STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30813 Based on observation, interview, and record review, the facility failed to ensure staff safely secured one resident (Resident #1), in a review of six residents, in the facility van during transport. The facility census was 93. On 10/2/24 at 11:25 A.M., the administrator was notified of the past noncompliance which occurred on 9/11/24. Upon notification of the incident, the facility completed an investigation and notified appropriate parties. The facility reeducated the transportation staff how to safely secure residents in the transport van. The deficiency was corrected on 9/11/24. During an interview on 10/1/24 at 11:15 A.M., the administrator said the facility did not have a policy for how to safely secure a resident in the transport van. 1. Review of Resident #1's significant change Minimum Data Set (MDS), a federally mandated assessment instrument, dated 7/24/24, showed the following: -Severely impaired cognition; -Required moderate assistance of staff for transfers; -Used a wheelchair for mobility; -Diagnosis frontotemporal neurocognitive disorder (group of brain diseases that mainly affect the frontal and temporal lobes of the brain). Review of the resident's care plan, last reviewed 8/18/24, showed the following: -Self performance fluctuates throughout the day; -Abilities range from independent to partial/moderate assistance of one staff for transfers; -Care plan does not include the use of a wheelchair for mobility. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's late entry progress note (from an incident that occurred on 9/11/24), dated 9/12/24, showed SSD/Transporter D called the facility and reported the resident slid out of his/her wheelchair on the transportation van. The transportation van was stopped at the end of the facility driveway. Code Blue fall was called and available staff responded. When staff entered the van, the resident lay on his/her left side with his/her head against the wall of the van. His/Her legs were slightly bent, his/her left arm was bent up against the wall of the van, and his/her right arm lay on the right side of his/her body. The resident had a skin abrasion on his/her left elbow. The resident complained of neck pain saying, feels like my neck is broke. The resident said he/she just slid out of the chair. Staff called 911, and facility staff assisted ambulance staff to place the resident on a backboard and then a stretcher. Administration and the Maintenance Supervisor provided transportation education to SSD/Transporter D. During interview on 10/1/24 at 9:20 A.M. and 10/2/24 at 11:25 A.M., the Administrator said SSD/Transporter D picked up the resident from the hospital (in the facility transportation van). SSD/Transporter D pulled into the end of the facility parking lot and the resident had scooted far enough forward to tip out of the wheelchair. The resident did not have foot pedals on his/her wheelchair. SSD/Transporter D called the facility for assistance. Staff called 911 and the ambulance took the resident back to the hospital for evaluation. SSD/transporter D trained with the previous SSD about a month before he/she was on his/her own. The Maintenance Director re-educated SSD/transporter D again after this incident occurred including making sure the resident has foot pedals on the wheelchair. SSD/Transporter D had worked at the facility for one and a half months and trained with the former SSD for a month. She did not have any documentation to show when SSD/Transporter D was trained and by whom. During interview on 10/1/24 at 9:51 A.M., the Director of Nurses (DON) said the facility got a call at end of the day (between 5:30 P.M. and 6:00 P.M.) from SSD/Transporter D who said there was an emergency in the parking lot. She called a Code Blue fall and several staff responded. The responding nurses assessed the resident and she interviewed SSD/Transporter D on what had happened. The resident lay on his/her left side in the wheelchair. The back wheels of the wheelchair were still secured and the shoulder/lap belt was still secured. SSD/Transporter D told her that when the transport van turned into the driveway, the wheelchair tilted to the left enough that the resident slid out and the wheelchair folded on itself (with the resident still in the wheelchair). The resident had a skin tear on his/her left elbow and was sent back to the hospital for evaluation. The Maintenance Director looked over the transport van to see if there was anything functionally wrong that would have caused the resident to tip over in his/her wheelchair. There wasn't anything wrong with the van. The Maintenance Director re-educated the SSD/Transporter D on the correct way to secure a resident in the van for transport, including making sure the seatbelt went under the arm rests of the wheelchair instead of over the top and making sure the front wheels of the wheelchair were secured with ratchet straps. During interview on 10/1/24 at 10:19 A.M., Licensed Practical Nurse (LPN) A said he/she responded to the code blue fall in the parking lot. The resident lay on his/her left side in the wheelchair with his/her head against the wall of the van. The resident had blood on his/her elbow. The resident told him/her that he/she slid out of the wheelchair but didn't know what happened. SSD/Transporter D said, I don't know what happened. He/She just fell over. The resident said, I think my neck is broken. Staff called 911 and assisted the ambulance crew to stabilize the resident and transfer him/her to the stretcher. He/She wasn't aware of any injuries other than the skin tear to the resident's left elbow. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital emergency room report, dated 9/11/24, showed facility staff transported the resident in the facility's van. Apparently, the resident slid out of his/her wheelchair. The resident complained of neck and pain to the back of his/her head. There was no loss of consciousness. There is no mental status change and no localizing motor or sensory deficits. CT scan (computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body) of cervical spine (neck area) showing moderately severe multilevel degenerative spondylosis (age-related arthritis) of the cervical spine encroaching the central canal at multiple levels. CT scan of the head with no acute pathology reported. Observation on 10/1/24 at 10:53 A.M., showed the following: -The administrator sat in a wheelchair; -Transporter C loaded the wheelchair onto the wheelchair lift on the transport van, locked the wheelchair, attached a seatbelt around the back of the wheelchair and flipped up the stopper on the bottom of the platform of the wheelchair lift (to stop anything from rolling off backwards); -Transporter C raised the wheelchair on the lift to the floor level of the van and wheeled the administrator on to the van; -Transporter C positioned the wheelchair at the back of the van, attached a ratchet strap (anchored to the floor) through the back wheel on each side and hooked them to the crossbar under the wheelchair, attached a ratchet strap (also anchored to the floor in front of the wheelchair on either side) to the bar above the front wheels on the wheelchair on both sides and secured a seatbelt run through/under the arm rests of the wheelchair so the seatbelt fit snugly against the administrator's stomach. During interview on 10/1/24 at 11:07 A.M., the Maintenance Director said he trained Transporter C and SSD/Transporter D on how to secure a resident for transport and retrained SSD/Transporter D after the resident fell in the van. SSD/Transporter D had not secured the front wheels of the wheelchair during the transport when the resident fell . During interview on 10/2/24 at 3:20 P.M., SSD/transporter D said she picked up the resident from the hospital, and when turning into the parking lot of the facility, she hit a bump. She then heard the resident yell. The hook popped off the right side of the wheelchair and the resident tipped over onto his/her left side. The resident was still in his/her wheelchair laying on his/her left side. The resident's wheelchair was locked and the back wheels were secured with hooks that went through each big wheel and attached to a bar under the wheelchair. She didn't remember being told to secure the front of the wheelchair prior to the incident. She was only trained twice with Transporter C (the main transporter). She secured the seatbelt around the front of the armrest of the wheelchair (not under the armrest). The Maintenance Director reviewed with him/her, after the resident went to the emergency room , how a resident should be secured in the van. MO242330