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	345389	A. BUILDING ______ B. WING ______	C 12/09/2022

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(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
E 000	Initial Comments An unannounced complaint investigation and recertification survey was conducted on 12/5/22-12/9/22. the facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID # 4ICQ11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation were conducted from 12/5/22 through 12/9/22. Even tID # 4ICQ11. The following intakes were investigated NC00192414, NC00191283, NC00134116, NC00190081, 12 of 12 allegatons were not substantiated. Immediate Jeopardy was identified at: CFR 483.70 at tag F835 at a scope and severity (K) CFR 483.25 at tag F689 at a scope and severity (K) Immediate jeopardy began on 3/31/22 and was removed on 12/9/22. An extended survey was conducted. Substandard Quality of Care was identified at: CFR 483.25 at tag F689 at a scope and severity (K) Immediate Jeopardy (IJ) at F726 was identified but then deleted after the case was transferred to and reviewed by the Centers for Medicare and Medicaid Services (CMS) and the 2567 was ammended to reflect the deletion. The Statement of Deficiencies was amended on 12/28/22 at tag F835 and tag F726 was deleted.	F 000		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		12/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/28/2022

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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F 689 SS=K	Continued From page 1 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 physician interview, resident interview, record review, observations, staff interviews, and Medical Director interview, the facility failed to secure a resident's wheelchair to the transportation van securement system per manufacturer instructions and failed to apply a lap and shoulder restraint across a resident per manufacturer instructions for 1 of 4 residents reviewed for accidents (Resident #26). Residents #26 had three falls on the transportation van. On March 31, 2022 the resident fell backwards in her wheelchair in the transportation van. The Resident had complaints of neck pain, back pain, and a skin tear on her left forearm. On June 30, 2022 the Resident fell from the wheelchair in the transportation van. On July 21, 2022 the Resident fell backwards in her wheelchair in the transportation van. An observation on 12/8/2022 revealed staff were unable to identify the recommended location per manufacturer's instructions, to apply retractors from a 4-point wheelchair securement system to a resident's wheelchair during transportation on the facility's van. The facility failed to complete a thorough investigation and implement interventions after Resident #26 had a fall while on the transportation van on March 31, 2022, June 30,	F 689	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 12/30/2022. Preparation and/or execution of this Plan of Correction does not constitute admission to, nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the Statement of Deficiencies. This plan is prepared and/or executed to ensure continued compliance with regulatory requirements. F689 Free of Accident Hazards/Supervision/Devices The facility is unable to correct the deficiency for resident #26 as it has already allegedly occurred. Resident #26 will not be transported on the facility transportation van and will only be transported via outside contract company to prevent further incidents on the facility transportation van for this specific resident. The Administrator completed an	

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2022, and July 21, 2022. In addition, the facility failed to have a policy and procedure for the 4-point wheelchair securement system located inside the facility's transportation van or a policy and procedure for the application of a safety lap and shoulder belt for residents during transit on the facility transportation van.

Immediate jeopardy began on 3/31/2022 when the facility failed to secure Resident #26's wheelchair to the floor securement system of the transportation van and the facility administration did not complete a root cause analysis so that effective interventions could be implemented to protect Resident # 26 and all residents during transport. This resulted in 2 additional avoidable accidents for Resident # 26. Immediate jeopardy was removed on 12/9/2022 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a "E" which is no actual harm with the potential for more than minimal harm that is not immediate jeopardy to complete staff education and ensure monitoring systems put in place are effective.

Findings included:

Review of a facility's policy titled "Transportation" dated 11/2016 did not include information about using the van's 4-point wheelchair securement system located inside the van to secure a resident's wheelchair when transporting residents to appointments away from the facility or address the application of a safety lap and shoulder belt.

Review of 4-point wheelchair securement system's use and care manual dated 2014 found on the manufacture's website included the

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incident and accident investigation of the incidents dated 3/31/2022, 6/30/2022 and 7/21/2022 regarding resident #26 on 12/07/2022 and 12/08/2022 by use of the Incident and Accident Investigation Form. The Administrator, Director of Nursing and Minimum Data Set Nurse (MDS Nurse) reviewed and revised the careplan for resident #26 related to fall interventions on 12/08/2022. Interventions include, but are not limited to: antirollbacks to wheelchair, appropriate positioning in wheelchair for transportation, appropriately strapped in for transportation, keep resident’s environment as safe as possible with even floors free from spills and/or clutter, adequate lighting, call light within reach, commonly used items within reach, avoid repositioning furniture, keep bed in the appropriate position, provide resident with activities to minimize the potential for falls, PT/OT evaluation and treatment as ordered or PRN. Resident #26 care plan was reviewed and revised by the Administrator, Director of Nursing and MDS Nurse again on 12/29/2022; resident should be transported via outside contracted transportation company for all outside appointments was added.

The Licensed Nursing Home Administrator (LNHA), The Director of Nursing (DON) and The Director of Clinical Service (DCS) Laurel Health Care Company reviewed all other residents that have the potential to be affected on 12/08/2022 by review of Transportation Log and the Incident and Accident Log,

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following information:
* J-Hooks must be attached to a sold wheelchair frame (no spokes or moveable components
* Compliant shoulder and pelvic belt restraint must go across occupant's shoulder and pelvis (lap).

Resident #26 was admitted to the facility on 2/4/2021 with cumulative diagnoses that included abnormal posture and bilateral amputation.

Resident #26's care plan in place on 3/31/2022 included an area of focus Resident #26 was at risk for fall related injury, at risk for acute/chronic pain, and had a potential for fluctuations in mood related to depression, anxiety, and psychosis. Interventions included ensure the environments was as safe as possible, anticipate residents need for pain relief, notify doctor if interventions are unsuccessful, administer medications as ordered, observe for ineffectiveness, and notify physician, consult with behavioral health as needed.

Resident #26's quarterly MDS dated 9/22/2022 indicated resident was cognitively intact. Resident #26 required the assistance of one staff with transfers and was unable to walk.

a. An incident report dated 3/31/2022 and completed by Nurse #1, read on 3/31/2022 at 11:40 A.M. Resident #26's wheelchair flipped back on the transportation van. The report indicated Resident #26 had a skin tear. The immediate interventions included Resident #26's appointment was rescheduled, and therapy was to check Resident #26 for wheelchair positioning.

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which was verified that no other residents have been affected by the alleged noncompliance. Any residents transported in the facility transportation van has the potential to be affected by the alleged deficient practice; therefore, a Root Cause Analysis was completed to determine the best system change to prevent this alleged deficient practice from (re)occurring. The Licensed Nursing Home Administrator and The Director of Nursing received education on Root Cause Analysis (RCA) and completion of facility incident and accident investigations by The Director of Clinical Service for Laurel Health Care Company on 12/07/2022. The LNHA and DON are the only staff responsible for the completion of investigations of incidents and accidents. The LNHA, DON and DCS completed a Root Cause Analysis on 12/07/2022 of the incidents dated 3/31/2022, 6/30/2022, 7/21/2022 regarding resident #26. The RCA determined that lack of facility policy and procedure on the transport of residents in the facility van as well as lack of competency training of the van transport driver resulted in the incident(s) occurring. The Root Cause Analysis included interventions to prevent further occurrences and have been implemented and completed on 12/08/2022. Interventions include: The LNHA and DCS developed and approved a policy and procedure for transportation of a resident in facility van on 12/08/2022, which does include information on the 4-point wheelchair securement system and the application of a safety lap and shoulder

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Nurse's progress note written by Nurse #1 dated 3/31/2022 showed Resident #26 flipped her wheelchair back while on transportation van. Resident #26 had complaints of neck pain, back pain, and a small skin tear noted to her left arm.

Nurse Practitioner (NP) note dated 3/31/2022 showed Resident #26 was evaluated by the NP after she fell backwards while on the transportation bus and hit her back on the floor. Resident #26 had complaints of left forearm pain, neck pain, and back pain. The note indicated Resident #26 had a small bruise noted on her wrist and a skin tear on her arm.

Physician order dated 3/31/2022 showed an xray ordered for the left forearm, cervical spine, and lumbar to sacral spine.

Review of the xray results for the forearm and spine dated 3/31/2022 showed Resident #26 had no acute fractures.

Review of a post fall evaluation report created by Nurse #1 dated 3/31/2022 showed "environmental factors (circle or write in): fell backwards in wheelchair on transportation van" was written in. The description of the position the resident was observed in at the time of the incident read "unknown did not observe guest." The type of assistance resident received at the time of the fall was documented as "buckled down on transportation van." The re-creation of fall read "guest had multiple items in back of wheelchair". The report indicated the cause of the fall was environmental factors/items out of reach. New interventions included Resident #26 was scheduled to follow up with physical therapy for

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belt for residents during transit. This policy was taken to the Quality Assurance committee on 12/08/2022 for approval and implementation. Additionally, the LNHA and DCS developed a Facility Van Transport Driver job description with required training and competency on 12/07/2022.

The Transportation of a Resident in Facility Van policy was reviewed with the facility Transportation Driver on 12/08/2022 and again on 12/27/2022 by the LNHA. The Facility Van Transport Driver job description with required training and competency was reviewed with the facility Transportation Driver on 12/07/2022 and again on 12/27/2022 by the LNHA. Additionally, the facility Transportation Driver reviewed the Q'Straint QRT Max Training Video on 12/07/2022. The facility Transportation Driver received education on safety guidelines for assisting residents with wheelchair transporting with subsequent competency evaluation by the Rehab Service Director on 12/07/2022 with review on 12/27/2022. Should the facility's current Transportation Driver leave the company for any reason, the newly hired Transportation Driver will receive the Facility Van Transport Driver job description by the LNHA or DON, education on guidelines for assisting residents with wheelchair transporting and review of the Q'Straint QRT Max Training Video by the LNHA or DON, receive the Transportation of a Resident in Facility Van policy by the LNHA or DON and initial

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F 689	Continued From page 5 wheelchair positioning. An interview was conducted on 12/7/2022 at 2:00 P.M. with Nurse #1. Nurse #1 indicated she was familiar with Resident #26. Resident #26 was a double amputate and had a lot of anxiety. Nurse #1 indicated during one of her shifts, Resident #26 had a fall on the transportation van, but due to the length of time since the incident, Nurse #1 was unable to provide a month Resident #26's fall occurred. Nurse #1 indicated she was told by transportation staff, the van had pulled away from the facility and Resident #26's wheelchair had flipped backwards. Nurse #1 responded to the van to assess Resident #26. When Nurse #1 walked onto the van, the back of the wheelchair was laying on the van floor and Resident #26 was lying on her back in the wheelchair facing the van roof. During the interview, Nurse #1 indicated Resident #26 had retractors secured to the wheelchair and to the best of her knowledge Resident #26 had a seatbelt in place. Nurse #1 stated she did not recall any items under the wheelchair or around the back of the van. She further indicated she did not recall Resident#26 to voice any concerns of pain. Review of Resident #26's Medication Administration Records (MAR) for March 2022 showed Resident #26's received oxycodone tablet 5 milligram (mg) ordered for severe pain on 3/31/2022 at 4:13 P.M. for a pain level of 4 on a 0-10 pain scale where 0 is no pain and 10 is the highest pain level. Review of Resident #26's MAR for April 2022 showed Resident's #26 received oxycodone tablet 5mg for severe pain one time a day from 4/3/2022 - 4/15/2022 for a pain level that ranged	F 689	competency evaluation by the RSD, prior to transporting a resident. Additional competency evaluations will be completed by the LNHA, DON or RSD. Education and subsequent competencies will be completed upon hire, at least annually and as needed as determined by the Quality Assurance Committee. Additionally, the LNHA and DON educated licensed nurses on Fall Management policy, which highlights the procedure for post-fall, which includes intervention by 12/28/2022. Education will be completed upon hire, at least annually and as needed as determined by the Quality Assurance Committee. The facility Transportation Driver will be monitored by the LNHA, DON, or RSD for proper transportation and securement of a resident in the facility transportation van every day there is a scheduled transport for three weeks (up to five days per week), then three days per week for two weeks, then once per week for two weeks, then as determined by the Quality Assurance Committee. The LNHA will be responsible for bringing audits to the Quality Assurance Meeting. Continued compliance will be monitored through the facility's Quality Assurance.	

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from 3-9 on a pain level scale. Resident #26's received two doses of oxycodone on 4/3/2022 and 4/9/2022.

Attempts were made to interview the Nurse Practitioner who assessed Resident #26 on 3/31/2022 were unsuccessful.

An interview was conducted on 12/8/2022 at 12:48 P.M. with the Medical Director. During the interview, the Medical Director reviewed Resident #26's electronic medical record. The Medical Doctor indicated Resident #26 was evaluated by the Nurse Practitioner on 3/31/2022 after she had a fall in the transportation van. Resident #26 had complaints of back and neck pain. The NP ordered and reviewed xrays of Resident #26's arm, neck, and back. The xrays indicated Resident #26 had no fractures. The Medical Director indicated Resident #26 had degenerative changes to her back

Review of a therapy evaluation and plan of treatment note dated 7/22/2022 showed Resident #24's last dates of therapy were 10/12021 - 1/8/2022.

An interview was conducted on 12/7/2022 at 11:50 A.M. with the Director of Nursing (DON). During the interview, the DON indicated she did not recall this incident due to the length of time since the event happened. She indicated Resident #26 was a double amputee and maybe her positioning contributed to her fall. The DON indicated an investigation would have been completed after the fall. The DON was unable to provide additional written information related to this incident.

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An interview was conducted on 12/7/2022 at 11:36 A.M. with the Administrator. During the interview, the Administrator indicated she did not recall the details of Resident #26's fall on the transportation van on 3/31/2022. The Administrator reviewed the incident report and indicated it appeared Resident #26 was retrieving items from a bag on the back of her wheelchair and the wheelchair flipped backwards. During the interview, the Administrator indicated Resident #26 was a bilateral amputee, which caused her center of gravity to be different when she sat in the wheelchair. The Administrator indicated physical therapy had worked with Resident #26 on positioning while she was in the wheelchair.

b. An incident report dated 6/30/2022 and completed by Nurse #2 showed on 6/30/2022 at 4:00 P.M., Resident #26 had a fall from a wheelchair on the transportation van. The report read Resident #26 had no injuries. The immediate interventions included range of motion, skin assessment, pain assessment, position secured in wheelchair, and make sure all seatbelts are fastened.

Nurse's progress note written by Nurse #2 and dated 6/30/2022 read Resident #26 observed sitting on floor of transportation van. Van driver stated she didn't have all the seatbelts secured to Resident #26.

Review of a post fall evaluated report created by Nurse #2 and dated 6/30/2022 showed Resident #26's seatbelt was not buckled securely, and resident slid to floor. Factors observed at the time of the fall had equipment malfunction and environmental factors checked. The description

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of the guest was described as "sitting on buttocks in transportation van." New interventions included ensure safety device in van is secure while in transit. The report included signatures under the section titled "IDT Signatures". One signature was the signature of the Director of Nursing.

An interview was conducted on 12/8/2022 at 1:08 P.M. with Nurse #2. She indicated she was familiar with Resident #26 and to her knowledge Resident #26 only had falls when she was transported in the facility's transportation van. During the interview, Nurse #2 indicated she was only involved in one of Resident #26's falls. She heard a page overhead that stated Resident #26 had fallen while on the transportation van. Nurse #2 went out to the van to assess Resident #26. She observed Resident #26 sitting on the van floor and her wheelchair was still sitting up. During the interview, Nurse #2 indicated to the best of her knowledge, she was told Resident #26 fell forwards when the driver started to drive the van out of the facility's parking lot. Nurse #2 was unable to recall if Resident #26's wheelchair was secured with retractors to the van's floor. Nurse #2 indicated Resident #26 was not wearing a seatbelt.

Attempts were made to interview Transportation Driver #2 who worked as the transportation driver from March 2022 through September 2022 were unsuccessful.

An interview was conducted on 12/8/2022 at 9:45 A.M. with the DON. During the interview, the DON confirmed she did not recall this incident.

c. An incident report dated 7/21/2022 created by

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F 689	Continued From page 9 Nurse #3 showed on 7/21/2022 at 9:30 A.M. Resident #26 had a witnessed fall on the transportation van during transportation. Resident #26 had no injuries during this fall. There were no immediate interventions listed on the report. Nurse's progress note written by Nurse #3 and dated 7/21/2022 read Resident #26 observed laying on her back still strapped to wheelchair inside transportation vehicle. Review of a post fall evaluation report dated 7/21/2022 listed no factors observed at the time of the fall. The description provided described Resident #26's as lying flat on her back and the fall was a witnessed fall to the floor. New interventions included add anti-roll back brakes on Resident #26's wheelchair and refer to physical therapy. An interview was conducted on 12/8/2022 at 10:13 A.M. with Nurse #3. Nurse #3 assessed Resident #26 after her fall on 7/21/2022. During the interview, Nurse #3 indicated it was reported to him when the van was leaving the parking lot and moving forwards when Resident #26's wheelchair rolled backwards and flipped. Nurse #3 indicated when he arrived on the van, he observed Resident #26 lying on her back, still in her wheelchair. The wheelchair appeared to have tipped over backwards and the back of the chair had come to rest on the floor of the van. Nurse #3 indicated he assisted additional staff to upright Resident #26's wheelchair. Resident #26 had no injuries and went to her scheduled appointment. Review of an occupational therapy note dated 7/22/2022 showed the reason Resident #26 was referred to therapy was due to a fall from	F 689		

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wheelchair during transportation to appointment. The listed goals included demonstrate improvement in trunk control/sitting balance and demonstrate good upright midline posture in wheelchair for 1-2 hours with appropriate system including anti tippers. The evaluation report showed Resident #24's last dates of therapy were 10/12021 - 1/8/2022.

An interview was conducted on 12/7/2022 at 12:21 P.M. with the Rehabilitation Service Director. During the interview, the Director indicated Resident had been referred to therapy after a fall a few months ago. The Director stated Resident #26 was a bilateral amputee and therapy worked with her to build her core strength and upper muscles. During the interview, the Director further indicated Resident #26 had a regular wheelchair and the therapy department had maintenance install anti tippers to her wheelchair. The Director indicated she was unable to recall the date of Resident #26's fall.

An interview was conducted on 12/7/2022 at 9:12 with Resident #26. Resident #26 indicated she did not recall her wheelchair falling in the transportation van and was unable to provide any additional information.

An interview was conducted on 12/7/2022 at 2:49 P.M. with the Transportation Driver #1, who was out on medical leave from March 2022 through September 2022. The Transportation Driver indicated when he was hired at the facility, he shadowed the previous transportation driver for thirty days and was showed by the previous driver how to secure residents into the transportation van for transportation to outside appointments. The Transportation Driver indicated the

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transportation van was equipment a 4-point wheelchair securement system that used retractors and this was the same system installed on the transportation van used during the time of each of Resident #26's falls. During the interview, Transportation Driver #1 indicated he had heard Resident #26 had a fall with Transportation Driver #2, but he was not at the facility during the times of the falls.

An interview was conducted on 12/8/2022 at 11:46 A.M. with Nurse Aide (NA) #1. During the interview, NA #1 indicated she was present on the transportation van when Resident #26 had a fall. NA #1 was unable to recall the date of the incident. She indicated Transportation Driver #2 secured Resident #26's wheelchair in the facility van. When the van started to pull out of the parking lot, Resident #26 and her wheelchair tipped over backwards. Resident #26 had no observed injuries. During the interview, NA #1 indicated a staff showed Transportation Driver #2 where to clip the safety straps to Resident #26's wheelchair to prevent the wheelchair from tipping backwards and Resident #26 continued to her scheduled appointment. NA #1 stated she sat behind Resident #26's wheelchair as Transportation Driver #2 drove and Resident #26's wheelchair did not tip over a second time that day. NA #1 was unsure which staff assisted Transportation Driver #2 with repositioning Resident #26's wheelchair after she fell backwards.

An interview was conducted on 12/8/2022 at 12:39 P.M. with NA #2. NA #2 indicated she was responsible to ride on the van and assisted as needed to secure residents into the transportation van when traveling to appointments away from

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the facility. During the interview, NA #2 stated she assisted with loading residents onto the transportation van when the residents had appointments away from the facility. She stated Transportation Driver #2 showed her where to hook the safety straps that attached from the van floor to the resident's wheelchair. NA #2 indicated she was told each of the straps were hooked on the outside wheel of the wheelchair.

An observation was completed on 12/8/2022 at 12:52 P.M. with NA #2. NA #2 used a resident's wheelchair and pointed to the location on the wheelchair she hooked the safety straps to if she had secured the resident on the transportation van for transport. NA #2 pointed to the outside wheel and verbalized that is where she would place the safety strap

An interview was conducted with the Director of Nursing (DON) on 12/9/2022 at 2:03 P.M. During the interview, the DON was made aware during an interview NA #2 was asked to demonstrate on a resident's wheelchair where the retractor straps would be attached if a resident needed to be secured on the transportation van in the transportation van. NA #2 indicated the J hooks would be clipped to the outside wheel on the wheelchair. The DON indicated the retractor straps were not to be clipped to the wheelchair wheel and further indicated the new policy created indicated the transportation drive was responsible for securing a resident in the transportation van.

An interview was conducted on 12/8/2022 at 9:15 A.M. with a Physical Therapist (PT) #1. PT #1 indicated he had showed Transportation Driver #2 how to use the retractors to secure Resident #26

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F 689	Continued From page 13 onto the transportation van after she had a fall. PT #1 was unable to provide an exact date of this incident. He did state it was about three months ago. During the interview, PT #1 indicated he was unsure how Resident #26's wheelchair fell backwards and further indicated he was unsure how Resident #26's wheelchair was secured when she fell backwards. He indicated Resident #26 was a double amputee and had a greater risk of falling forwards compared to falling backwards because there was no support in front of her body compared to the support of the back of the wheelchair. An interview was conducted on 12/8/2022 at 9:00 A.M. with the Assistant Director of Nursing (ADON). During the interview, the ADON indicated she was only aware Resident #26 had one fall and was unaware of additional falls. The ADON indicated when Resident #26 had a fall in the transportation van, PT #1 provided Transportation Driver #2 with training on how to secure a wheelchair for transportation on the facility transportation van. The ADON indicated PT #1 was responsible to train staff on the transportation van following an incident. During the interview, the ADON indicated she was present on the van with Transportation Driver #2 and PT #1 for the training on how to secure Resident #26's wheelchair on the transportation van. The ADON further indicated when the safety retractors were used on the transportation van, a resident should not fall, and she is unsure what caused Resident #26 to flip her wheelchair backwards. An interview was conducted on 12/7/2022 at 11:50 A.M. with the Director of Nursing (DON). During the interview, the DON indicated it was her	F 689		

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F 689	Continued From page 14 responsibility to investigate each fall Resident #26 had in the transportation van. During the interview, the DON indicated she only recalled Resident #26 to have one fall in July. The DON indicated she was unsure how the wheelchair flipped over during transportation on the van and stated physical therapy was consulted to assess Resident #26. The DON further indicated physical therapy also provided Transportation Driver #2 with additional training on how to secure Resident #26's wheelchair in the transportation van when traveling to appointments. Review of the incident report dated 3/31/2022, 6/30/2022, and 7/21/2022 showed the DON's signature. The post fall evaluation dated 3/31/2022 and 6/30/2022 revealed the DON signed under IDT signatures. A follow-up interview on 12/8/2022 at 2:27 P.M. with the DON indicated a clinical meeting was held each business day after Resident #26's falls. During these meetings the fall incident was discussed, and the interdisciplinary team worked to implement appropriate interventions. During the interview, the DON indicated the lack of training for the transportation staff in securing Resident #26 in the transportation van was not identified. On 12/7/2022 at 5:49 P.M., the facility's Administrator and Director of Nursing were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 12/9/2022. The allegation of immediate jeopardy removal indicated:	F 689		

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F 689	Continued From page 15 Credible Allegation of IJ removal The Laurels of Forest Glenn o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and The alleged jeopardous deficient practice resulted when resident #26's wheelchair tipped backwards while in the facility transport van. Resident # 26 was assessed by practitioner on 04.01.22. Resident #26 had a skin tear as a result of the incident which is healed. X-rays of the left lateral forearm, cervical and lumbar spine and all were without acute fracture. An incident and accident report form was completed by licensed nurse at the time of the incident. An investigation of the incident was completed by the licensed nursing home administrator on 12.07.22 Resident #26 had an incident on 06.30.22 in which she slid from wheelchair while in transport van. She was evaluated by licensed nurse and was without injury noted. An incident and accident report form was completed at the time of the incident by the licensed nurse. The licensed nursing home administrator and the Director of Nursing were aware of the incident that occurred on 06.30.22 when the incident report was signed by both on 07.05.22. Investigation of this incident was completed 12.08.22 by licensed nursing home administrator when this alleged deficient practice was identified in the Immediate Jeopardy Citation. Resident # 26 had an incident when wheelchair tipped backward on transport van on 07.21.22 without any injury noted. She was seen 07.21.22 by practitioner with no new orders received and no injuries noted. An incident and accident report form was completed at the time of the incident by the licensed nurse. An investigation of this	F 689		

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F 689	Continued From page 16 incident was completed on 12.08.22 by licensed nursing home administrator. The licensed nursing home administrator and the Director of Nursing were aware of the incident that occurred on 07.21.22 when the incident report was signed by the director of nursing on 07.22.22 and the licensed nursing administrator signed on 11.01.22. Investigation of this incident was completed 12.08.22 by licensed nursing home administrator when this alleged deficient practice was identified in the Immediate Jeopardy Citation. Care plan was reviewed 12.8.22 by the MDS nurse with interventions to ensure proper wheelchair positioning and securement while in the transport van. Resident remains at her baseline. The investigation of the incidents of 03.31.22, 06.30.22 and 07.21.22 have been completed using the Incident and Accident Investigation Form by the licensed nursing home administrator (LNHA) on 12.07.22 and 12.8.22. Identification of other residents in the facility that may be affected due to the alleged noncompliance was completed by the LNHA on 12.8.22 via review of the transportation log and Incident and Accident log and there have been no other residents that have been affected by the alleged noncompliance. Identified resident # 26 had two additional incidents in the transport van on 6.30.22 and 7.21.22 Resident did not have injuries related to the additional two incidents. Future residents requiring transportation with facility van have the potential to be affected by the alleged noncompliance and therefore the following has occurred to prevent this. o 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.	F 689		

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F 689	Continued From page 17 Action taken to alter the process to prevent recurrence (systemic corrective action): The facility LNHA and Director of Nursing received education on Root Cause Analysis and completion of facility incident and accident investigations by the Director of Clinical Service for Laurel Health Care Company on 12.07.22 The LNHA and DON are the only staff that are responsible for the completion of investigations of incidents and accidents. On September 15, 2022, the facility implemented the risk management incident and accident portion of the electronic medical record. The administrator and director of nursing log into the electronic medical record system and review the risk management console for any new incident and accident reports daily. The incident and accident reports are then reviewed by licensed nursing home administrator and the director of nursing during morning meeting. The facility administrator, the facility Director of Nursing, and the Director of Clinical Services (DCS) for Laurel Health Care, on 12.07.22, completed a root cause analysis (RCA) of the incident dated 03.31.22, 06.30.22 and 07.21.22 regarding resident #26. The RCA determined that lack of facility policy and procedure on the transport of residents in the facility van as well as lack of competency training of the van transport driver resulted in the incident occurring. The Root Cause Analysis included interventions to prevent further occurrences and have been implemented and completed on 12.08.22, including: A policy and procedure for transport of a resident in facility van was developed and approved on 12.8.22 by the LNHA and the Director of Clinical Services for Laurel Health Care. A job description	F 689		

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with required training and competencies was developed by the LNHA and DCS on 12.7.22 and reviewed with the transport van driver.
Additionally, the LNHA and DON developed a job description for the van transport driver, and he has reviewed and signed the job description which includes stated education and competency on 12.07.22. The only staff required to be educated on the policy and procedure for transport of resident in a facility van are the LNHA, DON and the van transport driver. All completed on 12.08.22. The facility has only one transport driver.
The transport driver reviewed the Q'Straint QRT Max Training video on 12.07.22 The transport driver also received verbal education with return competency demonstration on the securing of wheelchair into the transport van by the Director of Rehab Services on 12.07.22. There is only one van transport driver. If he is not available for transport for any situation, the facility will utilize an outside transportation company for resident transports. The facility has a contract with an outside transportation company for transportation and the medical records clerk would schedule the transportation. If the transport van driver leaves the company for any reason, the newly hired transport van driver would receive the same education and competency evaluations as well as job description prior to starting. The licensed nursing home administrator or the Director of Nursing are responsible for ensuring the job description and training has been completed, and the therapy director is responsible to complete the competency.
Date of IJ removal: 12/9/2022

The facility's credible allegation of Immediate Jeopardy removal was validated on 12/9/2022.

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F 689	Continued From page 19 The validation was evidenced by staff interviews, record reviews, and review of competency training logs. The interventions included creating a policy on transportation of a resident in facility van, a new job description for the transportation driver, verified the transportation drive watched the Qstraint (van's 4-point wheelchair securement system) video, verified the transportation driver completed a return demonstration with the physical therapy director on the steps to complete to secure a resident wheelchair to the floor of the van as well as properly securing the resident in the wheelchair, the facility provided a copy of a signed contract with an outside company for non-emergency transportation of residents, and an observation of the transportation driving securing a resident in the transportation van after he completed his competency training. The Administrator was notified the removal of the immediate jeopardy had a removal date of 12/9/2022 and was validated on 12/9/2022. The LNHA is responsible to implement the plan.	F 689		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's administration failed to provide effective leadership and oversight of processes and procedures to ensure a policy was in effect per	F 835	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 12/30/2022.	12/30/22

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manufacturer's instructions on the securement of a resident in the facility transportation van who required the use of a 4-point wheelchair securement system. In addition, the facility failed to assure transportation drivers were competent to operate the 4-point wheelchair securement system in the transportation van for 3 of 3 staff members (Transportation Driver #1, Transportation Driver #2, and Nurse Aide (NA) #2) and 1 of 4 residents (Resident #26) The facility's failure resulted in Resident #26 to have falls in the transportation van on 3/31/22, 6/30/22, and 7/21/22. The facility failed to thoroughly investigate each fall or provide evidence of surveillance and oversight for the transportation system within the facility. This practice had the high likelihood for serious injury and adverse outcomes to all residents transported by the facility.

Immediate jeopardy began on 3/31/22 when a resident fell in the facility transportation van as result of not being secured according to manufacturer's recommendations as a result of staff not being trained. Immediate jeopardy was removed on 12/9/22 when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective.

Findings included:

This tag is crossed referenced to F689:

F689 Based on physician interview, resident

F 835

Preparation and/or execution of this Plan of Correction does not constitute admission to, nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the Statement of Deficiencies. This plan is prepared and/or executed to ensure continued compliance with regulatory requirement.

F835 Administration

The facility is unable to correct the deficiency for resident #26 as it has already allegedly occurred. Resident #26 will not be transported on the facility transportation van and will only be transported via outside contract company to prevent further incidents on the facility transportation van for this specific resident. The Administrator completed an incident and accident investigation of the incidents dated 3/31/2022, 6/30/2022 and 7/21/2022 regarding resident #26 on 12/07/2022 and 12/08/2022 by use of the Incident and Accident Investigation Form. The Administrator, Director of Nursing and Minimum Data Set Nurse (MDS Nurse) reviewed and revised the careplan for resident #26 related to fall interventions on 12/08/2022 and again on 12/28/2022.

The Licensed Nursing Home Administrator (LNHA), The Director of Nursing (DON) and The Director of Clinical Service (DCS) Laurel Health Care Company reviewed all other residents that have the potential to be affected on

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interview, record review, observations, staff interviews, and Medical Director interview, the facility failed to secure a resident's wheelchair to the transportation van securement system per manufacturer instructions and failed to apply a lap and shoulder restraint across a resident per manufacturer instructions for 1 of 4 residents reviewed for accidents (Resident #26). Residents #26 had three falls on the transportation van. On March 31, 2022 the resident fell backwards in her wheelchair in the transportation van. The Resident had complaints of neck pain, back pain, and a skin tear on her left forearm. On June 30, 2022 the Resident fell from the wheelchair in the transportation van. On July 21, 2022 the Resident fell backwards in her wheelchair in the transportation van. An observation on 12/8/22 revealed staff were unable to identify the recommended location per manufacturer's instructions, to apply retractors from a 4-point wheelchair securement system to a resident's wheelchair during transportation on the facility's van. The facility failed to complete a thorough investigation and implement interventions after Resident #26 had a fall while on the transportation van on 3/31/22, 6/30/22, and 7/21/22. In addition, the facility failed to have a policy and procedure for the 4-point wheelchair securement system located inside the facility's transportation van or a policy which addressed the application of a safety lap and shoulder belt for residents during transit on the facility transportation van.

An interview was conducted on 12/8/2022 at 2:27 P.M. with the Director of Nursing (DON). During the interview, the DON indicated the clinical management team discussed resident accidents reported on a 24-hour report and put

F 835

12/08/2022 by review of Transportation Log and the Incident and Accident Log, which was verified that no other residents have been affected by the alleged noncompliance. Any residents transported in the facility transportation van has the potential to be affected by the alleged deficient practice; therefore, a Root Cause Analysis was completed to determine the best system change to prevent this alleged deficient practice from (re)occurring. The Licensed Nursing Home Administrator and The Director of Nursing received education on Root Cause Analysis (RCA) and completion of facility incident and accident investigations by The Director of Clinical Service for Laurel Health Care Company on 12/07/2022. The LNHA and DON are the only staff responsible for the completion of investigations of incidents and accidents. The LNHA, DON and DCS completed a Root Cause Analysis on 12/07/2022 of the incidents dated 3/31/2022, 6/30/2022, 7/21/2022 regarding resident #26. The RCA determined that lack of facility policy and procedure on the transport of residents in the facility van as well as lack of competency training of the van transport driver resulted in the incident(s) occurring. The Root Cause Analysis included interventions to prevent further occurrences and have been implemented and completed on 12/08/2022. Interventions include: The LNHA and DCS developed and approved a policy and procedure for transportation of a resident in facility van on 12/08/2022, which does include information on the 4-point

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F 835	Continued From page 22 interventions into place. The DON indicated the root cause for Resident #26's falls on 3/31/22, 6/30/22, and 7/21/22 were not identified during the investigation and interventions to prevent additional falls were not put into place. The DON further indicated she was unaware a policy for the safe transportation of residents on the facility transportation van had not been created and staff had not completed training on the use of the 4-point wheelchair securement system prior to transporting residents. During the interview, the DON stated she was unaware a training program for the transportation drivers was not in place and further indicated she expected staff to be trained on how to transfer, transport, and make sure the residents were secured during transit on the transportation van. An interview was conducted on 12/9/2022 at 2:35 P.M. with the Administrator. During the interview the Administrator stated the incident and accident policy indicated it was her responsibility to complete a full investigation to include a general timeline of events, staff/resident interviews, summary of investigation, identify the root cause for the incident, and create interventions to prevent additional accidents. The Administrator offered no explanation why the van accidents had not been thoroughly investigated. On 12/8/22 at 4:35 P.M., the facility's Administrator and Director of Nursing were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 12/9/22. The allegation of immediate jeopardy removal indicated:	F 835	wheelchair securement system and the application of a safety lap and shoulder belt for residents during transit. This policy was taken to the Quality Assurance committee on 12/08/2022 for approval and implementation. Additionally, the LNHA and DCS developed a Facility Van Transport Driver job description with required training and competency on 12/07/2022. The Transportation of a Resident in Facility Van policy was reviewed with the facility Transportation Driver on 12/08/2022 and again on 12/27/2022 by the LNHA. The Facility Van Transport Driver job description with required training and competency was reviewed with the facility Transportation Driver on 12/07/2022 and again on 12/27/2022 by the LNHA. Additionally, the facility Transportation Driver reviewed the Q'Straint QRT Max Training Video on 12/07/2022. The facility Transportation Driver received education on safety guidelines for assisting residents with wheelchair transporting with subsequent competency evaluation by the Rehab Service Director on 12/07/2022 with review on 12/27/2022. The Transportation Driver is the only one authorized to secure a resident in the facility transportation van. Should the facility's current Transportation Driver leave the company for any reason, the newly hired Transportation Driver will receive the Facility Van Transport Driver job description by the LNHA or DON, education on guidelines for assisting residents with wheelchair transporting and	

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	345389	A. BUILDING ______ B. WING ______	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Credible Allegation of IJ removal The Laurels of Forest Glenn F 835
o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;

The alleged jeopardous deficient practice resulted when resident #26's wheelchair tipped backwards while in the facility transport van. Resident # 26 was assessed by practitioner on 4/1/22. Resident #26 had a skin tear as a result of the incident which is healed. X-rays of the left lateral forearm, cervical and lumbar spine and all were without acute fracture. An incident and accident report form was completed by licensed nurse at the time of the incident. An investigation of the incident was completed by the licensed nursing home administrator on 12/7/22.

Resident #26 had an incident on 6/30/22 in which she slid from wheelchair while in transport van. She was evaluated by licensed nurse and was without injury noted. An incident and accident report form was completed at the time of the incident by the licensed nurse. The licensed nursing home administrator and the Director of Nursing were aware of the incident that occurred on 6/30/22 when the incident report was signed by both on 07/05/22. Investigation of this incident was completed 12/8/22 by licensed nursing home administrator when this alleged deficient practice was identified in the Immediate Jeopardy Citation.

Resident # 26 had an incident when wheelchair tipped backward on transport van on 7/21/22 without any injury noted. She was seen 7/1/22 by practitioner with no new orders received and no injuries noted. An incident and accident report form was completed at the time of the incident by

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review of the Q'Straint QRT Max Training Video by the LNHA or DON, receive the Transportation of a Resident in Facility Van policy by the LNHA or DON and initial competency evaluation by the RSD, prior to transporting a resident. Additional competency evaluations will be completed by the LNHA, DON or RSD. Education and subsequent competencies will be completed upon hire, at least annually and as needed as determined by the Quality Assurance Committee. Additionally, the LNHA and DON educated licensed nurses on Fall Management policy, which highlights the procedure for post-fall, which includes intervention by 12/28/2022. Education will be completed upon hire, at least annually and as needed as determined by the Quality Assurance Committee.

The facility Transportation Driver will be monitored by the LNHA, DON, or RSD for proper transportation and securement of a resident in the facility transportation van every day there is a scheduled transport for three weeks (up to five days per week), then three days per week for two weeks, then once per week for two weeks, then as determined by the Quality Assurance Committee. The LNHA will be responsible for bringing audits to the Quality Assurance Meeting. Continued compliance will be monitored through the facility's Quality Assurance.

In addition to aforementioned interventions, educations, and competencies, the facility now uses the

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the licensed nurse. An investigation of this incident was completed on 12/8/22 by licensed nursing home administrator. The licensed nursing home administrator and the Director of Nursing were aware of the incident that occurred on 7/21/22 when the incident report was signed by the director of nursing on 7/22/22 and the licensed nursing administrator signed on 11/1/22. Investigation of this incident was completed 12/8/22 by licensed nursing home administrator when this alleged deficient practice was identified in the Immediate Jeopardy Citation.

The investigation of the incidents of 3/31/22, 6/30/22, and 7/21/22 have been completed using the Incident and Accident Investigation Form by the licensed nursing home administrator (LNHA) on 12/7/22 and 12/8/22.

Identification of other residents in the facility that may be affected due to the alleged noncompliance was completed by the LNHA on 12/8/22 via review of the transportation log and Incident and Accident log and there have been no other residents that have been affected by the alleged noncompliance. Identified resident # 26 had two additional incidents in the transport van on 6/30/22 and 7/21/22. Resident did not have injuries related to the additional two incidents. Future residents requiring transportation with facility van have the potential to be affected by the alleged noncompliance and therefore the following has occurred to prevent this.
Based on the investigation and the root cause analysis completed by the LNHA, DON and Director of Clinical Resources (DCR) for Laurel Health Care Company on 12/7/22, it was determined that the lack of policies relative to resident transportation in facility van, lack of staff

Risk Management system as a part of the electronic medical records system since the alleged incident(s). The LNHA and DON have received education on general investigation guidelines for incident investigations of unusual occurrence and the implementation of effective interventions for such incidents by the DCS on 12/07/2022. The LNHA and DON will review incidents through the Risk Management System in the Clinical Meeting, complete a post-fall review to identify the most appropriate intervention for the applicable resident and subsequent revision of the resident's careplan and implementation of identified intervention. The clinical meeting occurs on weekdays unless it is an observed holiday whereby the LNHA and DON may not be in the facility.

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education and competency for the transport van driver is what led to each of the incidents forementioned.
o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The facility implemented the immediate actions to ensure policies and systems were in place to investigate, implement effective interventions, document, ensure training and competencies for all staff who provide resident with transportation to outside appointments to prevent future accidents/injuries.

1) On 12/7/22 the licensed nursing home administrator, the director of nursing, and the director of clinical services for Laurel Health Care completed a root cause analysis of the incidents related resident # 26's incidents.
a.The resulting interventions from the root cause analysis were:
i. The development of a policy and procedure for Resident Transportation with Facility Van was on 12/8/22 by the licensed nursing home administrator and the Director of Clinical Services.
ii. A job description for the transportation van driver was developed on 12/7/22 by the licensed nursing home administrator and the director of clinical services, which included training requirements and competencies to be completed initially and annually thereafter. This was reviewed and signed by the transport driver and competency completed on 12/8/22.
iii. Licensed nursing home administrator received education from the Director of Clinical Services on 12/7/22 regarding the incident and

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accident management policy and procedure, general investigation guidelines for incident investigations, how to develop a root cause analysis, and the implementation of effective interventions for incidents.

iv. The licensed nursing home administrator or director of rehab services will provide surveillance of the securement of residents in the facility transport van weekly and as needed by direct observation.

Date of IJ removal: 12/9/22

The facility's credible allegation of Immediate Jeopardy removal was validated on 12/9/22. The validation was evidenced by staff interviews, record reviews, and review of competency training logs. The interventions included creating a policy on transportation of a resident in facility van, a new job description for the transportation driver, verified the transportation drive watched the Qstraint (van's 4-point wheelchair securement system) video, verified the transportation driver completed a return demonstration with the physical therapy director on the steps to complete to secure a resident wheelchair to the floor of the van as well as properly securing the resident in the wheelchair, the facility provided a copy of a signed contract with an outside company for non-emergency transportation of residents, and an observation of the transportation driving securing a resident in the transportation van after he completed his competency training. An interview was conducted with the Administrator indicated she received education from the Director of Clinical Services on 12/7/22 about the incident and accident management policy and procedure.