STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING ______ B. WING ______	C 09/14/2023

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BERMUDA COMMONS NURSING AND REHABILITATION CENTER	**316 NC HIGHWAY 801 SOUTH** **ADVANCE, NC 27006**

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 09/13/23 through 09/14/23. Event ID# 7OZV11. The following intakes were investigated: NC00207064 and NC00207105. One (1) of seven allegations resulted in a deficiency. NC00207064 resulted in immediate jeopardy. Past Non-Compliance was identified at: CFR 483.25 at F689 at a scope and severity of J. The tag F689 constituted Substandard Quality of care. A partial extended survey was conducted on 09/14/23.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, staff, and Medical Director (MD) interviews the facility Transport Driver failed to ensure the lift gate (a mechanical platform designed to raise and lower to allow an individual with a wheelchair to enter and exit a vehicle) was in the elevated position before unloading a resident from the back of the facility van. On	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/18/2023

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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08/11/23 Resident #1 was rolled out of the back of the transportation van in her wheelchair and fell approximately 2.5 feet to the ground landing on her right side and hitting the back of her head. The Resident complained of mid back pain and right rib pain at 9 out of 10 (10 being the worst pain imaginable) and pain in her head at a 7 out of 10. Resident #1 was sent to the emergency department for evaluation and diagnosed with right 4th and 5th nondisplaced rib fractures. This occurred for 1 of 3 residents sampled for accidents (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 11/15/22 with diagnoses that included myasthenia gravis (neuromuscular disease that leads to skeletal muscle weakness) and long-term use of anticoagulant (blood thinner).

Review of the quarterly Minimum Data Set (MDS) assessment dated 06/30/23 revealed Resident #1 was cognitively intact and required limited to extensive assistance of one staff member with activities of daily living. The MDS also revealed that Resident #1 used a wheelchair and walker for mobility and complained of pain frequently of an 8 on a pain scale. The assessment also revealed that Resident #1 received scheduled pain medications and received as needed pain medication or was offered and declined. Resident #1 received 6 days of anticoagulant therapy during the assessment reference period.

Review of Resident #1's physician order sheet dated August 2023 revealed the following active orders: Eliquis (blood thinner) 5 milligram by

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mouth twice a day and Oxycodone 10 mg give half tab (5mg) by mouth as needed for pain every 8 hours.

Review of an incident report dated 08/11/23 read, Resident #1 had returned from a medical appointment and was being unloaded from the facility van and fell to the ground. Resident #1 was immediately assessed, and Emergency Medical Services (EMS) was called. The report was electronically signed by the Assistant Director of Nursing (ADON).

The Transport Driver was interviewed on 09/13/23 at 12:41 PM and confirmed that she had been driving the facility van since February/March of 2023. The Transport Driver confirmed that she transported Resident #1 to her medical appointment on 08/11/23. She stated upon picking Resident #1 up after her medical appointment on 8/11/23 Resident #1 had complaints of pain. She explained she was familiar with the resident, and this was normal for her to complain of pain. She stated she had told Resident #1 that she would get her back to the facility as quickly as possible so that she could lay down and get something for her pain and hopefully that would help her feel better. She stated when they returned to the facility, she pulled the van up to the front door under the awning and put the van in park. She indicated she engaged the parking brake, exited the driver's seat to the rear of the van, and opened the back double doors. The Transport Driver stated that she was so focused on getting Resident #1 out of the van and back into the facility so that she could get something to ease her pain that she lowered the lift gate to the ground instead of putting it in the up position for

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unloading. The Transport Driver stated she did not realize what she had done until she entered the van via the side door and un-secured Resident #1's wheelchair from the floor. Once the Transport Driver had removed her seat belt and began pushing her backwards out of the van, she realized the lift gate was on the ground instead of the up position. The Transport Driver stated that she and Resident #1 both fell out of the back of the van to the ground. She explained that she tried to wrap her arms around Resident #1 "like a koala bear" to break her fall and so the wheelchair would not land on Resident #1. The Transport Driver stated that she and Resident #1 came to rest on the ground. The staff had either heard the commotion or someone told them because the Transport Driver explained everyone came running out to help them and asked them if they were ok. The Transport Driver stated she was able to get up and went to check on Resident #1 and stayed by her side until EMS arrived and loaded her on the stretcher and then left the facility to go the Emergency Room (ER). The Transport Driver stated that she was suspended from work that day and was sent home and then was called to the facility on 08/14/23 where she gave her statement and was re-educated on the unloading/loading procedures from a staff member from the facility's corporation. Then on 08/15/23 she began driving the van again. She added that she had never had any incidents like this before or since the accident but stated she was just so distracted and focused on getting Resident #1 off the van and into the facility that she just made a mistake with the lift gate.

An observation of the facility van was made on 09/13/23 at 3:53 PM along with the Maintenance Director. The Maintenance Director measured the

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distance from the lift gate in the elevated/unloading position to the ground to be 2.5 feet.

Medication Aide (MA) #1 was interviewed via phone on 09/13/23 at 12:03 PM who confirmed that she was working on 08/11/23. She stated that she and Nurse Assistant (NA) #1 were carrying lunch trays down the hallway and NA #1 stated oh my goodness someone fell out of the van. She stated she sat her tray down and ran outside where she found Resident #1 lying on the ground on her back with her wheelchair flipped over next to her and the Transport Driver lying on her back about a foot away. MA #1 stated Resident #1 was complaining of pain on her left side. She explained that it was crowded outside at that time because there were so many employees outside. She further explained that she came back in the facility to finish collecting her meal trays while the Administrator and other staff waited on EMS to arrive.

NA #1 was interviewed on 09/13/23 at 3:18 PM and confirmed that he was working on 08/11/23. He stated that he saw a commotion at the front of the facility and went to see what was going on. NA #1 stated that when he got outside, he saw Resident #1 laying on the ground on the lift gate and the Transport Driver was laying on the concrete beside her. NA #1 stated he asked Resident #1 if she was ok and if she had hit her head and she stated she was ok, but she had hit her head. NA #1 stated that the Wound Nurse was coming over to take a look at Resident #1 and NA #1 did not want to be in the way, so he came back into the facility and continued with his assignment.

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F 689	Continued From page 5 The Unit Manager (UM) was interviewed on 09/13/23 at 11:57 AM who confirmed she was working on 08/11/23. She stated she was at the front nursing station and heard staff yelling to call EMS. The UM stated she looked up and saw Resident #1 lying on the ground outside of the facility. She stated that there were so many staff members outside that she really could not tell what had occurred, but she did as she was told and called EMS. She explained it took them about 10 minutes to arrive at the facility, once at the facility they loaded Resident #1 on the stretcher and took her to the local ER. The Wound Nurse was interviewed on 09/13/23 at 3:29 PM who confirmed that she was working on 08/11/23. She stated she was coming up the hall and looked out the front door and saw people lying on the ground and then heard someone say that Resident #1 had fallen. The Wound Nurse stated that she closed her computer and headed outside where there were already a lot of staff gathered. The Wound Nurse asked Resident #1 if she was hurting and she replied that she was hurting but no more than she previously did before the incident. Wound Nurse indicated she completed an assessment of Resident #1's head, and extremities for any obvious signs of injury and could not find any. She added that Resident #1 was wanting to sit up and once EMS arrived at the facility, they allowed the staff to stand Resident #1 up so she could get on the stretcher and then took her to the ER. The Wound Nurse could not say where Resident #1's wheelchair was at because people started moving things around when she arrived, she proceeded straight to Resident #1 and stayed with her until EMS arrived and she was loaded on the stretcher.	F 689		

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Review of Emergency Room (ER) records dated 08/11/23 read in part, Resident #1 had past medical history significant for prior deep vein thrombosis and pulmonary embolism on Eliquis (blood thinner) presented after a fall that happened earlier today. Resident #1 fell backward from the wheelchair lift and had the wheelchair on top of her. She hit her head but did not lose consciousness. She was endorsing pain in the back of her head and pain on right chest wall. The patient was prepared and sent to computerized tomography (CT) for a full trauma scan (scan of entire body). Significant findings from the CT included non-displaced fracture on right fourth and fifth ribs and osteopenia (low bone density).

Resident #1 returned to the facility on 08/12/23.

Review of a physician order dated 08/13/23 read: Oxycodone 5 mg by mouth every 4 hours as needed for pain.

An interview was conducted with Resident #1 on 09/13/23 at 10:14 AM who confirmed that she had been to a medical appointment in the facility van on 08/11/23 and when they (she and the Transport Driver) returned to the facility the Transport Driver pushed her wheelchair out of the back of the van without the lift gate elevated. She explained the lift gate was on the ground. Resident #1 stated the next thing she knew "my wheelchair went airborne and flipped because I fell out of it, and it landed on my lower legs." Resident #1 stated that her body hit the concrete and she hit her head on the concrete. All of the staff including the Administrator came outside. She stated, "my chest was hurting really bad on the right side" but staff would not move her until

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F 689	Continued From page 7 EMS came to transport her to the ER. Resident #1 stated that her right rib area was hurting at a 9 on a pain scale of 1-10 (10 is the worse pain imaginable) and her head was hurting at a 7 on a pain scale. Resident #1 stated that she normally had pain in her back area that range from 6-10 on a pain scale. She stated that EMS came rather quickly and took her straight to the ER as a trauma patient and they did full CT scan of her body and her 4th and 5th ribs on the right side were fractured but not displaced. Resident #1 stated she had a history of osteopenia, but the hospital staff stated her fractured ribs were due to the trauma of her fall from the van. She stated that after they got her settled in the ER, they gave her something for pain which helped. In addition, Resident #1 stated that they increased the frequency of her pain medication for a few weeks which was helping her pain and they also instructed Resident #1 to keep moving around, to use incentive spirometer (handheld medical device to help patients improve lung function), and to work with therapy. Resident #1 stated that the Transport Driver had driven her to many appointments before and never had any issues and she has also driven her to another appointment since 08/11/23 and had no issues. The MD was interviewed on 09/13/23 at 2:57 PM and confirmed that she had been made aware of Resident #1's fall from the van. She stated if Resident #1 had a history of osteopenia that would place her at increased risk of fractures. However, if the fractures were not present prior to the accident and after they accident they were present then "one would presume they came from the fall from the van." She added that they adjusted Resident #1's pain medication after the accident to ensure her pain was controlled as	F 689		

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F 689	Continued From page 8 much as possible. The Administrator was interviewed on 09/13/23 at 5:00 PM who confirmed that she was in her office on 08/11/23 when someone told her that Resident #1 and the Transport Driver were lying on the ground outside the facility. She stated she proceeded outside and saw Resident #1 and the Transport Driver lying on the ground and she asked them how they were doing. She stated that Resident #1 stated she was hurting but not anymore than she hurt before the incident and there was no bleeding. The Wound Nurse did a head-to-toe assessment and could not identify any injuries, and someone had already called EMS and they arrived and loaded Resident #1 on the stretcher and took her to the ER. Resident #1's wheelchair was lying off to the side of the van. The Administrator stated that the Transport Driver tried to take the brunt of the fall so Resident #1 would not get hurt when she realized that the lift gate was down and not in the up position. The Administrator stated that after Resident #1 had gone to the ER and they ensured the Transport Driver was ok they suspended her and sent her home. She stated she notified the people within her corporation that she needed to notify and brought Resident #1's wheelchair into her office and the van was parked out of use pending the investigation. The Administrator confirmed that the facility had video cameras but stated that they were only good for 14 days and so the video of the accident on 08/11/23 was unavailable. The Administrator stated she interviewed residents that had been transported on the facility van and driven by the Transport Driver for the last 6 months and no other issues were identified. On 08/14/23 the Transport Driver returned to the facility and gave	F 689		

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her account of what had occurred. The Transport Driver indicated she was so focused on Resident #1's pain and getting Resident #1 back into the facility that she did not realize the lift gate was down and not in the up position. Also, on 08/14/23 the Transport Driver went through the extensive education program on van safety and driving safety given by the insurance agent and director of transportation for the facility. The Administrator stated that she had been monitoring the Transport Driver at least weekly since the accident and had no issues. The Administrator added that they took the issue to the Quality Assurance (QA) committee on 08/15/23 as well.

The Administrator was notified of immediate jeopardy on 09/13/23 at 5:21 PM.

The facility provided the following corrective action plan:

Corrective Action for resident involved:

On August 11, 2023, around 2:10 pm, Facility Transport Driver arrived at the facility with Resident #1 and parked in front of the facility. At approximately 2:15pm, Transport Driver prepared to unload resident. Transport Driver placed the lift gate all the way to the ground and then Transport Driver unbuckled resident's seatbelt and removed seatbelt harness from wheelchair and proceeded to move resident to back lift gate. Upon reaching lift gate with Resident #1, Transport Driver realized the lift was in the down position. Resident #1's wheelchair started to disembark, and the Transport Driver attempted to prevent wheelchair from rolling out of van by grabbing hold of the wheelchair pedals which was unsuccessful

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F 689	Continued From page 10 therefore transport driver threw her body over resident to attempt to break fall while kicking wheelchair out of way resulting in resident and Transport Driver resting approximately two and one-half feet from the van to ground level. Administrator and Nurse #l responded to the incident immediately. Resident #1 was assessed by Nurse #l at the site of incident where she remained until Emergency Medical Service arrived. Resident #1 was assessed for increased pain and any injury on the resident's body as a result of the van incident while Unit Manager #1 notified Emergency Medical Services. The assessment revealed no obvious bruising, redness, or visible injuries noted to Resident #1. Resident #1 verbalized she was not hurting any more than she had been before the incident occurrence and denied hitting head. At approximately 2:25pm, Emergency Medical Services arrived and transported resident to hospital for evaluation and treatment. On 8/11/2023, the Administrator obtained a statement from the Transport Driver and instructed the Transport Driver to complete a reenactment of the incident and following this the Transport Driver was immediately suspended pending investigation. On 8/11/2023, the Transportation van was parked and taken out of use pending an investigation and inspection and the facility scheduled all transports with outside transportation service for the following Monday. Also, Resident #1's wheelchair was taken out of use and placed in the Administrator's office for inspection. On 8/11/2023, the Director of Nurses notified Resident #1's responsible party and the Medical Director of the van incident. On 8/12/2023 at 08:30am, resident returned to facility from the hospital with diagnosis of nondisplaced rib fractures of right fourth and fifth ribs with no	F 689		

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new orders. On 8/14/2023, the transport van and resident wheelchair was inspected by the risk management insurance agent. The inspection revealed no malfunctioning components of van's lift or wheelchair.

On 8/14/2023, Transport Driver was re-educated on safety protocols with skills checkoff and the need to make sure if she was distracted due to resident continued complaint of pain to immediately pull over facility transport van and call facility to speak with Administrator or Director of Nursing to receive instruction. Transport Driver was educated to pull over and call facility if a resident complained of pain or is having issues as well as if resident may need to go to hospital for evaluation if applicable. On 8/14/2023, Administrator concluded the van incident investigation and based on investigation findings root cause analysis of the incident was due to the Transport Driver being distracted by Resident #1's complaints of pain and lack of knowledge/skills of the Transport Driver to assess resident's pain. On 8/14/2023, a Quality Assurance and Performance Improvement meeting was held with the Interdisciplinary Team to review findings of investigation with no additional findings.

Corrective Action for potentially impacted residents:
Beginning 8/11/2023, the Administrator and Director of Nursing identified residents that would be potentially impacted by the alleged deficient practice by completing facility transportation audits for all current resident that had appointments in the past six months that had been transported by the facility van and asked if

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they had any issues or concerns when the Transport Driver transported them to or from an appointment. The results of the audit revealed no other residents identified with any issues or concerns with transports to or from appointments. On 8/11/2023, facility van was parked and taken out of use and all appointments scheduled for the following Monday were scheduled with outside transportation service. On 8/14/2023, after concluding investigation, the Quality Assurance Committee convened to discuss the alleged van incident and the status of the investigation. There were no additional findings at that time.

Systemic Changes:
On 8/14/2023 the Administrator in-serviced the facility's only Transport Driver on safety protocols pertaining to driving the van with skills checkoff. The training included reviewing van safety equipment, van system checklist, operations and skills which included observations of loading and unloading residents prior to and following transports. The Administrator will ensure that any newly hired facility transportation staff will receive this training during orientation.

Quality Assurance:
Beginning the week of 8/14/2023, The Administrator or designee will monitor the issue using the QA Tool for Transportation Van Training Skills Checkoff for Wheelchair Transport to ensure Transport Driver is operating facility van equipment correctly and loading and unloading residents according to facility policy. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING ______ B. WING ______	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	**316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of completion: 08/15/23. The corrective action plan was validated on 09/13/23 and 09/14/23 and verified the corrective action plan was completed on 08/15/23. The Transport Driver who was the only employee that was able to drive the facility van was re-educated on the unloading/loading process, driving safety, and what to do if the driver became distracted by the residents' complaints of pain. The education also included return demonstration. The van was inspected by the insurance agent and Director of Transportation at the facility and no issues were found with the van, lift, or safety mechanisms. The facility interviewed residents in the last 6 months that had been transported by the facility van and driven by the Transport Driver and no other incidents were reported. The facility's QA committee was updated on the plan on 08/15/23 and the Administrator had been conducting weekly audits of the Transport Driver unloading/loading procedures with no other issues identified. During the validation the Transport Driver was observed to load/unload a resident on/off the van with no issues noted. The lift gate was placed in the correct position each time. The corrective action plan's completion date of 08/15/23 was verified.	F 689		