STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195310	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Many Healthcare and Rehabilitation Center	120 Natchitoches Hwy 6 East Many, LA 71449

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** 38373 Based on record review, observation, and interview, the facility failed to ensure residents remained as free of accident hazards as possible for 1 (#3) of 4 (#1, #2, #3, & #4) residents reviewed for accidents. The facility failed to properly secure Resident #3's wheelchair prior to transporting the resident in 1 of the facility's 2 vans. This deficient practice resulted in an immediate jeopardy situation on 03/20/2024 at 9:50 a.m., when Resident #3 was placed in the facility's van, and her wheelchair was anchored/secured in the facility's van with only three of the four anchors required. While the van was in motion, Resident #3's wheelchair fell backwards, and Resident #3 hit the back of her head on the lift. Resident #3 sustained an abrasion with bleeding noted to the back of her head. The Administrator stated the weekly safety inspections on the transportation van had not been completed by the van driver prior to the accident, as directed by the facility's policy. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: Review on 04/11/2024 of the facility policy revised on 03/2023 titled Facility Vehicle Log, A Part of the Driver and Vehicle Safety Policy revealed in part . Driver's Weekly Vehicle Safety Inspection- To be completed by the company vehicle driver once each week, and prior to driving a vehicle that has been returned to service after repairs. If there are safety concerns noted during the inspection, they are to be noted on the Driver's Weekly Vehicle Safety Inspection form, and reported immediately to Maintenance or the Administrator. The vehicle should immediately be taken out of service if the driver or others determine that the vehicle cannot be driven safely. Maintenance and Repair Invoices- (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In addition to the form maintained above, all invoices for maintenance and repairs must be maintained either in the Facility Vehicle Log, or in another secure location so that a complete record of the vehicle's history is available. Securing Residents in Van - Competency Determination- Secure two front tie-downs to a solid, structural frame member of the wheelchair. Secure two back tie-downs to a solid, structural frame member of the wheelchair. Secure the passenger with shoulder and lap belts. Review of the Q'straint Installation Instructions - Vehicle Anchorages & Accessories for 4-Point Wheelchair Securement Systems dated September 2009, and reviewed on 04/09/2024 at 4:36 p.m. revealed in part . WARNINGS Do not alter or modify the system or components in any way without first consulting Q'Straint. The system is a complete, integrated system. Do not interchange or substitute any components. Q'Straint systems and components have been tested in a configuration similar to that recommended in these instructions. Any deviation from these recommendations is the responsibility of the installer. Systems and components should only be installed by an experienced technician. Review of Resident #3's medical record revealed an admitted [DATE], with diagnoses that included in part . Cerebral Infarction, Hemiplegia and Hemiparesis, Type 2 Diabetes Mellitus, Contracture of Left Hand, Bipolar Disorder, and Pain. Review of Resident #3's Quarterly MDS with an ARD of 02/07/2024, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Review of the MDS revealed Resident #3 used a manual wheelchair, and required substantial/maximal assistance with sit to stand and chair/bed to chair transferring. Review of Resident #3's Comprehensive Plan of Care, with a target date of 05/14/2024, revealed Resident #3 was care planned for the following problems: 1. Resident has an ADL self-care performance deficit due to left sided weakness. Interventions included: extensive assistance by two person assist with bed mobility, transfers, and toileting; and set up assist with eating. 2. Resident #3 is at risk for falls. Interventions included: anticipate and meet resident's needs. On 03/20/2024 - fall in van-wheelchair tipped backward/abrasion to back of head. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Incident/Accident report completed by S5 RN on 03/20/2024 at 10:07 a.m., revealed in part .This nurse was called by S4 CNA, who stated Resident #3 fell back and hit her head while on van. Resident was brought in wheelchair by S3 CNA/Transportation, who stated her chair flipped over backwards in van, and she hit her head. Blood noted to back of head. Resident brought to nurses' station and area to head cleaned and assessed by S5 RN, and small abrasion noted, no active bleeding. Abrasion also noted to base of neck between shoulders, no bleeding noted to area. Neuro checks started. Resident complained of headache, Tylenol offered. Resident Description: We hit a bump, and I tipped over in my wheelchair. Pain rated at 4, on a pain scale of 1 - 10. During an interview on 04/08/2024 at 2:30 p.m., Resident #3 stated she was coming back from a doctor's appointment with S3 Transportation and another employee the day the accident occurred on the van. Resident #3 stated they hit a bump, her wheelchair flipped backwards, and she hit her head on the back door. Resident #3 stated she felt the back of her head with her hand, and there was blood. Resident #3 stated she was sitting in her wheelchair which was buckled to the floor, and didn't know how she tipped over backwards. Resident #3 stated it did hurt, and she kept a headache for some days. During an interview on 04/09/2024 at 8:00 a.m., with S3 Transportation, she stated on the day of the accident, S4 CNA anchored Resident #3's wheelchair down in the van using 3 of the 4 required anchors. S3 Transportation stated the front right anchor was already broken prior to the accident, and had been replaced with a type of ratchet strap. She stated she didn't know how long the anchor had been broken. S3 Transportation stated while driving on 03/20/2024, she heard a click, looked back, and saw Resident #3 falling backwards, so she pulled the van over. S3 Transportation stated the wheelchair was tilted back, and once stopped, they repositioned the resident back into the wheelchair and secured the wheelchair again. S3 Transportation stated she saw a small amount of blood, and a small gash to the back of Resident #3's head. S3 Transportation stated she called the nursing home to report it, and S5 RN came out to check on the resident when they arrived. S3 Transportation stated the anchor was fixed now. Observation of the van at that time, 04/09/2024 at 8:00 a.m., revealed 4 silver anchors secured to the floor of the van. During an interview on 04/09/2024 at 8:12 a.m., S2 Maintenance stated about a month ago he replaced the right front anchor with a manual ratchet strap when one of the drivers told him the front right anchor was not working. S2 Maintenance said the manual ratchet strap was working at the time of the accident with Resident #3 on 03/20/2024, but it was harder to use. S2 Maintenance stated he didn't know if S3 Transportation and S4 CNA knew how to use the ratchet strap. S2 Maintenance stated since Resident #3's accident, he replaced the manual ratchet strap with the silver automatic one that was observed in place now. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/09/2024 at 8:20 a.m., S4 CNA stated on the day of Resident #3's accident, she strapped down Resident #3 into the van in her wheelchair. S4 CNA stated while they were traveling, the brakes were hit hard, she heard the wheelchair locks make a sound, and Resident #3 screamed. S4 CNA stated she looked and saw Resident #3 falling backwards in her wheelchair, and they pulled over. S4 CNA stated the wheelchair was tilted back, and they unstrapped Resident #3, fixed the wheelchair, put Resident #3 back in the wheelchair, and secured it down again. S4 CNA stated Resident #3 reached for the back of her head with her hand, and said it was bleeding. S4 CNA stated Resident #3 said My head hurts. S4 CNA stated she had strapped Resident #3's wheelchair down using the two back anchors and the front left one. S4 CNA stated the front right one was different, it was a tow strap that didn't work. S4 CNA described the tow strap as the kind that was used to tow cars. S4 CNA stated she didn't know how long the front right anchor had been broken. S4 CNA stated she had never been trained on how to secure residents' wheelchairs in the van, and didn't know she wasn't supposed to do it, or she wouldn't have. S4 CNA stated she secured Resident #3's wheelchair because S3 Transportation just got in the driver's seat, and it had to be done. S4 CNA stated she went on transports often, but had never used the tow strap before, and didn't know how long it had been in use. During a telephone interview on 04/09/2024 at 2:10 p.m., S2 Maintenance stated a driver reported the front right anchor wasn't working around the first week of 03/2024 (could not remember the exact date). S2 Maintenance stated he fixed it immediately by replacing the silver automatic anchor with the manual ratchet strap, and the van was not taken out of service. S2 Maintenance stated he did not report to the Administrator when he made the repairs and switched out the anchor to the ratchet strap. S2 Maintenance stated he switched the ratchet strap back to a silver automatic anchor on 03/20/2024 while inspecting the van after the incident. S2 Maintenance stated he did not document any of the repairs on the inspection form, or an invoice of any type, but should have. S2 Maintenance stated he had not received any special training or certification on how to repair the van. S2 Maintenance stated he swapped out the anchors when needed, but took the van to a business who repaired wheelchair accessible vehicles for all other repairs. During a telephone interview on 04/11/2024 at 8:38 a.m., S4 CNA stated on the day of the accident with Resident #3, she told S3 Transportation the tow strap wasn't working. S4 CNA stated S3 Transportation stated she had informed S2 Maintenance that the tow strap was not working; however, he said it was. During a telephone interview at 8:41 a.m. on 04/11/2024, S3 Transportation stated S4 CNA secured Resident #3's wheelchair into the van the day of the incident because We do team work. S3 Transportation stated she knew there were only 3 anchors working, and they had reported it to S2 Maintenance in the past, but maybe he forgot. S3 Transportation stated they had been using the van with only 3 working anchors for a while, (unable to remember how long), and this was not the first time a resident had been transported with only three anchors in use. S3 Transportation stated she wasn't aware that the CNA riding along shouldn't be securing residents' wheelchairs into the van. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/09/2024 at 10:11 a.m., S1 Administrator confirmed S4 CNA was not trained to secure residents' wheelchairs in the van. S1 Administrator stated S4 CNA was riding along on the transport because the resident required 2 person assistance. S1 Administrator stated S3 Transportation had been trained on securing residents' wheelchairs prior to the accident on 03/20/2024, and should have been the one to secure Resident #3's wheelchair into the van. S1 Administrator stated they only train the drivers to secure residents' wheelchairs. S1 Administrator was unable to provide the Driver's Weekly Safety Inspections for 02/2024 and 03/2024, as requested. S1 Administrator confirmed the drivers were not completing the Driver's Weekly Safety inspection of the van each week prior to the accident on 03/20/2024, and should have been. During an interview on 04/11/2024 at 12:00 p.m., S1 Administrator confirmed Resident #3's wheelchair had not been properly secured in the van on the day of the accident, because the wheelchair was secured with three anchors instead of the four that were required. S1 Administrator stated S2 Maintenance said the ratchet strap was working when checked immediately after Resident #3's accident. S1 Administrator acknowledged the CNAs and Drivers may not have known how to use the ratchet strap. S1 Administrator stated when S2 Maintenance replaced the silver automatic anchor with the ratchet strap, it was not reported to her. S1 Administrator stated it was her understanding that the manual ratchet straps were okay to use in place of the silver automatic anchor. S1 Administrator stated she did not have any manuals on the van, because the van was there when she was hired. S1 Administrator stated she obtained the Q'straint Installation Instructions from Corporate after the surveyor inquired about it. The facility has implemented the following actions to correct the deficient practice: Plan of Correction Date 03/23/2024 The monthly Healthstream topic for April is Driver and Vehicle Safety. This course, which includes videos and Driver and Vehicle Safety Policy, will be completed by all Nexion staff by April 30, 2024. Inservice on Driver and Vehicle Safety Policy was initiated by the Maintenance Director to all current company authorized drivers on March 20, 2024. Securing Resident in Van - Competency Demonstration for all drivers according to Driver and Vehicle Safety Policy initiated March 21, 2024 through present. Monitor each driver that is scheduled for transport once daily by Maintenance Director, Administrator, or DON. Monitored by Securing Residents in Van - Competency Demonstration. Began March 22, 2024 through present. All van Q'Straints are working properly. Inspected by Maintenance Director March 20, 2024 and monthly. Weekly van inspection log being completed by driver per policy and procedure. The Maintenance Director continues to complete the monthly van inspection log. The Maintenance Director was trained by Regional Maintenance Director. (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 was in compliance on March 23, 2024. Ongoing training will continue to be provided as determined by the QA team.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373 Based on record review, observation, and interview the facility failed to ensure a Certified Nursing Assistant (CNA) was competent in skills and techniques necessary to assure resident safety for 1 (#3) of 4 (#1, #2, #3, & #4) residents reviewed for accidents. The facility failed to ensure that an untrained CNA (S4) was not allowed to secure Resident #3, who was wheelchair bound, in a facility van prior to transportation. Findings: Review on 04/11/2024 of the facility policy revised on 03/2023 titled Facility Vehicle Log, A Part of the Driver and Vehicle Safety Policy revealed in part . Driver's Weekly Vehicle Safety Inspection- To be completed by the company vehicle driver once each week and prior to driving a vehicle that has been returned to service after repairs. If there are safety concerns noted during the inspection, they are to be noted on the Driver's Weekly Vehicle Safety Inspection form and reported immediately to Maintenance or the Administrator. The vehicle should immediately be taken out of service if the driver or others determine that the vehicle cannot be driven safely. Securing Residents in Van-Competency Determination- Secure two front tie-downs to a solid, structural frame member of the wheelchair. Secure two back tie-downs to a solid, structural frame member of the wheelchair. Review of Resident #3's medical record revealed an admitted [DATE], with diagnoses that included in part . Cerebral Infarction, Hemiplegia and Hemiparesis, Type 2 Diabetes Mellitus, Contracture of Left Hand, Bipolar Disorder, and Pain. Review of Resident #3's Quarterly MDS with an ARD of 02/07/2024, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Review of the MDS revealed Resident #3 used a manual wheelchair, and required substantial/maximal assistance with sit to stand and chair/bed to chair transferring. Review of Resident #3's Comprehensive Plan of Care, with a target date of 05/14/2024, revealed Resident #3 was care planned for the following problems: 1. Resident has an ADL self-care performance deficit due to left sided weakness. Interventions included: extensive assistance by two person assist with bed mobility, transfers, and toileting; and set up assist with eating. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #3 is at risk for falls. Interventions included: anticipate and meet resident's needs. On 03/20/2024 - fall in van-wheelchair tipped backward/abrasion to back of head. Review of the facility's Incident/Accident report completed by S5 RN on 03/20/2024 at 10:07 a.m. revealed in part .This nurse was called by S4 CNA who states Resident #3 fell back and hit her head on van. Resident was brought in in wheelchair by S3 CNA/Transportation stating her chair flipped over backwards in van and she hit her head. Abrasion also noted to base of neck between shoulders, no bleeding noted to area. Neuro checks started. Resident complained of headache, Tylenol offered. Resident Description: We hit a bump, and I tipped over in my wheelchair. Pain rated at 4, on a pain scale of 1 - 10. During an interview on 04/08/2024 at 2:30 p.m., Resident #3 stated she was coming back from a doctor's appointment with S3 Transportation and another employee the day the accident occurred on the van. Resident #3 stated they hit a bump, her wheelchair flipped backwards, and she hit her head on the back door. Resident #3 stated she felt the back of her head with her hand, and there was blood. Resident #3 stated she was sitting in her wheelchair which was buckled to the floor, and didn't know how she tipped over backwards. Resident #3 stated it did hurt, and she kept a headache for some days. During an interview on 04/09/2024 at 8:00 a.m., with S3 CNA/Transportation, she stated on the day of the accident, S4 CNA anchored Resident #3's wheelchair down in the van using 3 of the 4 required anchors. S3 CNA/Transportation stated the front right anchor was already broken prior to the accident, and had been replaced with a type of ratchet strap. She stated she didn't know how long it had been broken. S3 CNA/Transportation stated while driving on 03/20/2024, she heard a click, looked back, and saw Resident #3 falling backwards, so she pulled the van over. S3 CNA/Transportation stated the wheelchair was tilted back, and once stopped, they repositioned the resident back into the wheelchair and secured the wheelchair again. S3 CNA/Transportation stated she saw a small amount of blood, and a small gash to the back of Resident #3's head. S3 CNA/Transportation stated she called the nursing home to report it, and S5 RN came out to check on the resident when they arrived. During an interview on 04/09/2024 at 8:20 a.m., S4 CNA stated on the day of Resident #3's accident, she strapped down Resident #3 into the van in her wheelchair. S4 CNA stated while they were traveling, the brakes were hit hard, she heard the wheelchair locks make a sound, and Resident #3 screamed. S4 CNA stated she looked and saw Resident #3 falling backwards in her wheelchair and they pulled over. S4 CNA stated she and CNA/Transportation unstrapped Resident #3, fixed the wheelchair, put Resident #3 back in the wheelchair and secured it down again. S4 CNA stated Resident #3 reached for the back of her head with her hand and said it was bleeding. S4 CNA stated Resident #3 said My head hurts. S4 CNA stated she had strapped Resident #3's wheelchair down using the two back anchors and the front left one. S4 CNA stated the front right one was different, it was a tow strap that didn't work. S4 CNA stated she didn't know how long the front right anchor had been broken. S4 CNA stated she had never been trained on how to secure residents' wheelchairs in the van and didn't know she wasn't supposed to do it or she wouldn't have. S4 CNA stated she secured Resident #3's wheelchair because S3 Transportation just got in the driver's seat and it had to be done. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview at 8:41 a.m. on 04/11/2024, S3 CNA/Transportation stated S4 CNA secured Resident #3's wheelchair into the van the day of the incident because We do team work. S3 Transportation stated she knew there were only 3 anchors working, and they had reported it to S2 Maintenance in the past but maybe he forgot. S3 CNA/Transportation stated they had been using the van with only 3 working anchors for a while, and this was not the first time a resident had been transported with only three anchors in use. S3 CNA/Transportation stated she wasn't aware the CNA riding along shouldn't be securing the residents' wheelchairs into the van. Review of S3 CNA/Transportation's training records revealed competency checks were conducted on 08/03/2022 (Securing Residents in Van), and 01/17/2024 (Vehicle Safety Inspection). During an interview on 04/09/2024 at 10:11 a.m. S1 Administrator confirmed S4 CNA was not trained to secure residents' wheelchairs in the van. S1 Administrator stated S4 CNA was riding along on the transport because the resident required 2-person assistance. S1 Administrator stated S3 Transportation had been trained on securing residents' wheelchairs prior to the accident and should have been the one to secure Resident #3's wheelchair into the van. S1 Administrator stated they only train the drivers to do the securing of residents' wheelchairs. S1 Administrator confirmed the drivers were not completing the Driver's Weekly Safety inspection each week prior to the accident on 03/20/2024, and should have been. During an interview on 04/11/2024 at 12:00 p.m., S1 Administrator confirmed Resident #3's wheelchair had not been properly secured in the van on the day of the accident.