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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/20/24 to 8/22/24. Event ID#19Q011. The following intake was investigated: NC00220765. One (1) of the 5 complaint allegations resulted in a deficiency. Intake NC00220765 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/25/24. The facility came back in compliance effective 5/27/24. A partial extended survey was conducted.	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 record reviews, observation, and resident, staff, and transportation driver interviews, the facility failed to provide safe transportation for Resident #1 when she was being transported by a contracted van transport company from dialysis back to the facility on 5/25/24. Resident #1's wheelchair was not	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 09/04/2024

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secured to the floor securement system per the manufacturer's instructions. When Driver #1 accelerated the vehicle, Resident #1's wheelchair tipped backward, and the resident hit the right back side of her head. Driver #1 pulled the transportation van over to the shoulder of the road and called 911. Emergency Medical Services (EMS) arrived, assessed the resident, and determined she needed to go to the hospital for evaluation for her complaints of head pain. The accident occurred post hemodialysis and Resident #1 was prescribed and received Plavix (anticoagulant medication). There was a high likelihood of a serious adverse outcome for Resident #1 due to the resident's wheelchair not being secured to the floor of the van per the manufacturer's instructions. Resident #1 was evaluated in the emergency department and the physician noted a right parietooccipital hematoma (blood collection in the back of the head. The CT (Computed Tomography) scan of the neck and head was negative for a head injury. This was for 1 of 3 residents reviewed for accidents (Resident #1).

The findings included:

The manufacturer's instructions for the 4-point Wheelchair Securement Systems manual, dated 2012, were reviewed. The illustrated manual provided directions for wheelchairs to be secured with four separate floor-mounted restraints at all times when the vehicle was moving. The restraints were to be secured to the corners of the chair, on the frame structure of the wheelchair at approximately a 45-degree angle, not on the wheels or other parts of the chair. In addition to wheelchair securement, seat belts were to be used for securing passengers at all times. The

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lap belt must be securely fastened around each passenger any time the vehicle was moving, and a shoulder belt be used as well.

The 2023 agreement between the Transportation Company #1 and the nursing home was reviewed. The agreement indicated to immediately notify the nursing home of any accidents or incidents, involving any vehicle or clients, whether or not damage or personal injury results.

Resident #1 was re-admitted to the facility on 6/8/24. Her diagnoses included diabetes mellitus, end stage renal disease (ESRD) with hemodialysis, and bilateral below-knee amputations

The quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, indicated that Resident #1 was cognitively intact. She required extensive assistance with activities of daily living (ADL), used the wheelchair for mobility, and was non-ambulatory. The resident received hemodialysis three times a week.

Review of Resident 1's plan of care, dated 5/22/24, revealed her diagnoses of ESRD and hemodialysis three times a week, with goals and interventions.

Review of the physician's orders for May 2024 for Resident #1 revealed hemodialysis on Tuesday, Thursday, and Saturday outside the facility.

Record review of the nurses' notes revealed that on 5/25/24, the staff received a phone call from the Owner of Transportation Company #1 stating on the way from the dialysis center to the facility,

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Driver #1 did not secure the wheelchair with Resident #1 according to manufacturer recommendations to the van, causing the wheelchair to flip backward. The resident hit her head on the van's door. Driver #1 called EMS, and the resident was transported by EMS to the Emergency Department (ED) for hospital evaluation.

Review of the EMS report, dated 5/25/24, revealed at 3:04 PM the EMS dispatch received a call from Driver #1, stating that a (redacted) female fell in the van during the transportation from dialysis center to nursing home. The EMS team arrived on the scene to Resident #1 at 3:10 PM. Upon assessment, the patient had a hematoma, 1.5 by 2 inches, over the posterior (rear) head with moderate pain in her head and no bleeding or other injuries. Driver #1 explained that he had some issues with latching mechanism and thought he had it secured well. Per Resident #1, she flipped over backwards, striking the ramp. Resident #1 was transferred to the stretcher and brought to the ED of the hospital with no changes in condition at 3:39 PM.

Review of the hospital records, dated 5/25/24, revealed Resident #1 arrived at ED at 3:49 PM via EMS for her head injury. Upon arrival, the resident was not in acute distress with stable vital signs. She had notable right parietooccipital hematoma. Per resident, she was riding in her wheelchair on the wheelchair accessible van after her dialysis appointment. The wheelchair was not locked down to the van, and when the driver accelerated the vehicle forward, the resident fell backwards, hitting the back of her head on the chair lift. She was not sure if she lost consciousness. Resident #1 endorsed pain in the

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back of her head and reported that she took daily Plavix (anticoagulant). The resident denied all other pain. The CT (Computed Tomography) (diagnostic test) scan of the head and neck was negative for acute traumatic pathology (sudden onset injury). She received pain management, and during multiple reevaluations, reported a gradual improvement of her headache. Resident #1 was discharged to the nursing home at 10:13 PM in stable condition.

On 8/20/24 at 8:05 AM, during an interview, Resident #1 indicated she remembered on one Saturday in May 2024 (could not recall the exact day), she was in her wheelchair in the van for transportation from the dialysis center to the facility. Driver #1 was new to her and secured the wheelchair to the van with straps before leaving the dialysis center parking lot. The resident did not realize the driver secured only the back part of the wheelchair and the front part of the wheelchair frame was unsecured. Driver #1 locked the wheels of the wheelchair and applied the lap and shoulder seat belts to secure the Resident #1 in the wheelchair. On the way to the facility Driver #1 accelerated the vehicle forward, the resident's wheelchair tipped backward, and the resident fell backward together with her wheelchair and hit the right back side of her head against the van's door. The driver immediately pulled the transportation van over to the shoulder of the road and called 911. When EMS arrived, they assessed the resident, who reported moderate pain in her head and took her to the hospital for evaluation. Resident #1 could not recall if there was any blood coming from her head. Resident #1 continued she received a head CT scan (diagnostic procedure), which found no issues, and pain medications. In the ED, her pain

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was gradually reduced, and she returned to the facility in a few hours with almost no pain in her head. Resident #1 had not used Transportation Company #1 for dialysis appointments since the incident. Instead, the facility provided their van with a driver from the facility and there had been no issues.

Attempts to interview Van Driver #1 were unsuccessful.

On 8/20/24 at 9:50 AM, during the phone interview, the Owner of Transportation Company #1 indicated on 5/25/24, (did not recall the exact time), he received a phone call from Driver #1, who was assigned to transfer Resident #1 from the dialysis center to the facility. Driver #1 stated he did not fully secure the wheelchair to the van, and on the way to facility, Resident #1 fell backwards and hit her head. The Owner of Transportation Company #1 directed Driver #1 to call 911and then notified the facility. The administration of Transportation Company #1 conducted an internal investigation, which revealed Driver #1 disregarded the protocol and did not secure the wheelchair to the van per manufacturer's instruction, causing the incident with Resident #1. The Owner of Transportation Company #1 confirmed that Driver #1 was terminated, and the facility halted the contract with Transportation Company #1. The Owner of Transportation Company #1 continued that Driver #1 was hired in January 2024 and completed the training related to operating the van, patients' transportation in the van, including the 4-point Wheelchair Securement Systems manual, with return demonstration. Driver #1 did not have any issues prior to 5/25/24.

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On 8/20/24 at 11:10 AM, during an interview, the Director of Nursing (DON) indicated on 5/25/24, the staff received a phone call from Transportation Company #1, stating Resident #1 fell in the van on the way from the dialysis center to the facility and was sent to the hospital for evaluation via EMS. During further communication with the Owner of Transportation Company #1 via phone and email, the DON learned that Driver #1 did not follow the protocol to secure the resident's wheelchair according to the manufacturer's instruction. The resident fell backward and hit her head. Driver #1 was terminated from the transportation company, and the facility stopped the agreement with Transportation Company #1. Since the incident on 5/25/24, the facility had utilized their van and their own driver for dialysis appointments.

On 8/20/24 at 11:30 AM, during an interview, the Maintenance Director explained Driver #1 did not return to the facility and the Maintenance Director did not have a chance to inspect the condition of the securement system in the van as part of the facility's investigation. The Maintenance Director indicated that for newly hired Driver #2, he provided education and training for safe resident transportation in the van, including applying a 4-point securement system, seat belts, and straps with hooks according to the manufacturer's instruction. Driver #2 utilized the facility's van for dialysis appointments, and since the incident on 5/25/24, the Maintenance Director had been checking the van daily to monitor the securement system application.

On 8/21/24 at 10:10 AM, during an interview, the Medical Director indicated she was notified of the incident with Resident #1 in the van right after it

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happened. After the incident, the resident spent a few hours in ED and received the diagnosis of a small right parietooccipital hematoma with no acute abnormalities on imaging tests. The Medical Director understood it was a driver from the transportation company, but the facility should be responsible for providing care within the professional standard at any time. The Medical Director mentioned Resident #1 could have sustained a serious injury during a fall on the van due to her anticoagulant medications, primary diagnosis, and comorbidities.

On 8/21/24 at 11:25 AM, during an interview, the Administrator indicated he became aware of the incident on 5/25/24. The Director of Nursing (DON) notified him the staff received a phone call from Transportation Company #1, stating Resident #1 fell in the van during her transfer between the dialysis center and the facility. Her fall resulted in head trauma, EMS was called to the scene, and EMS took her to the hospital for evaluation. The DON and Maintenance Director discussed the issue with the Owner of Transportation Company #1, who clarified Driver #1 did not fully secure the resident in the van per protocol, which led to the fall with injury. Driver #1 was suspended and terminated according to the owner of the transportation company. The facility halted the agreement with Transportation Company #1. The Administrator reported after the incident, the facility conducted a Quality Assurance Performance Improvement (QAPI) meeting to discuss the incident and develop a Corrective Action Plan. The Administrator explained the facility utilized its van for resident's transportation after the accident on 5/25/24. The Maintenance Director was responsible for checking the safety equipment in the van and

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providing education and training for drivers. The newly hired Driver #2 received education and training for safe resident transportation in the van, including applying the 4-point securement system according to the manufacturer's instructions.

The Administrator was notified of immediate jeopardy on 8/21/24 at 10:00 AM.

The facility implemented the following Corrective Action Plan with a completion date of 5/27/24.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Residents requiring facility assisted transportation could be affected by the deficient practice.
Westwood Administrator halted the use of the contracted transportation service on May 26th, 2024, and all drivers within their transportation company had to complete education before any further usage. The affected residents are now transported by facility van to appointments. We have contracted with a second transportation service as a backup.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice
Any resident needing transportation has the potential to be affected.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
Westwood Administrator halted the use of the contracted transportation service on May 26th, 2024, and all drivers within their transportation

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company had to complete education before any further usage. Facility Director of Nursing and Maintenance Director completed education on properly securing residents prior to transport. The facility has contracted with a second transportation service who has provided credible evidence of safe transportation and securing residents to meet the potential appointment needs.

Residents are currently being transported to their appointments by our transportation aide. Upon hire, the transportation aide received education that including, but not limited to, properly securing residents safely in the vehicle, loading and unloading and vehicle condition. On May 26th, 2024, the Executive Director reeducated the Director of Nursing and Maintenance Director as it relates to vehicle safety while transporting residents to ensure resident are properly secured during transportation. The facility maintenance director provided training on June 7th, 2024, to the transportation aide. No new transportation vendors have been added since May 25th, 2024. We are utilizing our facility van with our transportation aide as the driver. The facility made the decision to monitor/audit and bring this to QA on May 26th, 2024.

4. Include dates when corrective action will be completed.
Ongoing audits began on 5/26/2024.

5. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained
Quality monitoring will be performed on 2 different residents weekly to ensure they are safely secured prior to transporting to appointments for

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12 weeks and then monthly for 3 months by DON and transportation aide to ensure resident is properly secured in van prior to transport. The immediate jeopardy was removed on 5/27/24. The deficiency was corrected on 5/27/24.

The Immediate Jeopardy was removed on 5/27/24.

The Corrective Action plan was validated on 8/22/24. The facility provided documentation to support their Corrective Action Plan, including education for the Maintenance Director and Driver #2. The pre-trip inspections were completed before any van transportation by Driver #2. The Maintenance Director audited these inspections three times per week from 5/27/24 to 7/22/24. During the observation, Driver #2 and the Maintenance Director demonstrated the correct method to restrain a wheelchair with a resident in the transportation van, using the 4-point securement system. QAPI meetings were discussed with the administrator, and meeting notes were reviewed.

The facility's completion date of 5/27/24 for the Corrective Action Plan was validated on 8/22/24.