STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175224	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moran Manor	3940 US Hwy 54 Moran, KS 66755

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** 46960 The facility reported a census of 34 residents, with one resident sampled for accidents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free of accident hazards during transportation. On 01/21/25, Transportation Staff E and Certified Nurse Aide (CNA) D did not ensure R1 was safely secured in the transportation vehicle before operating the vehicle. CNA D, who secured R1 in the transportation vehicle, lacked appropriate training and competency evaluation. Transportation Staff D failed to ensure R1's wheelchair was appropriately secured then operated the vehicle in a manner that caused the CNA to fear for her safety and the safety of the resident, by frequently looking at his phone which caused the vehicle to cross the [NAME] strips (corrugated pavement along the side of the road that causes rumbling and vibration when driven over to alert inattentive drivers of potential danger) on the right and left (center and shoulder) sides of the road multiple times during transportation. The driver of the vehicle rapidly brought the vehicle to a stop at an intersection which caused R1 to slide partially out of her wheelchair to the floor, injuring her left ankle. Transportation Staff E and CNA D failed to accurately communicate to the facility that the resident was injured and failed to activate 911 so the resident could be appropriately assessed. Additionally, the staff continued to the doctor's appointment and then drove approximately 50 miles back to the facility where the resident was then assessed to have an injury. This deficient practice placed R1 in immediate jeopardy. Findings included: - Review of the Electronic Health Record (EHR) revealed diagnoses that included diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebral (of or related to the brain) aneurysm (an abnormal bulge or ballooning in the wall of a blood vessel and if ruptured could cause serious internal bleeding with a potential to be life-threatening), and nontraumatic intracerebral hemorrhage (loss of a large amount of blood in a short period of time). The 11/24/24 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment documented R1 utilized a manual wheelchair and mechanical lift. The Care Plan reviewed 03/20/25, lacked instructions for staff related to securement in the facility vehicle during transportation. (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	Review of the Progress Notes dated 01/21/25 at 12:30 PM, written by Administrative Nurse B, documented Transportation Staff E notified the facility that the facility vehicle stopped abruptly and R1 slid out of her chair. The note included R1 had not completely fallen to the ground and R1's left foot became entangled in a locking mechanism on the floor. Transportation Staff E and CNA D assisted R1 back into her wheelchair and returned to the facility. R1 was assessed for injuries and had a swollen left ankle. The staff notified R1's physician. Review of the facility's investigation revealed the following: On 01/20/25 at an unknown time, Transportation Staff E received a verbal warning related to excessive use of speed and vehicle safety based on reports from citizens of the community. On 01/21/25 at an unknown time, CNA D documented in a witness statement Transportation Staff E drove the facility vehicle while looking away from the road as if Transportation Staff E was looking at his phone. CNA D documented Transportation Staff E drove on the [NAME] strips numerous times. CNA D documented Transportation Staff E delegated securing R1 in the vehicle to CNA D. CNA D documented Transportation Staff E came to a sudden stop and CNA D turned to check on R1 and discovered R1 had slid almost completely out of the wheelchair with R1's left foot stuck on the right wheelchair strap. CNA D documented R1 complained of pain to her left ankle and CNA D and Transportation Staff E assisted R1 back into her wheelchair. On 01/21/25 at an unknown time, Transportation Staff E documented in a witness statement the vehicle was operated doing the speed limit of 40 miles per hour (mph) when the traffic light turned to red when the vehicle was approximately one-half of a block away. Transportation Staff E documented brakes were applied heavily to stop due to a police officer being parked nearby. Transportation Staff E documented CNA D checked on R1 and discovered R1 had slid out of the wheelchair. Transportation Staff E documented the vehicle pulled into a nearby gas station. Transportation Staff E documented R1's foot was caught behind the anchor lock on the right front of the wheelchair and then assisted CNA D to return R1 to the wheelchair. The witness statement lacked documentation of R1 complaining of pain. On 01/22/25 at 03:56 PM, an x-ray report documented transverse (horizontal) impacted (a type of fracture where the broken ends were driven into each other) fractures of the distal (lower) tibia and fibula (bones of the lower leg), displaced approximately one quarter shaft width, and marked osseous (bone) demineralization (loss of minerals from bones which makes them more prone to fractures). On 01/27/25 at 10:30 AM, Transportation Staff E was terminated due to inability to follow basic safety procedures and rules of the road. During an interview on 03/20/25 at 09:58 AM, R1 revealed on 01/21/25 her seatbelt was on, but it was not tight. R1 said, when the driver of the facility vehicle stopped suddenly, she slid under the seatbelt and partially onto the floor and injured her left leg. R1 stated the driver then drove the vehicle to a gas station and both staff members assisted R1 back into her wheelchair. R1 reported she told both staff members about the pain in her left ankle. R1 was unable to recall which staff member secured her and the wheelchair in the facility vehicle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/25 at 12:45 PM, CNA D revealed she had not received any training or completed any competencies related to securing residents or the resident's wheelchairs in the facility vehicle. CNA D revealed on 01/21/25, Transportation Staff E requested CNA D secure R1 and R1's wheelchair in the facility vehicle and confirmed she had not received any training to perform this task. CNA D revealed on 01/21/25 while Transportation Staff E operated the vehicle, he looked away from the road at his phone which caused the vehicle to drift and crossed the [NAME] strips multiple times. CNA D revealed while riding in the vehicle operated by Transportation Staff E, she felt unsafe and was concerned for her own safety and the safety of R1. CNA D revealed after Transportation Staff E stopped the vehicle quickly, she turned around to check on R1 and noticed she had slid out from under the seatbelt and was partially on the floor. CNA D stated R1 complained of pain to the left ankle and the left ankle appeared swollen compared to the right ankle. Transportation Staff E then drove the van to the nearest gas station a short distance away and CNA D assisted R1 off the floor and directed Transportation Staff E to contact the facility for instructions. Transportation Staff E did not communicate to the facility that R1 was injured and complained of left ankle pain and received instructions to assist R1 back into her wheelchair and continue to their destination, then return to the facility. CNA D revealed neither her or Transportation Staff E considered calling 911 to activate EMS (emergency medical services) or go to the nearest emergency department (ED) During an interview on 03/20/25 at 01:08 PM, Transportation Staff E reported on the morning of 01/21/25 he had difficulty maintaining lane position due to strong winds and denied being distracted by looking at his phone. Transportation Staff E confirmed information documented in his witness statement listed above and revealed that he was unaware of any complaints of pain by R1. Transportation Staff E reported that he secured R1 and R1's wheelchair During an interview on 03/20/25 at 12:05 PM, Administrative Nurse B reviewed the progress note documentation from 01/21/25 at 12:30 PM and stated she could not recall if staff provided a time when the resident slid out of the wheelchair or if the staff reported to her any complaints of pain or injury. Administrative Nurse B revealed the expectation was that only staff members who were trained and had performed competencies would secure residents in the facility vehicle. Administrative Nurse B reviewed the facility investigation's witness statement from CNA D and confirmed documentation that indicated R1 had pain and restated staff did not communicate the discovery of pain when they called. Administrative Nurse B further stated that if transportation staff (driver or attendant) were alerted to pain after a similar incident, they should call 911 to activate EMS and/or go to the nearest ED to have the resident evaluated for injury. Administrative Nurse B defined a fall as an unintentional change in plane, and the incident on 01/21/25 should have been considered a fall with the appropriate response from staff. During an interview on 03/20/25 at 11:35 AM, Administrative Staff A revealed the driver of the facility vehicle was ultimately the one responsible to ensure residents were appropriately secured in the vehicle. Administrative Staff A reported that Transportation Staff E was terminated and remaining authorized drivers were reeducated related to their roles and responsibilities. Administrative Staff A revealed all CNA personnel have been instructed if they were riding in the facility's vehicle the driver of the vehicle was responsible to ensure the residents, and their wheelchairs were secured. The facility's undated Transporting a Resident (Facility Van) policy documented each resident would be secured in a seat with a seatbelt or in their wheelchair secured with wheelchair tie-downs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure Resident (R)1 remained free of accident hazards during transportation. On 01/21/25, Transportation Staff E and CNA D did not ensure R1 was safely secured in the transportation vehicle before operating the vehicle. The CNA who secured the resident lacked appropriate training and competency evaluation. Transportation Staff D failed to ensure R1's wheelchair was appropriately secured then operated the vehicle in a manner that caused the CNA to fear for her safety and the safety of the resident by frequently looking at his phone which caused the vehicle to cross the [NAME] strips (corrugated pavement along the side of the road that causes rumbling and vibration when driven over to alert inattentive drivers of potential danger) on the right and left (center and shoulder) sides of the road multiple times during transportation. The driver of the vehicle rapidly brought the vehicle to a stop at an intersection which caused R1 to slide partially out of her wheelchair to the floor, injuring her left ankle. Transportation Staff E and CNA D failed to accurately communicate to the facility that the resident was injured and failed to activate 911 so the resident could be appropriately assessed. Additionally, the staff continued to the doctor's appointment and then drove approximately 50 miles back to the facility where the resident was then assessed to have an injury. This deficient practice placed R1 in immediate jeopardy. On 03/20/25 at 03:35 PM, Administrative Staff A, Administrative Nurse B, Administrative Staff F and Consultant Nurse G were provided the Immediate Jeopardy (IJ) Template for failure ensure R1 remained free of accidents The facility immediately implemented corrective measures following the incident that involved R1 on 01/21/25. The facility's corrective measures included the following, which were verified by the surveyor on-site during the investigation. 1. All staff received education related to the roles and responsibilities of staff during transportation outside the facility, completed 01/23/25 at 01:00 PM 2. All staff authorized to drive for the facility were reeducated related to their roles and responsibilities, completed 01/28/25 at unknown time. 3. Transportation Staff E was terminated, completed 01/27/25 at 10:30 AM. All corrections were completed prior to the onsite survey, therefore the deficient practice was cited as past noncompliance at a scope and severity of G.