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F 000	INITIAL COMMENTS An onsite revisit was conducted on 01/03/24 through 01/05/24 and tags F554, F580, F641, F761, F791, and F812, were corrected as of 12/04/23. Repeat tags were cited. The facility is still out of compliance. Event ID #15B012.	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 review and resident, family member (RP), staff and Medical Director (MD) interviews, the facility failed to ensure safe securement per manufacturer recommendations of a resident during a van transport. Resident #1 flipped backwards in his wheelchair, hitting the van floor while being transported in the facility's transportation van when the transportation van drove over a speedbump located along the steep driveway leading to the facility. Resident #1 sustained a hematoma to the back of his head, a skin tear to his right hand and skin tear to his right wrist. This practice had the high likelihood of causing serious injury for 1 of 3 residents reviewed for accidents (Resident #1). The immediate jeopardy began on 12/21/23 when Resident #1 flipped backwards in his wheelchair	F 689		

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

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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hitting the transportation van floor. The immediate jeopardy was removed on 1/6/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "D" (no actual harm that is immediate jeopardy) to ensure monitoring systems are put into place are effective.

The findings included:

Review of the manufacturer's instructions for the 4-point wheelchair securement system (the system used on the facility's transport van to secure residents who are seated in wheelchairs during transport) indicated the following instructions were to be followed: 1)center the wheelchair facing forward in the securement zone and lock wheelchair brakes, 2) attach 4 retractors into floor anchorage points and lock them in place with an approximate distance of 48"-54" between the front and rear retractors. 3) completely pull out the arch webbing and attach J-hooks and compliant chair securement points near seat level at a 45-degree angle. 4) move wheelchair forward and backwards to remove webbing slack or manually tension webbing with retractor knobs. 5) make sure the chair's pelvic belt is buckled over the occupants hips 6) attach shoulder belt pin connector to pin located on the shoulder belt height adjuster 7) pull shoulder belt over occupants chest and attach shoulder belt pelvic connector to pin on pelvic belt and adjust shoulder belt height so it rest on the shoulder belt. 8) attach shoulder belt pin connector to pin on rear retractor closest to the wall 9) attach the removeable pelvic belt pin connector to pin on rear retractor closest to the aisle. 10) Pull the shoulder belt over the occupant's chest and

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buckle shoulder belt pelvic connector to remove pelvic belt.

Resident #1 was admitted to the facility on 10/5/23 with diagnoses that included aftercare following surgery for acquired absence of the left lower extremity below the knee (surgical amputation), osteoarthritis and diabetes.

A quarterly Minimum Data Set (MDS) dated 12/8/23 indicated Resident #1 was cognitively intact and required assistance for transfers and locomotion of his wheelchair.

A nurse progress note dated 12/20/23 indicated Resident #1 was scheduled for a follow-up visit with the general surgeon on 12/21/23 at 4:40 PM.

A nurse progress note dated 12/21/23 written by Nurse #1 indicated following the completion of a full body assessment, post a fall in the facility van, the on-call provider was notified of the injuries to Resident #1's head and right upper extremity. The on-call provider provided Nurse #1 with new orders to contact Resident #1's responsible party (RP) to determine if he/she wished to have further evaluation of Resident #1's injuries to include a computed tomography (CT) or be sent to the emergency room (ER). The note further indicated after Nurse #1 spoke to Resident #1 and his RP about the orders from the on-call provider, they both agreed to have Resident #1 monitored in the facility and not transfer him to the ER at that time.

An incident report completed by Nurse #1 dated 12/21/23 at 5:30 PM indicated Resident #1 had returned to the facility following transport from an appointment. The report revealed Nurse #1 was notified that Resident #1 "fell back in his

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wheelchair and landed on his back while in the parking lot of the facility". It further indicated Resident #1 notified Nurse #1 he "fell out of his wheelchair backwards when something that held his wheelchair inside the van snapped out". The report detailed that Resident #1 was placed in a lift sling and placed back into his wheelchair and transported into the facility for further evaluation.

A skin note dated 12/21/23 written by Nurse #2 indicated Resident #1 was assessed by herself and Nurse #1 which revealed a raised area at lower back of head that measured 2cm x 1.5cm without discoloration. A 2.5cm x2cm x 0.1cm superficial skin tear on top of his right hand that had scant amount of bleeding and a 1cm x 0.5cm x 0.1cm skin tear above right wrist area. Medication nurse aware and treatment was initiated.

A document titled "investigation questions" handwritten by Nurse #2 dated 12/21/23 indicated Resident #1 fell while on the van on 12/21/23. It revealed Nurse #2 was in her car in the parking lot when the transportation van pulled up and she was notified by the Transportation Aide that Resident #1 had fallen due to the seatbelt on van which had snapped.

An interview with Nurse #2 on 1/5/24 at 11:59 AM revealed she was present in her car in the facility parking lot speaking to Resident #1's RP and another staff member (she could not recall the staff member's identity) when the facility van containing Resident #1 pulled up near the traditional van parking spot outside the front door of the facility where she noticed the Transportation Aide exited the driver side of the van and yelled for her assistance when she

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F 689	Continued From page 4 stated, "he fell." Nurse #2 stated she exited her car and quickly approached the facility van where she saw Resident #1 lying on his back with his wheelchair tipped backwards onto the van floor and his right foot dangling in the air. Nurse #2 indicated she started to assess Resident #1 and saw and felt a raised hematoma on the back of Resident #1's head near the base of his skull but saw no bleeding present at the time along with a skin tear to Resident #1's right hand and another skin tear to his wrist with minimal bleeding present. Nurse #2 explained following her assessment of Resident #1 she requested Nurse #1's assistance in the van. Then, she removed the wheelchair from beneath Resident #1's body and sat it in an upright position in the van. Nurse #2 indicated she finished her assessment before Nurse #1 arrived and requested the total body mechanical lift be brought to the van, then both she and Nurse #1 placed the lift sling under Resident #1's body, slid him to the edge of the van, secured his body in the mechanical lift and placed him back into his wheelchair then lowered him from the lift gate in his wheelchair and wheeled him to his room where a thorough assessment was completed and treatments were initiated, followed by notification of the on-call provider. Nurse #2 stated Resident #1 remained alert and oriented during the entire assessment and was assuring his RP that he was going to be "okay" and was not in any pain related to the fall. Nurse #2 stated while she was in the van, she was focused on performing an assessment of Resident #1's condition and did not notice the floor securement device placement but noticed the rear straps were loosely attached to the rear of the wheelchair (which she removed); however, she did notice a "seatbelt looking thing" hanging down from the top of the van that was not	F 689		

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attached to the resident or his wheelchair.

An interview with Nurse #1 on 1/5/24 at 11:59 PM revealed a staff member whom she could not identify notified her that Resident #1 had fallen in the transportation van and Nurse #2 had requested her assistance. Nurse #1 indicated she went to the front of the building and approached the transportation van where she saw Resident #1 lying on his back with Nurse #2 next to him. Nurse #1 stated Nurse #2 notified her Resident #1 had a "knot" (hematoma) on the back of his head and needed to be transferred via total body mechanical lift back to his room for further examination. Nurse #1 explained she and Nurse #2 placed the lift sling under Resident #1 and using the mechanical lift placed Resident #1 back into his wheelchair and transported him to his room and placed him in the bed. Nurse #1 stated she obtained Resident #1's vital signs and began neurological checks then notified the on-call provider. Nurse #1 explained the on-call provider gave orders that Resident #1 could have a CT performed or be transferred to the ER if Resident #1 or his RP requested further evaluation or if a change of condition occurred. Nurse #1 clarified the instructions with Resident #1 and his RP who chose not to go to the ER at that time. Nurse #1 further explained she stayed with Resident #1 for approximately 30 minutes following the incident without any change of condition, complaints of pain, or abnormal neuro checks.

An interview with the Transportation Aide on 1/5/24 at 1:00 PM revealed she was the primary staff assigned for all resident transports for the facility since late November 2023. The Transportation Aide recalled on the early evening of 12/21/23, she transported Resident #1 from a

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surgical follow-up appointment to the facility; however, while driving up the inclined driveway to the facility, she passed over a speedbump and heard a "clink" and Resident #1 yell out. The Transportation Aide stated she immediately looked in her mirror located above her head and noticed Resident #1was no longer secured upright in his wheelchair but was lying on his back with his foot in the air. The Transportation Aide explained she asked Resident #1 if he saw any bleeding and when Resident #1 notified her, he did not see any obvious blood present, she told him she would move the transportation van closer to get assistance. The Transportation Aide stated without exiting the van to visualize Resident #1, she pulled the van to the top of the hill just outside the facility's front door where she saw Nurse #2 sitting in her parked car. The Transportation Aide stated she yelled at Nurse #2 for assistance and stated Nurse #2 immediately exited her car and approached the van where she began assessing Resident #1 who had a raised hematoma on the back of his head and a couple bleeding skin tears to his right hand and arm. The Transportation Aide stated when she got to the back of the van where Resident #1 was lying on his back, partially in his wheelchair, she noticed the floor securement straps were no longer attached to Resident #1's wheelchair and Resident #1 had partially came out of his wheelchair and was leaning on his side. The Transportation Aide indicated she thought, but could not be certain, before she began the transportation back to the facility, she had secured all straps (both shoulder and floor straps) tightly and that Resident #1's wheelchair was secured to the van.

An observation with the Transportation Aide on

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F 689	Continued From page 7 1/5/24 at 1:00 PM The Transportation Aide attempted to perform a reenactment of the steps that occurred which led to Resident #1's fall in the facility van on 12/21/23. The Transportation Aide made an attempt to secure a wheelchair (identified not to be Resident #1's personal wheelchair used on 12/21/23) containing a state surveyor to the van floor of which revealed the floor securement straps were placed on a declining bar along the bottom of the wheelchair in the front and back with difficulty as she struggled to be able to get around the lower extremities of the surveyor which were placed on the wheelchair pedals in order to reach the securement straps on the right side. The Transportation Aide attempted to attach the rear right strap from the left front portion of the wheelchair instead of from behind the chair. and she did not lock the right hand break which was obstructed by a folded bench seat on the right side of the wheelchair which allowed the front wheels of the wheelchair to be elevated off the floor with minimal force. A demonstration of how Resident #1 was positioned on the floor in the van reenacted by the Transportation Aide revealed Resident #1's wheelchair had tilted completely on its back pad and Resident #1's head was located near a metal locking groove strip near the lift gate at the rear of the van. The Transportation Aide acknowledged the wheelchair should not move when it is properly secured per manufacturers' guidelines. The Transportation Aide indicated her training was provided by a Former Transportation Aide briefly back in August 2023; however, she had not transported for several months following her training before she took over as the primary transpiration aide and she had not received any formal training with manufacturer's guidelines included.	F 689		

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An interview with Resident #1 on 1/4/23 at 4:15 PM revealed he was lying in his bed following a urology appointment where he had been transported in the facility van by the Transportation Aide. Resident #1 elaborated that he had been transported by the Transportation Aide to a urology appointment since the incident on 12/21/23 and verified that an additional nurse aide (or another facility staff member) per IDT recommendations had not been present for the transport. Resident #1 explained he recalled the fall in the facility van on 12/21/23 following his follow-up visit to the surgeon office. Resident #1 stated when the van began to start up the incline hill outside the facility, it hit a speed bump going too fast and the straps from his wheelchair fell off the chair and he fell backwards striking his head on the floor of the facility van.

An Interdisciplinary Team (IDT) progress note written by Nurse #2 dated 12/22/23 indicated the van was inspected by maintenance and the Administrator following the incident on 12/21/23. IDT recommended a nurse aide be with the transporter while transporting to all appointments.

A typed note dated 12/21/23 signed by the Maintenance Assistant indicated he inspected the van and the securement devices in the van and did not find any deficiencies in the integrity of the equipment.

An observation and interview with the Maintenance Assistant on 1/5/24 at 2:15 PM revealed he was present on 12/21/23 after the fall by Resident #1 occurred. The Maintenance Assistant indicated he made an observation of the van and the securement equipment for

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functioning on 12/21/23. The Maintenance Assistant indicated he did not find any concerns about the equipment and believed "human error" (straps were not placed in proper position and secured per manufacturer's guidelines by the Transportation Aide) in the attachment had occurred during the transport which caused the incident. The Maintenance Assistant demonstrated the proper attachment of the device to the wheelchair used on the date of the incident. The Maintenance Assistant ensured bilateral hand brakes on the wheelchair were firmly locked in place, then he tightly secured four locking straps to the bottom frame of the wheelchair then placed a seatbelt like wrapping device across the surveyor and locked it to an extension belt near the rear floor of the van. When all straps were secured, the wheelchair did not allow for movement by the surveyor who was seated to represent Resident #1 for demonstration. The Maintenance Assistant indicated he had provided driver training to both the Transportation Aide and the Maintenance Director following the incident on 12/21/23. The Maintenance Assistant said he was trained by the former Transportation Aide on how to place the securement system to a wheelchair.

An interview with the Maintenance Director on 1/5/24 at 3:45 PM revealed he had been the Maintenance Director since November 2023 but had no direct involvement in the incident which occurred on 12/21/23 involving Resident #1. The Maintenance Director stated he did not inspect the van for proper function following the incident and had not been asked to ride with the Transportation Aide before nor after the incident on 12/21/23 to monitor her driving or passenger securement safety. The Maintenance Director

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indicated that he received his driver and securement training from the Maintenance Assistant and had watched videos on the proper application of the securement system a week following the incident which occurred on 12/21/23.

An interview with the Administrator on 1/5/24 at 2:15 PM revealed she was present at the facility on 12/21/23 when the incident involving Resident #1 occurred. The Administrator indicated she was immediately made aware of the incident and notified the Maintenance Assistant so proper inspection could be completed. The Administrator stated she and the interdisciplinary team (IDT) determined the accident was caused by an error in securement of each strap per the manufacturer's guidelines by the Transportation Aide. She indicated she expected all transports to be performed in a safe and secure manner. The Administrator indicated she was unaware that the intervention was included that a NA would be on all transports with the van driver and thought since the Transportation Aide was a NA that was sufficient.

An interview with Resident #1's Responsible Party (RP) on 1/16/24 at 9:00 AM revealed she was present in the facility parking lot when the facility transport van returned Resident #1 from his surgical follow-up appointment on the evening of 12/21/23 as she was present at the appointment. Resident #1's RP stated she noticed the van begin up the driveway outside the facility and abruptly stop before it reached the normal parking area located adjacent to the front lobby of the building. The RP said she initially thought it was a little unusual but then the van proceeded on towards the top of the hill as normal. The RP explained when the van arrived

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and began to proceed towards the turn in just before reaching the front entrance, the van again abruptly stopped and she saw the Transportation Aide get out of the van and yell across the parking lot at a staff nurse who was in the parking lot. Resident #1's RP said she heard the Transportation Aide screaming "He fell, Help, He fell". Resident #1's RP said she and the staff nurse both ran towards the facility van asking if Resident #1 was hurt. Resident #1's RP said she was on the phone with her daughter when the nurse opened the rear lift gate so she could get to Resident #1. Resident #1's RP said Resident #1 was lying on his back with his wheelchair partially under him with his one leg in the air. She said Resident #1's right portion of his torso was located adjacent to the metal lift gate and she stated his head was lying on the floor of the facility van but could not give details as to the location or recall the positioning upon her visualization. The RP stated she recalled snapping a picture of Resident #1 immediately following the accident and sending it to another family member, but the photo had since been deleted from her telephone. Resident #1's RP stated the staff nurses "looked him over, then put him in his chair and took him to his room to put him to bed." Resident #1's RP said Resident #1 had a raised place on the back of his head and a couple "gashes" to his right hand, but he made the decision not to go for further evaluation and she respected his decision at that time.

An interview with the Medical Director (MD) on 1/10/23 at 5:37 PM revealed he was made aware on 1/9/24 of the fall in the transportation van which occurred on 12/21/23. The MD indicated Resident #1 had the potential to sustain significant injury when involved in a motor vehicle

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accident (MVA).

The facility Administrator was notified of immediate jeopardy on 1/5/24 at 12:21 PM.

The facility provided the following plan for IJ removal.

Credible Allegation of IJ Removal Plan for F 689 Accident and Hazards

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 12/21/23 at approximately 5:00 p.m. Resident #1 was on the facility van returning from an appointment, when the Van Driver was coming up the hill of the parking lot when she went over the speed bump resident #1 went over backward in his wheelchair. Charge Nurse was notified that resident fell back in his wheelchair in the facility van. Van was sitting in the parking lot stopped. Resident was on his back with the wheelchair under his back and legs. The securement straps were noted to be loose at this time. The wheelchair was unlocked at base from van hooks then the wheelchair was gently moved out from under resident. Resident then assessed for injuries. He was alert and oriented x 3 the entire time. Resident was transferred back into the wheelchair with use of total lift, while on the van. Then Resident # 1 was assisted off the van and into his room, to bed for full body assessment.

Resident assessed by nurse and suffered a skin tear to right hand measuring 2.5cm X 2.0cm x 0.1cm and a skin tear to his right wrist measuring 1.0 cm x 0.5 cm x 01 cm as well as a knot to the

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back of his head measuring 2 cm x 1.5 cm. First aid provided. Neuro checks were initiated on 12/21/23 at approximately 5:30 p.m. and continued until 12/25/23 without any negative findings.

The physician was notified of the incident on 12/21/23 by the staff nurse. Recommendations received to continue to monitor, send resident to emergency department with condition change.

Resident # 1 had a provider assessment completed on 12/28/23 with no new orders.

Resident's responsible party was notified of the incident on 12/21/23 by staff nurse.

The transport van was removed from service on 12/21/23 at 5:00 pm until it could be checked to ensure no broken parts or failures and a road test with the same wheelchair was conducted. The Maintenance Assistant completed this evaluation and road test immediately following the incident and found no issues or deficits noted with the securement system. No damage was noted to the straps of the securement system. The van was put back into service on 12/21/23 at approximately 6:00 pm.

Immediately following the incident on the evening of 12/21/23 a return demonstration was completed with the Van Driver and the Administrator; it was determined that the root cause of the event was that the driver had failed to apply the securement system straps in the proper location on the wheelchair.

Immediately following the incident on 12/21/23, the Van Driver received 1:1 education from the

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Maintenance Assistant, who is an alternate trained driver on proper resident securement, and she provided return demonstration of procedure (process for applying the securement system straps to the wheelchair). Training was per the manufacturer's driver training modules and included applying the securement system straps in the proper location on the wheelchair as outlined in the driver training modules.

All residents that are transported in the facility van are at risk. An audit was completed on December 22, 2023, by DON of all residents who were transported in the last 30 days. Residents with BIMs greater than 11 were interviewed regarding transportation and any concerns related to safety during wheelchair van transportation. All residents who were transported within the last 30 days with a BIMs of 10 or lower had skin checks completed to ensure no injuries were noted. No concerns were identified through these interviews/audits. No other residents or concerns were identified as having any circumstances resulting in falls in the van.

- 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.

On 12/22/23, The Maintenance Assistant trained the Van Driver and the Maintenance Director on proper resident securement and resident safety. Training was per the manufacturer's driver training modules and included applying the securement system straps in the proper location on the wheelchair.

All drivers (Van Driver, Maintenance Director and

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F 689	Continued From page 15 Maintenance Assistant) completed the Driver Training Program on 12/22/2023. Training was provided by the Regional Director of Operations. Training included review of policy and procedure for resident securement, proper handling of vehicles, use of safety equipment on board the vehicle, passenger safety and securement of passengers in vehicle. Training was per the manufacturer's driver training modules. The Van Driver resumed her duties after training and return demonstration on 12/21/23, however, on 1/5/24, the Van Driver completed return demonstration of resident securement and during this demonstration, sufficient securement was not ascertained due to the securing straps not being tight and the resident chair still moving while restrained with safety equipment. Following this failed return demonstration, the driver was removed from her responsibilities of driving the facility van. On 1/5/24, the two remaining drivers (The Maintenance Director and Maintenance Assistance) were educated by the Administrator on the process of securing a wheelchair into the van. This procedure now includes a 2-step process for ensuring the chair is immobile when preparing for transport. The 2 steps are as follows: - Test each of 5 straps by pulling on both the top and bottom of each strap to confirm that the strap is taut. - Attempt to move wheelchair forward, backward, and side to side to confirm that wheelchair does not move. If during either of the 2 steps the chair is mobile, the driver will cinch the securing straps to create more tension and complete the 2-step process	F 689		

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again to ensure that the chair does not move prior to placing the vehicle in motion.

The two remaining drivers (the Maintenance Director and Maintenance Assistant) were able to complete the new 2-step process effectively on 1/5/24. This was verified by the Administrator. No transportation occurred until the completion and validation of this training.

Administrator will validate 5 resident transports weekly X 8 weeks to ensure the new 2-step process is utilized correctly and that proper securing of residents/wheelchairs in the transport van occurs prior to departure from the center.

Alleged date of IJ removal: 1/6/24.

On 1/16/24, the corrective action plan for immediate jeopardy removal effective 1/6/24 was validated by the following: Interviews with the Maintenance Staff revealed they were performing facility transports when additional assistance was needed, and an outside transportation company was now scheduled due to the former Transportation Aide being relived from her duties as Transportation Aide. The Maintenance Staff indicated they had received formal training on how to properly secure residents for a safe transport for manufacturer's guidelines and for each transport conducted by a member of the Maintenance Staff a Nurse Aide has been required to ride in the facility van for additional safety reasons. An observation was made of the local transportation company pick up a resident from the facility and a nurse aide accompanied the resident to their appointment. Transportation audit tools were reviewed and confirmed resident safety and securement in the transport van were

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F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		

§483.75(c) Program feedback, data systems and monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to

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adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

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resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility's Quality Assessment and Assurance

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(QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following recertification and complaint investigation surveys completed on 11/12/21 and 11/3/23. This failure was for one deficiency in the area of supervision to prevent accidents that was subsequently recited on the current complaint investigation and revisit survey of 01/16/24. The repeat deficiency during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referred to:

F689- Based on observations, record review, Medical Director (MD), resident, family member (RP), and staff interviews, the facility failed to ensure safe securement per manufacturer recommendations of a resident during a van transport. Resident #1 flipped backwards in his wheelchair, hitting the van floor while being transported in the facility's transportation van. The transportation van drove over a speedbump located along the steep driveway leading to the facility when the wheelchair flipped backwards. Resident #1 sustained a hematoma to the back of his head, a skin tear to his right hand and skin tear to his right wrist. This practice had the high likelihood of causing serious injury for 1 of 3 residents reviewed for accidents (Resident #1).

During the recertification and complaint investigation survey conducted on 11/3/23, the facility failed to safely assist a resident without causing injury to 1 of 5 residents reviewed for accidents. The Resident was left standing

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without assistance in her room and fell. The Resident sustained a laceration to the head and a right fractured hip.

During the recertification and complaint investigation survey conducted on 11/12/21, the facility failed to secure smoking materials, failed to provide a smoking apron, and failed to supervise 1 of 2 residents reviewed for smoking.

During an interview with the Administrator on 1/16/24 at 10:00 AM, she reported her quality assurance team met monthly and included the Medical Director, Director of Nursing, Assistant Director of Nursing, Treatment Nurse, Dietary Manager, Pharmacist (quarterly), Registered Dietician (quarterly), Social Worker, Activities Director, and a rotating staff member. The Administrator stated she felt like they had resolved the issue of supervision to prevent accidents because she had no further falls with major injuries from being left unattended and did not think to include the potential for a fall in a motor vehicle in the plan.