STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175315	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pratt Health and Rehab	1221 Larimer Street Pratt, KS 67124

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 41 residents with three residents sampled for safety related to transportation outside the facility. Based on observation, interview, and record review, the facility failed to ensure that staff provided a safe environment, free of accident hazards during transportation in the facility van. On 03/11/25 at approximately 09:20 AM Certified Nurse Aide (CNA) C failed to ensure Resident (R)1 was safely secured in the facility van before operating the vehicle. CNA C began to drive the van and realized R1 did not have a seatbelt on. CNA C then stopped the vehicle and R1 fell out of the wheelchair onto the floor of the facility van and injured his head, face and left arm. This deficient practice placed R1 in immediate jeopardy. Findings included: - R1's Electronic Health Record (EHR) documented R1 had diagnoses which included diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), long-term use of anticoagulants (a class of medications that prevent or reduce blood clotting) and difficulty walking. The 09/21/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R1 utilized a wheelchair, required partial/moderate assistance for transfers, and received an anticoagulant medication. The 09/21/24 Falls Care Area Assessment (CAA) documented R1 was at risk for falls related to impaired gait (manner or style of walking) and mobility; R1 required assistance with transfers. The 02/19/25 Quarterly MDS documented a BIMS score of 14, which indicated intact cognition. The assessment documented R1 utilized a wheelchair, was dependent on staff for transfers, and received an anticoagulant medication. R1's Care Plan documented R1 was at risk for falls related to his recent surgery and cognitive loss, revised 03/17/23. R1's Care Plan documented an intervention with an initiated date of 03/11/25 that staff were re-educated on proper safety protocol in the facility vehicle. (continued on next page)

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	The Nursing: Progress Note dated 03/11/25 at 09:30 AM, by Licensed Nurse (LN) D documented CNA C notified the facility that R1 fell out of his wheelchair while in the facility's van. The note documented CNA C notified the staff at the hospital for assistance and one licensed hospital staff and one unlicensed hospital staff responded to the parking lot to assist CNA C and assess R1 for injuries. The note documented the hospital staff assessed R1 and discovered a skin tear to his left elbow, bruising to his left eye area, and an abrasion (scraping or rubbing away of skin) with bruising to the left side of R1's scalp. The Communication: SBAR to Physician dated 03/11/25 at 11:04 AM documented the situation was a fall on 03/11/25. The note documented the background was R1 fell from the wheelchair while being transported to an appointment; R1's seatbelt was not properly secured before the vehicle started moving. R1 had bruising below his left eye and on the left side of his head above the left ear. R1 had a small skin tear on his left elbow. The note documented staff would be re-educated on proper transportation safety protocol. A review of the facility's investigation revealed the following: CNA C's Witness Statement dated 03/11/25 documented she forgot to put R1's seatbelt on him and R1 slid out of the wheelchair. CNA C requested assistance from the hospital and two hospital staff came to the vehicle and assessed R1. The statement noted R1 had a bump on his head, a bruise under his eye and a skin tear on his elbow; R1 stated he was fine, just sore. LN D's Witness Statement dated 03/11/25 documented CNA C called the facility at 09:35 AM and notified LN D that R1 fell from his wheelchair in the facility van while out of the facility for an appointment. LN D documented CNA C revealed she had forgotten to ensure R1's seatbelt was secure. LN D documented CNA C stated the incident occurred at approximately 09:20 AM and CNA C requested assistance from the hospital staff who assessed R1 and assisted R1 back to his wheelchair. In another Witness Statement dated 03/11/25, LN D documented a telephone interview with hospital staff who reported hospital staff found R1 on his back in the facility vehicle with CNA C supporting his head. The statement noted that the hospital staff reported assessment findings that included a skin tear to the left elbow, an abrasion to the left side of R1's head, and bruising to the left eye related to R1's glasses. The statement noted the hospital staff reported R1 was able to stand with assistance and sat in his wheelchair without any complaints of pain or discomfort. During an observation and interview on 04/03/25 at 11:33 AM, R1 sat in his recliner with no visible wounds or bruises observed. R1 stated that he remembered the incident on 03/11/25 but was unsure of how he ended up on the floor. He reported that he was seated in his chair one moment and on the floor the next moment. R1 denied any major injuries. (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 04/03/25 at 12:16 PM, Administrative Staff A stated that after R1 fell on [DATE] at approximately 09:20 AM, CNA C's actions met Administrative Staff A's expectations. Administrative Staff A said CNA C followed the facility's fall procedure by immediately notifying a healthcare professional who was qualified to assess R1 for injuries and then immediately notifying the facility before returning to the facility. Administrative Staff A stated that an ad-hoc Quality Assurance Process Improvement (QAPI) meeting was held to discuss the event and CNA C was immediately re-educated related to safety protocol while transporting residents on 03/11/25. Administrative Staff A revealed red laminated cards were affixed to the facility vehicle on 03/11/25 in specific areas to remind drivers to ensure seatbelts were properly fastened before the vehicle was in motion. Administrative Staff A revealed that R1's Care Plan was reviewed and revised on 03/12/25 at an unknown time. Additionally, Administrative Staff A stated all additional staff who are qualified to drive the facility vehicle received re-education on 03/20/25 which included a skills check-off. Administrative Staff A stated that audits would be performed three times per week for 30 days. During an interview on 04/03/25 at 12:20 PM, Administrative Nurse B reported that CNA C followed the facility's fall protocol after R1's fall on 03/11/25. Administrative Nurse B stated that when CNA C and R1 returned to the facility, CNA C was immediately re-educated related to safety protocols when transporting residents in the facility vehicle; the education included a skills check-off. During an interview on 04/03/25 at 12:30 PM, CNA C revealed that on the date of the incident (03/11/25), R1 was supposed to have a doctor's appointment at the hospital, but when CNA C and R1 arrived at the hospital, the appointment had been canceled. CNA C then took R1 back out to the facility vehicle but failed to correctly secure R1 with a seatbelt in his wheelchair. CNA C said she started driving the facility vehicle and had traveled approximately 500 feet at speeds of 10-12 miles per hour (mph) when she realized R1 was not properly secured with a seatbelt. CNA C then stopped the vehicle and when she did, R1 fell from the wheelchair to the floor and was injured. CNA C stated she called the hospital for assistance and then called the facility. CNA C stated that R1 was offered treatment in the Emergency Department (ED) of the hospital by the hospital staff, but the resident declined. The facility's Transportation, Facility Van policy, dated 10/2024 documented that residents would be transported in the community vehicle in a safe manner and residents would be secured in the vehicle per the community's procedure. The facility failed to ensure R1 was safely secured in the facility van before operating the vehicle and R1 fell out of the wheelchair onto the floor of the facility van and injured his head/face and left arm. This deficient practice placed R1 in immediate jeopardy. On 04/03/25 at 02:15 PM, Administrative Staff A and Administrative Nurse B were provided a copy of the Immediate Jeopardy (IJ) Template for the failure to ensure R1 remained free of accidents. The facility's corrective measures, fully completed on 03/20/25, included the following, which were verified by the surveyor on-site during the investigation. 1. CNA C was immediately re-educated related to safety protocols while driving the facility vehicle, completed on 03/11/25. 2. Red laminated cards were placed in the vehicle at specific points to remind staff to ensure residents were properly secured before moving the vehicle, completed on 03/11/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. R1's Care Plan was reviewed and revised with an updated intervention on 03/12/25 to include an intervention that staff were re-educated on proper safety protocol for appointment transports in the facility vehicle. 4. All staff authorized to drive the facility vehicle received re-education with a return demonstration related to proper securement and safety during transports in the van, completed 03/20/25. 5. The facility continued audits of transports to ensure the residents were safely secured in the van before transport. All corrections were completed before the onsite survey; therefore, the deficient practice was cited as past noncompliance at a scope and severity of J.