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ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

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F 000	INITIAL COMMENTS A complaint investigation suvey was conducted from 02/20/23 through 02/21/23. The survey team returned to the facility on 02/23/23 to validate the credible allegations of IJ removal. Therefore, the exit date was changed to 02/23/23. Event ID #7H7J11. The following intakes were investigated NC00196327, NC00197068, NC00198170. One of the seven allegations investigated resulted in deficiency. Intake NC00198170 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag 684 at a scope and severity (J) PNC- Past Noncompliance CFR 483.25 at tag 689 at a scope and severity (J) PNC-Past Noncompliance The tags F684 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/04/23 and was removed on 02/10/23. A partial extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

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

Electronically Signed | 03/09/2023

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F 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and physician interviews, the facility failed to ensure Resident #1 was assessed following a fall from her wheelchair in the facility van on 2/4/23. The Transportation Aide did not report the accident to the Director of Nursing until the evening of 2/5/23. Nursing staff were not made aware of the accident and therefore no assessment was completed. The Nurse Practitioner was contacted on 2/6/23 for Resident #1's complaint of right leg pain and ordered x-rays of the resident's right hip and pelvis which were negative for fractures or dislocations. When Resident #1 was informed of negative x-ray results, she requested to be sent to the emergency room for evaluation on 2/6/23 due to increased pain. Resident #1 was assessed to have lumbar spinal tenderness upon examination and the computer tomography (CT) scan resulted in moderate spinal canal stenosis at L3-L4 (L=Lumbar region of the spine) with possible right paracentral disc protrusion. (Ligaments from the spinal disc are intact but form a pouch that presses on the nerves). The document referenced needed treatment to include ongoing pain management and a referral to an orthopedic therapist for therapy. This deficient practice occurred for 1 of 1 resident reviewed for accidents. Findings included: Resident #1 was re-admitted to the facility on 4/5/22 with diagnoses that included end stage renal disease (ESRD) and chronic pain syndrome. A quarterly Minimum Data Set (MDS) assessment dated 12/14/22 indicated Resident	F 684	Past noncompliance: no plan of correction required.	

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#1 was cognitively intact, no behavioral concerns, required 1-person physical assistance with transfers, was able to self-propel her wheelchair with supervision assistance, and walked with 1-person physical assistance. The assessment further indicated that Resident #1 did not receive scheduled pain medications, but she did receive 7 days of opioid medications prescribed on an as needed frequency and she received 7 days of anticoagulant mediations.

An interview with Resident #1 was conducted on 2/20/23 at 10:10 AM. Resident #1 was lying in her bed with the lights off and immediately voiced she was in pain in her lower back and right lower extremity. Resident #1 described the pain as a level 12 on a 1-10 scale (10 being the worst). Resident #1 stated she had some slipped discs in her lower back following a fall during transport in the facility van on 2/4/23 after an appointment with the local dialysis center. Resident #1 explained she was sitting in her wheelchair when the former Transportation Aide stopped which caused Resident #1 to be projected out of her wheelchair and into the aisle on the floor in the van. Resident #1 stated at the time of the fall, the wheelchair was not securely fastened to the van using the securing straps which caused the wheelchair to land on her when she fell out onto the van floor. Resident #1 explained when the Transportation Aide loaded her in the van, the straps which secure the wheelchair were not tightly strapped to the wheelchair and the shoulder harness/lap restraint portion was not in place. The Transportation Aide flagged down the firefighter for assistance to lift her back to her wheelchair. Resident #1 stated she initially had some pain; however, the intensity increased later that evening and over the next couple of days, but

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she was afraid to vocalized too much increase in severity to avoid getting questioned about not reporting the incident on the date of the occurrence. The Resident stated eventually her pain escalated to a level she felt needed to be treated more than with her routine PRN medication. Resident #1 explained on 2/6/23 she requested an emergency room evaluation and was sent to the ER and discovered she had suffered from a "slipped disc" and provided pain management and referred to the orthopedic outpatient center.

An interview with the former Transportation Aide on 2/20/23 at 12:05 PM revealed she was suspended from the facility on 2/6/23 and terminated on 2/9/23 following a fall in the van involving Resident #1. The Transportation Aide stated she was scheduled to pick up Resident #1 from dialysis on 2/4/23. Upon arrival to the dialysis center around 10:30 AM, she loaded Resident #1 into the van and quickly "fastened her in." The Transportation Aide explained shortly after the transport began, she was approaching a stop light at an intersection, she heard Resident #1 say "oh, oh" and she looked back towards Resident #1 and discovered Resident #1 was no longer in her wheelchair and was laying on the floor of the van with her wheelchair no longer fastened to the floor of the van. The Transportation Aide expressed she immediately put the vehicle in park in the middle of the road, got out and slid along the side of the van to the door where she was able to access Resident #1 and tried to lift Resident #1 out of the floor but was unable to and acknowledged she needed assistance to lift Resident #1 back into her chair. The Transportation Aide stated she got back out of the van and "ran into the middle of the street" where she saw a fire truck passing by and

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"flagged" the fireman down for assistance. The Transportation Aide detailed she and the firefighter placed Resident #1 back in her wheelchair and she was brought back to the facility then left her in her room and did not report the fall to Resident #1's assigned nurse nor administration at that time. The Transportation Aide reported it was not until the following evening following a conversation with Resident #1, (2/5/23) she notified DON #1 via telephone to make her aware of the fall. The Transportation Aide said DON #1 told her to come to the facility and leave a statement for her and to ask the assigned nurse to complete an incident report. The Transportation Aide further reported when she arrived at the facility to write a statement, she approached Nurse # 1 about completing an incident report of which she refused stating she was not involved. The Transportation Aide explained it was not until the following day (2/6/23) she was asked further about the fall and was suspended. The Transportation Aide stated she had previously called the facility when incidents of a resident falling in the van had occurred and they sent a staff member to assist her to put the resident back in their chair, but since this occurred on the weekend, she was not sure what to do and therefore she flagged a member of the fire department instead. The Transportation Aide explained when she first became the van driver in the fall of 2022, she was provided minimal training and stated "they just gave me the keys and turned me loose." She indicated she was never specifically provided training on what to do if a resident fell during transport. The Transportation Aide said she did not think Resident #1 was visibly injured and therefore did not call 911 or the facility on 2/4/23. The Transportation Aide stated she had asked

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Resident #1 if she was ok but she was not qualified to assess her for injuries and the fireman who assisted to place Resident #1 back in her chair only asked what happened to which Resident #1 replied she fell out of her wheelchair.

A review of the nurse progress notes dated 2/4/23 and 2/5/23 revealed there was no documentation of Resident #1's fall from the wheelchair during transport in the facility van.

An incident report initiated on 2/6/23 by the former Director of Nursing (DON #1) and dated 2/4/23 at 2:05 PM indicated Resident #1 was being transported to the facility from dialysis after the Transportation Aide secured Resident #1 in and ensured buckle was on, she stopped at a red light and Resident #1 fell out of her wheelchair. The report indicated the Transportation Aide attempted to pick Resident #1 up from the vehicle but was unsuccessful and flagged down a fire truck and firefighters were able to assist Resident #1 back into her wheelchair.

A telephone interview with the former Director of Nursing (DON #1) on 2/20/23 at 12:50 PM revealed on 2/5/23 around 5 PM she received a phone call from the Transportation Aide who told her Resident #1 had fallen out of her wheelchair on the return trip from dialysis on the morning of 2/4/23. DON #1 instructed the Transportation Aide to go to the facility and tell Resident #1's nurse to complete an incident report. DON #1 stated she did not contact the facility on 2/5/23 and DON #1 was unable to provide any additional information regarding the incident on 02/4/23 because she was suspended from the facility.

An interview with Nurse #1 on 2/21/23 at 11:00

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AM revealed she was assigned to Resident #1 from 7AM to 7 PM on both 2/4/23 and 2/5/23. Nurse #1 indicated she did not learn about the fall involving Resident #1 until she was on a telephone call with Nurse #4 on 2/6/23 about something unrelated and overheard DON #2 (current DON) notify Nurse #4 about the incident. Nurse #1 stated she was asked if she knew about the incident because she had not been notified in the oncoming shift report and Nurse #1 told her she was not aware of the incident herself. Nurse #1 explained she was on duty around 6 PM on 2/5/23 when the Transportation Aide arrived to the facility and mentioned she needed to write a statement about some incident with buying cigarettes involving Resident #1 of which Nurse #1 admitted she did not feel the need to write an incident report and told the Transportation Aide she was not completing one but to leave the statements for DON #1 and/or the Administrator and it would be handled when they arrived the following morning and therefore did not ask any further questions. Nurse #1 acknowledged Resident #1 expressed mild asymptomatic pain at times over the weekend, but she thought the pain was the same pain she routinely described, and she was not anything acute therefore no assessment was completed at the time.

An interview with Nurse #2 on 2/21/23 at 11:30 AM revealed she was assigned to Resident #1 from 7 PM to 7 AM on 2/4/23 and 2/5/23. Nurse #2 indicated she was not aware of the fall until 2/11/23 when she returned to work. Nurse #2 stated Resident #1 expressed some hip and lower extremity discomfort and received her scheduled PRN pain medication and Resident #1 was not evaluated further due to long term complaints of pain on the weekend of the fall.

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A progress noted written by the Nurse Practitioner (NP) dated 2/6/23 indicated Resident #1 was referred by nursing for right leg pain. The note detailed Resident #1 was involved in an incident on the transportation van over the weekend which resulted in her slipping out of her wheelchair onto the floor of the vehicle. It further indicated Resident #1 did not have her belts in place and had pain to her right leg since the time of the incident. An order for an x-ray of the right hip and pelvis was provided to rule out occult processes (not detectable by clinical methods alone).

Attempts were made to contact the Nurse Practitioner without success.

A review of the physician's orders revealed Resident #1 had an order for an x-ray of the right hip and pelvis dated 2/6/23.

A radiological report dated 2/6/23 revealed an x-ray was obtained of the right hip and pelvis which indicated no fractures or dislocations were noted.

A nurse progress noted written by Nurse #4 dated 2/6/23 at 4:04 PM revealed the x-ray results were communicated by staff to Resident #1 who requested further evaluation and was then transported to the ER via ambulance.

An interview with Nurse #4 on 2/23/23 at 10:00 revealed she was the nurse assigned to Resident #1 on 2/6/23 when radiological studies were ordered and obtained due to complaints of pain in the right lower extremity and lower back region. Nurse #4 indicated she was not aware that Resident #1 fell in the van until DON #2 approached her on 2/6/23 asking about the fall.

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Nurse #4 indicated she was on the telephone with Nurse #1 about an unrelated topic and therefore asked Nurse #1 if she was aware of the fall. Nurse #4 stated both she and Nurse #1 were confused and both without knowledge that Resident #1 had a fall in the van on 2/4/23. Nurse #4 stated Resident #1 seemed normal but had continued to complain of pain after her PRN pain medications were provided and therefore, she had notified the nurse practitioner and obtained an order for x-rays. Nurse #4 explained when the x-ray results returned she was not the nurse who provided the results to Resident #1, but did prepare her for discharge per request to the ER for further evaluation on 2/6/23. Nurse #4 further stated she was not present when Resident #1 returned from the ER and was not aware of the CT results until she returned to work on her next scheduled shift.

A review of the Emergency Room and ER radiological studies dated 2/6/23 indicated Resident #1 was assessed to have lumbar spinal tenderness upon examination by the ER provider and the CT scan resulted in moderate spinal canal stenosis at L3-L4 with possible right paracentral disc protrusion. (Ligaments from the spinal disc are intact but form a pouch that presses on the nerves). The document referenced needed treatment to include ongoing pain management and a referral to an orthopedic therapist for therapy.

An interview with the Medical Director (MD) on 2/21/23 at 12:31 PM revealed he was made aware of the fall involving Resident #1 on 2/7/23 when he arrived at the facility for routine rounds. The MD stated he had been told that Resident #1 was not properly secured in the facility van during

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the transport on 2/4/23 and had been evaluated by ER staff to have a disc protrusion and was experiencing lower lumbar pain that radiated to her sides. The MD indicated he could not say for sure that the injury was a result of Resident #1 sustaining a fall during transport or not, but that it was a possibility.

An interview with the Administrator on 2/23/23 at 10:15 AM revealed during her morning commute to the facility on 2/6/23, she learned of the fall experienced by Resident #1 on 2/4/23 while in transport from the dialysis. The Administrator indicated when she arrived, she placed all staff involved on suspension and began her investigation. She indicated that the Transportation Aide should have immediately pulled the van over, called emergency services to ensure Resident #1 was safe and without injury before moving her followed by contacting the facility Administrator and the Director of Nursing and/or the Manager on Duty.

On 2/20/23 at 5:20 PM, the facility Administrator and Regional Corporate Consultant were notified of the Immediate Jeopardy.

1. The facility failed to assess Resident #1 after she fell from her wheelchair while transported from dialysis in the facility van on 2/4/23. Resident #1 was lifted back into her wheelchair by the transporter and a member of a local fire department. Emergency Medical Services was not contacted, and the resident was transported back to the facility. Facility staff were not notified of the incident by the transporter until 2/5/23 at approximately 5:00 PM. Lack of a comprehensive assessment resulted in a delay of treatment for

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low back pain which required an orthopedic referral, pain management and therapy.

On 2/6/23 Resident #1 reported pain to her low back and right leg, the Nurse Practitioner, available in the facility assessed resident #1 and ordered an x-ray which was negative for fracture. Resident #1 subsequently went to the Emergency Room for evaluation per resident's request on 2/6/23 where a CT scan reflected a bulging disc to L4-S1 and a referral to the orthopedic surgeon for ongoing care on 2/6/23.

2. On 2/6/23 the Assistant Director of Nursing initiated an incident report and an investigation into the event and included an interview with the resident, transporter, and Director of Nursing.

An audit of current residents transported during the last 30 days was completed by the Assistant Director of Nursing and Regional Director of Clinical Services on 2/8/23 to identify any other residents possibly affected by the same practice. Any unreported events were documented on an incident report, investigated, assessment of the resident completed by the licensed nurse including safe repositioning following assessment for any injury, an SBAR documented in the resident medical record and the Physician and Responsible Party were notified by the Assistant Director of Nursing or Regional Director of Clinical Services by 2/9/23.

By 2/9/23 the Assistant Director of Nursing, Nurse Manager, Social Worker and Regional Director of Clinical Services conducted interviews with current residents to identify any unreported incidents during the last 30 days. Any new incidents identified were reported to the Assistant

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Director of Nursing and Administrator, with resident assessment and notification of responsible party and physician.

By 2/9/23 the Assistant Director of Nursing, Nurse Manager and Regional Director of Clinical Services completed a record review of all incidents and accidents to ensure completion of a nursing assessment and notification to the responsible party and physician.

Root cause analysis for Resident #1 was conducted by the Assistant Director of Nursing, Medical Director, Administrator and Regional Director of Clinical Services on 2/9/23 and it was determined the transporter failed to follow emergency procedures, call 911 for help and report the incident timely which resulted in a delay in assessment and treatment.

3. By 2/9/23 all staff including agency staff were re-educated by the Assistant Director of Nursing and Administrator on the facility policy for Managing Incidents, to include reporting events immediately to the Administrator or Assistant Director of Nursing, always encouraging residents to report concerns and allegations, never persuading residents to avoid reporting concerns and allegations. Nurses were also educated on the facility policy for assessment with a change of condition to include a complete head to toe assessment with range of motion to identify injuries prior to repositioning post fall. After 2/9/23, the Assistant Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any new hired staff and agency staff, without receiving this education.

By 2/9/23 the Assistant Director of Nursing, Nurse

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Manager and Regional Director of Clinical Services re-educated all nursing staff, including agency staff regarding completion of an assessment, notification of the responsible party and the physician following a reported incident/accident. After 2/9/23, the Assistant Director of Nursing and Nurse Managers will ensure no nursing staff will be allowed to work, including any new hired staff and agency staff, without receiving this education.

4. The Assistant Director of Nursing, Nurse Managers and Regional Clinical Director will review all incidents daily during the morning clinical meeting to ensure completion of an assessment and documentation of the SBAR for 12 weeks. 5 residents and 5 staff will be interviewed weekly by the DON or Nurse Manager for 12 weeks regarding incidents to ensure the reporting of incidents. Any opportunities identified during these audits will be corrected by the Assistant Director of Nursing or Nurse Managers.
5. The results of these audits will be reported by the Assistant Director of Nursing at the monthly QAPI meeting. A QAPI meeting was held on 2/9/23 to review this plan. The QAPI Committee will make recommendations as needed.

Date of IJ Removal: 2/10/23

The immediate jeopardy was removed on 2/10/23 and validated with a credible allegation on 2/23/23 through staff interviews and in service training records. Interviews confirmed the facility was trained to perform assessments on residents when any change of condition occurred. Staff were able to verbalize the need to notify a nurse immediately in the event a change of condition is

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F 684	Continued From page 13 noticed. The nurses verbalized they were to assess a resident immediately and document the result in a progress note, complete an incident report, e-interact form, and notify both the medical provider and the family to the noted changes. All staff were able to verbalize that witness statements would be obtained and provided for the Director of Nursing and/or the Administrator on the date of the incident.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of manufacturer's instructions, Nurse Practitioner, Medical Director, resident and staff interviews, the facility failed to ensure securement was according to manufacturer's recommendations to provide a safe van transport. Resident #1 fell out of her wheelchair onto her right side on the floor of the van with her wheelchair on top of her body after the transportation van made a left turn and stopped suddenly. The resident experienced pain in her back and right leg and was later sent to the emergency department and diagnosed with moderate spinal canal stenosis at L3-L4 with possible right paracentral disc protrusion (ligaments from the spinal disc are intact, but form a pouch that presses on the nerves) for 1 of	F 689	Past noncompliance: no plan of correction required.	

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1 resident reviewed for accidents (Resident #1).

The findings included:

Review of the manufacturer's instructions for the van's locking system which is the system used on the facility's transport van to secure residents who are seated in wheelchairs during transport indicated:
- secure each of the 4 retractors, 2 in front of the wheelchair and 2 in the rear metal locking link devices attached to the van floor
- secure the patient with a seatbelt and shoulder harness device
- pull each belt snug to ensure it is locked into place

Resident #1 was re-admitted to the facility on 4/5/22 with diagnoses that included end stage renal disease (ESRD) and chronic pain syndrome.

A quarterly Minimum Data Set (MDS) assessment dated 12/14/22 indicated Resident #1 was cognitively intact, no behavioral concerns, required 1-person physical assistance with transfers, was able to self-propel her wheelchair with supervision assistance, and walked with 1-person physical assistance. The assessment further indicated that Resident #1 did not receive scheduled pain medications, but 7 days of opioid medications prescribed on an as needed frequency and 7 days of anticoagulant mediations.

A review of the Medication Administration Record (MAR) dated February 2023 revealed Resident #1 was ordered to receive dialysis three times per week on Tuesday, Thursday, and Saturday. The

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MAR indicated Resident #1 received dialysis on Saturday, 2/4/23.

An incident report initiated on 2/6/23 by the former Director of Nursing (DON #1) and dated 2/4/23 at 2:05 PM indicated Resident #1 was being transported to the facility from dialysis after the Transportation Aide secured Resident #1 in and ensured buckle was on, she stopped at a red light and Resident #1 fell out of her wheelchair. The report indicated the Transportation Aide attempted to pick Resident #1 up from the vehicle but was unsuccessful and flagged down a fire truck and firefighters were able to assist Resident #1 back into her wheelchair.

A review of the nurse progress notes dated 2/4/23 and 2/5/23 revealed there was no documentation of Resident #1's fall from the wheelchair during transport in the facility van.

A telephone interview with the former Director of Nursing (DON #1) on 2/20/23 at 12:50 PM revealed on 2/5/23 around 5 PM she received a phone call from the transportation aide who told her Resident #1 had fallen out of her wheelchair on the return trip from dialysis on the morning of 2/4/23. DON #1 instructed the Transportation Aide to go to the facility and tell Resident #1's nurse to complete an incident report. DON #1 stated she did not contact the facility on 2/5/23 and DON #1 was unable to provide any additional information regarding the incident on 02/04/23 because she was suspended from the facility.

A progress noted written by the Nurse Practitioner (NP) dated 2/6/23 indicated Resident #1 was referred by nursing for right leg pain. The note detailed Resident #1 was involved in an incident

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on the transportation van over the weekend which resulted in her slipping out of her wheelchair onto the floor of the vehicle. It further indicated Resident #1 did not have her belts in place and had pain to her right leg since the time of the incident. An order for an x-ray of the right hip and pelvis was provided to rule out occult processes (a concealed or uneasily detected underlining disease).

A review of the physician's orders revealed Resident #1 had an order for an x-ray of the right hip and pelvis dated 2/6/23.

A radiological report dated 2/6/23 revealed an x-ray was obtained of the right hip and pelvis which indicated no fractures or dislocations were noted.

A nurse progress noted written by Nurse #4 dated 2/6/23 at 4:04 PM revealed the x-ray results were communicated by staff to Resident #1 who requested further evaluation and was then transported to the ER via ambulance.

A review of the Emergency Room and ER radiological studies dated 2/6/23 indicated Resident #1 was assessed to have lumbar spinal tenderness upon examination by the ER provider and the CT scan resulted in moderate spinal canal stenosis at L3-L4 with possible right paracentral disc protrusion. The document referenced needed treatment to include ongoing pain management and a referral to an orthopedic therapist for therapy. Resident #1 was discharged back to the facility the same day.

A 5-day facility reported incident report completed by the current Director of Nursing (DON #2) dated

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2/13/23 indicated on 2/4/23 Resident #1 sustained a fall during the transportation in the facility van following an appointment from dialysis. It further indicated the facility was notified of the accident on 2/5/23 at 9:00 AM by the Transportation Aide. The document indicated Resident #1 slid out of her wheelchair and no injuries were noted. It further detailed Resident #1 reported to the Administrator that the Transportation Aide had not secured the wheelchair to the van floor, nor did she tightly secured the seatbelt around her when she was loaded into the van on 2/4/23. When the van made a turn, the wheelchair began to roll, and Resident #1 slipped out of it and the wheelchair landed on top of Resident #1. Later in the evening on 2/4/23 and on 2/5/23, Resident #1 began complaining of pain to her lower extremities and was given a PRN (as needed) pain medication which was somewhat helpful. On Monday, 2/6/23, Resident #1 complained of her leg hurting and burning sensation and an x-ray was ordered and obtained which resulted in no acute fractures or dislocations. Resident #1 then requested further evaluation and was sent to the Emergency Room (ER) where a computer tomography (CT) was performed which indicated Resident #1 had a bulging disc at T4 (thoracic vertebrae #4).

An interview with Resident #1 was conducted on 2/20/23 at 10:10 AM. Resident #1 was lying in her bed with the lights off and immediately voiced she was in pain in her lower back and right lower extremity. Resident #1 described the pain as a level 12 on a 1-10 scale (10 being the worst). Resident #1 stated she had some slipped discs in her lower back following a fall during transport in the facility van on 2/4/23 after an appointment

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with the local dialysis center. Resident #1 explained she was sitting in her wheelchair when the former Transportation Aide made a left turn and suddenly stopped which caused Resident #1 to be projected out of her wheelchair and into the aisle on the floor in the van. Resident #1 stated at the time of the fall, the wheelchair was not securely fastened to the van using the securing straps which caused the wheelchair to land on her when she fell out onto the van floor. Resident #1 explained when the Transportation Aide loaded her in the van, the straps which secure the wheelchair were not tightly strapped to the wheelchair and the shoulder harness/lap restraint portion was not in place. Resident #1 indicated she did not say anything to the Transportation Aide before she was in transport about the securement device not being intact. The Transportation Aide flagged down the firefighter for assistance to lift her back to her wheelchair. Resident #1 stated she initially had some pain; however, the intensity increased later that evening and over the next couple of days, but she was afraid to vocalized too much increase in severity to avoid getting questioned about not reporting the incident on the date of the occurrence. The Resident stated eventually her pain escalated to a level she felt needed to be treated more than with her routine PRN medication. Resident #1 explained on 2/6/23 she requested an emergency room evaluation and was sent to the ER and discovered she had suffered from a "slipped disc" and provided pain management and referred to the orthopedic outpatient center.

An unsigned copy of a written statement by the former Transportation aide dated 2/5/23 read as follows: "Yesterday I went to pick up Resident #1

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from dialysis. I got her in the van, I secured her in the chair, and I put her seat belt on and left the dialysis place. At the light after making 3 left turns I stopped at the red light and she fell off her chair. Apparently, Resident #1 took off her seat belt and I was not aware of it so I put the van in park and I went to her. I couldn't pick her up and I saw a fire truck going by and I flagged them down. They came to help. They asked Resident #1 if she was hurting anywhere, she said no. They asked her if she wanted to go to the hospital, she said no. They asked her if she was OK, she said yes and asked to be put back in her wheelchair. She asked me not to say anything. Transportation Aide told Resident #1 she had to report the incident. Resident #1 said no don't, you're going to get in trouble, don't say anything, so I agreed to take her to the facility she was fine and moving around."

An interview with the former Transportation Aide on 2/20/23 at 12:05 PM revealed she was suspended from the facility on 2/6/23 and terminated on 2/9/23 following a fall in the van involving Resident #1. The Transportation Aide stated she was scheduled to pick up Resident #1 from dialysis on 2/4/23. Upon arrival to the dialysis center around 10:30 AM, she loaded Resident #1 into the van and quickly "fastened her in." The Transportation Aide explained shortly after the transport began, she was approaching a stop light at an intersection, she heard Resident #1 say "oh, oh" and she looked back towards Resident #1 and discovered Resident #1 was no longer in her wheelchair and was laying on the floor of the van with her wheelchair no longer fastened to the floor of the van. The Transportation Aide expressed she immediately

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put the vehicle in park in the middle of the road, got out and slid along the side of the van to the door where she was able to access Resident #1 and tried to lift Resident #1 out of the floor but was unable to and acknowledged she needed assistance to lift Resident #1 back into her chair. The Transportation Aide stated she got back out of the van and "ran into the middle of the street" where she saw a fire truck passing by and "flagged" the fireman down for assistance. The Transportation Aide detailed she and the firefighter placed Resident #1 back in her wheelchair and she was brought back to the facility then left her in her room and did not report the fall to Resident #1's assigned nurse nor administration at that time. The Transportation Aide reported it was not until the following evening following a conversation with Resident #1, (2/5/23) she notified DON #1 via telephone to make her aware of the fall. The Transportation Aide said DON #1 told her to come to the facility and leave a statement for her and to ask the assigned nurse to complete an incident report. The Transportation Aide further reported when she arrived at the facility to write a statement, she approached Nurse # 1 about completing an incident report of which she refused stating she was not involved. The Transportation Aide explained it was not until the following day (2/6/23) she was asked further about the fall and was suspended.

An interview with Nurse #1 on 2/21/23 at 11:00 AM revealed she was assigned to Resident #1 from 7AM to 7 PM on both 2/4/23 and 2/5/23. Nurse #1 indicated she did not learn about the fall involving Resident #1 until she was on a telephone call with Nurse #4 on 2/6/23 about

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something unrelated and overheard DON #2 notify Nurse #4 about the incident. Nurse #1 stated she was asked if she knew about the incident because she had not been notified in the oncoming shift report and Nurse #1 told her she was not aware of the incident herself. Nurse #1 explained she was on duty around 6 PM on 2/5/23 when the Transportation Aide arrived to the facility and mentioned she needed to write a statement about some incident with buying cigarettes involving Resident #1 of which Nurse #1 admitted she did not feel the need to write an incident report and told the Transportation Aide she was not completing one but to leave the statements for DON #1 and/or the Administrator and it would be handled when they arrived the following morning and therefore did not ask any further questions. Nurse #1 acknowledged Resident #1 expressed mild asymptomatic pain at times over the weekend, but she thought the pain was the same pain she routinely described, and she was not anything acute therefore no assessment was completed at the time.

An interview with Nurse #2 on 2/21/23 at 11:30 AM revealed she was assigned to Resident #1 from 7 PM to 7 AM on 2/4/23 and 2/5/23. Nurse #2 indicated she was not aware of the fall until 2/11/23 when she returned to work. Nurse #2 stated Resident #1 expressed some hip and lower extremity discomfort and received her scheduled PRN pain medication and Resident #1 was not evaluated further due to long term complaints of pain on the weekend of the fall

An interview with the Medical Director (MD) on 2/21/23 at 12:31 PM revealed he was made aware of the fall involving Resident #1 on 2/7/23 when he arrived at the facility for routine rounds.

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The MD stated he had been told that Resident #1 was not properly secured in the facility van during the transport on 2/4/23 and had been evaluated by ER staff to have a disc protrusion and was experiencing lower lumbar pain that radiated to her sides. The MD indicated he could not say for sure that the injury was a result of Resident #1 sustaining a fall during transport or not, but that it was a possibility.

A handwritten statement written by the Administrator dated 2/6/23 indicated Resident #1 came into the Administrator's office on 2/6/23 at 10:59 AM and stated she had fallen in the transportation van on 2/4/23 with Transportation Aide who did not put her seat belt on. Resident #1 stated that Transportation Aide was fabricating stories and telling people that Resident #1 had unstrapped her seat belt but that was not true. Resident #1 also stated that the Transportation Aide told her not to tell anyone and she had text messages regarding the conversation. The Administrator asked how Resident #1felt and she said she was okay, just a little pain.

An interview with the Administrator on 2/23/23 at 10:15 AM revealed during her morning commute to the facility on 2/6/23, she learned of the fall experienced by Resident #1 on 2/4/23 while in transport from the dialysis. The Administrator indicated when she arrived, she placed all staff involved on suspension and began her investigation. She indicated that the Transportation Aide should have immediately pulled the van over, called emergency services to ensure Resident #1 was safe and without injury before moving her followed by contacting the facility Administrator and the Director of Nursing and/or the Manager on Duty (MOD).

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On 2/20/23 at 5:20 PM, the facility Administrator and Regional Corporate Consultant were notified of the Immediate Jeopardy.

1. The facility failed to secure Resident #1 in her wheelchair while being transported from dialysis in the facility van on 2/4/23 at approximately 10:30 AM which resulted in a fall to the van floor when the van made a stop and her wheelchair landed on top of her. Resident #1 was lifted back into the wheelchair by the transporter Nurse Aide and a member of the local fire department. Resident #1 had pain which continued to her low back and right leg and was subsequently sent to the Emergency Room for evaluation per resident's request on 2/6/23 where a CT scan reflected a bulging disc to L4-S1 and a referral to the orthopedic surgeon for ongoing care.

2. On 2/6/23 the facility immediately suspended the transporter and the Director of Nursing and initiated an investigation of this event. On 2/6/23 the Administrator suspended all transports using the facility van. A 24-hour report was submitted and a call to Adult Protective Services completed. On 2/6/23 an incident report was initiated and an investigation into the event began and included an interview with the resident, transporter, and Director of Nursing.

An audit of current residents transported during the last 30 days was completed by the Assistant Director of Nursing and Nurse Managers on 2/8/23 to identify any other residents possibly affected by the same practice. Any unreported events were documented on an incident report,

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investigated, an assessment of the resident completed, documented in the medical record and Physician and Responsible Party were notified by the Assistant Director of Nursing and Nurse Managers by 2/9/23.

By 2/9/23 the Assistant Director of Nursing, Nurse Manager, Social Worker and Regional Director of Clinical Services conducted interviews with current residents to identify any unreported incidents during the last 30 days. Any new incidents identified were reported to the Assistant Director of Nursing and Administrator for further investigation, resident assessment and notification of responsible party and physician. By 2/9/23 the Assistant Director of Nursing, Nurse Manager and Regional Director of Clinical Services completed a record review of all incidents and accidents to ensure completion of a nursing assessment and notification to the responsible party and physician.

Root cause analysis for Resident #1 was conducted by the Assistant Director of Nursing, Medical Director, Administrator and Regional Director of Clinical Services on 2/9/23 and it was determined the transporter failed to follow manufacturer guidelines for securing a wheelchair in the van prior to transport.

3. Beginning 2/6/23 outside transportation services will be used for all required transports permanently, facility van keys secured with the Administrator until the facility van is relocated from the facility parking lot. Current and ongoing appointments were scheduled with the outside transportation service by the Assistant Business Office Manager on 2/6/23. The Assistant Business Office Manager was trained on this

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change of system by the Regional Director of Clinical Services on 2/6/23.

4. The Nurse Manager trained the Assistant Business Office Manager to randomly observe resident being secured in the outside transport van prior to leaving the facility, training included instruction to stop the transport in the event the wheelchair is not secured or the seatbelt is not in place and report to the Administrator or Assistant Director of Nursing immediately. The outside transportation service provided the Regional Director of Operations with proof of training on securing a resident in the outside transport van prior to moving the van.

The results of these audits will be reported by the Assistant Director of Nursing at the monthly QAPI meeting. A QAPI meeting was held on 2/9/23 to review this plan. The QAPI Committee will make recommendations as needed.
Date of IJ Removal: 2/10/23

The credible allegation was removed on 2/10/23 with a validation of the credible allegation was completed on 2/23/23 through observations, staff interviews and in-service training records. Observation confirmed the facility no longer uses their own transportation van. Staff were able to verbalize the process of the facility for notifying the nurse and administrative staff of any incident and validate their observations and knowledge immediately and document all necessary details. Review of audit reports verified the system for monitoring to ensure residents were secured for transportation.