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F 000	INITIAL COMMENTS A complaint investigation was conducted on 10/12/21 through 10/14/21. Event ID BR3P11. 2 of the 3 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 689 SS=G	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 and staff and physician ' s interviews the facility failed to transfer a resident in a manner that prevented an injury that resulted in a toe fracture during a transfer by an outside transport company for 1 of 3 residents reviewed for accidents (Resident #3). The findings included: Resident #3 was admitted to the facility on 5/5/20 and had a diagnosis of end stage renal disease, diabetes and diabetic neuropathy. The most recent Minimum Data Set (MDS) Assessment dated 8/25/21 revealed the resident was cognitively intact, was not ambulatory and required total assistance with transfers. The MDS noted the resident had impaired range of motion of the upper and lower extremities on one side.	F 689	Past noncompliance: no plan of correction required.	10/22/21

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

Electronically Signed | 10/22/2021

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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A progress note dated 9/22/21 at 4:30 PM revealed a phone call was received from a family member indicating the resident had suffered an injury to her left foot and had been transported to the hospital for treatment. The nurse called and spoke with the dialysis nurse who confirmed the resident had arrived with blood in her left sock and stated something happened during transport. Spoke with the transport service who also confirmed the resident complained of pain during transport.

A progress note dated 9/23/21 at 1:12 PM noted on 9/22/21 at approximately 2:30 PM dialysis called to report an incident that happened on the wheelchair ramp while transferring the resident. The Dialysis Nurse stated she saw a trail of blood on the floor and it was coming from the resident ' s foot. The Dialysis Nurse stated she applied direct pressure to it and that dialysis would send the resident to the Emergency Department (ED) after her dialysis treatment. A progress note dated 9/23/21 at 2:35 (Late Entry) noted the transportation Driver called to inform them an incident happened with the resident ' s left foot getting hit with the wheelchair ramp on the van.

Review of the Emergency Department Record revealed Resident #3 arrived at the ED on 9/22/21 at 4:24 PM. The physician note revealed a dialysis patient had gone for dialysis and the left big toe was injured during transport and the nail got partially avulsed. Brought to the ED for evaluation of the toe injury. The patient otherwise had no symptoms. The ED treatment included a procedure to remove the left big toenail and an X-ray of the left toes. The X-ray report revealed a fracture of the distal phalanx of the left great toe. The resident was discharged back to the facility

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and was to follow-up with an orthopedist. An avulsed nail is when part or all of the nail is torn away from the nail bed on a finger or toe.

A progress note dated 9/23/21 at 2:30 AM revealed the resident had returned from the ED and had an avulsion of the toe and the nail was removed in the ED and no new orders. The note revealed dark bruising across the top and bottom of the foot and the second, third, fourth and fifth toenails were dark in color with no swelling noted. The note revealed the resident stated her foot was sore but no pain at present. The Director of Nursing (DON) was notified and a call was placed to the Responsible Party (RP) and a message left for the RP to call the facility. A message was left for the oncoming shift to call the physician for treatment orders in the morning.

There was a physician ' s order dated 9/23/21 for an antibiotic medication to be given twice a day for 7 days for the left great toe prophylactically. Clean with normal saline and apply a clean non adherent dressing to the left great toe and wrap the foot with a gauze dressing.

On 10/12/21 at 9:40 AM, Resident #3 stated in an interview that when going to dialysis her foot got caught on the ramp and she broke her foot. The Resident further stated she yelled out when it happened but after that she did not feel any pain.

On 10/12/21 at 12:43 PM an interview was conducted with the resident ' s physician in the facility. The Physician stated the resident was in a transport van and a bar fell on her foot and she was bleeding and she was sent to the ED from dialysis. The Physician stated the resident ' s foot was healing and there had been no further

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problems with the resident ' s foot.

On 10/12/21 an interview was conducted with the DON and the Administrator. The DON stated the person that transported the resident on 9/22/21 put the resident in the van and the resident said "ouch" and the transport person asked her if she was okay and the resident stated she was and was taken to dialysis. The DON stated there was no staff from the facility present during the transfer to the van. The DON further stated when she arrived at dialysis the nurse went to the waiting room to get her and saw blood near the wheelchair and when the nurse pulled off the resident ' s sock the nail was hanging and the resident told the dialysis nurse that something happened on the van on the way to dialysis and she felt a sharp pain and then nothing else. The DON stated the dialysis nurse called the facility around 2:30 PM and said something happened to her left toe and if she still had bleeding after dialysis she was going to send her to the hospital. The DON further stated when dialysis was complete the resident still had some bleeding so the nurse at dialysis sent her to the hospital. The DON stated they tried to get the transport company to do a re-enactment of the incident but the company declined.

On 10/21/21 at 1:56 PM an attempt was made to interview Dialysis Nurse #1, but the nurse was not available for an interview.

On 10/13/21 at 9:08 AM an interview was conducted with the employee that transported the resident to dialysis on 9/22/21. The Employee stated the resident had on thick socks but no shoes and there were no footrests on the wheelchair. The Employee further stated the

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resident usually held both legs up when the wheelchair was moving. The Employee stated she pushed the resident in the wheelchair on the ramp, locked the wheelchair and was using the lift to raise the chair up to the van and the resident screamed out "My foot." The Employee stated she stopped and the resident was holding up the right leg but the left leg was down and her foot was on the floor. The Employee further stated there was a metal bar on the lift that folds out and she thinks the resident ' s foot got caught between the metal bar and the lift. The Employee stated when the resident screamed out, she stopped and looked at the foot and it looked okay and the resident stated she was okay and she proceeded to transfer the resident to the van and transported her to dialysis. The Employee stated when she arrived at the dialysis center she rolled the resident in her wheelchair to the waiting room and asked the resident if she was okay and the resident stated she was okay and she left the dialysis center. The Employee stated she had not had this happen during transports in the past.

On 10/12/21 at 3:50 PM the Administrator stated the facility had a contract with the transport company that transported Resident #3 to dialysis on 9/22/21 and the company ' s services were suspended on the day of the incident. The Administrator further stated she had completed a plan of correction related to the incident.

The facility ' s corrective actions implemented after the accident to prevent a reoccurrence included the following: 1. Corrective action for the resident involved: On 9/22/21 the resident was transported to the ED for evaluation, following completion of her dialysis appointment at approximately 4:24 PM.

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2. Identification of potentially affected residents and corrective actions taken: All current residents requiring wheelchair van transportation have the potential to be affected. On 9/23/21: Van transportation via wheelchair by external van companies were reviewed by the Administrator/DON for the past 30 days for any incidents related to safely transporting residents to and from appointments. No other incidents were found. On 9/23/21 Residents that were cognitively intact who were transported to an appointment were interviewed by the social worker for any concerns related to their transportation and there were no concerns identified. On 9/23/21 grievances and incident reports for the last 30 days were audited by the Administrator and the DON for any identified concerns or incidents and there were no other incidents found. On 9/23/21 any change in condition while out on an appointment that was communicated back to the facility was reviewed by the DON for timely notification of the RP and the physician and no incidents were found.

3. On 9/22/21 the DON began education of all full time, part time and PRN (as needed) nurses/CNAs (Certified Nursing Assistants)/Medication Technicians and agency staff on the following:
Leg/footrests are to be in place on the wheelchair for residents who are being transported to appointments. No resident is to be transported to an appointment in a wheelchair without foot/leg rests in place, unless they are a double below or above knee amputee.
Leg/footrests help ensure proper body alignment and positioning as well as prevent injuries during transport or when assisting the resident on/off the

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F 689	Continued From page 6 van. Appropriate footwear/foot coverings are to be worn when up in the wheelchair for appointments to help aide in potentially preventing alterations in skin integrity such as abrasions/scrapes/scratches or other potential injuries to the feet. When the facility is notified that a resident has experienced a change in condition, while outside of the facility on an appointment, the DON/Administrator are to be notified timely and the physician and the RP are to be notified timely by the assigned nurse of the DON/Administrator. The DON will ensure that any of the above identified staff who do not complete the in-service training by 9/27/21 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. The Administrator will assure that the outside contacted company will not resume transporting residents until education has been completed by the contracted van company to assure that residents are safely assisted on/off and are able to verbalize the steps to take if an incident occurs before leaving the facility premises. Education of the van company drivers will be completed by the contracted company by 9/29/21. Quality Assurance Plan: The Administrator will monitor this issue using the Quality Assurance Tool for monitoring of compliance with the safe transport process of wheelchair residents. The monitoring will include monitoring of and direct observation of 2 wheelchair residents who are to be transported to an appointment by the	F 689		

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contracted van company to assure they are appropriately positioned in the wheelchair, have leg/footrests in place and are safely loaded on the van prior to leaving the facility premises. The DON will also audit for compliance the notification of change in condition when out on an appointment to assure the RP and physician have been notified timely utilizing the Change in Condition Notification Tool. This will be completed weekly times 4 weeks, then monthly times 3 months or until resolved by the Quality Assurance (QA) Committee. Reports will be presented to the weekly QA committee by the Administrator to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Therapy, Health Information Management and the Dietary Manager. Date of Compliance: 9/30/21.

On 10/13/21 at 1:49 PM the Administrator stated all current staff had been in-serviced. As we are using agency staff, the education is ongoing. If new agency staff work, they are in-serviced prior to working the shift.

On 10/13/21 the facility ' s Plan of Non-compliance was validated by the following: Audits conducted by the facility were reviewed and were found to be completed according to the plan of correction. Staff education was completed as well as education of the employees of the transport company involved in the incident including the employee that transported Resident #3 on 9/22/21. The In-service included the following: 1. Report any complaint from the patient and/or any concerns you may have to the

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F 689	Continued From page 8 nurse before leaving a facility with the patient. Call the station and report the same to person in charge before leaving the facility with the patient. 2. Ensure all wheelchair van patients that are unable to step up in the van is safely in a wheelchair. Call the station to report any concerns. 3. Ensure the patient ' s wheelchair is working properly. Make sure the chair has foot and leg rest as needed. 4. Report anything that may be a hazard to the person in charge immediately. 5. In the event of an emergency on a wheelchair van, call 911. Do what you can to help the patient until help arrives and then call your supervisor immediately. Interviews were conducted with nurses and certified nursing assistants who stated they had received training related to residents being transported to appointments by van and were knowledgeable of the elements in the in-service documented for the staff.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview the facility failed to ensure a resident received physician services that resulted in a delay in treatment for placement of a dialysis shunt for 1 of 1 resident reviewed for dialysis (Resident #3).	F 698	This Plan of Correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors findings or the	10/29/21

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F 698	Continued From page 9 The findings included: Resident #3 was admitted to the facility on 5/5/20 and had a diagnosis of end stage renal disease. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 8/25/21 revealed the resident was cognitively intact and required extensive assistance with bed mobility and total assistance for transfers, toileting, and bathing. The MDS noted the resident was not ambulatory and used a wheelchair for mobility. The MDS noted the resident received dialysis while in the facility. The care plan updated on 8/20/21 noted the resident was scheduled for hemodialysis three times a week due to renal disease. The interventions included to arrange transportation to dialysis on scheduled dialysis days. A progress note dated 7/27/21 at 1:35 PM noted the physician ' s office had called and scheduled an appointment for a consult for an AV (arteriovenous) shunt for dialysis for 9/1/21 at 1:30 PM. The note revealed that transport had been arranged with (name of transport company). Review of hospital records revealed the resident was sent to the hospital on 8/26/21 due to a clotted perma cath and was admitted to the hospital. A perma cath is a catheter placed through a vein into or near the right side of the heart and is used for dialysis until a long-term device (AV shunt) is ready to use. A progress note dated 8/27/21 at 10:17 AM noted the resident had a nephrology appointment for	F 698	conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the facility□s or community□s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility / community or any employee, agent, officer, director, attorney, or shareholder of the facility / community or affiliated entities. F698 1. For resident # 3, a corrective action was obtained on 10/22/2021. The nurse who cancelled the appointment with nephrologist was verbally counseled by the Director of Nursing on 10/19/21 regarding verifying outside doctor appointments with the physician office (specifically dialysis related) prior to cancelling and or rescheduling any appointments and the transportation process. Appointment with and transportation to Dr. Ketoff on 11/4 was confirmed by Director of Nursing on	

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F 698	Continued From page 10 9/1/21 for evaluation and placement of a shunt for dialysis however the resident has already received it therefore the appointment was cancelled. (Name of transport company) made aware to cancel that appointment. The note was signed by Nurse #1. Hospital records revealed the resident was re-admitted from the hospital on 8/29/21. A progress note dated 9/8/21 at 9:19 AM revealed the resident had an appointment with a nephrologist scheduled for 9/30/21 at 2:40 PM. Resident currently has a perma-cath. This appointment is for an AV shunt. A progress note dated 9/30/21 at 3:26 PM revealed the resident had an appointment on November 4, 2021 with a nephrologist and transportation had been arranged with (name of transport company). On 10/12/21 at 1:07 PM an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated the resident was sent to the hospital with a clogged perma cath (8/26/21) and was admitted to the hospital. The DON stated that Nurse #1 thought the resident was having the AV shunt while in the hospital, so she cancelled the appointment with the nephrologist for the consultation. Nurse #1 joined the interview at 1:15 PM and stated the resident had just had her perma cath changed and thought the doctor ' s appointment was for a clogged perma cath and when the resident went to the hospital she thought the appointment was no longer needed and she cancelled the appointment. The DON stated the resident had an appointment with a nephrologist for a	F 698	10/22/21. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. At this time there are no other residents with the potential to be affected by the alleged deficient practice as there are no other dialysis residents in this facility. 3. Systemic changes On 10/20/21, the Director of Nursing began education of all full time, part time, as needed, and agency nurses on the appointment process to include: not cancelling or rescheduling appointments without DON notification, physician verifying reason for appointment, and responsible party notification and transportation arrangement which includes: all transportation requests being completed by one designated person and all transportation requests being verified the day before the scheduled appointment to ensure no appointments are missed. Any nurse who has not completed the education by 10/29/2021 will have education completed prior to working the scheduled shift. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will	

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F 698	Continued From page 11 consultation on 10/4/21 at 2:40 PM. The DON further stated that the company that was to transport the resident to the appointment arrived at the facility at 3:00 PM and they called the doctor ' s office to see if they would still see the resident and was told it was too late and that the appointment would need to be rescheduled. The DON stated she asked the van driver why she was late and the driver could not tell her and stated she dropped someone off somewhere else and then came to the facility to transport Resident #3. The DON stated the resident had a consult with a nephrologist on 11/4/21 for her dialysis shunt. On 10/14/21 at 8:45 AM an interview was conducted with the nephrologist that cared for Resident #3. The Nephrologist stated the resident had a perma cath that was being used for dialysis until a shunt could be placed. The Nephrologist further stated there was a chance for infection and they liked to have a shunt put in within 90 days but some patients have a perma cath for a year though this is not preferred. The Nephrologist further stated the delay in getting the shunt had caused no harm and they were monitoring the resident very closely in the clinic.	F 698	monitor the process for making, rescheduling appointments and arranging transportation for appointments using the appointment process audit tool. Monitoring will include auditing resident appointments and transportation logs daily Monday through Friday for compliance, this will be completed weekly x4 weeks and then monthly or until compliance is achieved. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	