STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK CENTER FOR NURSING AND REHABILITATION	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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 An onsite complaint investigation survey was conducted from 05/21/24 through 05/23/24 and offsite on 5/24/24. The corrective action plan was validated onsite on 05/29/24. Therefore, the exit date was changed to 05/29/24. Event ID# RLGL11. Intake NC00217071 was investigated. Two of six complaint allegations were substantiated resulting in a deficiency. Intake NC00217071 resulted in immediate jeopardy. Immediate jeopardy 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 Immediate jeopardy began on 3/20/24 and was removed on 5/25/24. The tags F684 and F689 constituted substandard quality of care. A partial extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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 observations, record review, and staff,	F 684	Resident #1 is no longer residing at the	6/18/24

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

Electronically Signed | 06/18/2024

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F 684	Continued From page 1 Medical Director and Transportation Agent staff (Driver #1, Supervisor #1, Supervisor #2) interviews, the facility failed to have Resident #1 assessed by a medical professional before repositioning the resident after he was thrown forward out of his wheelchair while inside a contracted transportation van. On 03/20/24 Driver #1 for the Transportation Agent applied the van brakes suddenly to avoid a collision and Resident #1 slid out of his wheelchair onto the floor of the contracted transportation van. Driver #1 repositioned Resident #1 back into his wheelchair before the Resident was assessed by an emergency professional. Resident #1 complained of left knee pain 6 out of 10 (with 10 being the highest pain scale) and right foot pain, 10 out of 10 and was transferred to the hospital where he was diagnosed with an acute impacted oblique left femoral fracture (a break in the thighbone that occurs at an angle caused by direct trauma when the ends of the thighbone are jammed together) with edema (swelling) and bleeding around the left knee. This was for 1 of 3 residents reviewed for quality of care (Resident #1). Immediate jeopardy began on 3/20/24 when Resident #1 was repositioned into his wheelchair after a fall in the contracted transportation van without an assessment by a medical professional. Immediate jeopardy was removed on 5/25/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains 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 and monitoring systems put into place are effective.	F 684	facility. Residents who require transportation services for outside physician services have the potential to be affected by the deficient practice. On 5/23/24 the Director of Plant Operations educated the facility van driver and company-contracted van drivers to pull over, not move a resident if he/she slides down or falls out of their wheelchair, call 911, and wait for paramedics to assess the resident, as well as the risks of moving a resident prior to EMS arrival. The Director of Plant Operations provided the same education to the Maintenance Director on 6/11/24. Drivers will not be allowed to transport any resident until education has been received. Newly hired van drivers will be educated during orientation. The Director of Maintenance or designee will audit five residents a week for four weeks in the transport vehicle for proper securement and question the driver on the procedure should there be an accident/incident during transport. The administrator will review the plan and audits during the Quality Assurance committee meetings time two months and continue audits at the discretion of the committee. Completion date: 6/18/24	

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The findings included:

Resident #1 was admitted to the facility 10/5/23 with diagnoses that included end stage renal disease, dependence on hemodialysis, diabetes mellitus, type 2, atherosclerotic heart disease, osteopenia, spinal stenosis, cervical disc degeneration and cerebrovascular accident.

A 2/1/24 Transfer, Mobility Evaluation, assessed Resident #1 required the caregiver to perform 100% of the transfer task with the use of a mechanical lift because he was non-ambulatory, unable to stand, non-weight bearing and unable to sit at the bedside without full back and head support.

A 3/1/24 quarterly Minimum Data Set assessment indicated Resident #1 expressed himself with clear speech, made himself understood, understood others, moderately impaired cognition with no acute changes in mental status, and used a wheelchair for mobility. Pain was assessed as almost constant pain that frequently interfered with activities and rated 10 out of 10.

The facility's Appointment Schedule for 3/20/24, recorded Resident #1 had a 10:00 AM appointment. He was scheduled for transportation pick up at 9:30 AM on 3/20/24 by the Transportation Agent.

A written statement by Driver #1 for the Transportation Agent, dated 3/20/24, recorded that on 3/20/24 at approximately 12:40 PM, Driver #1 was transporting Resident #1 to the facility while during transport she had to make a quick stop to avoid a collision. Because of the sudden stop, Resident #1 slid under his seat belt and

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landed partially on the floor of the van. Driver #1 pulled into the nearest driveway, Resident #1 was frightened and asked Driver #1 to help him up. Supervisor #1 for the Transportation Agent advised Driver #1 to call 911 and not to try to move Resident #1. Driver #1 recorded that she called 911.

A 3/20/24 Emergency Medical Service (EMS) Report, recorded receipt of a call at 12:39 PM. EMS arrived on the scene at 12:55 PM, in response to injury from a fall for Resident #1. The EMS report documented once on the scene; Driver #1 directed EMS to Resident #1. The EMS Report recorded Resident #1 was alert to the event, person, place, and time, and he was found seated in a wheelchair. The Report recorded that to avoid a collision, Driver #1 slammed on the brakes and when this happened Resident #1 was thrown forward out of his wheelchair onto the floor. Resident #1 complained of left knee and right foot pain. Resident #1 complained his left knee was chronically painful, but he currently had increased pain. He reported his left knee pain was 6 out of 10 and his right foot was rated 10 out of 10. He was transported to the hospital at 1:19 PM on 3/20/24.

An incident report dated 3/20/24 at 1:00 PM, recorded by the Regional Nurse Consultant, recorded the facility received a call from the Transportation Agent who reported that Resident #1 slid out of his wheelchair during transport, Driver #1 stayed with the Resident but did not attempt to move the Resident and called 911 immediately.

A hospital History & Physical report dated 3/21/24 at 2:35 AM recorded Resident #1 presented for

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evaluation after he was riding in a wheelchair van when he tipped over, fell upon his left leg, and developed sudden severe left leg pain. Hospital x-ray results dated 3/21/24 revealed an acute impacted oblique left femoral fracture with swelling and bleeding around the left knee. A leg immobilizer was applied for non-surgical management due to a history of a blood clot in the same leg. Resident #1 discharged back to the facility on 3/27/24.

Driver #1 for the Transportation Agent was interviewed via phone on 5/22/24 at 10:05 AM with Supervisor #1. During the interview, Driver #1 stated that on 3/20/24 she transported Resident #1 to an appointment and on the way back to the facility suddenly a car cut right in front of the van such that she had to hit her brakes to keep from running into the car. Driver #1 continued that when she hit the brakes Resident #1 slid forward. She immediately pulled over into the parking lot of a restaurant not more than 200 feet away and Resident #1 kept repeating, "I need to get up."

The interview with Driver #1 on 5/22/24 at 10:10 AM continued in person and included an observation of the securement system on the contracted transportation van. During the observation and continued interview, Driver #1 stated that when she applied brakes, Resident #1 did not hit anything and that he did not come out of the wheelchair onto the floor.

During a follow up phone interview with Driver #1 on 5/22/24 at 12:06 PM with the Administrator and Regional Nurse Consultant present in person, Driver #1 stated that Resident #1's bottom moved out of the wheelchair and hung

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partially off the seat, while the top of his body was held in the wheelchair by the restraint. Driver #1 stated Resident #1 repeated "pull me up, pull me up" and said he was in pain. Driver #1 stated she called her Supervisor (Supervisor #1, Vice President) who advised Driver #1 to call 911 and not to move Resident #1. Driver #1 stated she called 911 and then positioned Resident #1 back into his wheelchair. Driver #1 described that she reached her arms under the arms of Resident #1 and pulled his bottom back into to the chair. Driver #1 stated she positioned his bottom back into the wheelchair because he kept asking her to pull him up. Driver #1 described that Resident #1 was in a "panic state" and stated that his bottom hung off the seat of the wheelchair. Driver #1 stated "I called my supervisor and he said to call 911 and not to move him, but I did move him because he was in a panic state and complained of pain and I did not know how long it was going to take medic {paramedics} to get there, I did not want him yelling in pain that whole time." Driver #1 stated that when EMS arrived Resident #1 was not in the same position he was in at the time of the accident and that she told the facility and Supervisor #1 that she did not move him. Driver #1 denied that Resident #1 was thrown out of his wheelchair to the floor of the contracted transportation van.

A phone interview occurred on 5/22/24 at 8:41 AM with Supervisor #1 (Vice President) of the Transportation Agent. Supervisor #1 stated that Driver #1 called him on 3/20/24 after the van accident to let him know someone pulled out in front of the van, she had to brake quickly, when she did, Resident #1 slid forward in his wheelchair, he complained of pain, and she was unable to pull him up. Supervisor #1 said he told

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Driver #1 not to move Resident #1, but to call 911. Supervisor #1 said he contacted the facility, told the Administrator and Regional Nurse Consultant about the accident, that Resident #1 complained of pain, but that he told Driver #1 not to move Resident #1, but to call 911.

A follow up phone interview occurred on 5/23/24 at 8:43 AM with Supervisor #1 (Vice President) who asked Supervisor #2 (President) of the Transportation Agent to join the call. During the interview, Supervisor #1 stated that Driver #1 called him to notify of the accident and that he provided instructions not to move the Resident but to call 911. Supervisor #1 and Supervisor #2 both stated they were not aware that Driver #1 moved the Resident before EMS arrived. Supervisor #1 stated, "That was not the training she received" and that moving a Resident could cause further injury.

The Administrator and the Regional Nurse Consultant were both interviewed on 5/21/24 at 12:54 PM. The Regional Nurse Consultant stated that on 3/20/24 in the afternoon, the facility received a call from Supervisor #1 of the Transportation Agent. Supervisor #1 informed the facility that there was an incident with the contracted transportation van, someone pulled out in front of Driver #1 and when she applied her brakes Resident #1 slid down in his wheelchair. Supervisor #1 stated that Driver #1 pulled over immediately, she did not touch the resident and she called 911.

During a follow up interview with the Administrator and Regional Nurse Consultant on 5/22/24 at 12:06 PM, the Regional Nurse Consultant stated that Driver #1 did not report that she moved the

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F 684	Continued From page 7	F 684		

Resident but that she left him in place until EMS arrived. The Regional Nurse Consultant stated that the facility was not aware that Resident #1 was moved by Driver #1 before EMS arrived and that moving a Resident involved in a car accident if you are not clinically trained could cause further injury. The Regional Nurse Consultant further stated if Driver #1 had called the facility, she would have asked questions to assess the situation and given Driver #1 further instruction based on the situation.

During an interview on 5/22/24 at 12:30 PM the Medical Director stated that he was not aware that Driver #1 moved Resident #1 before EMS arrived to assess him. He stated that Resident #1 should have remained in place to avoid the risk of further injury until EMS arrived to assess Resident #1.

The Administrator was notified of immediate jeopardy on 5/23/24 at 3:15 PM.

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 3/20/24, Resident #1 was being transported back to the facility from dialysis appointment when the contracted Driver #1 quickly stepped on the brakes to avoid hitting a car that pulled out in front of her. Driver #1 pulled over at a safe location to check on the resident. At that time, Driver #1 observed that Resident #1's bottom slid to the edge of his wheelchair, he had a lap restraint that was positioned across his chest,

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both arms were positioned on the armrests, and both feet were off the footrests and his left leg bent. Resident #1 complained of pain to Driver #1. Resident #1 asked Driver #1 to reposition him back into his wheelchair. Driver #1 called her supervisor and received instruction not to move Resident #1, but to call 911. Driver #1 called 911 and then repositioned Resident #1 back into his wheelchair before paramedics arrived. When paramedics arrived, he expressed left knee pain that he rated 6 out of 10, and right ankle pain he rated 10 out of 10. Resident #1 was transferred to the emergency department for further evaluation and diagnosed with an acute left femoral fracture with soft tissue edema and bleeding around the left knee.

Residents who require transportation services for outside physician services have the potential to be affected as a result of the lack of a full assessment for injury by Paramedics before a resident is moved does not allow for a thorough assessment of injury and places the resident at risk for further injury.

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.

To ensure no other residents are affected, the involved contracted transportation company contract was terminated on 5/23/24 in writing by the facility administrator. Driver #1 originally wrote in her 3/20/24 statement that she did not touch the resident. However, on 5/22/24 she stated she moved the resident because Resident #1 was crying in pain and pleading that she reposition him.

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F 684	Continued From page 9	F 684		

Education was provided in person by 5/23/24 by the Director of Plant Operations to the facility van driver and provided the education to the company-contracted van drivers to pull over, not move a resident if he/she slides down or falls out of their wheelchair, call 911, and wait for paramedics to assess the resident, as well as the risks of moving a resident prior to EMS arrival. A reiteration of education and return demonstration was completed again on 5/24/24 in the presence of the Director of Plant Operations. Questions regarding education may be directed to nursing administration. Drivers will not be allowed to transport any resident until education has been completed. Education will be tracked by the Director of Plant Operations or Maintenance Director with documented signatures. Newly hired transportation drivers will be required to receive the same education in orientation prior to any transportation.

The alleged date of immediate jeopardy removal was 5/25/2024.

The immediate jeopardy removal plan of 5/25/24 was validated on 5/29/24. Staff were interviewed regarding the training received not to move a resident prior to the assessment of a medical professional, but to call 911, and to wait for a medical professional to assess the resident due to the risk involved for the potential of further injury. Documentation of staff training was reviewed. Interviews with alert and oriented residents who were transported to appointments by the facility staff or by a Transportation Agent were conducted. The interviews included if the residents were assessed by a medical professional prior to being moved after an

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F 684	Continued From page 10 accident. The immediate jeopardy removal on 5/25/24 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 observations, record review, and staff, Medical Director, Regional Nurse Consultant and Transportation Agent (Driver #1, Supervisor #1 and Supervisor #2) interviews, the facility failed to utilize an occupant restraint system, complete with a shoulder restraint and lap belt, per manufacturer's instructions for Resident #1 who slid out of his wheelchair during transport in a contracted transportation van. Driver #1 applied a shoulder restraint under the armrest of the wheelchair and across the lap of Resident #1 for transport, but did not apply a lap restraint. When Driver #1 applied brakes to avoid hitting a car, Resident #1's buttocks slid out of his wheelchair with his left leg bent forward, and his right leg extended straight out in front. Resident #1 expressed pain to Driver #1. Driver #1 called 911 and when paramedics arrived, Resident #1 complained of left knee pain 6 out of 10 (with 10 being the highest pain scale) and right foot pain, 10 out of 10. Resident #1 was transferred to the hospital where he was diagnosed with an acute impacted oblique left femoral fracture (a break in	F 689	Resident #1 no longer residing at the facility. Residents who require transportation services for outside physician services have the potential to be affected by the deficient practice. On 5/22/24 the facility van driver was educated by the Director of Plant Operations, who is knowledgeable of the restraint system of the single facility vehicle, on the proper restraints per manufacturer guidelines and the risks of serious injury or death if they are not followed. A return demonstration was performed by the facility van driver on 5/22/24 to ensure competence of manufacturer guidelines. Drivers with the contracted van company were educated by their company management on 5/23/24 regarding the same restraint system usage per manufacturer guidelines and the risks of serious injury death if they are not followed. A second education and	6/18/24

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F 689	Continued From page 11 the thighbone that occurs at an angle caused by direct trauma when the ends of the thighbone are jammed together) with edema (swelling) and bleeding around the left knee. The death certificate recorded Resident #1's date of death as 5/5/24 and the primary cause of death was due to complications from the left femoral fracture. This failure occurred for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). Immediate jeopardy began on 3/20/24 when Driver #1 failed to secure Resident #1 per manufacturer's instructions for safe transport. The immediate jeopardy was removed on 5/25/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains 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 and monitoring systems put into place are effective. The findings included: The June 2001 manufacturer's operation instructions for the securement system posted inside the contracted transportation van, recorded the following, in part. Attach the lap belt. Secure the occupant by attaching the ends of the lap belt around the occupant, threading down and through opening between wheelchair side panel and seat, or through gap between wheelchair back and seat. Attach the shoulder belt. Bring the triangular fitting of the shoulder belt over the shoulder and across the upper chest of occupant. For track anchored shoulder belts install the belt track fitting into the desired opening that provides proper extension and placement. Connect	F 689	return demonstration was given and observed by the Director of Plant Operations on 5/24/24 for both the facility van driver and contracted van drivers of the other company. The Director of Plant Operations provided the same manufacturer's education an associated risk factors and observed a return demonstration from the Maintenance Director on 6/11/24. Drivers will not be allowed to transport any resident until education has been received. Newly hired van drivers will be educated during orientation. The Maintenance Director or designee will conduct audits of residents using facility and contracted transportations to ensure usage of lap and shoulder restraints per manufacturer guidelines five times a week for four weeks, then three times a week for four weeks. Administrator will review the plan and audits during the Quality Assurance committee meeting for two months and continue audits at the discretion of the committee.	

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triangular fitting to the stud of the lap belt latch plate. Pull loose end of the belt through the adjuster to achieve firm, but comfortable fitting. Pull on the belt to ensure that all fittings are properly attached. Always ensure that the shoulder belt is properly extended over the shoulder and across the upper torso of the occupant.

According to the manufacturer's website, https://sure-lok.com/products/occupant-restraints/ , for standards of compliance, the occupant restraints should be properly used as a complete system to include the wheelchair tie-down, track and anchorages, lap belt and shoulder restraint and to always secure the occupant in the vehicle using the complete system.

A Transportation Agreement, effective 3/23/21, recorded the Transportation Agent would provide wheelchair lift vehicles which met all government regulations, requirements, and licensing. The Transportation Agent would ensure that all vehicles had equipment that included 4 Wheelchair Restraints per chair transported, a shoulder strap and a lap safety belt.

A manufacturer's securement systems Training Completion dated 4/9/22 and signed by Driver #1 for the Transportation Agent recorded in part, "Note: We strongly recommend the use of lap and shoulder belts to reduce the possibility of impact with vehicle components."

Resident #1 was admitted to the facility 10/5/23 with diagnoses that included end stage renal disease (ESRD), dependence on hemodialysis, diabetes mellitus, type 2 (DM2), atherosclerotic heart disease, spinal stenosis, osteopenia,

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cervical disc degeneration and cerebrovascular accident.

A 3/1/24 quarterly Minimum Data Set assessment indicated Resident #1 expressed himself with clear speech, made himself understood, understood others, moderately impaired cognition with no acute changes in mental status, and used a wheelchair for mobility.

The facility's Appointment Schedule for 3/20/24, recorded Resident #1 had a 10:00 AM appointment. He was scheduled for Transportation Agent pick up at 9:30 AM on 3/20/24.

A written statement by Driver #1 for the Transportation Agent, dated 3/20/24, recorded that on 3/20/24 at approximately 12:40 PM, Driver #1 traveled with Resident #1 back to the facility when a car pulled in front of the van and Driver #1 had to make a quick stop to avoid a collision. The statement recorded that because of the sudden stop, Resident #1 slid under his seat belt and landed partially on the floor of the van. Driver #1 recorded that she pulled into the nearest driveway, Resident #1 was frightened and asked Driver #1 to help him up. Driver #1 recorded that Supervisor #1 (Vice President) for the Transportation Agent advised Driver #1 to call 911. Driver #1 recorded that she called 911, Resident #1 was transported to the hospital for further evaluation.

A 3/20/24 Emergency Medical Service (EMS) Report, recorded receipt of a call at 12:39 PM and arrived on the scene at 12:55 PM, in response to injury from a fall for Resident #1. The EMS report documented once they arrived, Driver

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#1 directed EMS to Resident #1. The EMS Report indicated that Resident #1 was alert to the event, person, place, and time, found by EMS seated in his wheelchair and complained of left knee and right foot pain. The EMS Report documented Resident #1 described that his left knee was chronically painful, but due to the accident, he currently had increased pain. The EMS Report indicated that Resident #1 reported his left knee pain was 6 out of 10 and his right foot pain was rated 10 out of 10. The report documented that Driver #1 reported to EMS that to avoid a collision, Driver #1 slammed on the brakes when a car pulled out in front of the van and when this happened Resident #1 was thrown forward out of his wheelchair onto the floor of the van. The EMS Report documented that Resident #1 and Driver #1 both reported that during transport Resident #1 wore a seat belt, and the wheelchair was properly restrained. The Report documented that Resident #1 requested to be transferred to the hospital for further evaluation. The EMS Report documented Resident #1 was transported to the hospital at 1:19 PM on 3/20/24 for further evaluation.

An incident report dated 3/20/24 at 1:00 PM, completed by Regional Nurse Consultant, recorded the facility received a call from the Transportation Agent who reported that Resident #1 slid out of his wheelchair during transport. The incident report recorded Resident #1 sustained a left femur fracture.

A hospital History & Physical Report dated 3/21/24 at 2:35 AM recorded Resident #1 presented for an evaluation after he was riding in a wheelchair van when he tipped over, fell upon his left leg, and developed sudden severe left leg

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pain. Hospital Xray results dated 3/21/24 revealed an acute impacted oblique left femoral fracture with swelling and bleeding around the left knee. A leg immobilizer was applied for non-surgical management due to a history of a blood clot in the same leg. Resident #1 discharged back to the facility on 3/27/24.

A death certificate for Resident #1 recorded the date of death as 5/5/24 and the cause of death as complications from a left femur fracture.

Driver #1 for the Transportation Agent was interviewed via phone on 5/22/24 at 10:05 AM with Supervisor #1 for the Transportation Agent present on the phone. During the interview, Driver #1 stated that on 3/20/24 she transported Resident #1 to an appointment and on the way back to the facility suddenly a car cut right in front of the van such that she had to hit her brakes to keep from running into the car. Driver #1 continued that when she hit the brakes Resident #1 slid forward and she immediately pulled over into the parking lot of a restaurant not more than 200 feet away.

The interview with Driver #1 continued in person on 5/22/24 at 10:10 AM on the contracted transportation van. Driver #1 continued that she used the shoulder restraint equipped on the vehicle to transport occupants. She stated that to secure larger occupants, she applied the shoulder restraint per manufacturer's instructions, secured across the shoulder of the occupant, and for smaller occupants or occupants who could not maintain an upright position, she secured the shoulder restraint under both arm rests and across the lap of the occupant. Driver #1 stated that she secured the shoulder restraint attached

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to the contracted transportation van under both armrests and across the lap of Resident #1 for transport on 3/20/24 because she did not have a lap belt on the vehicle, he leaned forward as his usual position, and because that was her usual practice when securing Resident #1 for transport. Driver #1 stated that Resident #1 usually leaned forward as his typical posture during transport, so she did not secure the shoulder restraint across his shoulder according to the manufacturer instructions because she thought it would be a choking hazard for him. Driver #1 stated that when Resident #1 slid forward in his wheelchair, after she applied brakes to avoid hitting a car, he did not hit anything and that only his legs landed on the floor of the van, but that he did not come completely out of the wheelchair onto the floor. Driver #1 stated that when she applied brakes, Resident #1 slid forward until his bottom slid to the edge of his wheelchair, the shoulder restraint was across his chest, both arms remained on the armrests, both feet came off the footrests, his left leg was bent forward, and his right leg was straight out in front. Driver #1 said Resident #1 kept asking her to help him up because he said he was in pain.

During a follow up phone interview with Driver #1 on 5/22/24 at 12:06 PM while the Administrator and Regional Nurse Consultant were present in-person, Driver #1 stated that Resident #1 was in a "panic state", said he was in pain and that he wanted to go to the hospital. Driver #1 stated she called her supervisor (Supervisor #1); he advised her to call 911 and not to move Resident #1. Driver #1 stated she and Resident #1 both confirmed with paramedics that Resident #1 was wearing a seat belt and was properly restrained in his wheelchair during transport on 3/20/24.

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The Administrator and the Regional Nurse Consultant were both interviewed on 5/21/24 at 12:54 PM. The Regional Nurse Consultant stated that on 3/20/24 in the afternoon, the facility received a call from Supervisor #1 of the Transportation Agent. The Regional Nurse Consultant stated that Driver #1 came to the facility on 3/20/24 and wrote a statement and told the Regional Nurse Consultant and the Administrator about what happened. The Regional Nurse Consultant said that on 3/20/24, Driver #1 transported Resident #1 to an appointment, and on the way back to the facility, Resident #1 was the only passenger in the van, someone pulled out in front of the van and the Driver had to slam on brakes to keep from hitting the car. The Regional Nurse Consultant said the Driver described that when she slammed on brakes, Resident #1 slid forward in his wheelchair, but remained secured in the wheelchair with his arms on the arm rests. Driver #1 reported that she pulled into the parking lot nearby and called 911 immediately because Resident #1 said he was in pain. The Regional Nurse Consultant said when she read the EMS Report, it documented that Driver #1 and Resident #1 both reported that the wheelchair and the Resident were both secured properly. The Regional Nurse Consultant stated that the facility reviewed the manufacturer's instructions, for occupant securement and the wheelchair tie-down points, how to secure an occupant in the van, the Driver statement, the EMS Report and the hospital records to determine the root cause but could not identify what went wrong. The Regional Nurse Consultant reported that Driver #1 and Resident #1 both reported that he was wearing a seat belt that was secured properly and

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that his wheelchair was locked in place. The Administrator stated that when Resident #1 returned from the hospital, he was interviewed by the Administrator and he reported that he was coming from an appointment on 3/20/24, he was strapped in the wheelchair with a restraint, the wheelchair was tied down, during the transport, the driver pushed on the brakes hard and he slid forward.

A follow up in-person interview with Driver #1 and an observation of the contracted transportation van occurred on 5/23/24 at 12:45 PM. Driver #2 from the Transportation Agent, the Administrator and the Regional Nurse Consultant were also present for this interview and observation. During this interview and observation, Driver #1 stated that she wanted to clarify her interview and the observation of the contracted transportation van that occurred on 5/22/24 at 10:10 AM. Driver #1 stated that the contracted transportation van observed on 5/22/24 at 10:10 AM was not the same contracted transportation van used to transport Resident #1 on 3/20/24, as previously stated, but that the contracted transportation van she currently had was the actual vehicle used to transport Resident #1 on 3/20/24. Driver #1 stated that the clarification was important because the occupant securement systems between the two contracted transportation vans were different.

During the follow up in-person interview on 5/23/24 at 12:45 PM, Driver #1 and Driver #2 provided a demonstration of how Resident #1 was secured for transport on 3/20/24 in the actual van used to transport him on 3/20/24. The manufacturer's instructions for the occupant securement system were observed posted on the

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wall interior of the contracted transportation van. For the observation, Driver #2 sat in a wheelchair in the contracted transportation van while Driver #1 demonstrated that she centered the wheelchair between the floor tracks, applied the wheelchair brakes, applied the front tie-downs and secured them into the floor tracks of the contracted transportation van. Then Driver #1 applied the rear tie-downs and secured them into the floor tracks of the contracted transportation van. Driver #1 shook the wheelchair; it was observed not to move, and Driver #1 stated that the wheelchair was secure. While Driver #2 was seated in the wheelchair, Driver #1 was observed to thread the shoulder restraint (attached to the track on the wall of the van which was the difference in the occupant securement system of the two vans) under both arm rests of the wheelchair, securing it across the lap of Driver #2 rather than across the shoulder of Driver #2. Driver #1 stated she did not secure Resident #1 with a lap belt, because she did not have one available on the contracted transportation van at the time of transport, but rather used the shoulder restraint secured across the lap of Resident #1. Driver #1 stated that the contracted transportation van was equipped with a shoulder restraint but did not come equipped with a lap belt. The contracted transportation van was observed and did not have a lap belt attached, neither was a lap belt observed available for use. Driver #1 obtained a lap belt from Driver #2 for the demonstration. Driver #1 stated that she was trained to check the contracted transportation van before transport to ensure all parts of the wheelchair and occupant securement system were in place and functioning. Driver #1 stated she checked the van and occupant securement system on 3/20/24 before she transported

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Resident #1, she did not have a lap belt on the van but did not think she needed one because she usually used the shoulder restraint secured across the lap of Resident #1 for transport. Driver #1 stated that she did not routinely use both a shoulder restraint and lap belt to transport occupants, but when she did need a lap belt, she obtained a lap belt from Driver #2.

A phone interview occurred on 5/22/24 at 8:41 AM with Supervisor #1 (Vice President) for the Transportation Agent. Supervisor #1 stated Driver #1 was employed as a driver with the Transportation Agent for the past two years with no prior driving experience. He described that she received two weeks of training, for a total of "about" 28 training hours. He stated that she drove with other experienced drivers to learn the routes, the global positioning system, loading/unloading residents in the vehicle, the wheelchair and occupant securement system, and required a competency evaluation with a return demonstration to a supervisor of these tasks for completion of the training. Supervisor #1 stated that Driver #1 called him on 3/20/24 to let him know someone pulled out in front of the van, she had to brake quickly, when she did, Resident #1 slid forward in his wheelchair, Resident #1 complained of pain, and that Driver #1 was unable to pull him up. Supervisor #1 said he told Driver #1 not to move the Resident, but to call 911. Supervisor #1 said he contacted the facility, told the Administrator and Regional Nurse Consultant about the accident, that Resident #1 complained of pain, and that he told Driver #1 to call 911.

A follow up phone interview with Supervisor #1 occurred on 5/23/24 at 8:43 AM with Supervisor

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#2 (President) also on the phone. During the phone interview, Supervisor #2 stated that drivers were trained to routinely use either a lap restraint or a shoulder restraint based on the size of the occupant. He stated drivers were trained to typically use a lap restraint for a smaller framed person and the shoulder restraint for a larger framed person. He stated that both a shoulder restraint and a lap belt were used together as needed for occupants who could sit in an upright position, but that a shoulder restraint was not used for passengers who could not maintain an upright position due to the risk of the restraint presenting a choking hazard, but rather a lap belt was used to make sure there was no movement across the waist. Supervisor #1 described that the driver should thread the lap belt under both armrests of the wheelchair so that it fits snuggly around the occupant's waist and attach each end of the lap restraint to the floor latch.

During a follow-up phone interview on 5/24/24 at 1:45 PM with Supervisor #1 and Supervisor #2 both on the phone, Supervisor #1 and Supervisor #2 stated they did not realize Driver #1 did not have both a shoulder restraint and lap belt on the van to transport Resident #1 on 3/20/24. Supervisor #2 stated when the contracted transportation van was purchased, it came equipped with a shoulder restraint but not a lap belt. Supervisor #2 stated the lap belt was purchased later and all contracted transportation vans should have both a shoulder restraint and a lap belt on the van for use during transportation. Supervisor #2 stated that for occupants who leaned forward and did not sit upright in the wheelchair, a shoulder restraint could present a choking hazard, so it was left to the driver's discretion in these situations to determine which

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restraint to use. Supervisor #2 stated that the contracted van used to transport Resident #1 on 3/20/24 had the shoulder restraint attached to a tracking device on the wall interior of the van and should be adjusted to the occupant for comfort and safety. Supervisor #2 stated that drivers were trained to conduct weekly safety checks on the assigned vehicles to check all items necessary for the wheelchair and occupant securement system and if anything was needed the driver should advise a supervisor.

An interview with the Medical Director (MD) occurred on 5/21/24 at 2:39 PM. The MD stated that he was notified that on 3/20/24, during transportation in a contracted transportation van, Resident #1 sustained an acute left femur fracture with bleeding around the fracture because the muscle was also injured that was treated with non-operative management due to a history of a blood clot in the same leg. The MD stated he was told that a car pulled out in front of Driver #1, and she had to hit the brakes, but that according to the Resident and to the Driver, Resident #1 was properly secured in the van. The MD described Resident #1 was at high risk for fractures due to a history of fractures, advanced age, heart failure, DM2, and demineralized bones from ESRD. The MD stated that given everything considered Resident #1 was at high risk for spontaneous pathological fractures, due to his weakened bones. The MD stated that fractures in the case of Resident #1 could occur with or without impact, and if there was impact, the impact did not have to be of great force.

The Administrator was notified of immediate jeopardy on 5/23/24 at 3:15 PM.

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F 689	Continued From page 23 The facility provided the following credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 3/20/24, Resident #1 was being transported back to the facility from dialysis when the contracted Driver #1 quickly stepped on the brakes to avoid hitting a car that pulled out in front of her causing Resident #1 to slide forward from the wheelchair with the lap restraint positioned across his chest, both arms positioned on the armrests, both feet were off the footrests, and his left leg was bent. Driver #1 pulled over at a safe location to check on the resident. When EMS arrived, it was noted in the report that the resident was properly secured in a seat belt and the wheelchair was properly restrained. However, it was discovered that Driver #1 was not following the restraint manufacturer's guidelines during the surveyor observation reenactment on 5/23/24. Resident #1's normal posture was to lean forward. Driver #1 stated she applied a lap restraint but did not apply a shoulder restraint as per her training before transporting Resident #1. Driver #1 stated that she applied the shoulder restraint as a lap restraint, and she did not have an additional lap restraint available for use. It was discovered at the hospital that Resident #1 was diagnosed with an acute left femoral fracture with soft tissue edema and bleeding around the left knee. Residents who require dialysis and external physician services being transported by the facility and contracted drivers have the potential to be affected as a result of noncompliance with properly securing residents in the vehicle which may cause risk for serious injury or death.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK CENTER FOR NURSING AND REHABILITATION	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 689	Continued From page 24 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 To ensure no other residents are affected, the involved contracted transportation company contract was terminated by the facility on 5/23/24 in writing for noncompliance with not using an effective restraint system to safely secure a resident. Education of proper securement per manufacturer guidelines was provided to the one facility van driver on 5/22/24 by the Director of Plant Operations who is knowledgeable of the manufacturer guidelines for the single facility vehicle. A return demonstration was also completed on 5/22/24 to show full compliance and understanding. Other contracted van drivers will be educated by 5/23/24 by their company management who is knowledgeable on their specific vehicle's manufacturing guidelines. Re-education and return demonstration was completed on 5/24/24 by the facility and contracted van drivers by the Director of Plant Operations. Education included following the manufacturer's guidelines for the specific vehicle being used to prevent this event from reoccurring. Drivers will not be allowed to transport any resident until education has been completed. Newly hired transportation drivers will be required to receive the same education provided by the Director Plant Operations or Maintenance Director during orientation. The Administrator will be responsible for tracking the education. Facility will require return demonstrations of correct securement per the manufacturer's guidelines	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 25	F 689		

before transport and monitored by the Maintenance Director or designee. If stretcher transport is required, the facility will utilize the services of a medical transport company that specializes in stretcher transport. Residents with poor center of gravity will utilize the appropriate equipment for safe securement following the manufacturer guidelines.

The alleged date of immediate jeopardy removal was 5/25/2024.

The immediate jeopardy removal plan of 5/25/24 was validated on 5/29/24. Observations were made of staff securing residents for transport according to the manufacturer instructions which included the use of both a shoulder restraint and a lap belt. Staff were interviewed regarding training received on securing residents for transport according to the manufacturer instructions and the use of both a shoulder restraint and a lap belt. Documentation of staff training was reviewed. Interviews with alert and oriented residents who were transported by the facility or by a Transportation Agent were conducted and revealed residents were secured for transport with both a shoulder restraint, a lap belt and that the wheelchair was secured to the floor with tie-down restraints. The immediate jeopardy removal on 5/25/24 was validated.