

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Timberlane Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Timberwood Road El Dorado, AR 71730	
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure two front locking mechanisms were locked during a wheelchair transport of one (Resident #1) of five residents reviewed for van transportation safety. This failed practice resulted in an injury associated with the death of Resident #1. 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 CFR 483.25(d) (Accidents) at a scope and severity of J. The Administrator was informed of the IJ on [DATE] at 2:25 PM, and notified it was considered to be Past Non-Compliance (PNC). The findings include: A review of an admission Record for Resident #1 indicated the facility admitted Resident #1 with diagnoses that included dependence on renal dialysis, muscle weakness, and cerebrovascular disease (stroke). A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS also indicated Resident #1 was a maximum assist or dependent on staff with all activities of daily living and used a manual wheelchair for mobility. A review of Resident #1's Care plan, revised on [DATE], revealed the resident was at risk for bleeding due to being on antiplatelet medications. Interventions included monitoring for any adverse reactions including black tarry stools, sudden and severe headaches, and blood tinged or red blood in the urine. Dependence on dialysis was noted on the Care Plan with three appointments a week, Monday, Wednesday, and Friday. Interventions to assist with dialysis involved monitoring the resident's left upper arm for any bleeding or infection. A review of the Medication Administration Record, (MAR) for July of 2026 revealed Resident #1 had received an antiplatelet medication on [DATE]. (continued on next page)		

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Motor Vehicles policy with a revision date of [DATE] revealed if driving the facility van, the employee must be trained on proper procedure and van usage During an interview on [DATE] at 3:59 PM, Driver #1 described the process to load residents into the facility van. They first load in one resident, applying the wheelchair brake and two wheelchair securement system (WSS) straps to the front of the resident's wheelchair before tightening the locking mechanism until a click was heard. Then a second resident was loaded, and the process was repeated. Driver #1 stated they would then move back to the first resident; staff would secure the back of the wheelchair with two more WSS straps and tighten the locking mechanism until a click was heard. A WSS strap was placed around the resident's waist, and the wheelchair was then shaken to see if it moved. This process was repeated for the second resident. -Driver #1 stated they (Driver #1) interrupted the normal process on [DATE] as they were in a hurry to start up the van to get the air conditioner running to cool off the residents. Driver #1 loaded in both Resident #1 and Resident #5, then applied the wheelchair brakes and WSS straps to the front of their wheelchairs and tightened the locking mechanisms. Then Driver #1 went to the front of the van and started it before returning to finish securing the residents. Driver #1 stated normally they fully strap down the residents in the van before starting it. I thought I had it tight enough, but I obviously didn't because it came loose. Driver #1 stated when returning from the dialysis center, during an uphill portion of the road, Resident #1's wheelchair fell backwards. Driver #1 immediately stopped the van and called the Director of Nursing (DON), who arrived onsite within 10 minutes. Upon the DON's arrival, Resident #1 became unresponsive. The DON did not find a pulse and immediately started Cardiopulmonary Resuscitation (CPR). Emergency Medical Technicians (EMT) arrived at the scene approximately two minutes later and Resident #1 was transported to the Emergency Department (ED). A review of the Transporter wheelchair safety check offs provided by the Administrator on [DATE] revealed that Driver #1 completed several training in-services prior to the incident, with the last one completed on [DATE]. A review of Driver #1's employee file revealed their background check and license were verified in July of 2024. A review of the medical files from the ED included a computed tomography (CT) scan that showed a fracture of the thoracic 1 (T1) vertebra of the spine along with a 3-millimeter subdural hematoma (brain bleed). Resident #1 was later transported to a tertiary care center on [DATE]. A review of the medical files from the tertiary care center revealed that Resident #1 passed away on [DATE] secondary to an anoxic brain injury resulting from cardiac arrest. A review of the Transport Van weekly Inspection done by the Maintenance Director showed it had last been inspected on [DATE] with a Monthly Transport Van Inspection by the Maintenance Director completed on [DATE]. The Maintenance Director inspected the facility van again on [DATE] after the incident with no negative findings of the wheelchair securement system A review of the third-party wheelchair securement service provider on the facility van, last dated (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], did not reveal an issue with the systems transport straps. During an interview on [DATE] at 2:14 PM, Resident #5 confirmed that Driver #1 loaded Resident #1 into the van first and subsequently loaded Resident #5. They stated both of their wheelchairs had their wheelchair brakes applied and that Driver #1 had applied the front two wheelchair securement system straps and locked the straps before starting the van to run the air conditioner. Driver #1 returned and applied the back two WSS straps to both resident's wheelchairs and locked them before starting to drive. When going uphill the front two straps came flying off of Resident #1's wheelchair and the resident fell backwards. Resident #5 confirmed that the van immediately stopped, the DON arrived and started CPR with EMTs arriving shortly after. During an interview on [DATE] at 9:04 AM, Driver #2 was asked to describe the process of securing residents in the transport and revealed residents were placed into a transport-only wheelchair with nonskid pads underneath them. From there, staff load the residents into the facility van and apply the wheelchair brakes. Driver #2 stated they apply the front WSS straps to the front of the wheelchair and tighten the locking mechanism until it clicks. They then load in the second resident, apply the WSS to the front of the second resident's wheelchair, and turn the locking mechanism until it clicks. They return back to the first resident and apply two WSS straps to the back of their wheelchair, tightening the locking mechanism until it clicks and applying a WSS strap around the resident's waist before shaking the wheelchair to check for movement. They then move to the second resident and repeat the process. During an interview on [DATE] at 2:00 PM, the Maintenance Director revealed he inspects the transport straps weekly. He stated that he places red tape on the transport wheelchairs to mark where the straps go on the axial bolts for each of the structural parts, because it will hold up that way. The Maintenance Director reported attending the service provider's in-service training on the transport system including straps every six months and providing the facility's own in-service training upon return. During an interview on [DATE] at 10:13 AM, the General Manager from the service provider stated, There is no way, if the wheelchair is properly hooked up, that it could fall backwards. They stated if the front wheelchair securement system straps were properly applied and tightened with the locking mechanism there was no way for it to come loose without equipment failure. The General Manager stated that he had just serviced the facility van on [DATE] and found no mechanical failure with the installed transport straps. The General Manager also reported inspecting the van on [DATE] after the incident involving Resident #1 with no negative findings. The General Manager also confirmed that the facility employees attended an in-service training held by the service provider on the wheelchair securement system every six months with a service inspection of the facility vans. During a subsequent interview on [DATE] at 10:55 AM, Driver #1 stated she thought she had locked both locks on the front wheelchair wheels but must not have tightened them since both wheels came up off the ground. During an interview on [DATE] at 11:42 AM, the Director of Nursing (DON) stated that they called 911 and rushed over to the scene as soon as they received the phone call from Driver #1. Upon arrival, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Driver #1 and Resident #5 were prompting Resident #1 to respond with no response. The DON reported immediately starting CPR after checking for a pulse and continued until the EMTs arrived. Driver #1 had already moved the wheelchair out from underneath Resident #1 and folded it in the corner of the van. The DON stated that they implemented transport specific wheelchairs after the accident to ensure there would be no issues with the wheelchair for future incidents. Driver #1 was suspended pending investigation. They confirmed that the facility van was immediately sent to the service provider for inspection and retraining was performed for all transport drivers. During an interview on [DATE] at 12:16 AM the Administrator confirmed that after the incident the van was sent to be evaluated and Driver #1 was suspended. They implemented retraining of all transport drivers and included the riders in the wheelchair securement system training, just as a second trained pair of eyes. The Administrator also made a Transporter List of all trained and approved drivers and riders on [DATE] and gave the list of approved drivers and riders to the DON and Social Services Director. They also confirmed that Maintenance inspected a group of wheelchairs and marked them as transport wheelchairs to be specifically used for that purpose after the incident. The Administrator stated the Social Services Director and DON were in-serviced on the use of the Transporter List. A laminated picture guide of where to place the locking transport straps was also implemented and attached to the driver seat in the facility vans. The Administrator also implemented a daily check-off sheet stating what drivers, riders, and residents were traveling and required the Administrator's signature prior to departure. They stated on [DATE] all transports to and from the facility were monitored by a second trained staff member for accuracy for two weeks and after that period once a week for four weeks. The Administrator stated that Resident #1 had been seated in a facility-owned wheelchair at the time, and the Maintenance Director had inspected it after the incident with no deficits. The Administrator elected to decommission the wheelchair regardless. A review of the in-service training notes and the Transporter list was conducted with no issues found. The laminated picture guide for locking transport straps was observed in the vans. The daily check-off sheet and transport specific wheelchairs were also reviewed and verified. A review of the in-services, daily check-off sheet, transport specific wheelchairs and laminated picture guide was determined to return the facility to compliance on [DATE].		