STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105522	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lehigh Acres Healthcare & Rehab Center	1550 Lee Boulevard Lehigh Acres, FL 33936

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Actual harm Residents Affected - Few	Based on observation, record review, review of facility's policy and procedure, staff and resident interview the facility failed to follow safety precautions during transportation to doctor's appointments to prevent avoidable accident and injury to 1 (Resident #900) of 2 residents reviewed. The findings included:Review of the facility's policy and procedure for Securing Residents in Wheelchairs for Van Transport (no effective date) revealed, It is the policy of this facility to ensure the safe and secure transport of all residents traveling in wheelchairs. All residents must be properly secured suing approved wheelchair tie-downs in compliance with Americans with Disabilities Act (ADA) and National Highway Traffic Safety Administration (NHTSA) guidelines. Staff must follow the outlined procedures at all times to prevent accidents or injuries. Securing the wheelchair. Attach two front tie-downs to solid frame points on the wheelchair (not on the footrests or detachable parts). Attach two rear tie-downs to the rear frame of the wheelchair. Tighten all straps to remove slack and prevent movement. Securing the resident. Final Safety Check. Verify all four tie-down straps are tight and locked. Ensure the lap and shoulder belts are properly secured.On 8/22/25 at 9:10 a.m., during a tour of the facility, Resident #900 was observed in bed. The resident's left lower extremity was wrapped in bandages. Multiple scabbed wounds were observed to the resident's arms. In an interview Resident #900 said on 8/18/25, her wheelchair was not strapped in the facility's van, causing it to fall backwards during transportation and scrape the skin right off her leg. Resident #900 said, It scared the hell out of me. Resident #900 said the scabbed wounds to her arms were from the skin tears she sustained during the incident. On 8/22/25 at 9:25 a.m., in an interview related to Resident #900's injuries, the Assistant Director of Nursing (ADON) verified on 8/18/25 the resident's wheelchair fell backwards in the company's van during transportation to an appointment. She said the facility's driver stopped at a red traffic light. As the driver was taking off when the light turned green, the resident's wheelchair tilted, and Resident #900 fell backwards. Emergency Medical Services (EMS) were called but Resident #900 refused to go to the hospital for evaluation. On 8/22/25 at 9:37 a.m., in an interview Driver Staff A said he started employment at the facility on 7/29/25. He said on 8/18/25 at approximately 10:00 a.m., he picked up Resident #900 from a doctor's appointment. He placed the resident's wheelchair in the middle section of the van. He secured the wheelchair to the van with two tie-down straps to the back frame of the wheelchair and applied the seatbelt. As he was leaving a red light, he heard the resident yell from the back of the van. He pulled over. A State Trooper pulled right behind the van and asked if he needed assistance. He said the resident's wheelchair tipped back slowly. Resident #900 was still strapped to the wheelchair. He unstrapped Resident #900. EMS arrived and bandaged the resident's arms. The resident refused to go to the hospital. EMS helped him place the resident in a regular seat and he secured her with a seatbelt. Driver Staff A said the wheelchairs are secured in the van with 4 tie-down straps, 2 in the front and 2 in the back. He said the problem was that there were no tie-down straps available to secure the front of the wheelchair. He said after the incident, the facility placed him back in training. Driver Staff A said he knew what he was doing, he just didn't have the right equipment. He confirmed he received training and did not properly secure Resident #900's wheelchair.On 8/22/25 at 10:30 a.m., in an interview the Administrator said the facility investigated the incident. He said tie-down straps were available to secure the wheelchairs. The driver did not use them properly, he failed to follow the process in his training. The transport drivers are responsible to make sure the tie-down straps are there and in proper working order.Review of the Compliance Training Attendance Log revealed Driver Staff A attended a 2 hour training on 8/14/25. The training consisted of a lecture, a written posttest, general compliance, and job specific.On 8/22/25 at 2:05 p.m., observation of the van with Driver Staff B revealed 7 removable tie-down straps in the wheelchair tracks. Driver Staff B demonstrated how to move the tie-down straps and place them where needed to ensure the wheelchairs are properly secured.Review of the facility provided investigation revealed Driver Staff A provided a written statement which noted on 8/18/25 at about 10:00 a.m., he was leaving a red light turned green. He heard the resident yell and saw the resident' s wheelchair had gone backwards on the floor. He pulled over, released the tie-downs and safety belt and slid the chair out from under her. 911 was called but the resident refused to go to the hospital.The Assistant Director of Nursing documented in a statement Resident #900 said she was in the van and the chair was all strap down and so we thought. The resident said the driver went to take off when a light changed and she went backward. The resident said a police officer stopped to help and they called EMS. She refused to go to the hospital. They picked her up and placed her in a regular seat in the van, then drove back to the facility