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F 000	INITIAL COMMENTS A complaint investigation was conducted from 6/24/25 to 6/26/25. Event ID #IIBG11. The following intake was investigated NC00228080. Intake NC00228080 resulted in immediate jeopardy. Past-noncompliance was identified at: 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 F684 and F689 constituted Substandard Quality of Care. Non-compliance began on 6/05/25. Immediate jeopardy was removed and the facility came back in compliance effective 6/06/25. A partial extended survey was conducted.	F 000		
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, observation, and	F 684	Past noncompliance: no plan of	

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

Electronically Signed | 07/10/2025

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interviews with staff, resident, and the physician, the facility failed to have Resident #1 assessed for injury by a qualified professional prior to moving the resident following a fall in the transportation van. On 6/05/25 when Transportation Driver #1 made an abrupt stop to avoid a collision, Resident #1 slid out of her wheelchair and her left foot wedged under the driver's seat. Transportation Driver #1 stopped the van to check on the resident, she pulled the resident's left foot out from under the driver's seat, repositioned Resident #1 in her wheelchair, and then continued to the hospital for the resident's appointment. Upon arrival at the hospital, the resident had again slid out of the wheelchair, her back was against the legs of the wheelchair, and the rest of her body was on the floor of the van. The resident's ankle was visibly swollen and she was in pain. Hospital staff instructed Transportation Driver #1 to take the resident to the Emergency Department (ED). The resident was identified with a nondisplaced trimalleolar fracture of the left ankle (involves a fracture of three parts of the ankle). There was a high likelihood of further injury from moving a resident after a fall prior to a clinical assessment of injury. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 2/11/25 with diagnoses which included stroke with right sided hemiparesis (weakness on one side of the body), end stage renal disease with dependence on dialysis, anxiety and depression.

The Minimum Data Set (MDS) quarterly assessment dated 5/07/25 revealed Resident #1

correction required.

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was cognitively intact. Resident #1 was assessed as having upper and lower extremities impairment on one side and she was dependent upon staff for transfers and wheelchair mobility.

An Incident/Accident Event report completed by the Director of Nursing (DON) dated 6/05/25 revealed Resident #1 was out to an appointment when the brakes on the van were put on suddenly to avoid an accident. The resident was taken to the Emergency Room (ER) due to ankle swelling and was diagnosed with a left ankle fracture.

An undated statement completed by Transportation Driver #1 revealed on 6/05/25 while transporting Resident #1 she had to swerve and slam on her brakes to avoid a collision. She indicated she was looking in the mirror and heard Resident #1 say "my foot", noted that the resident had slid down in the wheelchair. Transportation Driver #1 indicated she noticed Resident #1's foot was "cramped up" under the driver's seat. She went to back of the van, undid Resident #1's straps, and took the seatbelt off of the resident to readjust. Transportation Driver #1 pulled the resident up in the wheelchair by getting behind the resident and pulling her up with her arms. She strapped Resident #1's chair back in, replaced the resident's seatbelt and continued to drive. When they arrived at the hospital Transportation Driver #1 noted that the resident had slid down again but was too far down in her chair for her (Transportation Driver #1) to pull her back up. Transportation Driver #1 called the Administrator and made her aware of the situation. Transportation Driver #1 lowered the resident to the ground and then went into the building and asked for assistance. Hospital staff provided a sling to get Resident #1 back into the

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chair. Registration staff at the hospital stated that the resident should go to the ER for imaging. Transportation Driver #1 and hospital staff took the resident to the ER.

An interview was conducted with Transportation Driver #1 on 6/24/25 at 1:31 PM. Transportation Driver #1 stated that she was driving Resident #1 to an appointment on 6/05/25 when a car flew in front of her, slammed on their brakes and she slammed hard on her brakes to avoid hitting the other car. She revealed she could not see Resident #1 in her rear-view mirror, so she stopped the van at the exit ramp to check on the resident. She observed Resident #1 had slid down in her wheelchair, the seat belt was above her chest and across her neck. She reported the resident was yelling "my foot, my foot" when she saw her foot was caught up under the driver's seat. Transportation Driver #1 stated she pulled the resident's foot out from under the driver's seat then unstrapped the seatbelt, unsecured the tie down straps to move the wheelchair back so she could put her arms under the resident's arms and pulled the resident back into the wheelchair. She indicated she made sure the wheelchair was secured, fastened the resident's seatbelt and continued to the appointment as they were approximately one mile from the hospital. When they arrived at the hospital Transportation Driver #1 noted that the resident had slid down again, her back was against the legs of the wheelchair and the rest of her body was on the floor of the van. Transportation Driver #1 lowered Resident #1 to the ground and went into the hospital's colonoscopy facility to request help with repositioning the resident. She revealed the hospital staff assisted Resident #1 back into her wheelchair and told her the resident needed go to

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the ER for x-rays. Transportation Driver #1 indicated she called the Administrator and made her aware of the situation. She reported the Administrator told her to take Resident #1 to the ER and not her appointment. Transportation Driver #1 revealed she was a Nursing Assistant (NA) and Medication Assistant (MA). She stated she had no training on what to do in a driving emergency. She revealed the incident happened so fast, she forgot her NA training and wanted to find help for the Resident, so she drove on to the colonoscopy appointment at the hospital.

The ER documentation dated 6/5/25 indicated Resident #1 slipped out of her wheelchair when the driver had to slam on the breaks. Her left ankle became wedged under the seat in front of her resulting in left ankle swelling and pain. X-rays demonstrated a non-displaced trimalleolar fracture. Orthopedics reviewed images and recommended a posterior splint with ankle stirrups due to the fracture being non-displaced and the resident being non-ambulatory. She was noted with severe pain and was given a dose of liquid oxycodone (opioid pain medication) to help with pain control. The discharge instructions indicated the splint was to be kept on and dry until evaluated by orthopedics and the resident's leg was to be elevated for swelling. Ice was to be applied over the splint material for 15 to 20 minutes at a time 6 times daily. Resident #1 could continue her regularly prescribed acetaminophen and a prescription for oxycodone was given to take every 6 hours as needed (PRN) for severe breakthrough pain symptoms. The resident was discharged back to the facility the same day (6/5/25).

An interview and observation of Resident #1 was

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conducted on 6/24/25 at 10:44 AM. Resident #1 verified on 6/05/25, enroute to an appointment at the hospital she slid out of her wheelchair and her left foot was wedged under the driver's seat. Resident #1 stated when Transportation Driver #1 stopped the van and came to her she was screaming due to the intense pain in her foot and her foot was swollen. She reported the Transportation Driver pulled her foot out, got behind her and pulled her up into her wheelchair. Resident #1 indicated they were at the highway exit ramp to the hospital at the time of the incident so Transportation Driver #1 drove on to the appointment. Resident #1 stated when they stopped at the colonoscopy location at the hospital, she had slid down in the wheelchair again and her buttocks was resting on the footrests. She stated her foot was swollen, she was "in a lot of pain and could not feel her left foot". Resident #1 indicated Transportation Driver #1 ran inside the hospital and came out with hospital staff who put her (Resident #1) into the wheelchair and one of the staff took her to the emergency department. Resident #1 reported her leg was X-rayed and she learned her ankle was broken and had a splint placed on her lower leg. She was observed with the splint in place.

In an interview on 6/24/25 at 2:00 PM the Administrator stated Transportation Driver #1 called on 6/05/25 to notify her of the van incident. Transportation Driver #1 reported Resident #1 had a swollen ankle, wanted to continue to her colonoscopy appointment and the Administrator instructed Transportation Driver #1 to take the resident to the ER for evaluation. During their phone conversation on 6/05/25 the Administrator reported she instructed Transportation Driver #1 anytime she was involved in a motor vehicle

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accident or an emergency to call 911 and herself (the Administrator) immediately. She stated Transportation Driver #1 should have called the facility first to notify them of the van incident and report if Resident #1 had any pain or injuries.

In an interview conducted on 6/24/25 at 4:10 PM the Physician stated the Director of Nursing (DON) called him on 6/05/25 to notify him that Resident #1 was in a van incident and had a broken ankle. 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.

On 6/24/25 at 5:02 pm the Administrator was notified of immediate jeopardy.

The facility provided the following corrective action plan:

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

On June 5, 2025, at approximately 9:00 AM, Resident #1 was being transported by Transportation Driver #1 to a scheduled medical appointment. During the trip, Transportation Driver #1 made a sudden stop due to a vehicle in front abruptly braking. As a result, Resident #1, who was seated in a wheelchair, slid forward and landed on the footrests of the wheelchair. Resident #1's left foot lodged under the driver's seat. Her left foot twisted inward, resulting in a fracture of the left ankle.

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Transportation Driver #1 immediately pulled the van over to a safe location, entered the back of the van through the side door, and repositioned Resident #1. Transportation Driver #1 failed to have resident assessed by a qualified professional prior to moving the resident. Transportation Driver #1 ensured the wheelchair was locked, secure, and that the seatbelt was fastened. Resident #1 stated she felt fine but did have some foot/ankle pain, but she requested that the trip to the appointment continue. Transportation Driver #1 did not contact the facility to inform of the incident at this time.

Upon arrival at the appointment, Transportation Driver #1 identified that Resident #1 had slid down in the wheelchair in a squatting position on the footrests of the wheelchair. Transportation Driver #1 unsecured Resident #1 from the seatbelt and lowered Resident #1 to a safe position onto the floor of the van.

Transportation Driver #1 and two on-site hospital staff members lifted Resident #1 back into the wheelchair. Resident #1 was transferred via wheelchair to the emergency room, where she was diagnosed with a trimalleolar fracture of the left ankle. Transportation Driver #1 did not contact the facility about the incident until Resident #1 was at the hospital when she was being assessed in the Emergency Room.

On June 5, 2025, at approximately 11:00 AM, the Director of Nursing arrived at the Emergency Room to assist with Resident #1's return to the facility.

On June 5, 2025, the Administrator placed Transportation Driver #1 on administrative leave

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pending re-education and return-to-duty competency checks.

An ad hoc Quality Assurance and Performance Improvement (QAPI) was held on June 5th 2025 to discuss deficient practice and implement a plan of correction with monitoring tools. In attendance were the Administrator, Regional Operations Manager, Maintenance Director, Director of Nursing, Marketing and Admissions Coordinator, and Transportation Driver #2. It was determined the root cause analysis for the deficient practice was Transportation Driver #1 did not call the facility to report the incident and therefore Resident #1 was not assessed before Transportation Driver #1 moved the resident and resumed the drive to the appointment. Transportation Driver #1 should have immediately notified the facility of the incident and waited with the resident for a facility nurse or the Emergency Medical Services (EMS) to assess the resident before resuming the transfer. Transportation Driver #1 should not have moved Resident #1 before she was assessed.

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

On June 5, 2025, an audit was completed by the Administrator and Regional Operations Manager of all alert and oriented residents for the past 30 days that were transferred by the facility to determine if there were any falls during transport. No new issues were identified. The audit included the following:
- Review of the medical record to ensure there were no falls during transport.
- Interviews with all transportation drivers to

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ensure there were no unreported falls during transport.

On June 5, 2025, the Unit Manager performed skin checks on any non-alert and oriented residents that were transported to appointment in the past 30 days. Reviews indicated no issues related to transport.

On June 5, 2025, the Regional Operations manager interviewed all van drivers to determine if any other van incidents, falls, or accidents had occurred ever. No other incidents, falls, or accidents were reported.

The facility does not utilize outside transportation services.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On June 5, 2025, the Administrator and Maintenance Director provided education to the transportation drivers on the following:
- If the facility van is involved in any type of incident the driver should pull over immediately to a safe place and call the facility to inform them of what happened.
- They were instructed to wait until a nurse or EMS could assess the resident before moving the resident. Only trained staff can transfer residents.

Transport drivers had to complete a post-test and pass after the education was received before they could transport residents.

On June 5, 2025, the Administrator was informed by the Regional Operator that the above

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education will be added to the New Hire orientation for Transportation Drivers and they will not be allowed to work until education has been completed.

Indicate how the facility plans to monitor its performance to make sure solutions are sustained:

Beginning June 5, 2025, the Maintenance Director or designee will conduct ride-along audits to ensure if there is any incident of a resident falling or sliding out of the wheelchair in the van that the driver pulls over immediately, contacts the facility, and waits on staff or EMS to arrive before moving the resident with five residents per week for 3 weeks then 3 resident ride-along audits per week for 3 weeks, and then one resident ride along audit per week for 3 weeks.

As of June 5th 2025, it was determined all findings will be reviewed and reported to the facility's QAPI committee monthly for a period of three months by the Administrator. Any concerns identified will be addressed promptly with corrective actions and follow-up education as needed.

Alleged Date of Immediate Jeopardy Removal and Compliance: 6/6/2025

The corrective action plan was validated onsite on 6/26/25. Interviews with alert and oriented residents transported by the facility in the past 30 days did not reveal any concerns with their transportation. Review of staff education materials and sign-in sheets for the education were reviewed to determine that education was

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F 684	Continued From page 11 provided to all transportation drivers, if involved in any accident, to include wait until a nurse or EMS could assess the resident before moving the resident. Review of the facility documents revealed initial audits and ongoing ride-along monitoring audits were done per the facility's corrective action plan. Interviews were conducted with the transport drivers who confirmed they received education and completed a post-test regarding if involved in any accident to pull over safely, call the facility and wait until a nurse or EMS could assess the resident before moving the resident. The 6/06/25 immediate jeopardy removal date and compliance date 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, observation, and interviews with staff, resident, and the Physician, the facility failed to ensure a resident was safely secured in accordance with the manufacturer's instructions in the facility transportation van during a trip to a medical appointment at the hospital. On 6/05/25 when Transportation Driver #1 made an abrupt stop to avoid a collision Resident #1 slid out of her wheelchair and her left foot wedged under the driver's seat. Transportation Driver #1 stopped the van to	F 689	Past noncompliance: no plan of correction required.	

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check on the resident, she pulled the resident's left foot out from under the driver's seat, repositioned Resident #1 in her wheelchair, and then continued to the hospital for the resident's appointment. On arrival at the hospital, Resident #1 had again slid out of the wheelchair, her back was against the legs of the wheelchair, and the rest of her body was on the floor of the van. She was taken to the Emergency Department (ED) and identified with a nondisplaced trimalleolar fracture of the left ankle (involves a fracture of three parts of the ankle). Her ankle was swollen, she required a splint, and she suffered pain rated up to a 10 (on a scale of 0-10 with 10 being the worst pain possible) requiring opioid medication for pain management. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident # 1).

The findings included:

The transportation van's manufacturer's instructions for securing the passenger indicated the following information:
- The lap belts utilize integrated stiffeners to feed belts through openings between seat backs and bottoms and/or armrests to ensure proper fit around the occupant. The lap belt attaches to the rear tie down pin connector (attached into the floor anchors to secure the wheelchair) ensuring the buckle rests on the passenger's hip.
- The shoulder belt extends over the passenger's shoulder and across the upper torso, and fastens to the lap belt via a pin connector.
- Ensure belts are adjusted as firmly as possible, but consistent with user comfort.

The manufacturer's instructions also included the following warnings:

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- Lap and shoulder belt should not be held away from passenger's body by wheelchair components or parts such as the wheelchair's wheels, armrests, panels or frame.
- Occupants belts should always bear upon the bony structure of the passenger's body and be worn low across the front of the pelvis, with the junction between lap and shoulder belts located near passenger's hip.

Resident #1 was admitted to the facility on 2/11/25 with diagnoses which included stroke with right sided hemiparesis (weakness on one side of the body), end stage renal disease with dependence on dialysis, anxiety and depression.

The Minimum Data Set (MDS) quarterly assessment dated 5/07/25 revealed Resident #1 was cognitively intact. Resident #1 was assessed as having upper and lower extremities impairment on one side and she was dependent upon staff for transfers and wheelchair mobility. Resident #1 had no pain.

An Incident/Accident Event report completed by the Director of Nursing (DON) dated 6/05/25 revealed Resident #1 was out to an appointment when the brakes on the van were put on suddenly to avoid an accident. The resident was taken to the Emergency Room (ER) due to ankle swelling and was diagnosed with a left ankle fracture.

An undated statement completed by Transportation Driver #1 revealed on 6/05/25 she escorted Resident #1 into the facility van for transport. Transportation Driver #1 noted that Resident #1 rests her foot on top of footrest instead of placing her foot correctly on the footrest of wheelchair. She indicated all straps

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were in place and tightened, with Resident #1's seat belt in place correctly. On the highway a car came off the exit and slammed on the brakes in front of the facility van, cutting Transportation Driver #1 off who had to swerve and slam on her brakes to avoid a collision. Transportation Driver #1 was looking in mirror and heard Resident #1 say "my foot", noted that the resident had slid down in the wheelchair, but was still in wheelchair. Transportation Driver #1 indicated she noticed Resident #1's foot was "cramped up" under the driver's seat. She went to back of the van, undid Resident #1's straps, and took the seatbelt off of the resident to readjust. Transportation Driver #1 pulled the resident up in the wheelchair by getting behind the resident and pulling her up with her arms. She strapped Resident #1's chair back in, replaced the resident's seatbelt and continued to drive. When they arrived at the hospital Transportation Driver #1 noted that the resident had slid down again but was too far down in her chair for her (Transportation Driver #1) to pull her back up. Transportation Driver #1 called the Administrator and made her aware of the situation. Transportation Driver #1 lowered the resident to the ground by standing behind the resident and pushed the wheelchair out of the way. Transportation Driver #1 went into the building and asked for assistance and someone arrived to assist, but they needed another person to assist with getting Resident #1 back into the chair. Hospital staff called for another set of hands for assistance. Hospital staff provided a sling for getting Resident #1 back into the chair. The hospital staff took Resident #1 into the building with the help of Transportation Driver #1 and then Transportation Driver #1 left to go park the van. Resident #1 stayed with hospital staff while

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Transportation Driver #1 parked. Registration staff at the hospital stated that the resident should go to the ER for imaging and reschedule appointment for colonoscopy. Transportation Driver #1 and hospital staff took the resident to the ER.

An interview was conducted with Transportation Driver #1 on 6/24/25 at 1:31 PM. Transportation Driver #1 stated that she was driving Resident #1 to an appointment on 6/05/25 when a car flew in front of her, slammed on their brakes and she slammed hard on her brakes to avoid hitting the other car. She revealed she could not see Resident #1 in her rear-view mirror, so she stopped the van at the exit ramp to check on the resident. She observed Resident #1 had slid down in her wheelchair, the seat belt was above her chest and across her neck. She reported the resident was yelling "my foot, my foot" when she saw her foot was caught up under the driver's seat. Transportation Driver #1 stated she pulled the resident's foot out from under the driver's seat then unstrapped the seatbelt, unsecured the tie down straps to move the wheelchair back so she had room to put her arms under the resident's arms and pulled the resident back into the wheelchair. She indicated she made sure the wheelchair was secured, fastened the resident's seatbelt and continued to the appointment as they were approximately one mile from the hospital. Transportation Driver #1 reported when she arrived at the hospital for Resident #1's colonoscopy appointment, Resident #1 had slid down in her wheelchair again. Resident #1 had her back against the legs of the wheelchair and the rest of her body was on the floor of the van with the seat belt above her chest and across her

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neck. Transportation Driver #1 indicated she removed the seatbelt, unsecured the wheelchair and moved the wheelchair backwards so she had room to lower Resident #1 to the floor of the van and went into the hospital's colonoscopy facility to request help with repositioning the resident. Two hospital staff helped the resident back up into wheelchair and one staff member took her into the colonoscopy appointment, while she (Transportation Driver #1) went to park the facility van and called the Administrator. Transportation Driver #1 reported when she called the facility the Administrator told her to take Resident #1 to the ER.

The ER documentation dated 6/5/25 indicated Resident #1 slipped out of her wheelchair when the driver had to slam on the breaks. Her left ankle became wedged under the seat in front of her resulting in left ankle swelling and pain. X-rays demonstrated a non-displaced trimalleolar fracture. Orthopedics reviewed images and recommended a posterior splint with ankle stirrups due to the fracture being non-displaced and the resident being non-ambulatory. She was noted with severe pain and was given a dose of liquid oxycodone (opioid pain medication) to help with pain control. The discharge instructions indicated the splint was to be kept on and dry until evaluated by orthopedics and the resident's leg was to be elevated for swelling. Ice was to be applied over the splint material for 15 to 20 minutes at a time 6 times daily. Resident #1 could continue her regularly prescribed acetaminophen and a prescription for oxycodone was given to take every 6 hours as needed (PRN) for severe breakthrough pain symptoms.

A nursing progress note dated 6/05/25 at 6:10 PM

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written by Nurse #1 revealed Resident #1 returned from an appointment and was noted to have an ace bandage wrapped on the left ankle. Her ankle was fractured and she had a new order for oxycodone.

A phone interview was conducted on 6/24/25 at 12:53 PM with Nurse #1 who was assigned to Resident #1 on 6/05/25. Nurse #1 stated that Resident #1 was returned to her room by the DON who reported that Resident #1 had been in a van accident. The DON reported Resident #1 had been to the hospital and diagnosed with a broken ankle. Nurse #1 revealed Resident #1 had not been on any pain killers prior to that day and had returned from the ED with a prescription for oxycodone due to her ankle fracture.

Physician's orders for Resident #1 included the following:

- An active order (initiated on 2/19/25) for acetaminophen 325 mg; administer 2 tablets four times a day for pain.
- An order dated 6/05/25 for oxycodone 5 mg (milligrams) tablet; administer 1 tablet every 6 hours for pain PRN.
- An order dated 6/06/25 for ice and elevation to the left ankle every 6 hours and as needed as resident will allow.

Review of the Medication Administration Record for June 2025 revealed from 06/05/25 through 06/07/25 Resident #1 received PRN oxycodone 4 times. Resident #1's pain level varied going up to a pain rating of 10 between 6/05/25 through 6/07/25. The as needed oxycodone was discontinued on 6/09/25.

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The nursing progress note dated 6/12/25 at 6:10 PM written by the Administrator revealed Resident #1 returned from an orthopedic appointment with recommendations to maintain her splint for 4 weeks and return for follow up x-rays.

An interview and observation of Resident #1 was conducted on 6/24/25 at 10:44 AM. She revealed on 6/05/25 she was on the way to a colonoscopy appointment when Transportation Driver #1 was cut off in traffic and had to make a sudden stop to avoid hitting a car that braked in front of them. Resident #1 stated when Transportation Driver #1 stopped the van she slid out of her wheelchair onto the wheelchair's footrest, the seat belt was loose at her waist and her left foot was wedged under the driver's seat. Resident #1 stated the Transportation Driver had strapped her in the best she could and tied the seatbelt across her the best she could. Resident #1 stated when Transportation Driver #1 stopped the van and came to her she was screaming due to the intense pain in her foot and her foot was swollen. She reported the Transportation Driver pulled her foot out, got behind her and pulled her up into her wheelchair. Resident #1 indicated they were at the highway exit ramp to the hospital at the time of the incident so Transportation Driver #1 drove on to the appointment. Resident #1 stated when they stopped at the colonoscopy location at the hospital, she had slid down in the wheelchair again and her buttocks was resting on the footrests, and the seat belt was loose at her waist. She stated her foot was swollen, she was "in a lot of pain and could not feel her left foot". Resident #1 indicated Transportation Driver #1 ran inside the hospital and came out with hospital staff who put her (Resident #1) into the

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wheelchair and one of the staff took her to the emergency department. Resident #1 reported her leg was X-rayed and she learned her ankle was broken and had a splint placed on her lower leg. She was observed with the splint in place.

In an interview on 6/24/25 at 1:53 PM the Regional Operations Director revealed that on 6/05/25 Transportation Driver #1 had to slam on her brakes to avoid hitting a car that had cut her off. Transportation Driver #1 stopped the van to check on Resident #1 and noted the resident had slid down in her wheelchair and the resident's foot was caught up under the driver's seat. Transportation Driver #1 pulled the resident's foot out from underneath the driver's seat, unbuckled the seatbelt, repositioned the resident in her wheelchair, secured the wheelchair and fastened the seatbelt. The Regional Operations Director stated the accident happened due to Resident #1 not being strapped in securely per the manufacturer's guidelines.

A re-enactment was conducted on 6/24/25 at 2:08 PM in the transportation van with the Regional Operations Director and Maintenance Director to demonstrate how Resident #1 was able to slide out of the wheelchair on 06/05/25. The Regional Operations Director explained the accident happened due to Resident #1's wheelchair's armrest preventing Resident #1 from being strapped in securely per the manufacturer's instructions. The Regional Operations Director was seated in a wheelchair behind the driver's seat in the same location that Resident #1's wheelchair was positioned on 6/05/25. The Maintenance Director secured the wheelchair to the van floor following the manufacturer's instructions. He then demonstrated that the

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combination lap/shoulder belt was positioned over the wheelchair's arm on 06/05/25. This resulted in the lap belt not being firmly pressed against the resident's lap and allowing the resident to be able to slide out of the wheelchair's seat and her left foot getting wedged under the driver's seat.

On 6/26/25 at 11:00 AM Transportation Driver #2 explained in interview that the combination lap/shoulder belt should be latched under the wheelchair's armrest in order for the belt to firmly secure the resident.

In an interview on 6/24/25 at 2:00 PM the Administrator stated Transportation Driver #1 called to notify her of the van incident after colonoscopy hospital staff assisted Resident #1 into the hospital. The Administrator revealed Transportation Driver #1 reported that Resident #1 had slid under her seatbelt onto the floor of the van. She revealed during the reenactment they realized the wheelchair's armrest prevented the seat belt from correctly securing the resident.

An interview was conducted on 6/24/25 at 4:10 PM with the Physician. The Physician stated the DON called him on 6/05/25 to notify him that Resident #1 had a broken ankle with swelling and a new order for Oxycodone for pain.

On 6/24/25 at 5:02 pm the Administrator was notified of immediate jeopardy.

The facility provided the following corrective action plan:

Address how corrective action will be accomplished for those residents found to have

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been affected by the deficient practice:

The facility failed to safely secure Resident #1 per manufacturer's instructions in her wheelchair in the facility transport van. On June 5, 2025, at approximately 9:00 AM, Resident #1 was being transported by Transportation Driver #1 to a scheduled medical appointment. During the trip, Transportation Driver #1 made a sudden stop due to a vehicle in front abruptly braking. As a result, Resident #1, who was seated in a wheelchair, slid forward and landed on the footrests of the wheelchair. Resident #1's left foot lodged under the driver's seat. Her left foot twisted inward, resulting in an injury.

Transportation Driver #1 immediately pulled the van over to a safe location, entered the back of the van through the side door, and repositioned Resident #1 safely. Transportation Driver #1 ensured the wheelchair was locked, secure, and that the seatbelt was fastened. Resident #1 stated that she felt fine and requested that the trip to the appointment continue.

Upon arrival at the appointment, Transportation Driver #1 identified that Resident #1 had slid down in the wheelchair in a squatting position on the footrests of the wheelchair. Transportation Driver #1 unsecured Resident #1 from the seatbelt and lowered Resident #1 to a safe position onto the floor of the van.

Transportation Driver #1 and two on-site hospital staff members lifted Resident #1 back into the wheelchair. Resident #1 was transferred via wheelchair to the emergency room, where she was diagnosed with a trimalleolar fracture of the left ankle.

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At approximately 11:00 AM, the Director of Nursing arrived at the Emergency Room to assist with Resident #1's return to the facility.

On June 5, 2025, the Administrator placed Transportation Driver #1 on administrative leave pending re-education and return-to-duty competency checks.

An ad hoc Quality Assurance and Performance Improvement (QAPI) was held on June 5, 2025, to discuss deficient practice and implement a plan of correction with monitoring tools. In attendance were the Administrator, Regional Operations Manager, Maintenance Director, Director of Nursing, Marketing and Admissions Coordinator, and Transportation Driver #2. It was determined the root cause analysis for Resident #1 sliding out of the wheelchair was the transportation driver did not secure her in the wheelchair per the manufacturer's instructions.

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

On June 5, 2025, an audit was completed by the Administrator and Regional Operations Director of all alert and oriented residents for the past 30 days that were transferred by the facility to determine if there were any concerns with their transport. No new issues were identified. The audit included the following:
" Did your chair move during the transport?
" Did you feel unsafe or have a fall during transport?
" Did you have any concerns about your safety

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during transport?
On June 5, 2025, the Unit Manager performed skin checks and on any non-alert and oriented residents that were transported to appointments in the past 30 days. Reviews indicated no issues related to transport.

On June 5, 2025, the Regional Clinical Manager completed medical records reviews on any non-alert and oriented residents that were transported to appointments in the past 30 days. Reviews indicated no issues related to transport.

On June 5, 2025, all van drivers were interviewed to determine if any other van incidents, falls or accidents had occurred ever. No other incidents, falls, or accidents were reported.

The facility does not utilize outside transportation services.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On June 5, 2025, the Administrator and Regional Operations Director conducted immediate education with Driver #1 on the importance of ensuring the resident is properly secured in the van and not moving the van if the resident is not fully secure.

On June 5, 2025, the Administrator and Maintenance Director began re-educating all facility transportation drivers on transportation safety protocols including proper securement and not moving the van if the resident is not fully secure. This includes hands-on return demonstrations and a post-test. No driver was

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permitted to operate the transportation van until they successfully completed both components. On June 5, 2025, the Administrator was informed by the Regional Operator that the above education will be added to the New Hire orientation for Transportation Drivers and they will not be allowed to work until education has been completed.

Indicate how the facility plans to monitor its performance to make sure solutions are sustained:

Beginning June 5, 2025, the Maintenance Director or designee will conduct ride-along audits that include ensuring the resident is safely secured in the wheelchair per the manufacturer instructions before the van leaves the parking lot, they will also ensure the wheelchair does not move during transport with five residents per week for 3 weeks then 3 resident ride-along audits per week for 3 weeks, and then one resident ride-along audit per week for 3 weeks.

As of June 5, 2025, it was determined all findings will be reviewed and reported to the facility's QAPI committee monthly for a period of three months by the Administrator. Any concerns identified will be addressed promptly with corrective actions and follow-up education as needed.

Alleged Date of Immediate Jeopardy Removal and Compliance: 6/6/2025

The corrective action plan was validated onsite on 6/26/25. Review of staff education materials and sign-in sheets for the education were

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F 689	Continued From page 25 reviewed to determine that education was provided to all transportation drivers on safety protocols including proper securement and not moving the van if the resident is not fully secure. This included a hands-on return demonstration and a post-test. Review of the facility documents revealed initial audits and ongoing monitoring audits were done per the facility's corrective action plan. Interviews were conducted with the transport drivers who confirmed they received education regarding safety protocols and the proper use of the facility van seatbelt. Observations were conducted of transport staff connecting the securement system and properly securing a resident in a wheelchair. The 6/06/25 immediate jeopardy removal date and compliance date was validated.	F 689		