hurt and she wanted to go to bed. Nurse #2 stated the Contracted Transport Driver left the dialysis communication book at the desk and left the facility. Nurse #2 stated that at no time did the Contracted Transport Driver report that Resident #1's wheelchair had tipped backwards during the return trip to the facility or that Resident #1 had hit the floor of the van. Nurse #2 stated she contacted the Physician and they discussed the option of in-house radiology testing but they decided it was best to send Resident #1 to the hospital because her pain was all over. She stated Resident #1 was medicated with pain medication but she was in such pain and continued to cry out while waiting for the ambulance to arrive. Nurse #2 stated she notified the Director of Nursing of the incident. Resident #1 was interviewed on 5/08/25 at 9:01 am and revealed she had some difficulty talking about the incident because she was so upset by what happened. Resident #1 stated when the Contracted Transport Driver went to take a turn or something she felt her wheelchair tip backwards and then the only thing she could see was the ceiling of the van. Resident #1 stated the Contracted Transport Driver pulled the van over and came to check on her and asked if "I (Resident #1) was okay." Resident #1 stated she could not even say anything at that time, she stated she felt "confused and in shock". Resident #1 stated that somehow the Contracted Transport Driver was able to pick her and her wheelchair up from the floor while she was still sitting in it and	F 684	The Maintenance Director, or designee, will audit 10 instances when a resident is secured in a transport van at the facility to ensure the resident chair is securely fastened in the transport vehicle weekly, for 12 weeks. The facility will address any concerns that are identified during audits and take appropriate follow up action. Weekly transportation audits for securely fastening resident chairs in the transport vehicle will continue after 3 months, to ensure ongoing compliance. The DON, or designee, will audit 10 falls per month, to ensure that the resident was assessed for fall by a qualified professional prior to the resident being moved, for 3 months. The facility will address any concerns that are identified during audits and take appropriate follow up action. Monthly audits will continue after 3 months, to ensure ongoing compliance. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Maintenance Director will present the analysis of the transportation safety/fastening audit compliance percentage to the Nursing Home Administrator (NHA) at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The Maintenance	

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F 684	Continued From page 17 put her and the wheelchair back upright. Resident #1 stated the Contracted Transport Driver then hooked her wheelchair to the floor and drove her back to the facility. Resident #1 stated when she got back to the facility her pain was at least 10 out of 10 so she had to tell the staff what happened when she was transported by the Contracted Transport Driver. An attempt to interview the Contracted Transport Driver on 5/07/25 was unsuccessful. The Director of Nursing (DON) was interviewed on 5/05/25 at 2:08 pm. The DON stated she was at the facility when the Contracted Transport Driver brought Resident #1 back from the dialysis appointment on 4/25/25. She stated she was notified by Nurse #2 of the van incident with Resident #1, but she stated when she went to find the Contracted Transport Driver he had already left the facility so she was unable to obtain a statement. The DON stated she asked the Health Information Management (HIM) Director to contact the Contracted Transportation Company and report Resident #1's incident. The DON stated she was told by staff that the Contracted Transport Driver never reported the van incident when he returned Resident #1 to the facility. An interview with the HIM Director was conducted on 5/05/25 at 2:21 pm. She reported she contacted the Contracted Transportation Company as requested by the DON and reported the incident that involved Resident #1 on 4/25/25. The HIM Director stated the Contracted Transportation Company obtained the statement from the Contracted Transport Driver and the company provided the information to the facility.	F 684	Director is responsible for implementing and maintaining the acceptable plan of correction related to transportation safety/fastening. The DON will present the analysis of the fall assessment audit compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The DON is responsible for implementing and maintaining the acceptable plan of correction related to fall assessment and documentation. 1. Completion Date: 5/22/25	

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The Contracted Transportation Company provided the facility with a written statement from the company which included a statement from the Contracted Transport Driver dated 4/25/25 regarding the incident. The statement revealed Resident #1 was picked up on 4/25/25 at approximately 4:30 pm for transport back to the facility by the Contracted Transport Driver. He reported that as he took off, the wheelchair tilted over backwards causing Resident #1 to fall hitting her head and back. The statement further noted that the Contracted Transport Driver immediately stopped, asked the resident if she was okay, set the wheelchair upright, secured it to the van floor, and returned Resident #1 to the facility. He further noted that he wanted to report the incident to the facility management but Resident #1 asked him not to tell anyone because she did not want to get anyone in trouble. The statement concluded that the Contracted Transport Driver was terminated due to not reporting the incident, not securing Resident #1's wheelchair, and gross negligence.

A telephone interview was conducted on 5/05/25 at 1:56 pm with the Contracted Transportation Company's Office Manager who revealed they had provided the facility with the information regarding the incident with Resident #1 and at this time they had no further information to provide.

The EMS record dated 4/25/25 revealed the facility contacted EMS for Resident #1's emergent transport to the hospital at 6:40 pm and they arrived at the facility at 6:54 pm. The signs and symptoms listed on the report indicated acute pain due to trauma. The resident stated she was

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hurting all over and she was unable to describe the pain. Staff indicated Resident #1 had received 2 tramadol prior to EMS arrival. EMS departed the facility with Resident #1 at 7:11 pm and arrived at the hospital at 7:27 pm.

Review of the hospital record dated 4/25/25 through 5/01/25 revealed Resident #1 was seen in the emergency room provider on 4/25/25 at approximately 7:32 pm after sustaining a fall in the transportation van with reports of head, neck, chest, abdominal, and back pain. A computed tomography (CT) scan of the cervical spine without intravenous contrast was completed on 4/26/25 at 4:45 am with no acute findings. The hospital record further noted that Resident #1continued to report "pain all over" and on 4/29/25 a magnetic resonance imaging (MRI) was performed on 4/29/25 which showed a fracture at the superior endplate of L1 without height loss (a less severe fracture that is not fully compressed). Resident #1 did not require any surgical interventions and was stable for transfer back to the facility on 5/01/25. Resident #1's discharge activity level was noted "as tolerated" and she was prescribed oxycodone (opioid pain medication) 5 mg tablet every 4 hours as needed for moderate or severe pain for 5 days and a lidocaine 4% pain patch daily.

A telephone interview was conducted with NA #3 on 5/05/25 at 1:18 pm who was assigned to Resident #1 on 4/25/25 during the 3:00 pm through 11:00 pm shift. NA #3 stated when she went to Resident #1's room she (Resident #1) was crying out every time she was touched and she had never seen Resident #1 in pain like that before. NA #3 stated when she was told what happened in the van she could not understand

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why the Contracted Transport Driver did not report what happened to Resident #1 when he dropped her off at the facility.

During an interview on 5/05/25 at 1:50 pm with NA #1 she revealed that she was working on 4/25/25 when Resident #1 returned from dialysis. NA #1 stated the Contracted Transport Driver came to the nursing station desk and he reported that Resident #1 had been "crying like this and was not feeling good". She stated Resident #1 was visibly upset and when she was back in her room Resident #1 reported what had occurred on the transport van. NA #1 immediately notified Nurse #2. NA #1 stated the Contracted Transport Driver had the "audacity to stand right in front of her face and not say one word about what happened to Resident #1 in the van when it was obvious Resident #1 was in extreme pain."

An interview was conducted on 5/08/25 at 12:34 pm with the Physician who revealed he had been the medical provider for Resident #1 for over 3 years at the facility. The Physician indicated that Resident #1 should have been assessed before being moved since the Contracted Transport Driver was not able to know if Resident #1 had been injured at the time and it could have worsened an injury. The Physician stated when he spoke with Nurse #2 the initial plan was to obtain in-house radiology testing for Resident #1. He stated they discussed that since the nurse was at the bedside she was best to determine Resident #1's pain level and current status so they made the decision to send the resident to the hospital for the testing because of the extreme pain throughout her body. The Physician stated Resident #1 was "very sharp and alert" and he would see her 2-3 times per week at the

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facility to manage her chronic and acute illnesses. He stated Resident #1 was normally very clear in her cognition and speech and she was a reliable source of information.

A follow-up interview was conducted on 5/08/25 at 1:15 pm with the DON who stated the Contracted Transport Driver should have called 911 when Resident #1's wheelchair tipped backwards and he should have reported it to the facility.

During an interview on 5/05/25 at 2:29 pm with the Administrator she revealed she had confirmed the incident occurred but the Contracted Transport Driver did not report the incident to any staff at the facility when he returned Resident #1 from the dialysis appointment. The Administrator stated the Contracted Transport Driver should have had Resident #1 assessed at the time of the incident and immediately report the incident to the facility.

On 5/05/25 at 4:51 pm the Administrator was notified of immediate jeopardy.

The facility provided the following Immediate Jeopardy removal plan:

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

On 4/25/25 Resident #1 had a fall in the Contracted Transportation Van and the Contracted Transport Driver moved the resident prior to having the resident assessed for injuries by a qualified professional. Upon return to the facility the Contracted Transport Driver informed

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the staff the resident wanted to go to bed and did not feel good but he failed to notify the facility nursing staff of the fall in order for the resident to be clinically assessed for injuries from the fall.
On 4/25/25 at 5:30 p.m., Resident #1 reported to Nurse #2 that her back was hurting and stated that her wheelchair flipped back in the contracted transportation van, the driver forgot to lock her wheelchair down, and she bumped her head.

Nurse #2 went directly to evaluate Resident #1 and identified that the resident was tearful and reported pain.

Nurse #2 completed a neurological assessment of Resident #1, which was normal. Resident #1 was given Tramadol for pain at 5:45 p.m. for pain.

Nurse #2 contacted the primary Medical Doctor (MD) for Resident #1 to report the resident complained of pain in her back, neck and shoulder. The MD provided an order to transport Resident #1 to the Emergency Department (ED) for evaluation. Nurse #2 called Emergency Medical Services (EMS) for transportation to the ED and Resident #1 left for the ED at 6:45 p.m. Nurse #2 contacted the Responsible Party (RP) to report the incident that occurred in the contracted van, the resident report of pain and the MD order to transport the resident to the ED.

Resident #1 remained in the hospital undergoing a CT Scan on 4/25/25 with negative results for acute diagnosis. Due to continued complaints of pain at the hospital, the hospital completed an MRI on 4/29/25 which identified a lumbar 1 fracture.

The Health Information Management (HIM)

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Director contacted the Contracted Transportation Company Owner on 4/25/25 at approximately 5:45pm to report Resident #1's allegation that Resident #1 stated her wheelchair flipped back and she hit her head. On 4/25/25 the Contracted Transportation Company Owner provided a statement to the Facility in an email from the Contracted Transportation Company Owner. The email from the Contracted Transportation Company Owner described an interview that the Contracted Transportation Company Owner had with the Contracted Transport Driver following the incident on 4/25/25 with Resident #1. Per the Contracted Transportation Company Owner, the Contracted Transport Driver reported that Resident #1's wheelchair tilted backwards causing her to fall and hit her head and back. The Contracted Driver reported he immediately stopped, asked Resident #1 if she was OK, sat her chair upright and returned her to the facility. The Contracted Transport Driver stated Resident #1 reported to him that she was OK. Per the Contracted Transportation Company Owner, the Contracted Transport Driver did not follow the policy by notifying 911 to assess the resident for injury prior to moving the resident and not notifying the facility of the fall. The Contracted Transportation Company Owner reported that the Contracted Transport Driver was terminated due to gross negligence and is ineligible for rehire.

The Director of Nursing (DON) will review all facility falls within the last 30 days to verify that all residents were assessed by a licensed nurse for injury following a fall and non-medical staff notified staff who were qualified to perform clinical assessments prior to the resident being moved. The facility will complete an investigation for any concerns that are identified and take appropriate

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follow-up action based upon the results of the investigation. The Administrator will assume responsibility to ensure the investigation and follow-up are completed.

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:

The facility will have effective systems in place for residents to be assessed in the event of an accident and for non-medical staff to notify facility staff who are qualified to perform clinical assessments for injury following a fall prior to the resident being moved.

The Administrator spoke with the Contracted Transportation Company Owner regarding the need for education and documentation on 5/6/25. The Transportation Vendor who will be utilized for appointment transportation will provide training for all contract transport drivers who transport residents from the facility starting on 5/6/25. Training will be provided by the Contract Transportation Vendor Supervisors and will include notifying 911 to assess the resident for injury prior to moving the resident and the requirement to notify the facility of falls by calling the facility at the time of the fall after calling 911. Effective 5/6/25 all contracted transport drivers this Transportation Vendor sends to the facility will have this training completed prior to being assigned transportation trips for the facility residents. Training documentation will be provided to the Administrator by the Contracted Transportation Company Owner or Designee to be maintained at the facility. Newly hired contract transport drivers for this vendor will be provided

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this training by the Contracted Transportation Company Owner or Designee prior to being assigned transportation trips for the facility residents.

On 5/6/25 100% of facility staff received re-education provided by the Administrator regarding the facility policy not to move the resident after a fall until he/she has been examined by a licensed nurse for possible injuries. Department Supervisors will provide this education for their respective staff on 5/6/25. All staff who did not complete this training on 5/6/25 will have the training provided prior to working their next shift, provided by their respective Department Supervisor. The Clinical Competency Coordinator will be responsible for tracking to ensure that 100% of staff receive the training. This training will be provided during general orientation for all newly hired staff after 5/6/25.

On 5/6/25 100% of the facility's transport drivers will receive training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility transport driver will notify the facility of any fall that occurs during transport. The facility's Transport Driver training was provided by the facility Maintenance Director on 5/6/25.

Newly hired facility transportation drivers will be provided training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and

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prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility transport driver will notify the facility of any fall that occurs during transport provided by the Maintenance Director.

Alleged date of immediate jeopardy removal: 5/07/25

Onsite validation of the immediate jeopardy removal plan was completed as follows:

Review of the facility documentation revealed an audit of falls within the last 30 days was completed as outlined in their removal plan. The audits included review for documentation that a licensed nurse assessed the resident for injury following a fall and that non-medical staff notified qualified staff to perform a clinical assessment prior to the resident being moved. No concerns were identified.

Review of the contracted transportation company's education documentation revealed all staff had completed education on 5/06/25. The education included notification of 911 to assess the resident for injury prior to moving, and to notify the facility of any van related incident after calling 911. The education was verified by sign-in sheets from both service locations. Newly hired contract transport drivers for this vendor will be provided this training by the Contracted Transportation Company Owner or Designee prior to being assigned transportation trips for the facility residents.

The Administrator confirmed this was the only

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contracted transportation company the facility currently used for transportation effective 5/05/25.

The Administrator verified that effective 5/05/25 the facility ceased use of the vendor for the company that provided transportation for Resident #1 on 4/25/25.

Review of the facility education materials and sign-in sheets were reviewed to confirm that education was provided to all facility staff was completed on resident occurrences (falls). The education included not moving a resident after a fall until the resident has been examined by a licensed nurse for possible injury.
The Clinical Competency Coordinator will be responsible for tracking to ensure that 100% of staff receive the training. This training will be provided during general orientation for all newly hired staff after 5/6/25.

Review of the facility education materials and sign-in sheets were reviewed regarding the facility transportation staff in the event of a fall. The education included to call 911, a resident was to be assessed by a qualified professional in the event of a fall during transport, not to move the resident until the resident had been assessed for injury, and to notify the facility of the incident.
Newly hired facility transportation drivers will be provided training related to ensuring the resident is assessed by a qualified professional in the event the fall occurs during transportation and prior to moving the resident. Per the policy, they should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility transport driver will notify the facility of any fall that occurs during transport provided by the Maintenance

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F 684	Continued From page 28 Director. Interviews were conducted on 5/08/25 with facility staff, facility transportation staff, and contracted facility staff to confirm that education was received regarding how to manage a resident occurrence. The facility's immediate jeopardy removal date of 5/07/25 was validated.	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 record review and interviews with staff, resident, Contracted Transportation Company, and the Physician, the facility failed to ensure a resident was safely secured in the contracted transport van during the return trip from an appointment back to the facility. On 4/25/25 the Contracted Transport Driver failed to secure Resident #1's wheelchair in accordance with the manufacturer's instructions prior to departing with the resident from the dialysis clinic. During travel, Resident #1's wheelchair flipped backwards landing with the backrest of wheelchair (the support structure for the user's back) on the floor of the van. Resident #1 remained in the wheelchair during the fall resulting in her head	F 689	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility has observed Resident #1 being correctly secured prior to transportation to an appointment, in a transport vehicle, following her fall in the contracted transport vendor transport vehicle on 4/25/25. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	5/22/25

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F 689	Continued From page 29 hitting the van floor and her back sustaining impact when the backrest of the wheelchair hit floor. Resident #1 suffered pain rated a 10 out of 10 (with 10 being the worst pain possible) in her neck, shoulders, and back. Staff reported the resident was moaning and crying out and that they had never seen Resident #1 in pain like that before. The resident was transferred to the hospital where she was identified with a fracture at the superior endplate (flat surface at the top of each vertebra) of the L1 (lumbar spine region, first vertebra). Resident #1 returned to the facility on 5/01/25 and continued to need opioid pain medication to control her pain. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident # 1). Immediate jeopardy began on 4/25/25 when the Contracted Transport Driver failed to secure Resident #1's wheelchair to the floor securement system in the transportation van. Immediate jeopardy was removed on 5/07/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: The manufacturer's detailed instructions for wheelchair tie-downs were noted to identify the four anchor points in the vehicle designed for securing wheelchairs, position the wheelchair in the designated securement area, connect the tie-down straps to the floor anchor points, and	F 689	The facility had 18 alert and oriented residents who had transportation in a transport vehicle between 4/7/25 and 5/6/25. Social Services interviewed these 18 residents related to whether they were safely secured during transport on 5/6/25. No residents reported any incidents when they were not safely secured during transport. The facility identified 5 residents who had transportation in a transport vehicle between 4/7/25 and 5/6/25, who were not alert and oriented. The facility completed a skin note and pain assessment for these 5 residents, conducted by the Director of Nursing, Assistant Director of Nursing or Licensed Nurse, on 5/6/25 . No areas of concern were identified during these evaluations. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 5/6/25 100% of the facility□s Transport Drivers received training related to securing wheelchairs in the transport vehicle. Training uses the Sure-Lok Safe and Secure Program and includes a return demonstration of safely securing a wheelchair. The facility□s Transport Driver training was provided by the facility Maintenance Director on 5/6/25. Newly hired facility Transportation Drivers will be provided training related to	

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then to the wheelchair's securement points (two at the front and two at the rear of the chair) with a minimum of four tie-down points. The instructions further noted to tighten the tie-downs to ensure the wheelchair was firmly secured and the occupant was properly restrained before driving.

Resident #1 was admitted to the facility on 3/24/22 with diagnoses which included a left above the knee amputation, right below the knee amputation, and dependence on dialysis.

The Minimum Data Set (MDS) quarterly assessment dated 1/29/25 revealed Resident #1 had severe cognitive impairment. Resident #1 was dependent upon staff for transfers and wheelchair mobility. Resident #1 was not coded for pain or for the use of opioid pain medication.

Resident #1 had a physician order dated 3/22/25 for ibuprofen (a nonsteroidal anti-inflammatory medication used to relieve pain and inflammation) 200 milligram (mg) tablet; administer 2 tablets every 4 hours as needed (PRN) for pain.

Resident #1 had a physician order dated 4/04/25 for tramadol (opioid pain medication) 50 mg tablet; administer 2 tablets for left hip pain every 6 hours as needed.

Review of the April 2025 Medication Administration Record (MAR) and pain monitoring revealed Resident #1 was administered the PRN tramadol 11 times and the PRN ibuprofen 2 times and her pain level varied from 0 to 7 from 4/01/25 through 4/24/25.

The nursing progress note dated 4/25/25 at 6:54

securing wheelchairs in the transport vehicle, using the Sure-Lok Safe and Secure Program including a return demonstration of safely securing a wheelchair, by the Maintenance Director, prior to providing transportation services to a resident.

Drivers for the vendor who is providing contracted transportation services received training related to safely securing a wheelchair, using the Q-Straint QRT Training Video, including a return demonstration of safely securing a wheelchair. The vendor provided documentation to the NHA on 5/7/25. Newly hired contract transport drivers for this vendor will be provided the Q-Straint QRT Training Video, including a return demonstration of safely securing a wheelchair, by the contracted transportation company owner, or designee, prior to being assigned transportation trips for the facility residents.

The Maintenance Director, or designee, will audit 10 instances when a resident is secured in a transport van at the facility to ensure the resident chair is securely fastened in the transport vehicle weekly, for 12 weeks. The facility will address any concerns that are identified during audits and take appropriate follow up action. Weekly transportation audits for securely fastening resident chairs in the transport vehicle will continue after 3 months, to ensure ongoing compliance.

" Indicate how the facility plans to

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F 689	Continued From page 31 pm written by Nurse #2 revealed Resident #1 returned from her dialysis appointment at approximately 5:30 pm and it was reported by the Contracted Transport Driver that Resident #1 had reported back pain and wanted to go to bed. Nurse #2 further noted that Resident #1 began moaning and crying out that her back hurt and Resident #1 explained that her wheelchair had flipped backwards while being transported back to the facility from dialysis. Resident #1 reported the Contracted Transport Driver forgot to lock the wheelchair down. Resident #1 reported a pain score of 10 out of 10 for her back from top of neck all the way down the back, neck on both sides, and both shoulders. Resident #1 was administered as needed pain medication. Nurse #2 further noted that Resident #1 continued to yell out in pain and was transferred to the hospital for further evaluation by EMS (emergency medical services). Review of the Controlled Drug Record revealed Resident #1 was administered 2 tramadol 50 mg tablets for pain on 4/25/25 at 5:45 pm and the medication was signed out by Nurse #2. A telephone interview was conducted on 5/05/25 at 1:05 pm with Nurse #2 who was assigned to Resident #1 on 4/25/25 when the Resident returned from the dialysis appointment. Nurse #2 stated she was sitting at the nursing station when the Contracted Transport Driver approached the desk with Resident #1 and he reported that Resident #1's back hurt and she wanted to go to bed. Nurse #2 stated the Contracted Transport Driver left the dialysis communication book at the desk and left the facility. Nurse #2 stated she was notified by Nurse Aide (NA) #1 that Resident #1 had reported she had a fall in the	F 689	monitor its performance to make sure that solutions are sustained: The Maintenance Director will present the analysis of the transportation safety/fastening audit compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The Maintenance Director is responsible for implementing and maintaining the acceptable plan of correction related to transportation safety/fastening. 1. Completion Date: 5/22/25	

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transportation van and she immediately went to the room. She stated Resident #1 appeared to be panicked, "like talking all over the place and rambling". She indicated the resident seemed hesitant to report what happened, "almost nervous like not looking at her [Nurse #2]" when she asked her about what happened on the ride back from dialysis. Resident #1 did tell her that the Contracted Transport Driver did not lock the wheelchair to the van floor and the wheelchair tipped back and she hit the floor. Nurse #2 stated Resident #1 reported pain from the neck down and described it as really bad, everything hurt. She stated she contacted the physician and Resident #1 was transferred to the hospital since she had such severe pain all over her body. She stated Resident #1 was medicated with pain medication but she was in such pain and continued to cry out while waiting for the ambulance to arrive. Nurse #2 stated that at no time did the Contracted Transport Driver report that Resident #1's wheelchair had tipped backwards during the return trip to the facility or that Resident #1 had hit the floor of the van. Nurse #2 stated she notified the Director of Nursing of the incident.

Review of the hospital record dated 4/25/25 through 5/01/25 revealed the following information. Resident #1 was seen in the emergency room on 4/25/25 after sustaining a fall in the transportation van with reports of head, neck, chest, abdominal, and back pain. The resident was also noted to be hypoxic (low blood oxygen level) and was placed on 2 liters of oxygen via nasal canula. Resident #1 reported she had received pain medication at the facility and her pain scale was now 8 out of 10. A computed tomography (CT) scan of the head was

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completed on 4/26/25 at 4:41 am with no acute intracranial findings. A CT of the cervical spine without intravenous contrast was completed on 4/26/25 at 4:45 am with no acute findings. The hospital record further noted that Resident #1continued to report "pain all over" and on 4/29/25 a magnetic resonance imaging (MRI) was performed on 4/29/25 which showed a fracture at the superior endplate of L1 without height loss (a less severe fracture that is not fully compressed). Resident #1 did not require any surgical interventions and was stable for transfer back to the facility on 5/01/25. Resident #1 had a discharge activity level noted "as tolerated" and was prescribed additional pain medication which included oxycodone (opioid pain medication) 5 mg tablet every 4 hours as needed for moderate or severe pain for 5 days and a lidocaine 4% pain patch daily.

Review of the MAR for May 2025 revealed Resident #1 received the as needed oxycodone for moderated to severe pain 9 times and her pain level varied from 0 through 8 from 5/01/25 through 5/06/25. The as needed oxycodone was discontinued on 5/06/25.

During an interview on 5/06/25 at 11:50 am with the Rehabiliation Manager she revealed that Resident #1 had been evaluated for occupation therapy on 5/02/25 and her pain was reported as significant across her shoulders and lumbar area. The Rehabiliation Manager stated Resident #1 was educated along with nursing staff on proper positioning and turning for safety and comfort.

Resident #1 was interviewed on 5/08/25 at 9:01 am and revealed she had some difficulty talking about the incident because she was so upset by

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what happened. Resident #1 stated she recalled getting into the transportation van and recalled someone from the dialysis center came out to give her something and the Contracted Transport Driver was talking with them. She stated he then closed the doors and got in the van and began to drive away. Resident #1 stated at that time she did not realize that the Contracted Transport Driver had not hooked her wheelchair to the van floor. She stated he went to take a turn or something and she felt her chair tip backwards and then the only thing she could see was the ceiling of the van. Resident #1 stated the Contracted Transport Driver pulled the van over and came to check on her and she stated that he (the Contracted Transport Driver) kept saying to her that he was going to get fired and that he was going to lose his job for this. Resident #1 stated she could not even say anything at that time, she stated she felt "confused and in shock". Resident #1 stated during the ride back to the facility her pain continued to get worse and when she got back to the facility her pain was at least a 10 out of 10. Resident #1 stated she initially felt bad for the Contracted Transport Driver because the entire ride back he just kept saying he was going to be fired and that "I [Resident #1] would be okay" but when she got back to the facility the pain was so bad that she had to tell the facility staff what happened. Resident #1 stated she still had pain from the incident and she stated it was hard to describe just that she "felt pain all over her body."

The Director of Nursing (DON) was interviewed on 5/05/25 at 2:08 pm. The DON stated she was present at the facility when the Contracted Transport Driver brought Resident #1 back from the dialysis appointment. She stated she was

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notified by Nurse #2 of the incident and when she went to find the Contracted Transport Driver he had already left the facility. The DON stated she asked the Health Information Management (HIM) Director to contact the Contracted Transportation Company and report Resident #1's incident.

An interview was conducted with the HIM Director on 5/05/25 at 2:21 pm. She reported she contacted the Contracted Transportation Company as requested by the DON and reported the incident that involved Resident #1 on 4/25/25. The HIM Director stated the Contracted Transportation Company obtained the statement from the Contracted Transport Driver and the company provided the information to the facility.

The Contracted Transportation Company provided the facility with a written statement from the company which included a statement from the Contracted Transport Driver dated 4/25/25 regarding the incident. The Contracted Transport Driver reported he was loading Resident #1 into the transportation van and was about to secure her for travel when he was distracted by a person from the dialysis center. He noted that he stopped what he was doing to get something from the person from the dialysis center, then he secured the lift, shut the doors, and took off without realizing he had not secured Resident #1's wheelchair to the floor. The Contracted Transport Driver reported that as he took off, the wheelchair tilted over backwards causing Resident #1 to fall hitting her head and back. The statement further noted that the Contracted Transport Driver immediately stopped, asked the resident if she was okay, set the wheelchair upright, secured it to the van floor, and returned Resident #1 to the facility. He further noted that

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he wanted to report the incident to the facility management but Resident #1 asked him not to tell anyone because she did not want to get anyone in trouble. The Contracted Transport Driver stated Resident #1 reported she was okay and he left Resident #1 at the facility. The statement concluded that the Contracted Transport Driver was terminated due to not reporting the incident, not securing Resident #1's wheelchair, and gross negligence.

A telephone interview was conducted on 5/05/25 at 1:56 pm with the Contracted Transportation Company's Office Manager who revealed they had provided the facility with the information regarding the incident with Resident #1 and at this time they had no further information to provide.

An attempt to interview the Contracted Transport Driver on 5/07/25 was unsuccessful.

A telephone interview was conducted on 5/05/25 at 1:12 pm with Nurse Aide (NA) #2 who was assigned to Resident #1 on the 7:00 am through 3:00 pm shift on 4/25/25. NA #2 reported that Resident #1 had no pain or discomfort prior to leaving the facility for the dialysis appointment.

A telephone interview was conducted with NA #3 on 5/05/25 at 1:18 pm who was normally assigned to Resident #1 on 4/25/25 during the 3:00 pm through 11:00 pm shift. NA #3 stated when she went to Resident #1's room after she returned from dialysis she noticed immediately something was wrong by the expression on Resident #1's face, "just looked different". NA #3 stated Nurse #2 was already present in the room and Resident #1 reported that when she was in

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the van her wheelchair had flipped backwards and her whole body was hurting. NA #3 stated Resident #1 was crying out every time she was touched and she had never seen Resident #1 in pain like that.

An interview was conducted on 5/05/25 at 1:49 pm with NA #4 who revealed she was not assigned to Resident #1 on 4/25/25 but she knew the resident well. NA #4 stated she did see the Contracted Transport Driver pushing Resident #1 down the hall in her wheelchair on 4/25/25 and she stated Resident #1 was sitting "slumped down", unable to sit upright in the chair with her lower body close to the front edge of the wheelchair and her neck resting on the back of the chair. She reported Resident #1 appeared to be upset and in pain because of the way she was sitting in the wheelchair and the way Resident #1 looked at her when they went by. NA #4 stated she tried to speak to Resident #1 and ask what was wrong but the Contracted Transport Driver continued to push the wheelchair down the hall without stopping.

During an interview on 5/05/25 at 1:50 pm with NA #1 she revealed that she was working on 4/25/25 when Resident #1 returned from dialysis. NA #1 stated the Contracted Transport Driver came to the nursing station desk and he reported that Resident #1 had been "crying like this and was not feeling good". She stated Resident #1 was visibly upset and when she was back in her room Resident #1 reported that the Contracted Transport Driver did not put her wheelchair in the van right and that her wheelchair tipped back and she had hit her head and back. NA #1 stated Resident #1 was crying saying she was in so much pain so she immediately told Nurse #2 who

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came right down to Resident #1's room.

An interview was conducted on 5/08/25 at 12:34 pm with the Physician who revealed he had been the medical provider for Resident #1 for over 3 years at the facility. He stated Resident #1 had some diffuse left hip pain prior to the 4/25/25 incident with occasional use of opioid pain medication. The Physician stated Resident #1 was "very sharp and alert" and he would see her 2-3 times per week at the facility to manage her chronic and acute illnesses. He stated Resident #1 was normally very clear in her cognition and speech and she was a reliable source of information.

A follow-up interview was conducted with the DON on 5/08/25 at 1:15 pm who revealed the Contracted Transport Driver should have checked to make sure Resident #1's wheelchair was secured as required before he left the dialysis center.

During an interview on 5/05/25 at 2:29 pm with the Administrator she revealed she had initiated an investigation into the incident for Resident #1 and confirmed that the incident did occur and that it was with the Contracted Transportation Company's van and driver. The Administrator stated the Contracted Transport Driver was responsible to ensure Resident #1's wheelchair was secured to the van floor prior to driving.

On 5/05/25 at 4:51 pm the Administrator was notified of immediate jeopardy.

The facility provided the following Immediate Jeopardy removal plan:

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

The Contracted Transport Driver failed to safely secure Resident #1's wheelchair to the floor of the Contracted Transportation Van. On 4/25/25 at 5:30 pm Resident #1 reported to Nurse #2 that her back was hurting and stated that her wheelchair flipped back in the transportation van, the driver forgot to lock her wheelchair down, and she bumped her head.

Nurse #2 went directly to evaluate Resident #1 and identified that the resident was tearful and reported pain.

Nurse #2 completed a neurological assessment of Resident #1, which was normal. Resident #1 was given Tramadol for pain at 5:45 p.m. for pain.

Nurse #2 contacted the primary Medical Doctor (MD) for Resident #1 to report the resident complained of pain in her back, neck, and shoulder. The MD provided an order to transport Resident #1 to the Emergency Department (ED) for evaluation. Nurse #2 called Emergency Medical Services (EMS) for transportation to the ED and Resident #1 left for the ED at 6:45 pm. Nurse #2 contacted the Responsible Party (RP) to report the incident that occurred in the contracted van, the resident report of pain and the MD order to transport the resident to the ED.

Resident #1 remained in the hospital undergoing a CT Scan on 4/25/25 with negative results for acute diagnosis. Due to continued complaints of pain at the hospital, the hospital completed an MRI on 4/29/25 which identified a lumbar 1

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fracture.

The Health Information Management (HIM) Director contacted the Contracted Transportation Company Owner on 4/25/25 at approximately 5:45pm to report the Resident #1's allegation that the Contracted Transport Driver failed to secure the wheelchair and Resident #1 stated her wheelchair flipped back and she hit her head. On 4/25/25 the Contracted Transportation Company Owner provided a statement to the facility in an email from the Contracted Transportation Company Owner. The email from the Contracted Transportation Company Owner described an interview that the Contracted Transportation Company Owner had with the Contracted Transport Driver following the incident on 4/25/25 with Resident #1. The email stated that the Contracted Transport Driver confirmed he did not secure Resident #1's wheelchair to the floor. Per the Contracted Transportation Company Owner, the Contracted Transport Driver reported that Resident #1's wheelchair tilted backwards causing her to fall and hit her head and back. The Contracted Driver reported he immediately stopped, asked Resident #1 if she was OK, sat her chair upright, secured her properly and returned her to the facility. The Contracted Transport Driver stated Resident #1 reported to him that she was OK. Per the Contracted Transportation Company Owner, the Contracted Transport Driver did not follow the policy by not securing a passenger. The Contracted Transportation Company Owner reported that the Contracted Transport Driver was terminated due to gross negligence and is ineligible for rehire.

On 5/6/2025 the HIM Director identified all residents who have been transported by all

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transportation providers within the last 30 days using the facility transportation calendar. The Social Worker will identify alert and oriented residents on this list using the Brief Interview for Mental Status (BIMS) score of 10 and above. Social Services will interview alert and oriented residents to identify any incident where the transport driver failed to safely secure the wheelchair in the transportation van. These interviews will be completed on 5/6/25 and the results will be reported to the facility Administrator and/or the facility Director of Nursing (DON). The facility will complete an investigation for any concerns that are identified and take appropriate follow-up action based upon the results of the investigation. The Administrator will assume responsibility to ensure the investigation and follow-up are completed.
The facility licensed nurses will complete a Skin Note and Pain Assessment for all residents with a BIMS of less than 10 who have had transportation in the last 7 days to identify potential injury which may have occurred during transportation. Results of the Skin Note and Pain Assessment will be completed on 5/6/25 and the results will be reported to the Administrator and/or the DON. The facility will complete an investigation for any concerns that are identified and take appropriate follow-up action based upon the results of the investigation. The Administrator will assume responsibility to ensure the investigation and follow-up are completed.

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:

The facility will have effective systems in place for

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safe transportation.

The facility ceased use of the outside vendor who was responsible for transportation of Resident #1 as of 5/5/25. The facility has one additional outside vendor utilized for appointment transportation.

The Administrator spoke with the Contracted Transportation Company Owner regarding the need for education and documentation on 5/6/25. The Transportation Vendor who will be utilized for appointment transportation will provide competency training for all contract transport drivers who transport residents from the facility starting on 5/6/25. Training will be provided by the Contract Transportation Vendor Supervisors using the manufacturer's instructional Training Video and will include a return demonstration of safely securing a wheelchair. Effective 5/6/25 all contracted transport drivers this Transportation Vendor sends to the facility will have this training completed prior to being assigned transportation trips for the facility residents. Training documentation will be provided to the Administrator by the Contracted Transportation Company Owner or Designee to be maintained at the facility. Newly hired contract transport drivers for this vendor will be provided this training by the Contracted Transportation Company Owner or Designee prior to being assigned transportation trips for the facility residents, including a return demonstration of safely securing a wheelchair.

On 5/6/25 100% of the facility's transport drivers will receive competency training related to securing wheelchairs in the van. The facility's transport driver training was provided by the facility Maintenance Director on 5/6/25. Training

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uses the manufacturer's instructions and includes a return demonstration of safely securing a wheelchair.
Newly hired facility transportation drivers will be provided this training and include a return demonstration of safely securing a wheelchair, prior to being scheduled to provide transportation trips, provided by the Maintenance Director.

Alleged date of immediate jeopardy removal: 5/07/25.

Onsite validation of the immediate jeopardy removal plan was completed as follows:

Interviews were conducted on 5/06/25 and 5/08/25 with multiple residents who utilized transportation services with no reported problems or concerns regarding the safety of transportation services.

Review of the facility audit documentation revealed interviews were conducted with those residents who had a BIMS of 10 and up and utilized transportation in the last 30 days and a skin/pain assessments was completed for residents with a BIMS of less than 10 for the last 7 days. No concerns were identified.

The Administrator verified that effective 5/05/25 the facility ceased use of the vendor for the company that provided transportation for Resident #1 on 4/25/25.

Review of the facility education materials and sign-in sheets were reviewed to confirm that education was provided to all facility staff who provided resident transportation. The facility transportation staff were educated by the

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Maintenance Director regarding manufacturer guidelines for securing a resident for transportation and included a return demonstration of securing a wheelchair. Newly hired facility transportation drivers will be provided the educational video which will include a return demonstration of safely securing a wheelchair, prior to being scheduled to provide transportation trips, and will be provided by the Maintenance Director.

The facility provided the contracted transportation company's education documentation for review. The documentation revealed that all staff at both service locations had completed video and written education on safely securing a wheelchair when transporting residents on 5/06/25. The education included a manufacturer instructional video on how to properly secure a resident wheelchair to the van floor and a return demonstration. The education was verified by sign-in sheets. Newly hired contract transport drivers for this vendor will be provided this training by the Contracted Transportation Company Owner or Designee prior to being assigned transportation trips for the facility residents, including a return demonstration of safely securing a wheelchair.

The Administrator confirmed this was the only contracted transportation company the facility currently used for transportation effective 5/05/25.

Interviews were conducted on 5/08/25 with transportation drivers and the Maintenance Director to confirm the education was provided and the return demonstration was completed.

The facility's immediate jeopardy removal date of 5/07/25 was validated.

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