

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 620 E Wood Street Clearwater, KS 67026	

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** 40689</p> <p>The facility reported a census of 39 residents. The sample included three residents who required transportation in the facility van. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remain free from accidents when Certified Medication Aide (CMA) R did not utilize the safety belt for R1 before transporting in the facility van. On 12/11/24 at approximately 03:00 PM, Certified Medication Aide R failed to secure dependent R1 in her wheelchair with the wheelchair safety belt in the facility van, prior to transporting. CMA R entered a busy highway with a speed limit of 60 miles per hour (MPH) and had to slam on the brakes to avoid an accident, which caused the resident to slide forward out of her wheelchair onto the floor of the van due to the lack of the seatbelt use. R1 sustained multiple injuries including skin tears and a laceration.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - R1's undated Physician Order Sheet (POS) documented the resident admitted on [DATE] with the following diagnoses: cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), abnormality of gait and balance (any unusual or unexpected patterns of movement or changes in the way an individual walks or moves), lack of coordination (difficulty performing physical movements smoothly, accurately, and efficiently), weakness (lack of physical or muscle strength), and unsteadiness of feet (pattern of walking that's unstable). <p>The Baseline Care Plan, dated 12/11/24, instructed staff that the resident was alert, cognitive, her vision was intact, and hearing was adequate. She required partial/moderate assistance with sit to standing and transfers. She ambulated independent with cane and self-propelled with a walker.</p> <p>Review of the Admission Note, dated 12/11/24 at 07:32 PM by Licensed Nurse (LN) G, documented the resident arrived at the facility via the facility van accompanied by CMA R. The resident transferred from the acute care hospital with a diagnosis of cerebral infarction. The resident was alert and oriented to person, place, time, and situation. The resident presented with left-sided weakness to upper and lower extremities (arms and legs) and face. She ambulated with her wheelchair and used of a four-wheel walker with one person assistance. LN G documented R1 had a skin tear located on her left forearm and to the top of her right hand. LN G cleansed the skin tears and covered with a wound dressing.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 175454
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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>Review of the Admission Skin Assessment, dated 12/15/24, documented R1's skin had the following skin issues:</p> <p>Skin tear located on her left forearm: 1.3 centimeters (cm) in width, small amount of sanguineous (leakage of fresh blood from an open wound) exudate (fluid that leaks from blood vessels) and dressing saturation was minimal (less than 25%).</p> <p>Skin tear located on top of her right hand: 0.5 cm in width, small amount of sanguineous exudate and dressing saturation was minimal.</p> <p>Abrasion located on her left knee: 0.5 cm in width, small amount of sanguineous exudate and dressing saturation was minimal.</p> <p>Review of the Facility Investigation, dated 12/19/24, documented R1 admitted to the facility on [DATE] from the hospital. Certified Medication Aide (CMA) R was the transportation driver and Certified Nurse Aide (CNA) M rode along as a companion. CMA R reported that the passenger safety belt for a wheelchair passenger had not been functional since she began work in April 2024, so instead, she had been using a gait belt on this transport and she did not secure the resident in her chair. After leaving the hospital, CMA R reported a vehicle pulled out in front of her, and she had to slam on the brakes, and R1 fell out of her chair onto the floor which resulted in a skin tear to her right hand and an abrasion to her left knee. CMA R and CNA M both stated that they stopped the van and helped the resident back into the chair. When asked if they had taken measure to secure the resident in her chair after the incident, both CMA R and CNA M both stated that they used a gait belt that was in the van. Upon returning to the facility, Administrative Nurse E, Administrative Staff A, Consultant GG, and Durable Power of Attorney were notified of the event. Administrative Staff E assessed the resident for fall protocols. CMA R was interviewed by Administrative Staff A, and she stated she had never used the passenger safety belt in the facility van because she was told it had not been functional since she started in April 2024, and she had never been trained on the use of the safety belt. She did not recall who told her it was not functional. CMA R was asked if she had ever reported that the safety belt was not functional to anyone. She reported that she did not. She was asked if she knew if anyone else had reported that the safety belt was not functional. She reported that she did not know if anyone reported it. CMA R was then told she was suspended pending an investigation. CNA M reported she also regularly accompanied CMA R during transports and had not observed how CMA R secured residents during transports. Social Services X reported she always used the safety seatbelt when transporting residents and able to safely demonstrate how secure a resident safely with the seatbelt in the van. Social Services X reported the safety belt had not been malfunctioning. She reported that she regularly accompanied CMA R during transports and had not noticed how CMA R secured the residents during transports. After learning this, Social Services X and CNA M were suspended.</p> <p>During an interview on 01/13/25 at 03:00 PM, Administrative Nurse D reported she reviewed the Facility Report and CMA R notified Administrative A and Administrative Nurse E, who are no longer employed with the facility at the time of the incident. Administrative Nurse D reported she visited with Consultant GG while she was in the facility when the resident arrived and did not feel the resident needed to be evaluated at the Emergency Department (ED). CMA R failed to notify Administration when she began transporting in April 2024 when she was advised that the seatbelt was not working appropriately before transporting residents. Administrative Nurse D reported she contacted CMA R on 01/13/25, and CMA R verified she had declined to complete a witness statement on 12/11/24. Administrative Nurse D was unable to reach CNA M.</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>During an interview on 01/13/24 at 08:08 PM, CMA R reported she transported R1 from the hospital to the facility on [DATE]. CMA R reported on 12/11/24 at approximately 03:00 PM, she was in a hurry due to the cold temperature. CMA R secured the resident into the facility van with the four-point straps but failed to secure the seatbelt across the resident's wheelchair. She used a gait belt to loop around each of the arm rests of the wheelchair. She had been advised by another staff member that the seatbelt in the facility van was not functioning properly. CMA R reported during transport at approximately 03:00 PM she entered a busy highway with a speed of 60 miles per hour (MPH) and had to slam on the brakes to avoid an accident, which caused the resident to slide forward out of her wheelchair onto the floor of the facility van. R1 sustained multiple injuries including skin tears and a laceration. CMA R said she contacted Administrative Staff A and Administrative Nurse E of the incident, who advised since there was no accident and the resident was not injured, other than skin tear and abrasion, to continue to the facility and Consultant GG would meet the resident at the facility. CMA R reported she declined to complete a witness statement, was suspended that evening, and later terminated from her position.</p> <p>During an interview on 01/13/25 at 04:33 PM, Maintenance Director U reported on 12/11/24 he was advised of the incident. He advised Administration to stop all transportation of both facility vans until he could inspect each of them on 12/12/24. He reported he completed an inspection on both facility vans on 12/12/24 and the seatbelts were working appropriately.</p> <p>During an interview on 01/14/25 at 11:45 AM, Consultant GG reported she was at the facility when R1 arrived. Consultant GG reported the resident did have a skin tear to the top of her right hand and a laceration to her left knee. Consultant GG did not feel the resident required an evaluation at the Emergency Department (ED).</p> <p>The Correct Procedures and Operation of the Transport Van, dated 12/11/24, included wheelchair straps, ramp operations, and seat belt to secure resident in a wheelchair for safety.</p> <p>On 01/13/25 at 12:43 PM, the IJ template was provided to Administrative Staff A and Administrative Nurse D and notified the facility failed to ensure R1 remained free from accidents when Certified Medication Aide R did not utilize the facility transportation van seatbelt for R1 before transporting. CMA R used a gait belt to loop around each of the arm rests of the wheelchair for R1. During transport, CMA R entered a busy highway with a posted speed of 60 miles per hour (MPH) and had to slam on the brakes to avoid an accident, which caused the resident to slide forward out of her wheelchair onto the floor of the facility van. R1 sustained multiple injuries including skin tears and a laceration.</p> <p>The immediate jeopardy was determined to first exist on 12/11/24 at 03:00 PM, when CMA R transported R1 without a seatbelt.</p> <p>The facility identified and implemented the following corrective actions, completed on 12/18/24:</p> <ol style="list-style-type: none"> 1. On 12/11/24 at 05:00 PM, the facility suspended CMA R. She was terminated on 12/18/24. 2. On 12/11/24 at 05:00 PM, the facility suspended CNA M. She self-terminated on 12/17/24. 3. On 12/11/24 the facility van was immediately taken out of service until the van could be inspected. <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>4. On 12/12/24, the facility van was inspected, and it was discovered that the passenger safety belt was not in despair but rather working as was intended.</p> <p>5. All staff members were trained in lock out/tag out for equipment that was out of order.</p> <p>6. All staff members were trained on when to report equipment that was not functional and how to use the work order system to alert the administration.</p> <p>7. Staff members who transported residents for passenger pick up were educated on van safety and asked to demonstrate how to use the safety equipment in the van.</p> <p>8. All staff were educated that passenger safety was the responsibility of both the driver and transportation companion.</p> <p>The facility presented an acceptable plan for removal of the immediate jeopardy on 01/14/25 at 08:45 AM.</p> <p>The surveyor validated that the immediate jeopardy was removed on 01/14/25 at 01:45 PM following the implementation of the plan for removal of the immediate jeopardy.</p> <p>Due to the corrective actions the facility completed prior to the onsite survey, the deficient practice was deemed past non-compliance and remain as a scope and severity of a J.</p>		