STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible by failing to properly secure the resident's wheelchair to all of the locking mechanisms used to hold the resident's wheelchair in place during transport to another facility (Resident #1). This failure resulted in the wheelchair to fall/flip over backwards during a turn with the resident still in his/her wheelchair. The resident sustained a small gash in the back of his/her head which required first aid to stop the bleeding. The census was 53. The Administrator was notified on [DATE], of the past non-compliance. On [DATE], the facility initiated an investigation, interviewed staff, completed an evaluation of the van with no concerns, and provided video education to the driver related to review of all straps and proper securement of residents for transportation. The deficiency was corrected on [DATE]. Review of the facility's Vehicle and Driver Safety Program, showed: -The purpose of this policy is to ensue the safety of those individuals who drive company vehicles, their passengers, and the public. Vehicle accidents are costly to our company, but more importantly, they may result in injury to you or others. It is the driver's responsibility to operate all vehicles in a safe manner and to drive defensively to prevent injuries and property damages; -Definitions: -Company Vehicle: Includes any car, van, SUV (Sport Utility Vehicle), truck, or other motorized transport owned by the company; -Driver: Shall include employees designated to perform duties that require operating a company vehicle; -Rules: -All drivers and passengers operating or riding in company vehicles must wear seat belts; -All drivers must ensure that a proper vehicle restraint system in used for all passengers in wheelchairs; (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 - Minimal harm or potential for actual harm Residents Affected - Few	-Report any mechanical difficulties or repair needs immediately to the Administrator; -Driving Safely -Starting: -Conduct pre-trip inspection; -Wear seatbelts at all times; -Authorized Employees: -Agree to abide by all Vehicle and Driver Safety Policies; -Conduct a pre-trip inspection before any first daily use; -Ensure all vehicle occupants wear seatbelts before moving the vehicle; -Ensure all wheelchairs are tied down securely and resident is secure in the chair before moving the vehicle; -Participate in driver training programs; -Training: All employees authorized to operate company-owned or leased vehicles will participate in initial and ongoing driver-safety training. Review of the facility's investigation, dated [DATE], showed: -On [DATE] at approximately 11:15 A.M. the Administrator was notified by the Activity Director of an incident involving a resident during transportation. Resident was fidgeting with the straps that secure the wheelchair and resident fell backward, hitting his/her head on the floor of the van. The driver immediately pulled into a parking lot, Activity Director completed first aid as resident sustained a small laceration to the back of his/her head. Driver (Maintenance Worker A) completed trip to receiving facility. Driver and Activity Director returned to the facility and evaluation of van was completed; -Initial interventions: -Staff interviews completed: -Activity Director's investigation statement, dated [DATE], showed: -Doing a ride along transport leaving the facility and taking a resident to another facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	While transporting, the resident fell backwards and hit his/his head on the van floor. We (Maintenance Worker A and Activity Director) pulled the van over in a safe place. Activity Director and Maintenance Worker A assessed the resident and upon assessment of the resident, he/she had a small gash on the back of his/her head. Activity Director looked over the resident's head. She assessed the resident, stopped the bleeding, and called the ambulance. They also called the resident's family. When the ambulance came to the scene, the bleeding was stopped. The ambulance only took the resident because he/she was on blood thinner (medications that prevent blood clots); -Maintenance Worker A's investigation statement, dated [DATE], showed: -Today left the facility to take a resident to another facility. Before leaving, we (Maintenance Worker A and Activity Director) used all straps on all four wheels along with seatbelt to strap the resident in. Maintenance Worker A and Activity Director secured the resident and proceeded to drive to the new facility. Five minutes away from our destination, the wheelchair flipped and the resident was in the back of the van, due to he/she had flipped out of the wheelchair. We immediately pulled over, got out of the van and helped the resident back into his/her chair. We noticed blood, so we pulled the chair in the up-right position, (the chair) still caught in the strap. Once he/she was back in (the chair), the ambulance was called. The Activity Director, who was with me administered care. The resident seemed to be fine. The paramedics did take the resident to the hospital. Family was called. Report was given to the other facility about what took place and returned to the facility; -Evaluation of van completed with no concerns; -Education with Driver (Maintenance Worker A); -Review of education document, dated [DATE], showed: -Video (FaceTime) education conducted with the Regional Director of Plant Operations with Maintenance Worker A on review of all straps and proper securement of residents for transportation; -No signature of Maintenance Worker A and/or Regional Director of Plant Operations on the training document; -No education/re-education of Activity Director noted; -Findings: There were not any malfunctioned items discovered during the evaluation of the van. All straps were functional; -Conclusion: On [DATE], resident was being transported to another facility. This individual sustained a fall in the van with a minor scrape to the head. Staff immediately pulled into a parking lot and provided first aid; all proper entities notified. The van was returned to the facility where an inspection was completed with no faulty equipment identified. At this time, we were unable to determine the cause of the fall. Review of Maintenance Worker A's Transportation Safety Competency, dated [DATE], showed: -Instructor/Trainer: Administrator; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Reason for Competency: Orientation; -Task: -Uses of seat belts at all times: Goal Met was checked; -Safely Securing a resident in van/bus: Goal Met was checked: -Ensure resident is seated properly in the wheelchair before loading in van/bus: Goal Met was not checked; -When securing resident/wheelchair, uses proper technique: Goal Met was not checked; -Floor straps secured properly: Goal Met was not checked; -Ensures wheelchair is secure, including wheelchair locks being engaged: Goal Met was not checked; -Seatbelt is safely secured: Goal Met was not checked. Review of Resident #1's medical record, showed: -admitted : [DATE]; -Diagnoses included nondisplaced simple supracondylar fracture (a break in the upper arm bone (humerus) just above the elbow where the bones are still aligned) without intercondylar fracture (a break in the condyles, which are the thickened areas at the ends of bones where they meet other bones) of right humerus, subsequent encounter for fracture with routine healing, muscle weakness, generalized. Review of the resident's Baseline Care Plan, dated [DATE], effective date [DATE], showed: Falls: -Problem(s): At risk for falling -Goals: Maintain safety from falls. Will not experience any injuries related to falling; -Interventions: Observe for unsafe actions and intervene. Review of the resident's progress notes, dated [DATE] at 10:44 A.M., showed: -Nursing note: Resident discharged to a different skilled facility and the current facility provided transportation; -No documentation related to the resident falling in the van. Review of the resident's emergency room discharge note, date [DATE] at 2:05 P.M., showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clinical Impressions: -Fall from wheelchair, initial encounter; -Abrasion to scalp, initial encounter; -Anticoagulated (treated with anticoagulants, medications that prevent blood clot). During an interview on [DATE] at 1:14 P.M., Maintenance Worker A said he assisted with transportation sometimes. He couldn't say if the facility really had a transporter, but the Activity Director did most of the transporting. He said the Activity Director was CPR (Cardiopulmonary Resuscitation - is an emergency lifesaving procedure performed when the heart stops beating) certified, but he was not. Maintenance Worker A said the last time he transported a resident, there was an accident whereby the resident fell out of his/her wheelchair in the van. He and the Activity Director strapped the resident in the way he was shown. About five minutes away from the destination, the long seatbelt came undone or broke, he wasn't sure. The resident fell backwards in his/her wheelchair. They pulled the van over and stopped. There was blood on the resident's head. They tried to turn the wheelchair upright with the resident in it, but realized part of the chair was still strapped in. They pulled the resident out of the wheelchair and carried him/her out of the van by placing hands underneath the resident's arms and legs. Afterwards, they unstrapped the wheelchair, pulled it out of the van, and put the resident back in his/her wheelchair. There was a small gash in the back of the resident's head. The Activity Director gave the resident first aid to stop his/her head from bleeding. The ambulance and police were called. The ambulance took the resident to the hospital as a precaution because he/she was on blood thinners. Maintenance Worker A said it was really sad. He drove that day against his better judgement, and he strapped the resident in like they showed him. During an interview on [DATE] at 2:04 P.M., the Activity Director said she transported a resident to another facility, but couldn't remember his/her name. The date was [DATE]. She said that was the only resident transported that day. She was CPR certified but didn't have any in-service training on how to strap residents in wheelchairs in facility vehicles. The resident was strapped in the van prior to driving off from the facility. She said while they were driving, Maintenance Worker A moved from one lane to the next and when he did that, the resident went backwards in the wheelchair. After the resident fell backwards, she told Maintenance Worker A to go to a safe place, which was a parking lot, to pick the resident up. They pulled over, both unbuckled their seatbelts, exited the van, and preceded to enter the van through the double doors. The resident was still laying back in the wheelchair on the van floor. She said the resident wasn't secured anymore. The seatbelt came undone from the securing latch on the floor. She told Maintenance Worker A they would try to sit the resident upright in the wheelchair inside the van but that didn't work. They grabbed the resident's legs and upper part of his/her body and scooted him/her towards the door and then out of the van. Once they got out of the van, they saw the resident had hit the back of his/her head. There was a small gash. There was blood on the van ramp. The resident was talking and said he/she had fell . The Activity Director got the first aid kit. She called the Administrator and told her what happened. The ambulance, police, and the resident's family were called/notified. (continued on next page)

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