| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| WALNUT COVE HEALTH AND REHABILITATION CENTER | 511 WINDMILL STREET<br>WALNUT COVE, NC 27052 |

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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted on 12/11/24 through 12/13/24. Event ID# WF3N11. Additional information was obtained on 12/18/24. Therefore, the exit date was changed to 12/18/24.<br><br>The following intake was investigated: NC00224790.<br>Intake NC00224790 resulted in immediate jeopardy.<br>1 of the 4 complaint allegations resulted in a deficiency<br><br>Immediate Jeopardy was identified CFR 483.25 at tag F689 at a scope and severity (J).<br><br>The tag F689 constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 10/24/24 and was removed on 10/29/24. A partial extended survey was conducted. | F 000 | | |
| F 689<br>SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interviews with facility staff including Transport | F 689 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/06/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Aide/Driver #1, the facility failed to ensure the lift gate/platform was in the elevated position before unloading a resident from the back of the facility van for 1 of 3 residents sampled for accidents (Resident #1). On 10/24/24 Transport Aide Driver #1 pushed Resident #1 backwards out of the van and he fell approximately 17 and ½ inches out of the transport van to a lift platform that was located on the ground. Resident #1 fell out of his wheelchair and landed on his left side with half of his body on the lift platform and the other half of his body on the asphalt, and he struck his head on the asphalt. Resident #1 was prescribed and administered a blood thinner twice a day which increases the risk of bleeding. After being assessed by the nurse, the resident was transported to the hospital via Emergency Medical Services (EMS) transport and at the hospital. Resident #1 was found to have sustained a subarachnoid hemorrhage (bleeding on the brain), a small laceration to the left side/back of his head, and a skin tear to his left elbow. There is a high likelihood of a serious adverse outcome or injury when the manufacturer's instructions for unloading residents from the transportation van are not followed.

The findings included:

Review of the manufacturer's operating instructions showed the following instructions for the use of the transportation van lift to unload a resident in a wheelchair.
1. Stand clear and press the unfold switch until the platform stops (reaches floor level of the vehicle - unfold fully).
2. Load passenger onto platform from floor level of the vehicle and lock wheelchair brakes. Notice:

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Passenger must be positioned fully inside yellow boundaries, roll stop must be UP, and roll stop latch must be engaged.
3. Press the DOWN switch until the entire platform reaches ground level and the roll stop unfolds fully (ramp position).
4. Unlock wheelchair brakes and unload passenger from platform.

Resident #1 was admitted to the facility on 8/11/21. The resident's diagnoses included in part a history of vascular dementia, chronic atrial fibrillation, chronic muscle weakness, abnormal gait, and chronic lumber pain.

Resident #1's annual Minimum Data Assessment, dated 8/7/24, coded the resident as moderate cognitive impairment. The resident was coded to use a wheelchair for ambulation, and as needing substantial to maximum assistance to wheel at least 150 feet.

Record review of Transportation Aide/Driver #1's personnel file showed she had completed initial transportation web classes and return demonstrations when using the lift. Further review showed annual transportation training review with the most recent training being completed on 10/17/24. The training included web-based courses which consisted of driving basics, defensive driving, how to prepare a resident for transport, and a return demonstration of using the lift to load and unload a resident checklist.

Review of physician orders showed Resident #1 had an order dated 8/23/24 for apixaban (a blood thinner) 5 milligrams, take one tablet twice daily.

Review of the October 2024 Medication

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Administration Record showed Resident #1 he was administered the apixaban twice daily including the a dose on the morning of 10/24/24. There had been no documented dose omissions for October 2024.

Review of a statement signed by Transportation Aide/Driver #1 dated 10/24/24 read in part, "I unsecured Resident #1 and removed his seatbelt and unlocked his brakes. I leaned over so that I could push his wheelchair back onto the lift. I didn't realize that the lift was still on the ground, so his wheelchair fell, landed in a sitting position on the lift, but then the wheelchair fell over backwards. When the wheelchair fell over backwards, he fell backwards out of the wheelchair. I jumped out of the van to see that he was conscious." The statement continued to say "I ran to the door to inform staff I needed help and returned to Resident #1's side. I did not see anyone anywhere outside when he fell as I looked around to see if there was anyone outside that could help me."

An interview was conducted by phone with Transportation Aide/Driver #1 on 12/11/24 at 11:38 AM. She stated she had worked at the facility for 3 years as a Social Service Assistant/Transportation Aide/Driver fill-in. Transportation Aide/Driver #1 said she had been trained on how to transport residents by the facility Director of Nursing (DON) who was the acting Staff Development Coordinator at that time. Transportation Aide/Driver #1 also said she completed her annual review on 10/17/24. Transportation Aide/Driver #1 confirmed how to use the facility van lift was part of that training and she felt very comfortable transporting residents to their appointments. Transportation Aide/Driver #1

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| F 689 | Continued From page 4 said she would fill in for Transportation Aide/Driver #2 who normally drove the transport van. Transportation Aide/Driver #1 said on 10/24/24, the DON asked her to transport two residents to and from their appointments. Transportation Aide/Driver #1 said that when she returned to the facility, she opened up the back door of the transport van and moved the lift from its stowed position. Transportation Aide/Driver #1 said she unsecured the first resident, moved that resident onto the lift, used the lift control to lower the resident, and then rolled the resident into the facility. Transportation Aide/Driver #1 then said she returned to the van and stepped into the van through the side door entrance, unsecured Resident #1 by unhooking the straps, disengaging his wheelchair brakes, and began pushing him backwards out of the van to where the lift should have been. She said Resident #1's wheelchair rolled backwards out of the van and landed about 2 feet onto the lift that was still at ground level. She stated the next thing she knew Resident #1 was lying on his left side, completely out of the wheelchair, halfway onto the asphalt and half on the lift with his wheelchair off to the side of him. She added she couldn't remember exactly if Resident #1 flipped over backwards in his wheelchair before he landed or if he dropped 2 feet and then fell out of the wheelchair because, "It all happened so quickly." Transportation Aide/Driver #1 said she knew immediately that she had forgotten to raise the lift back up and it was still at the ground level when she attempted to unload him from the van. Transportation Aide/Driver #1 said she knew she was supposed to check the lift was in the right position prior to moving the second resident. She said she didn't know why she didn't check the lift and that she must have had her mind on something else. The | F 689 | | |

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transportation aide/driver went to the front door of the facility to get assistance. Transportation Aide/Driver #1 said both Nursing Assistant (NA) #1 and NA #2 heard her banging on the front door and came to help. She said one of them, couldn't remember which one, ran to get Nurse #1 who also responded quickly. Transportation Aide/Driver #1 thought she may have moved Resident #1's wheelchair out of the way but wasn't sure.

An interview was conducted with NA #2 on 12/11/24 at 11:25 AM. She said during the afternoon on 10/24/24, unsure of the time, she heard someone banging on the front door. She stated both her and NA #1 responded to the banging on the door. She said when she saw Resident #1 on the ground, she went out to help while NA #1 went to find a nurse. She stated Resident #1 was partially on the blacktop and half on the lift. She said she may have moved the wheelchair out of the way but could not remember if she did or if Transportation Aide/Driver #1 did. NA #2 remarked she noticed a skin tear on the left side of his head and one on his left arm. She explained neither area was bleeding very much, and she didn't notice any blood on the ground or lift. She said Resident #1 was lying on his left side and was conscious. NA #1 also stated Transportation Aide/Driver #1 told the NA#1 she had moved another resident off the van and forgot to raise the lift again before attempting to push Resident #1 off of the transport van. She further stated another staff member had called 911, unsure who, and EMS came to get him pretty quickly and transported him to the hospital for assessment.

An interview was conducted with Nurse Aide (NA)

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#1 on 12/11/24 at 11:14 AM. NA #1 stated on 10/24/24 in the afternoon, unsure of time, she heard banging on the front door, came around the corner and saw it was Transportation Aide/Driver #1. She said both her and NA #2 responded to the banging on the door. She said when she saw Resident #1 on the ground, she immediately turned around to go find a nurse while NA #2 went outside to assist with Resident #1. NA #1 said when she went out to the van, she observed Resident #1 to be lying partially on the van lift and partially on the ground toward his left side. She did not remember seeing where his wheelchair was at that time. She commented she also noticed a small amount of blood on Resident #1's left arm and Resident #1 was conscious. She said she was unsure how Resident #1 fell at that time.

Review of Resident #1's electronic medical record revealed an incident entry by Nurse #1 on 10/24/24 at 3:30 PM noting in part, "Staff alerted nurse that resident was on the ground behind the van ...skin tear to head and left elbow noted and occurred during transfer off of transportation van upon return from an appointment. Vital signs obtained. Skin tears are cleansed and dressed. Resident is being transported to the ER [emergency room] for evaluation by EMS [emergency medical services]."

An interview was conducted with Nurse #1 on 12/11/24 at 12:12 PM. Nurse #1 said on the afternoon of 10/24/24, unsure of time, one of the NAs came to get her and told her that a resident was lying in the front parking lot. She said she grabbed her blood pressure monitor and pulse oximeter (a device used to measure the percentage of oxygen in the blood and pulse) and

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responded immediately. She said she found Resident #1 lying partially on the van lift and partially on the blacktop. She said he was conscious and was bleeding minimally from a wound on the left side/back of his head and from a small laceration on his left elbow. She further stated she performed an assessment, his vital signs were normal, and he was alert. She stated his hearing aid was not attached so communication was difficult, but he responded appropriately to her questions and pointed to his head when she asked if he had any pain. She explained she called 911 from her phone and the volunteer rescue squad arrived within a few minutes. Nurse #1 said she stayed on the ground with Resident #1 talking with him until the county EMS ambulance arrived and transported him to the hospital

A review of Emergency Medical Services (EMS) record for showed the call was received by dispatch at 3:06 PM and EMS arrived at the facility on 10/24/24 at 3:33 PM. The record read Resident #1 was alert and wearing a cervical collar with abrasion noted to left arm and side/back of head. The record further read "Patient fell backwards off an estimated 18-inch platform striking his head on the asphalt. No loss of consciousness per staff. Noted to be on a blood thinner". The record said Resident #1 remained alert during transport to the hospital for evaluation.

A review of hospital records for Resident #1 for the hospitalization period of 10/24/24 through 10/28/24 revealed the following. Resident # 1 was seen in the Emergency Room (ER) on 10/24/24 following the fall out of a van. The physician noted the resident "was alert and in no acute distress"

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at the time of the physician's assessment. The physician's head to toe assessment of Resident #1 was normal except for a small laceration to the left side of head and another small laceration to the left elbow. The radiology report indicated that a computed tomography (CT) (a CT is a noninvasive medical imaging procedure that uses x-rays to create cross-sectional detailed pictures of the inside of the body) scan showed a "small volume of acute subarachnoid hemorrhage" along Resident #1's left frontal lobe. The report explained the volume of hemorrhage was not enough to cause pressure on the brain. Resident #1 was admitted to the hospital for observation. A follow-up CT dated 10/28/24 revealed the bleed had not grown in size and there were no new areas of concern identified. The physician discharge note dated 10/28/24 documented Resident #1's "hospital course was unremarkable." Resident #1 was discharged from the hospital back to the facility on 10/28/24 with no new orders.

An interview was conducted on 12/11/24 at 2:45 PM with the acting Director of Nursing (DON). She stated she was not in the role of DON when the incident occurred but was made aware of what happened the same day. She explained Transportation Aide/Driver #1 had completed the necessary training to safely load and unload residents from the facility van. The DON explained the Transportation Aide/Driver #1 stated she didn't know what happened other than she made a mistake and should have followed the steps on how to unload residents from the van laid out in her training. The DON stated Transportation Aide/Driver #1 no longer worked at the facility.

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An interview was conducted on 12/11/24 at 3:37 PM with the Administrator. She stated the facility immediately identified the incident on 10/24/24 as needing a plan of correction and it was implemented to ensure all residents were kept safe. She also said no other staff member will be allowed to operate the transport van lift if they have not fully completed the necessary training.

During a follow-up call with the Administrator on 12/18/24 at 3:34 PM, she confirmed the measurement from the floor of the van to the ground was 17 and one half inches.

On 12/11/24 at 4:03 PM, the Administrator was notified of immediate jeopardy.

The facility implemented the following corrective action plan:

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

On October 24, 2024, at approximately 3:30 pm, 2 residents were returning to the facility from scheduled outside appointments via facility transportation service. Transportation Aide/Driver #1 pulled up outside the facility at the front entrance. Transportation Aide/Driver #1 unloaded Resident #2 from the lift that is located at the back doors of the van. Transportation Aide/Driver #1 then took Resident #2 inside the facility. When Transportation Aide/Driver #1 returned to the van, she did not raise the van lift to rear entrance of the van, she entered the van from the side door, and did not realize the van lift was still on the ground. Transportation Aide/Driver #1, while facing Resident #1 and the rear of the van, began

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| F 689 | Continued From page 10 to remove the wheelchair tie down straps and seatbelt from Resident #1's wheelchair, and unlocked the brakes of the wheelchair. The Transportation Aide/Driver #1 bent over forward and began to push Resident #1's wheelchair backward, towards the rear of the van. The Transportation Aide/Driver was unaware the lift remained on the ground. When Resident #1 reached the rear exit of the van, the wheelchair fell backward and resident #1 fell out of wheelchair onto the lift that was on the ground. As a result of the fall, Resident #1 hit his head on the base of the van lift. Resident #1 landed in a position where he was on his left side with his head and body in a fetal position with wheelchair on the left side, beside of resident #1. Transportation Aide/Driver #1 then jumped off the back of the van to check on the resident. Resident #1, who was alert and oriented, stated to her that his head hurt. Transportation Aide/Driver #1 ran 10 feet to the front door to call for help and returned to the resident's side. The Transportation Aide/Driver did not move Resident #1. Registered Nurse (RN) #1 responded to Resident #1 and assessed him. During RN #1's assessment, it was noted that he had a laceration (cut) to the back of his head with small amount of bleeding, and that his left arm was bleeding with superficial (on the surface of the skin) lacerations. RN #1 notified 911 and stayed with Resident #1 until local emergency services arrived. Emergency Medical Services (EMS) arrived at the facility after the local emergency services arrived and the resident was transported to the local hospital via EMS. The facility also notified the responsible party, and the facility physician. At the hospital, a Computed Tomography (CT) scan of Resident #1's head was completed that revealed a small volume left frontal subarachnoid | F 689 | | |

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hemorrhage, which is when there is bleeding in the space between the brain and the membrane that covers it. Resident #1 was admitted to the hospital on October 24, 2024. During his stay at the hospital, the small volume frontal subarachnoid hemorrhage resolved, and Resident #1 continued at baseline cognitive status. Resident #1 returned to the facility on October 28, 2024, and is a current resident in the facility. The resident did not have any long-term effects from his injury. Resident #1 was taking anticoagulant for a diagnosis of Atrial Fibrillation at the time of the fall.

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

On October 25, 2024, the Executive Director, the Regional Nurse Consultant, and the Director of Nursing completed an audit of all appointments in the last 90 days, and it was determined any resident could be at risk for this deficient practice if they were transported to an appointment on the facility van. Residents with a Brief Interview for Mental Status (BIMS) indicating mild cognitive loss to being cognitively intact were interviewed by the Social Worker and there were no concerns identified regarding the van ride or use of the lift. On October 25, 2024, skin sweeps were conducted on all current residents by the nurse managers with no issues. The Transportation Aide/Driver was interviewed by the Executive Director and the Human Resources Director on October 24, 2024, regarding any other falls during the onloading, off-loading or transport of any resident and there were no issues noted.

3. Address what measures will be put into place

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| F 689 | Continued From page 12<br>or systemic changes made to ensure that the deficient practice will not recur.<br><br>The Transportation Aide/Driver #1 was immediately suspended on October 24, 2024, and an investigation was initiated. At the conclusion of the investigation, it was determined that the expected standards of safety procedures were not followed. The Transportation Aide/Driver #1 stated that when she exited the building after taking Resident #2 into the building that she entered the open door on the side of the van, not remembering that she had not put the lift back up into the receiving position. She said that because of her posturing in front of the resident to release the safety devices, she could not see that the lift was not in place. As she rolled Resident #1 backwards toward the lift, she was in a bent forward position and again, could not see that the lift was not in proper position. The Transportation Aide/Driver #1 is no longer employed at the facility.<br><br>The 1 other facility van driver, Transportation Aide/Driver #2 was provided education regarding the use of the facility van and the proper use of the lift, utilizing the manufacturer's lift instructions, to include safe practice provided by the Executive Director on October 25, 2024. The Executive Director also completed a competency training with Transportation Aide/Driver #2. This was followed by an evaluation of her knowledge of the training which was conducted through observation utilizing the competency checklist by the Executive Director. This education and competency will be completed for all newly hired Transportation Aides/Drivers prior to being allowed to use the facility van or lift by the Executive Director, the Director of Nursing, or the | F 689 | | |

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| F 689 | Continued From page 13<br>Assistant Director of Nursing. All facility van transportation will have another staff member riding along and observing all on and off loading of the residents going to outside appointments on the van for 90 days starting on the afternoon of October 28, 2024. The observer is a patient care assistant (PCA) assigned to go on outside appointments as needed to ensure the safety of the residents. The PCA was educated by the Executive Director on October 25, 2024. Any further observers will receive the training by the Executive Director prior to riding on the transportation van. This education included what to observe while onloading and offloading of residents. This included safe transferring from van to lift (offloading) and from the lift to the van (onloading). The observer was also made aware to inform the Transportation Aide/Driver of any unsafe practice so it could be immediately corrected or intervene if necessary to ensure resident safety. If the unsafe practice was not immediately corrected, the PCA was educated to call the Executive Director immediately. All residents who had outside appointments were taken by outside transport vendors during the time when the facility van was not in service, October 24, 2024, through October 28, 2024. The outside transport companies were contacted by the Executive Director to confirm that their drivers/transportation aides were properly trained on how to onload and offload residents safely on their van. Outside transport vendors provided proof of education about onloading and offloading residents while using the lift prior to transportation services to ensure the safety of the residents. The van lift was inspected on October 28, 2024, by an authorized lift service station, and the lift was deemed safe for use. The van was ready for routine operation after it was inspected on the | F 689 | | |

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| F 689 | Continued From page 14<br>morning of October 28, 2024, and began providing service to our residents on the afternoon of October 28, 2024. Transportation Aide/Driver #2 is currently utilizing the facility van to transfer residents to and from appointments and there have been no wheelchair van related incidents.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br><br>Quality monitoring will be performed by the Executive Director, or a nurse manager, Director of Nursing, or Unit Manager, in the absence of the Executive Director. This will be conducted on 2 different residents weekly that are being loaded and unloaded by the transportation aides/drivers, to ensure residents are safely loaded and unloaded from facility van prior to transporting to and from appointments per manufacturer's instructions for 12 weeks and then monthly for 3 months. Any observed unsafe practices will be drawn to the attention of the Transportation Aide/Driver for correction. In the case of any unsafe practice, the Transportation Aide/Driver will be re-educated, that will include a competency at the conclusion of the education. The facility made the decision to monitor/audit and bring this to Quality Assurance (QA) on October 24, 2024, to include review of the Quality Monitoring.<br><br>5. Include dates when corrective action will be completed.<br><br>The facility's corrective action plan was validated by the following: | F 689 | | |

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| F 689 | Continued From page 15<br>The facility provided documentation of Transportation Aide/Driver #2 web-based training courses on driving basics, defensive driving, and a checklist that included return demonstrations on how to load and upload residents from the transportation van. The facility provided documentation of van service records provided by an outside company which validated the lift was working properly following the incident, along with evidence of their audits as outlined in their plan of correction. Their audits included observation of Transportation Aide/Driver #2 to ensure she continues to follow lift and van safety instructions regarding boarding safety, patient securement, and patient assistance, including Resident #1. Daily monitoring of all residents using the transport van lift was being conducted and that information was presented in the facility's weekly QA meetings.<br><br>On 12/11/24 at 2:19 PM Transportation Aide/Driver #2 was observed loading and unloading Resident #5 from the facility van using the lift. Transportation Aide/Driver #2 explained in detail the steps she takes and the safety measures she followed when using the lift as she was loading and unloading Resident #5. An interview conducted with a resident who had been recently transported to an appointment revealed he had no concerns with being loaded or unloaded from the van, being secured safely in the van, and felt the transport was safe. Transportation Aide/Driver #2 stated she completed the refresher course as part of the facility plan of correction on 10/24/24 following the incident. Transportation Aide/Driver #2 provided documentation showing she was cleared to transport residents using the lift. | F 689 | | |

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| F 689 | Continued From page 16<br>The facility's implementation for corrective action plan with a date of compliance of 10/29/24 was validated on 12/11/24.<br><br>The IJ removal date was 10/29/24. | F 689 | | |