

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Rector Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1023 Highway 119 Rector, AR 72461	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43262</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure transport staff correctly secured a resident in a wheelchair according to the manufacturer's instructions and was properly trained with return demonstration on the use of the van's safety restraints prior to securing and transporting 1 (Resident #1) resident in a wheelchair to prevent serious injury for 1 resident who was transported on the facility van. The lack of effective training for the transport driver resulted in Resident #1 falling backward in a wheelchair during transport and being positioned in the wheelchair in a manner that had the likelihood to affect Resident #1's ability to breathe.</p> <p>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to the State Operations Manual, Appendix PP, S483.25 (Quality of Care) at a scope and severity of J.</p> <p>The IJ began on [DATE] at 1:30 PM when Certified Nurse Aide (CNA) #1 put Resident #1 on the facility transport van to take to a doctor appointment approximately 40 miles away without proper training.</p> <p>The Administrator and the Registered Nurse Consultant (RNC) were notified of the Past Non-Compliance (PNC) Immediate Jeopardy (IJ) on [DATE] at 3:51 PM. A corrected IJ Template was requested by the NC and resubmitted at 5:51 PM.</p> <p>The facility was found to be in Compliance on [DATE] at 3:00 PM when the facility's Plan of Correction (POC) was confirmed complete by the State Survey Agency.</p> <p>The findings include:</p> <p>A review of an Admission Record indicated the facility admitted Resident #1 with diagnoses of type 2 diabetes mellitus (a condition where the pancreas doesn't make enough insulin), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (COPD-a lung disease that blocks airflow and makes it difficult to breathe) and chronic kidney disease (a progressive loss of kidney function).</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact, and had functional impairment of lower extremities requiring the use of a walker for short distance and a wheelchair for long distance mobility.</p> <p>Review of Resident #1's Care Plan, initiated [DATE], revealed the resident's code status was Do Not Resuscitate (DNR).</p> <p>Review of Resident #1's Care Plan, initiated [DATE], revealed the resident had emphysema/COPD related to smoking in the past, interventions included monitor for difficulty breathing (dyspnea) on exertion and to remind the resident not to push beyond endurance.</p> <p>Review of Resident #1's Care Plan, initiated [DATE], revealed the resident had limited physical mobility related to legs giving way, and was able to ambulate for short distances or propel by wheelchair by self.</p> <p>Review of Resident #1's Care Plan, initiated [DATE], revealed the resident had oxygen therapy related to a respiratory illness, interventions included oxygen via nasal cannula (nasal prongs) at 2 l/min (liters per minute) as needed (PRN).</p> <p>A review of a Incident Narrative # PFD2500497 from (911 provider) revealed the call was received on [DATE] at 2:18:04 PM, where Certified Nurse Aide (CNA) #1 reported she was on the side of the road across from (business name). Resident #1's wheelchair had slipped backwards, and the resident wasn't breathing. CNA #1 said she couldn't get the wheelchair out from underneath the resident. She hit a bump, and the wheelchair flipped backwards. The resident had too many clothes on, and she couldn't tell if Resident #1's chest was going up and down, but there was no way she could do Cardiopulmonary Resuscitation (CPR) but could see Resident #1's eyes twitching. At 2:22 PM (city name) Fire Department (PFD) arrived on scene and at 2:24 PM CPR was initiated. The dispatch call disconnected at 2:31 PM.</p> <p>A review of a Incident Narrative #,d+[DATE] from PFD dated [DATE] at 2:19 PM revealed PFD was dispatched to a call where the patient had fallen and was no longer responsive. PFD arrived on scene at a transit van parked on the side of the highway. PFD was approached by the driver of the van who alerted PFD the patient was not breathing and was inside at the back of the van. When PFD entered the van, the patient was in a wheelchair which had fallen backwards, pinning the patient between the wheelchair and the wheelchair lift on their back. PFD then sat the wheelchair in the upright position while checking for responsiveness of the patient. When the wheelchair was sitting upright PFD observed that the patient was unresponsive and not breathing. PFD then moved the patient from the chair and onto the floor of the van and began CPR. PFD continued rotations of CPR while also giving breaths through a BVM (Bag-Valve-Mask). When EMS (Emergency Medical Service) arrived, PFD and EMS removed the patient from the van onto the stretcher and continued CPR. EMS and PFD loaded the patient into the ambulance for further treatment. PFD entered the ambulance to help with continuing CPR and other treatment. When EMS was ready to transport, firefighter (PFD #7)) drove the ambulance while firefighter (PFD #4) followed in Unit L-1. When all units arrived on scene at (named hospital), PFD assisted with unloading the patient from the ambulance and taking them into the hospital. PFD continued CPR until EMS and hospital staff advised PFD they were no longer needed. PFD cleared the scene and returned to service.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of a Criminal Investigation Note Case Note - 25-F-123 dated [DATE] at 2:44 PM, revealed PPD Officers contacted a Detective from Criminal Division regarding a (named facility) patient, later known as Resident #1, that was being transported to a doctor's appointment in (named a city approximately 40 miles from the facility). Officers explained that during the transport, Resident #1 had fallen over and was unconscious. Officers stated that EMS was on scene and currently providing lifesaving aid. Officers stated that they will be escorting an ambulance through town going to (named hospital) for additional medical services. The driver of van, (CNA #1), was interviewed at the police department, located at (address). The interview was conducted by Detective (name). CNA #1 stated she works at (named facility). She was taking Resident #1 to a scheduled doctor's appointment. CNA #1 said she had been an employee with the nursing home for about six years and was familiar with the resident. CNA #1 said she loaded Resident #1 in the van around 1:30 pm. CNA #1 said it took about 10 minutes to get resident in the van and strapped down inside the van. CNA #1 said they left the nursing home in (named city of facility) around 1:40 pm. CNA #1 said they were talking and at some point, Resident #1 stopped talking. CNA #1 said that when she came up to the (name of High School), she noticed that Resident #1 had fallen backwards. CNA #1 said the resident never said anything about any of the buckles or straps coming loose during transport. CNA #1 said when she realized Resident #1 had fallen, she immediately pulled over and attempted to pick resident up. CNA #1 said she was not able to get resident up and called 911. CNA #1 said that she doesn't know what happened or how Resident #1 fell. CNA #1 said she doesn't know if she may have hit a bump just right or what. CNA #1 said that Resident #1 was talking and told her I can't breathe and then suddenly passed out. When she couldn't get the resident up, she called for help. CNA #1 said EMS arrived and immediately began performing CPR. CNA #1 said she has transported patients on several occasions and nothing like this has ever happened. Following the interview, photographs were taken of the transport van along with a demonstration from CNA #1 explaining how the straps were used during the transport. After strapping the wheelchair down, it was apparent that the wheelchair was still able to be pushed backwards. The video from (intersection identified) was reviewed and downloaded into the case file. After reviewing all evidence in this case, probable cause for an arrest was not established and no criminal charges will be filed.</p> <p>A review of a Progress Note Type: Nursing Incident & Accident (I & A) dated [DATE] at 7:33 PM revealed the Administrator received a call from the transport CNA #1 that resident had tilted back in the wheelchair. CNA #1 reported she heard Resident #1 say I flipped so she pulled over and went back to the resident to assist with no luck sitting resident back upright, so CNA #1 then called for an ambulance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of a facility incident report dated [DATE] at 2:15 PM indicated the Administrator received a phone notification from the van driver (CNA #1) approximately 2:30 PM that she had to pull over and call 911 for a resident in transport who tilted backward in a wheelchair. The Findings and Actions Taken: During transport the resident tilted back in a chair and notified the driver (CNA #1). Van driver (CNA #1) immediately pulled over to a safe place and climbed to the back of van to assist. When the van driver (CNA #1) found she could not assist Resident #1 back to upright position, she called 911 at approximately 2:17 pm. Resident #1 stated they could not breathe and then went unconscious. First on scene was the fire department at which time they entered the van and were able to assist Resident #1 to the floor on the van and initiate CPR. EMS arrived shortly after and was able to take resident through the back of van on stretcher and into ambulance to be transported to (named hospital) for treatment. The report indicated CNA #1 performed a demonstration of securing the wheelchair for the officer, and the straps securing the wheelchair were loose and allowed the wheelchair to be moved backwards without force. It was noted CNA #1 did not tighten the strap using a black knob designed to be used to remove slack from the securement straps. It was indicated this failure to properly tighten the straps allowed Resident #1's wheelchair to move to the tilted position.</p> <p>A review of a Coroner Report Investigation Summary dated [DATE] at 11:39 pm indicated Resident #1 was brought in from (named nursing home). According to (named hospital) clinical notes, Resident #1 arrived by EMS due to patient collapsing. The decedent was examined. There appeared to be a contusion on the upper part of the chest, but no other apparent trauma. The suspected cause of death was indicated to be cardiac.</p> <p>A review of Witness Statement with a date of [DATE] revealed Certified Nurse Aide (CNA) #1 loaded Resident #1 in the facility van to transport to doctor appointment. She had never taken this resident in the van, so it took her about 10 minutes to strap all 4 straps and hook the seat belt. She started with the back strap and tightened it and proceeded to the rest of the straps. After strapping them down, she pushed the button to make sure the straps were fastened. CNA #1 then went behind the wheelchair and shook it from side to side to make sure it was secure. She proceeded to get in and drive the van. CNA #1 and Resident #1 were talking during the transport and the next thing she knew she heard Resident #1 say they had flipped. CNA #1 said the resident was actually tilted back with Resident #1's head against the lift gate. Resident #1's feet were off the floor and all the straps were still fastened. She was trying to get the resident and chair up but was unable to, so she called 911 at 2:17 pm. CNA #1 said 911 wanted her to start CPR but she was unable to with the position the resident was in and being by herself. When the PFD arrived, CNA #1 got out of the van and opened the back doors to let the lift gate down. PFD got Resident #1 to the floor and the wheelchair out of the van by unstrapping the rest of the straps.</p> <p>On [DATE] at 1:30 PM, Transport CNA #2 and Transport CNA #3 demonstrated loading, unloading, and securing of a resident in a wheelchair. During the demonstration, it was determined when the wheelchair wheels were locked, the 4 tie-down straps were attached to the wheelchair (2 on the front and 2 on the back) and the tension of the straps manually tightened by a black tension retractor knob, no movement of the wheelchair would occur.</p> <p>On [DATE] at 08:30 AM, the Administrator and Maintenance Director demonstrated the black tension retractor knob on the floor anchors had dual action with two steps to be completed. First, push the button to remove the slack in the tie-down straps then turn the black tension retractor knob to remove all the slack.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the manufacture User Instructions QRT-1 Series Q ' Straint indicated to secure a wheelchair: 1. Place w/c facing forward in securement area; apply wheel locks or turn power off. 2. Attach tie-down into floor anchorages (fig 1) and ensure they are locked in. 3. Attach the four tie-down hooks to solid frame members or weldments, near seat level. Ensure tie-downs are fixed at approximately 45 degrees and are within angles shown in (Fig 2). Do not attach to wheels, plastic or removable parts of wheelchair. 4. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs (if present) to take up additional webbing slack. To secure a passenger, the lab belts and shoulder blet were secured and adjusted as firmly as possible, but consistent with user comfort.</p> <p>A review of manufacture Sure-Lok Installation/Operation Instructions for L Track Applications of Retractors with S-hooks indicated to 1) center wheelchair in a forward-facing position between the front and rear retractors. Push the rear retractor release lever and pull out the webbing. Release the lever and place the S-hook securely around the structural member of the chair. Pull on the S-hook to ensure full engagement around the structural member. Push the release lever until the loose webbing is retrieved into the retractor. Repeat procedure with the other rear retractor. 2) Push the front retractor release lever and pull out the webbing. Release the lever and place the S-hook securely around the structural member of the chair. Pull on the S-hook to ensure full engagement around the structural member. Push the release lever until the loose webbing is retrieved into the retractor. Repeat procedure with the other front retractor and 3) Tension the retractors by turning the tensioning handles until the straps are tight.</p> <p>During a telephone interview on [DATE] at 3:06 PM, Certified Nurse Aide (CNA) #1 said she pushed Resident #1 to the van and put wheelchair on the lift then lifted to go inside van. CNA #1 said she started with the back two straps, used the hook to attach to the wheelchair, then proceeded to the front two straps at the front of the chair. She pushed the button on the straps to make sure it was tight, then put the shoulder seat belt and the belt across Resident #1's stomach. CNA #1 said she then shook the wheelchair left to right to make sure it was secure. After Resident #1 was secure, she noted that it was 1:40 PM when they actually left the facility. CNA #1 said she was driving along and occasionally looking in the rearview mirror at Resident #1 while they were talking. When she got close to (name of school), Resident #1 quit talking so she looked back at the resident. Resident #1 said I fell back. CNA #1 said she pulled over and went through the van to the resident. Resident #1 told CNA #1, I'm having trouble breathing. She said she couldn't lift the wheelchair back up, Resident #1 was too heavy for her to lift. CNA #1 said she immediately called 911 for help. The 911 dispatch advised her to do CPR, but she said she couldn't, due to the position Resident #1 was in. The (city name) Fire Department (PFD) showed up and got Resident #1 out of the wheelchair and on the floor on the van and then started CPR. EMS showed up and took over CPR until they could transfer Resident #1 to the hospital. When EMS got there, CNA #1 called the Administrator and told her what happened. CNA #1 said police wanted her to tell them what happened, so she gave a witness statement before driving back to the facility. CNA #1 said she was not the regular driver; she was doing it as a favor because regular transport CNA #2 had a doctor appointment and CNA #3 had a family emergency. She confirmed she worked at the facility for almost 6 years and had taken residents to appointments a couple of times, but the residents she had transported could walk on the van and seatbelt themselves in. She had never taken a resident that required securing of a wheelchair. CNA #1 confirmed she had never been trained to transport a resident in a wheelchair; she was shown once how to do it, but she never had signed off on a check list or been formally trained.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>15. Incidents/Accidents - All incidents/accidents will immediately be reported to the Administrator and Director of Nursing. Completed [DATE]</p> <p>16. Incidents/Accidents will be investigated, and an incident report completed. A Red Alert will be sent to the risk management team. Completed [DATE]</p> <p>17. Monitoring - Every transport from the facility will be monitored by a second trained staff member for accuracy weekly for 4 weeks. Completed upon return from (van company name) clearance inspection with no negative findings.</p> <p>18. Monitoring - A second trained individual will monitor weekly for 2 weeks.</p> <p>19. Monitoring - The above plan will be presented to the QAA committee monthly, and any negative finding.</p> <p>20. Follow up - Any transport driver found that not following the appropriate transport policies will be immediately taken off transportation duty and disciplined up to and including termination. Completed [DATE]</p> <p>21. Suspension of Van - Van was taken out of commission until it could be checked by (van company name) and cleared for use. Completed [DATE]</p> <p>22. Employee Suspension - Employee involved in incident was suspended pending investigation. Completed [DATE]</p> <p>23. Van inspection by life Safety Consultant - Life Safety inspected van and reviewed/observed required trainings per facility protocol with facility trainer. Completed [DATE]</p> <p>24. Life Safety checked off for [NAME] - Life Safety completed all required checkoffs with van drivers on proper positioning when strapping down wheelchair to ensure safety, with return demonstration. Completed [DATE]</p> <p>25. New tools to be initiated - Visual cues to be placed on transport w/c (in red) and any personal w/c used for transport, to indicate placement for hooks on the straps. Completed [DATE]</p> <p>26. New tools to be initiated - Visual step by step instructions be placed on back of headrest of bench seat for transport driver. Completed [DATE]</p>		