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F 000	INITIAL COMMENTS The following citations are a result of complaint investigation KS00174754, KS00174514, KS00175542, KS00174570. The 2567 was sent electronically on 10/24/22.	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: The facility identified a census of 34 residents with three residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to provide a safe environment and adequate supervision for Residents (R) 1 and R2. On 09/05/22, while the facility transported R1 Certified Nurse Aide (CNA) M failed to apply safety belts to R1's wheelchair in the transportation van, causing R1 to fall backwards in the van, which resulted in a laceration (a deep cut or tear in skin or flesh) to the back of R1's scalp measuring 3 centimeters (cm) by 0.5 cm and required four staples, and a laceration to R1's outer left ankle measuring 4 cm by 3 cm, requiring 13 sutures. On 09/05/22, CNA N transported R2 via wheelchair back to her room but took the corner to R2's room too sharply and caught R2's left foot into the door jam, which resulted in fractures (broken bones) to R2's third,	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/24/2022

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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fourth, and fifth toes and lacerations to the bottoms of R2's toes.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), end stage renal disease (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Admission Minimum Data Set" (MDS), dated 07/06/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R1 required extensive assistance of one to two staff for bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene, and bathing. The MDS further documented R1 required a wheelchair for locomotion and had not had any falls.

The "Activities of Daily Living (ADL) Care Area Assessment (CAA)," dated 07/06/22, documented R1 required assistance with bed mobility, locomotion, dressing, toilet use, and personal hygiene. R1 struggled with strength and mobility and could not remember to perform daily tasks.

The "Fall CAA," dated 07/06/22, documented R1 did not remember to use the call light to call for assistance, did not usually try to transfer or ambulate by herself, and would usually wait for staff assistance. The "Fall CAA" further

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documented R1 required assistance of one to two staff for transfers and was not steady during transitions.

The "Cognitive Loss Care Plan," dated 07/17/22, directed staff that R1 could not remember appointment times, mealtimes, and activity times and R1 depended on staff to remember these things for R1 and assist her to such.

The "Dialysis Care Plan," dated 07/17/22, directed staff that R1 required dialysis appointments on every Monday, Wednesday, and Friday.

The "Fall Care Plan," dated 07/7/22, documented R1 was dependent on staff for locomotion in a manual wheelchair.

The "Progress Note," dated 09/05/22, documented R1 went to dialysis at 01:34 PM via the facility van.

The "The State Agency Triage Intake Note," dated 09/05/22, documented R1 went to the local emergency room after not being buckled into the facility van after receiving dialysis. The facility staff [CNA M] took off in the van and R1 flew backwards, sustaining a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) and a laceration to the back of R1's head and a laceration to R1's right ankle. Social Services X reported the incident to Adult Protective Services (APS).

The "Progress Note," dated 09/05/22 at 09:55 PM, documented R1 returned from the emergency room per van without incident, R1 denied losing consciousness, and did not know

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how to explain what happened in the van.

The "Non-witnessed fall/Head injury fall Assessment," dated 09/05/22 at 11:45 PM, documented staff performed neurological checks on R1 every fifteen minutes for one hour, every thirty minutes for two hours, hourly times two hours, and every eight hours times nine hours. All of R1's neurological checks were within normal limits.

The "Weekly Wound Assessment," dated 09/07/22, documented R1 had a laceration to the back of her head measuring 3 cm by 0.5 cm with four staples securing the laceration. The wound assessment noted R1 had a laceration to her right ankle with 13 sutures securing the wound.

The "Facility Incident Report," dated 09/08/22, documented R1 was transported back to the facility from dialysis. While CNA M was in route back to the facility, CNA M heard a noise, looked back in her rear-view mirror and did not see R1. CNA M pulled over and found that R1 had tipped backwards while sitting in her wheelchair in the van. CNA M found that R1 had a laceration to the back of her head and contacted the facility for directions. CNA M was directed to take R1 to the emergency room. R1 was treated for a laceration to the back of her head measuring 3cm by 0.5 cm and a laceration to her right ankle measuring 4 cm by 3 cm. R1 was treated by the emergency room and released back to the facility. CNA M reported when she found R1 tipped over, she noted the straps were still attached to the wheelchair, but were loose. R1 was not able to say what had happened. CNA M stated she tightened the straps as best as she could. Maintenance Personnel U checked all of the

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safety features of the van and verified they were working appropriately, and Maintenance Personnel U could not replicate the incident unless the straps to the front wheels of the wheelchair were not attached. It was determined that CNA M had failed to attach the van's safety straps to the front of the wheelchair.

On 10/10/22 at 11:30 AM, observation revealed R1 sat in her wheelchair at the dinner table visiting with another resident.

On 10/10/22 at 10:00 AM, CNA O stated that she had not been at work the day of the incident, but she heard in report that CNA M had forgot to put the breaks on to R1's wheelchair and the wheelchair had flipped backwards causing R1's injuries.

On 10/10/22 at 10:30 AM, Licensed Nurse (LN) G stated that she had not been on shift the day that incident had happened with R1, but during report she learned the incident was caused by staff not applying the straps correctly or not putting the breaks to the wheelchair on.

On 10/10/11 at 11:30 AM, R1 stated that she did not know how the incident in the van happened. R1 stated, "It happened so fast." R1 stated she was scared and her head hurt at the time, but it no longer hurt and was healed.

On 10/11/22 at 12:00 PM, Maintenance Personnel U stated after the incident he completely checked over all of the safety belts in the van and determined they were all operating correctly. Maintenance Personnel U stated he tried to duplicate the incident and the only way the wheelchair could have tipped over backwards

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was if the front straps were not applied correctly. Maintenance Personnel U stated the incident was caused by operator error. Maintenance Personnel U stated he had all of the CNA's that drive for the facility complete new competencies showing that they knew how to run all of the safety features on the van. Maintenance Personnel U stated van driving competencies were normally performed yearly, and CNA M had passed her competency on 04/27/22.

On 10/10/22 at 12:30 PM, Administrative Nurse D stated she was informed of the incident on 09/05/22 involving CNA M and R1. Administrative Nurse D stated CNA M said that she was distracted when she tried to assist another dialysis patient and could not remember if she had completely strapped R1's wheelchair into the van. Administrative Nurse D stated that she expected all her staff to put the resident's safety before anything else; she told CNA M her responsibility was keeping R1 safe at that moment.

The facility's "Occurrences," policy, revised 11/28/17, documented the facility will ensure that each resident receives adequate supervision and assistive devices to reduce risk occurrences. Any accident or occurrence will be thoroughly investigated to rule out abuse and neglect and to determine a root cause. Appropriate interventions will be developed based on the root cause analysis.

The facility failed to provide a safe environment free from avoidable accidents for R1, when staff failed to properly secure R1's wheelchair in the transport van. As a result, R1 sustained lacerations to her head and leg which required

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treatment at the emergency room.

On 09/08/22 the facility completed all corrective actions which included staff education, transportation vehicle safety inspection and staff competencies. The deficient practice was cited as past noncompliance.

- R2's Electronic Medical Record (EMR) documented R1 had diagnoses of type 2 diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), morbid obesity (an abnormally high body mass), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set (MDS)," dated 09/01/22, documented R2 had a Brief Interview for Mental Status score of seven, which indicated severely impaired cognition. The MDS further documented R2 required extensive assistance of one to two staff for bed mobility, transfer, locomotion, dressing, toileting, personal hygiene, and bathing.

The "Cognitive Loss Care Area Assessment (CAA)," dated 12/09/21 documented R2 occasionally was unable to understand what staff were trying to communicate to her, and she was unable to communicate to staff her needs and concerns.

The "Fall CAA," dated 12/09/21, documented R2 had impaired cognition, incontinence, and impaired mobility. R2 required a full body mechanical lift for transfers, a wheelchair for locomotion; she was dependent on staff for most activities of daily living (ADL's).

The "Fall/Mobility Care Plan," dated 12/04/21

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directed staff R2 used a manual wheelchair with an extended back head rest and bilateral foot pedals with a calf support device that helped R2 from sliding down in her chair, and helped her sit upright better. The care plan directed staff to assist R2 with locomotion.

The "Incident Report," dated 09/05/22, documented R2 was sent to the emergency room due to cutting her foot on the door frame when Certified Nurse's Aide (CNA) N wheeled R2 in her wheelchair. The report noted CNA N reported R2's foot slid too far up on the foot pedal and caught on the door frame.

The "Witness Statement," dated 09/05/22, from CNA N noted R2's foot hit the doorway when CNA turned R2's wheelchair into R2's room.

The "Radiology Report," dated 09/05/22, documented R2 sustained fractures to the proximal phalanx (bone of the toe) of the third, fourth, as well as the distal (farthest away from the body) of the fifth toe.

The "Emergency Room Discharge Instructions," dated 09/05/22, documented R2 sustained lacerations to the toes of the left foot and had an open fracture of the toe. The discharge instructions directed staff to keep bandages to R2's foot in place until seen by orthopedics (the branch of medicine dealing with the correction of bone deformities), keep appointment with orthopedics the next day, follow up with R2's primary care physician as needed, and return to the emergency department for new or worsening symptoms.

The "Progress Note," dated 09/06/22 at 10:32

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AM, documented R2 was back to the facility from the emergency room with new orders to start Augmentin (antibiotic) 875/125 milligrams (mg) by mouth twice a day for ten days and to keep the bandages to the left foot in place until R2 was seen by orthopedics.

The "Progress Note," dated 09/07/22, documented R2 had a boot in place to the left foot with a gauze dressing covering the left toes. Staff observed blood through the gauze dressing. R2 was scheduled to see orthopedics that same day, but R2 could not fit into the van. The charge nurse called the orthopedic clinic to see if they could perform a remote visit to the facility and if they wanted the facility to remove and re-dress the wound as the dressing was soiled. The orthopedic clinic called back and ordered R2 to follow up with her primary care physician. R2's primary care physician was called, and the facility awaited a response.

The "Progress Note," dated 09/08/22, documented new orders from R2's primary care physician regarding dressing changes. The order directed staff to cleanse the toe lacerations with normal saline, pat dry, apply triple antibiotic ointment, apply nonadherent pad and wrap foot with gauze. Staff were to monitor the dressing each shift to ensure dressing was clean, dry and intact and monitor left foot lacerations for signs and symptoms of infection or worsening.

The "Progress Note," dated 09/14/22, documented staff assessed R2's lacerations to her left toes. The lacerations were scabbed, and the sutures were embedded into scabs and hard to visualize. The nurse was able to visualize thirteen sutures to the bottom of R2's toes and

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possibly two to three more she was unable to visualize. The was an area between the fourth and fifth toes, which was open with a moist wound bed. R2 denied pain at rest.

On 10/10/22 at 09:45 AM, R2 sat up in her wheelchair in her room and watched television. R2's legs were elevated in a foot box attached to her wheelchair and the left foot was noted to be in a protective boot with a gauze dressing on her upper foot.

On 10/10/22 at 09:45 AM, R2 stated that CNA N ran R2's foot into the doorway when CNA N brought R2 back to her room from supper. R2 stated that her foot hurt badly at first, but was just numb now.

On 10/10/22 at 10:00 AM, CNA O stated she was not on shift the day of the incident, but she heard in report that staff had ran R2's foot into the door, broke her toes and split her skin open.

On 10/10/22 at 10:30 AM, Licensed Nurse (LN) G stated she was not on shift the day the incident with R2 happened. LN G stated she heard the accident happened when staff wheeled R2 into her room, and R2 foot got caught on the doorframe. LN G verified dressing changes to R2's left toes were performed daily.

On 10/10/22 at 12:30 PM, Administrative Nurse D stated she was notified of the incident on 09/05/22 and came up to the facility. Administrative Nurse D stated she talked with CNA N about the incident and CNA N stated R2's foot slid up and out on her foot pedal and when CNA N went to wheel R2 into her room, R2's foot got caught on the doorway. Administrative Nurse

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D stated she educated CNA N regarding making sure to square up wheelchairs to the doorway when wheeling a resident into their room instead of rounding the corner to ensure that all of the residents body parts were in so they would not get caught on anything.

On 10/11/22 CNA N remained unavailable for interview.

The facility's "Occurrences," policy, revised 11/28/17, documented the facility will ensure that each resident receives adequate supervision and assistive devices to reduce risk occurrences. Any accident or occurrence will be thoroughly investigated to rule out abuse and neglect and to determine a root cause. Appropriate interventions will be developed based on the root cause analysis.

The facility failed to provide a safe environment free from avoidable accidents when staff failed to ensure safe passage through a doorway for R2, who was dependent upon staff for wheelchair mobility. As a result, R2's foot was caught on the doorframe and R2 sustained fractures to her left third, fourth, and fifth toes and a laceration to her left toes which required treatment at the emergency room.

On 09/05/22, the facility provided education to staff regarding wheelchair positioning and ensuring safety when maneuvering wheelchairs through doorways in order to avoid preventable accidents. The deficient practice was cited as past noncompliance.