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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 4/15/25 through 4/16/25. Additional information was obtained offsite on 4/17/25. Therefore, the exit date was changed to 4/17/25. Event ID# 8MYN11. The following intake was investigated NC00229282. 1 of 1 complaint allegation resulted in a deficiency. Intake #NC00229282 resulted in Immediate Jeopardy.<br><br>Past-noncompliance was identified at:<br><br>CFR 483.25 at tag F689 at a scope and severity (J); the IJ began 4/08/25 and was removed 4/10/25.<br><br>Date of compliance was 4/10/25.<br><br>The tag F689 constituted Substandard Quality of Care.<br><br>A partial extended survey was conducted. | F 000 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices 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 observations, record review, and staff, Medical Director, and Legal Guardian interviews, the facility failed to ensure Resident #1, who had | F 689 | Past noncompliance: no plan of correction required. | |

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

Electronically Signed | 05/07/2025

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cognitive impairment, was safely transported back to the facility following an orthopedic appointment on 4/08/25. Driver #1 failed to secure Resident #1's wheelchair to the van floor and secure Resident #1 in the wheelchair per the manufacturer's instructions during transport in the facility van. When Driver #1 drove out of the parking lot and turned right onto the main road, Resident #1 and the wheelchair she was in fell over to the left landing on the van floor. Driver #1 pulled over to the side of the road and observed Resident #1's head was bleeding and called 911. Resident #1 was transported by emergency medical services (EMS) to the hospital for further evaluation and diagnosed with a frontal scalp laceration, left middle finger fracture, and transverse cervical 7 (neck) fracture. The resident experienced an adverse outcome and injury when Resident #1's wheelchair was not secured in the transportation van per the manufacturer's instructions. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #1).

The findings included:

A review of the manufacturer's instruction manual for the transport van 4-point wheelchair securement and occupant restraint system provided by the facility read in part: Attach the tie-down (fabric strap connecting a hook and a floor anchor) anchor into the floor anchorages and lock them into place. Attach the tie-down hooks to a solid part of the wheelchair frame below the seat ensuring the tie downs are fixed at approximately 45 degrees. Ensure all tie-downs are locked and properly tensioned (tightened). Connect both sides of the lap belt across the occupant's pelvis. Pull the shoulder belt across

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the occupant's chest and attach it to the lap belt connector. Adjust the height of the shoulder belt so it rests on the occupant's shoulder.

Driver #1's training records revealed she completed van transportation training, provided by the Administrator, on 10/16/24. A competency evaluation dated 1/14/25, completed by the Administrator, indicated Driver #1 was reviewed for securing a wheelchair into the facility's transport van per the manufacturer's instructions and all competencies were checked as met.

Resident #1 was admitted to the facility on 6/01/23 with diagnoses including right femur fracture and dementia.

The significant change Minimum Data Set (MDS) dated 2/14/25 revealed Resident #1 was severely cognitively impaired, had lower extremity impairment to one side, utilized a manual wheelchair for mobility and required substantial to maximal assistance with transfers. The MDS further revealed Resident #1 was not receiving an anticoagulant.

The care plan dated 3/04/25 indicated Resident #1 was non-ambulatory, required substantial to maximal assistance with transfers, and utilized a wheelchair and the assistance of one person for mobility.

Driver #1's statement dated 4/08/25 indicated she transported Resident #1 to an orthopedic appointment in the facility van. After the appointment she loaded Resident #1 back into the van, secured the wheelchair, shoulder and lap belt. Driver #1 drove out of the parking lot and turned right onto the main road when she heard a

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loud crash. She looked in the review mirror and observed Resident #1 lying on the van floor. Driver #1 immediately pulled over on the left side of the road, stopped the van and went to check on Resident #1. Resident #1 was lying on her left side with her head facing upward and she had a laceration to her forehead that was bleeding. Driver #1 noted the wheelchair was tipped over, the shoulder and lap belt were disconnected, and the front left tie down strap was unhooked from the wheelchair. Driver #1 called 911 and used a blanket to apply pressure to Resident #1's forehead. Resident #1 was transported by EMS to the Emergency Department (ED) for further evaluation. Driver #1 was unsure how the wheelchair tipped over and reported to EMS she thought Resident #1 tried to stand up from the wheelchair or had released the shoulder and lap belt.

A phone interview was conducted with Driver #1 on 4/15/25 at 12:07 PM. She revealed she started working at the facility in October 2024 and was trained to transport residents in the facility van. Driver #1 indicated the training included reading material, instructional videos, and demonstrations from the Administrator on how to secure a wheelchair in the van using the manufacturer's instructions. She stated she also completed 3 to 4 return demonstrations which included the Administrator sitting in a wheelchair, while she secured the wheelchair in the van and then she drove the van on the main road for a few miles and returned to the facility. She stated she received training for approximately a month and the Administrator completed a skills check before she started transporting residents on her own. Driver #1 revealed on 4/08/25 she transported Resident #1 to an orthopedic appointment and

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stayed with the resident during the appointment. Driver #1 revealed when the appointment was finished, she loaded Resident #1 back into the van, secured the wheelchair, applied the shoulder and lap belt, and drove out of the parking lot toward the main road. She indicated she stopped the van before turning right onto the main road, looked in the review mirror and observed Resident #1 was repositioning herself in the wheelchair but was seated and the shoulder and lap belt were still connected. Driver #1 stated she turned right onto the main road and heard something crash and thought her clipboard fell. Driver #1 revealed she looked in the rear-view mirror and observed the wheelchair had fallen over and Resident #1 was lying on the van floor. She stated she immediately pulled over on the left side of the road and stopped the van. Driver #1 indicated she went to the back of the van and observed Resident #1 lying on her left side with her head facing upward, and the resident had a laceration to her forehead that was bleeding. She stated she also observed that the wheelchair had fallen over, the seat and lap belt were disconnected, and the front left tie down was no longer hooked on the wheelchair. Driver #1 indicated she called 911, used a blanket to apply pressure to Resident #1's forehead and sat with her until EMS arrived. She indicated while waiting for EMS to arrive she also contacted the Administrator and reported the incident. Driver #1 revealed Resident #1 was not crying or yelling and was not exhibiting any signs of pain or distress. Driver #1 indicated when EMS arrived, they asked her to move the wheelchair so they could provide treatment to Resident #1. She stated the Administrator arrived as Resident #1 was loaded into the ambulance and then transported to the ED for further evaluation.

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Driver #1 revealed the Administrator instructed her to drive the van back to the facility, and when she returned, she wrote a statement about what occurred. She stated she also performed a reenactment of how she secured the wheelchair and Resident #1 in the van with the Administrator and Director of Nursing observing after they returned to the facility. Driver #1 revealed during the reenactment when she connected the shoulder and lap belt it clicked twice. She stated she did not recall the shoulder and lap belt clicking twice when she was securing Resident #1 and that must have been why it disconnected causing the wheelchair to fall over. Driver #1 revealed she did not check the wheelchair or the shoulder and lap belt to ensure they were properly secured because she was rushing to get back to the facility for another resident that had an appointment. She stated she should have checked to ensure the wheelchair and Resident #1 were secured properly in the van. Driver #1 revealed she was suspended on 4/08/25 pending an investigation and had not returned to work.

An observation was conducted on 4/15/25 at 4:00 PM of Driver #1 demonstrating how she secured the wheelchair and Resident #1 in the facility van on 4/08/25 with the Regional Clinical Director sitting in the wheelchair. Driver #1 hooked the front tie downs and then the back tie downs to the frame underneath the seat of the wheelchair. Driver #1 crossed the shoulder belt over the Regional Clinical Directort's chest, connected both sides of the lap belt and then connected the shoulder belt over her left hip. Driver #1 then stepped away from the wheelchair and concluded the demonstration. Driver #1 was not observed during the demonstration tightening any of the tie downs, ensuring the shoulder belt and lap belt

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were fully connected or checking the wheelchair to ensure it was secured properly.

A review of the facility incident report dated 4/08/25 written by the Director of Nursing indicated Resident #1 was returning from a medical appointment and fell from her wheelchair in the van. Driver #1 reported Resident #1 had a laceration to her forehead and was bleeding. Driver #1 called 911 and Resident #1 was transported by emergency medical services (EMS) to the emergency department (ED) for further evaluation. The Medical Director and Legal Guardian were notified of the incident.

The EMS records dated 4/08/25 revealed when they arrived on scene Resident #1 was located in the transport van. Driver #1 reported she was transporting Resident #1 in the van, looked in the review mirror and observed that Resident #1 was standing up from the wheelchair and fell hitting her head. Resident #1 was assessed to have a laceration to her forehead and left index finger and bruising to her left cheek. Resident #1 was removed from the back of the transport van, secured in the ambulance, and transported to the ED for further evaluation.

Attempts made to interview EMS staff were unsuccessful.

A review of the ED records dated 4/08/25 revealed Resident #1 was evaluated due to a fall from a wheelchair in the transport van. Resident #1 had lacerations to the back of her head, forehead, and left hand. A computed tomography (CT) scan of the head and spine, and an x-ray of the left hand were obtained. The CT scan of the head was negative for intracranial hemorrhage

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(brain bleed), the CT scan of the spine revealed a cervical 7 (neck) fracture, and the left-hand x-ray revealed a comminuted (broken into multiple pieces) mildly displaced fracture of the index finger. Resident #1 had a non-adhesive dressing applied to the skin tear on her left finger and a splint was placed due to the fracture. The laceration to Resident #1's forehead was repaired with dissolvable sutures and laceration/hematoma to the back of her head was cleaned thoroughly but required no further treatment. Resident #1 was in stable condition and discharged back to the facility.

A nurse's Note dated 4/08/25 at 2:33 PM written by Nurse #1 indicated Resident #1 returned to the facility at approximately 2:00 PM from the ED due to a fall in the facility van. Resident #1 had bruising to the left side of her face, a laceration to her forehead with stitches, a diagnosis of a neck fracture, and left index finger fracture. Resident #1's pain medication was ordered as needed and was administered.

An interview with Nurse #1 on 4/16/25 at 11:58 AM indicated she was the nurse assigned to Resident #1 on 4/08/25 from 7:00 AM to 7:00PM. Nurse #1 revealed Resident #1 left the facility at 8:30 AM with Driver #1 for an orthopedic appointment. She stated Resident #1 had a fall on the facility van during transport back to the facility and was transported to the ED for further evaluation. Nurse #1 indicated Resident #1 returned to the facility around 2:00 PM accompanied by her Legal Guardian and was observed with bruising to the left side of her face, and a laceration to her forehead with stitches. She stated the ED report indicated Resident #1 was also diagnosed with a cervical 7 neck

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fracture and left index finger fracture. Nurse #1 revealed Resident #1 was at her baseline, was exhibiting no signs of distress and fed herself dinner. Nurse #1 stated she initiated neurological checks and monitored Resident #1 closely till the end of her shift. Nurse #1 indicated Resident #1 required extensive assistance with standing and transfers and was unable to attempt standing on her own. Nurse #1 revealed Resident #1 had remained at her baseline since the incident and there had been no changes to her level of cognitive or physical function.

During a phone interview with the Legal Guardian on 4/17/25 at 7:56 AM she revealed on 4/08/25 she was notified by the Administrator Resident #1 fell on the facility van and was transported to the ED for further evaluation. The Legal Guardian stated she arrived at the ED and Resident #1 had a laceration to her forehead, bruising to the left side of her face and after a CT scan and x-ray was diagnosed with a neck fracture and left index finger fracture. She indicated Resident #1 was exhibiting no signs of distress and was at her baseline. The Legal Guardian revealed since the fall Resident #1 has remained at her baseline and had no residual effects from her injuries. The Legal Guardian stated Resident #1 had a history of trying to stand up without staff assistance, but in the past few months she was requiring more assistance with standing and transfers and was not strong enough to attempt standing on her own. The Legal Guardian revealed she was very concerned the facility did not ensure Resident #1 was safe while being transported in the facility's van and the Administrator was aware of her concerns.

An interview was conducted with the Director of

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Nursing (DON) on 4/16/25 at 12:53 PM. She stated the morning of 4/08/25 she was informed by the Administrator Resident #1 fell over in her wheelchair while being transported in the facility van and was transported by EMS to the ED for further evaluation. She stated Resident #1 had a laceration to her forehead which required sutures and was diagnosed with a cervical 7 neck fracture and left index finger fracture. The DON revealed Resident #1 returned to the facility on 4/08/25 at approximately 2:30 PM and was assessed to be at her baseline. She indicated neurological checks were initiated, and staff were monitoring her closely. She stated Resident #1 had remained at her baseline with no changes in her condition and no residual effects from her injuries. The DON revealed following the incident on 4/08/25 she observed Driver #1 perform a reenactment. She indicated during the reenactment Driver #1 reported after securing Resident #1 and the wheelchair in the van she did not check the tie downs or the shoulder and lap belt to ensure they were secured properly. The DON revealed Driver #1 also reported she did not think the shoulder and lap belt were fully connected which caused the wheelchair to tip over. She indicated Driver #1 was suspended on 4/08/25 and had not returned to work. The DON stated the facility was now using a contracted transportation company for all resident appointments.

A phone interview with the Medical Director on 4/16/25 at 3:47 PM revealed she was notified on 4/08/25 Resident #1 fell while being transported in the facility van due to the wheelchair not being secured properly. She stated Resident #1 was transported to the ED for further evaluation and received sutures to the laceration on her

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forehead, was diagnosed with a cervical 7 neck fracture, and a fracture to her left index finger. The Medical Director revealed Resident #1 returned to the facility on 4/08/25 at her baseline and has had no residual effects from her injuries and no changes in her level of cognitive or physical function. The Medical Director stated that residents should be secured properly in the transport van to ensure they were safe.

During an interview with the Administrator on 4/16/25 at 12:31 PM he indicated Driver #1 started working at the facility in October 2024. He stated Driver #1 received training on how to safely transport residents in the facility van. He indicated the training included reading materials, instructional videos, and how to secure a wheelchair in the van per the manufacturer's guidelines. The Administrator indicated he trained Driver #1 on how to secure a wheelchair in the van and she completed 3 to 4 return demonstrations. The Administrator revealed he observed Driver #1 secure the wheelchair in the van per the manufacturer's instructions during all return demonstrations and all requirements on the skills checklist were met. He stated on 4/08/25, at approximately 9:55, AM Driver #1 called and informed him Resident #1 fell in the van, and she called 911. The Administrator revealed he went to where Driver #1 was located, and Resident #1 was being loaded into the ambulance to be transported to the ED for further evaluation. The Administrator revealed Driver #1 drove the van back to the facility, wrote a statement, and completed a reenactment of the incident. He indicated that during the reenactment Driver #1 connected the shoulder and lap belt and commented that there were two clicks, and she did not recall hearing two clicks

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when she was securing Resident #1 in the van. The Administrator stated that Driver #1 thought the shoulder and lap belt were not fully connected and that was the cause of Resident #1 and wheelchair to fall over. The Administrator revealed Driver #1 also reported she did not check the tie downs or the shoulder and lap belt to ensure Resident #1 and the wheelchair were properly secured. He stated Driver #1 was suspended pending an investigation and had not returned to work. The Administrator revealed Driver #1 should have secured the wheelchair in the facility van per the manufacturer's instructions to ensure Resident #1 was transported safely. He stated the facility started using a contracted transportation company on 4/09/25 for all resident appointments and would continue using the contracted company for the foreseeable future.

The facility was notified of Immediate Jeopardy on 4/15/25 at 5:55 PM.

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.

4/08/25 at approximately 9:50 AM, Resident #1, who had severe cognitive impairment, was loaded onto the facility van by the facility Van Driver to be transported back to the facility following an orthopedic appointment. The Van Driver stated she secured the resident in the van. The resident was transported via the facility's van which was being driven by the facility Van Driver. Resident #1 was placed on the passenger side (right side) in the back of the van. There were no

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other residents or staff members in the van. The orthopedic office is 1.5 miles away from the facility.

The Van Driver stated at approximately 9:55 AM on 4/08/25 she pulled off on the side of the road on East Roosevelt Blvd driving west bound, approximately 1.5 miles from facility. After making a right turn on East Roosevelt Blvd, the Van Driver stated she heard a "boom" sounding noise and saw resident #1 and her wheelchair turned over on its left side on the van floor. After pulling over, the Van Driver stated she put the van in park and immediately called Emergency Medical Services (EMS). She then stepped past the driver's seat, to the rear of the van, and walked towards Resident #1. She observed Resident #1 on the aisle floor of the van, lying on her left side with the wheelchair on its left side. The Van Driver stated she saw blood coming from the front of the resident's head and used a blanket she had on the driver's seat to apply to the area which was bleeding. She stated she did not see the seatbelt on the resident and the resident was not in the wheelchair. Once EMS arrived, the Van Driver stated she moved the wheelchair out of the way to allow EMS staff to enter the van and access the resident.

At approximately 9:55 AM 4/08/25, the Van Driver, notified the Administrator that Resident #1 had fallen out of her wheelchair while being transported back to the facility from an orthopedic appointment. Emergency Medical Services (EMS) were present, and resident#1 was being evaluated. Immediately following the call, the resident's state appointed guardian was notified by the Administrator and the facility's Medical Director was notified by the Director of Nursing.

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At approximately 10:06 AM 4/08/25, the Administrator arrived at the site where the van was parked. The van was driven back to the center by the Van Driver with no one else in the van.

Upon return to the facility, the Regional Clinical Director (RCD), the Director of Nursing, and the Administrator, watched the Van Driver complete a detailed reenactment of how the Van Driver had secured Resident #1 in the van. The Regional Clinical Director sat in the wheelchair on the right side of the van in the same position where Resident #1 had been in the van and asked the Van Driver to secure the resident exactly how the Van Driver had secured Resident#1 before leaving the orthopedic office. The Van Driver proceeded by latching the back two chair hooks first to the back of the wheelchair frame. The wheelchair latching devices were secured to the floor via the track in the floor. The Van Driver did not tighten them after they were latched. The Van Driver took the right rear tie down strap mounted to the van floor and attached its right hook to the right bottom bar rear of the wheelchair. Then she took the left rear tie down strap mounted to the van floor and attached the left hook rear to the left bottom bar on the bottom of the wheelchair. The Van Driver communicated she did not tighten either of the two rear straps. The lap melt mounts to the wheelchair latching device, which mounts to the van floor. The Van Driver then applied the lap belt over from left to right and attached it to the lap belt buckle. The shoulder restraint was mounted to the right back wall of the van. The shoulder restraint belt went immediately over the right shoulder to the lap belt buckle. As she buckled the shoulder restraint she stated,

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"Oh there were two clicks there, that must've been where it happened." The Administrator asked the Van Driver to explain. The Van Driver stated the buckle clicked "twice" to fully engage the latch. The Van Driver explained she did not remember hearing two clicks when she buckled Resident #1 in. The Director of Nursing disengaged and reengaged the seatbelt locking mechanism several times to see if they could hear/feel the two clicks referenced by the Van Driver. The two clicks were neither heard nor felt during the attempts. The Van Driver proceeded by latching the front two chair hooks first to the front of the wheelchair frame. The wheelchair latching devices were secured to the floor via the track in the floor. The van driver did not tighten them after they were latched. The Van Driver took the right front tie down strap mounted to the van floor and attached its right hook to the right bottom bar on the front of the wheelchair. Then she took the left front tie down strap mounted to the van floor and attached it to the left front hook to the left bottom bar on the bottom of the wheelchair. The Van Driver communicated she did not tighten any of the four straps. The Director of Nursing then unbuckled the over the lap belt and pulled the chair towards the left in effort to see if the chair could flip/fall on its side. The chair was able to sway but not able to be tilted /flipped even with a large amount of force. When asked if the front floor locks were intact at the time Resident #1 was observed on the floor, the Van Driver stated the left front was not, but the right front was. The Van Driver also stated both back floor hooks were attached to the wheelchair after the chair had tipped over.

At approximately 1:30 pm on 4/08/25, Van Driver was interviewed by the Administrator and a

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written account of the incident was obtained. Another reenactment of the position of the resident and the wheelchair was performed in the Administrator's office using a desk chair, as the wheelchair, and the Administrator, as the resident. The Regional Clinical Director and Director of Nursing were also in attendance. The Van Driver was able to position the chair on its left side to mimic how the resident was found in the van. The Van Driver also positioned the Administrator's head in the same manner to which the Van Driver observed Resident #1's head. During the interview, the Van Driver stated when she re-accounted locking the front two floor locks and then the back two, that she didn't pull back on the handles of the wheelchair to check for movement of the chair. She went on to say she usually did check as her own confirmation the wheelchair was secure. The Administrator then asked the Van Driver if she did a check of the seatbelt to ensure it was engaged and she replied tearfully, no but she would from that point on. The Van Driver was suspended 4/08/25 at the completion of the written statement pending the results of the investigation by the Administrator.

At approximately 3:00 PM on 4/08/25, Resident #1 returned with diagnoses that included: frontal scalp laceration, left middle finger fracture, and transverse cervical 7 (neck) fracture. The physician was notified of the residents' return from the emergency room on 4/8/25. Additional orders were obtained, to include, monitor for increased pain.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

The facility's van driver education records were

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audited on 4/08/25 by the facility Administrator and/or Director of Nursing, to ensure the Van Driver received the necessary education to drive the van safely. The driver was noted to have the necessary training and qualifications to drive the facility van to include what to do in case of an emergency. The Van Driver also provided a return demonstration to the Administrator and Vice President of Operations. The facility Van Driver was trained on the manufacturer's instructions on 10/16/24.

The Director of Nursing reviewed the facility incidents and accidents for the period of time of 2/08/25 to 4/08/25 to ensure no other falls/incidents had occurred related to van transport. No occurrences were noted.

On 4/08/25, an audit of all appointments via van transport scheduled for 4/09/25 was completed by the Director of Nursing and the Administrator to ensure that the residents were rescheduled with contracted wheelchair transport company and that residents, and/or their responsible parties (RP) were notified of scheduled appointments. Starting 4/09/25, all appointments requiring van transportation were reviewed during the center's morning clinical meeting by the Director of Nursing, administrator and or nurse designee to verify transfer vehicle and resident/RP notification.

On 4/09/25 an audit was completed for the previous seven days to identify any interviewable residents that were transferred to ensure no incident or accident occurred during their van transport. There were no interviewable residents identified during the audit. This audit was conducted by the Administrator.

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| F 689 | Continued From page 17<br><br>On 4/08/25 prior to rescheduling van transport, the contracted wheelchair transport company transport staff training and certification, which included manufacturer's instruction for transport safety, were reviewed and validated to be in place by facility Administrator.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.<br><br>On 4/08/25, the van was sent to the wheelchair transport van service center for inspection. There were no problems found as a result of inspection.<br><br>Immediately after the incident on 4/08/25 all transport appointments which would have required residents to be transported via the facility van were scheduled through a contracted wheelchair transport company.<br><br>Effective 4/08/25 the facility contracted all resident van transports with contracted wheelchair transport company.<br><br>Starting 4/09/25, all appointments requiring van transportation were reviewed via the center's morning clinical meeting by the Director of Nursing or Administrator to determine if additional assistance was necessary for van transport.<br>On 4/09/25, the Administrator was educated by the Vice President of Operations on checking the locking mechanisms/restraints on the van for the wheelchair and for the seatbelt prior to transporting residents via the van per manufacturer's instructions. Additional education was provided to the Administrator by the employee of wheelchair transport van service | F 689 | | |

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center on 4/09/25 at the completion of the van inspection regarding manufacturer's instruction for the van wheelchair securement system.

On 4/09/25, the Administrator provided education to the Maintenance Director and Director of Nursing regarding van safety related to checking the locking mechanisms/restraints on the van for the wheelchair and for the seatbelt prior to transporting residents per manufacturer's instructions.
The facility will continue to use the contracted wheelchair transport company verses the facility transporting residents in the van.

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

An ADHOC quality assurance (QA) meeting was held on 4/09/25 to review the incident and identify the root cause. During the ADHOC Quality Assurance (QA) meeting with the Interdisciplinary team it was determined the facility failed to provide safe van transportation for Resident #1 by not securing her wheelchair in the transportation van per the manufacturer's instructions.

An audit will be completed of two residents receiving transport services by the Administrator twice a week for twelve weeks to ensure the contracted wheelchair transport company is compliant with the safety guidelines of residents being secured and wheelchairs being properly secured by the manufacturer's guidelines.

Once a new van driver is identified, they will go through the facility's motor vehicle and driver

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safety program including components of a safe driver and vehicle maintenance program, record keeping, routine vehicle inspection/maintenance, motor vehicle record questionnaire, driver skills validation, securing wheelchair training program (video), safety responsibilities for authorized drivers and vehicle inspection validation. A return demonstration will also be included and conducted by the Administrator and Vice President of Operations. The Administrator will provide education and training.

Effective 4/08/25, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance and that the education and training are provided.
The Quality Assurance Improvement committee will review the results of the weekly audits during monthly QA meeting for three months. The committee will determine if further actions are needed.

Alleged date of IJ removal: 4/10/25.

The facility's alleged date of compliance is 4/10/25.

The facility's implementation of the Immediate Jeopardy removal and corrective action plan was validated on 4/16/25. Interviews conducted with nursing staff revealed transportation for all resident appointments from 4/09/25 were provided by a contracted transportation company. A phone interview conducted with the van service center employee indicated he completed a safety inspection of the facility's van and wheelchair securement system on 4/08/25 and all equipment was working properly, and education was

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| F 689 | Continued From page 20<br>provided to the Administrator on how to secure a wheelchair in the van per the manufacturer's instructions. An observation was conducted of the Administrator securing a wheelchair in the facility's van, the wheelchair was secured per the manufacturer's instructions and no concerns were identified. A review of the audit of incident/accident reports from 2/08/25 to 4/08/25 that was completed on 4/09/25 revealed no other resident van incidents had occurred. Interviews conducted with the Maintenance Director and DON revealed they received training from the Administrator on how to secure a wheelchair in the facility's van per the manufacturer's instructions and both completed return demonstration. Driver basic skills checklists were completed for the DON and Maintenance Director and all areas of competency were checked as met. An interview conducted with the Administrator revealed on 4/08/25 the transportation company provided records, and he verified that all the company's van drivers had completed a driver safety program, and skills checks were completed with all competencies met. The alleged immediate jeopardy removal date of 4/10/25 and alleged compliance date of 4/10/25 were validated on 4/16/25. | F 689 | | |