

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Willard		STREET ADDRESS, CITY, STATE, ZIP CODE 370 E Howard St Willard, OH 44890	

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** Based on facility bus observation, staff interviews, medical record review, review of the incident log, review of the facility internal investigation, review of facility provided photographs, review of hospital records, review of facility bus safety manual, review of facility bus wheelchair restraint user manual, review of wheelchair manual, and review of facility policy, the facility failed to ensure Resident #11, who was identified to be dependent on staff for all aspects of care, was safely secured with a seat belt and positioned properly in a wheelchair during a transport on the facility bus. This resulted in Immediate Jeopardy and the potential for serious life-threatening injuries when Resident #11 fell out of her wheelchair mid-transport and landed on the floor, sustaining a subdural hematoma and subarachnoid hemorrhage to the left side of her head, requiring admission to the intensive care unit (ICU) for monitoring. This affected one (#11) of three residents reviewed for use of assisted device during transportation. The facility identified a total of 47 residents who utilized a wheelchair. The facility census was 56.</p> <p>On 04/17/25 at 11:55 A.M., the Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #884 were informed that Immediate Jeopardy began on 03/26/25 when Transportation Driver #830 failed to safely secure and position Resident #11's wheelchair appropriately. During the trip, Resident #11's left wheelchair arm broke and Resident #11 fell out of her wheelchair and onto the floor of the bus. Resident #11 hit her head and Transportation Driver #830 drove her to a local emergency room (ER) for evaluation. A computed tomography (CT) scan of Resident #11's head revealed a left subdural hematoma and subarachnoid hemorrhage, and Resident #11 was subsequently admitted to the ICU.</p> <p>The Immediate Jeopardy was removed on 03/28/25 when the facility implemented the following corrective actions:</p> <ul style="list-style-type: none"> o <p>On 3/26/25 at 5:10 P.M., the DON was notified of Resident #11's fall in the facility's bus and subsequent injury by Transportation Driver #830.</p> <ul style="list-style-type: none"> o <p>On 03/26/25 at 5:10 P.M., Resident #11's son was present at the appointment and was notified of the incident by Transportation Driver #830.</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
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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>o</p> <p>On 03/26/25 at 5:15 P.M., the facility initiated an incident report following the DON's notification of the incident. The incident report was completed on 03/28/25 after the resident's return to the facility.</p> <p>o</p> <p>On 03/26/25 at 5:43 P.M., Resident #11's provider, Certified Nurse Practitioner (CNP) #885, was notified of Resident #11's injury on the facility transport bus. This notification was completed by the DON.</p> <p>o</p> <p>On 03/26/25 at approximately 6:00 P.M., a written statement was obtained by Transportation Driver #830 following the incident upon his return to the facility.</p> <p>o</p> <p>On 03/27/25, all in-house wheelchairs were assessed by Maintenance Supervisor #880, Therapy Director #824, ADON #848, and Minimum Data Set (MDS) Nurse #835 for proper functioning. Any issues or concerns were corrected at the time of the assessments. All assessments were completed on 03/27/25.</p> <p>o</p> <p>Transportation Driver #830's personnel file was reviewed by the Administrator on 03/27/25. Transportation Driver #830 had no previous disciplinary action. Disciplinary action was given by the Administrator on 03/27/25.</p> <p>o</p> <p>On 03/27/25, Maintenance Supervisor #880 completed an inspection of the facility bus, including the lift, seatbelts and restraint mechanisms to assess for any malfunctioning or fraying of belts. There were no abnormalities identified; the bus was in good working order.</p> <p>o</p> <p>The facility identified three additional staff members, Certified Nurse Aide (CNA) #854, CNA #853, and Housekeeping Aide #866, approved to drive the facility bus. The additional bus drivers' personnel files were reviewed by the Administrator on 3/27/25 for bus safety and training. The personnel files were complete with no negative findings.</p> <p>o</p> <p>All facility bus drivers were re-educated by Maintenance Supervisor #880 on 3/27/25 with emphasis on proper securement of residents, proper positioning of residents in wheelchairs, and proper use of the bus's lifting mechanism. This included a step-by-step instruction on proper technique, and a return demonstration by each driver.</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>On 3/28/25, upon return to the facility, neurological checks for Resident #11 were initiated by RN #857 for a duration of 72 hours. The series of neurological checks were completed on 04/01/25 by a staff nurse. This was completed on 03/31/25. There were no identified physical or psychosocial changes. Resident #11 remained at her baseline.</p> <p>o</p> <p>On 03/28/25, the facility began 72-hour monitoring. Resident #11 was comprehensively assessed every shift by the direct care nursing staff. This was completed on 03/31/25, with the documentation overseen by the DON. There were no identified physical or psychosocial changes. Resident #11 remained at her baseline.</p> <p>o</p> <p>On 03/31/25, the facility began a daily comprehensive assessment of Resident #11, with the documentation overseen by the DON. There have been no negative findings or declines in condition.</p> <p>Although the Immediate Jeopardy was removed on 03/28/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #11 revealed an admission date of 01/09/25 and diagnoses including left non-dominant side hemiplegia (paralysis) and hemiparesis (muscle weakness), dysphagia following cerebral infarction (stroke), dysarthria (difficulty speaking) following cerebral infarction, diabetes mellitus with diabetic polyneuropathy, generalized muscle weakness, and lack of coordination.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed Resident #11 had unclear speech and rarely/never understands others or was understood by others. Resident #11 had short- and long-term memory deficits. Resident #11 had impairment of upper and lower extremity on one side and was dependent on staff for activities of daily living (ADLs). Resident #11 was unable to ambulate or stand on her own. Resident #11 utilized a wheelchair for mobility.</p> <p>Review of the care plan revised 04/15/25 revealed Resident #11 required assistance for ADLs due to hemiparesis and history of a cerebrovascular accident (stroke). Listed interventions included utilizing a wheelchair for mobility and transferring Resident #11 by using two staff and a Hoyer lift (a mechanical lift used by caregivers to safely transfer those with limited mobility). An additional care plan focus, revised 04/16/25, revealed Resident #11 had the potential for bleeding or hemorrhage related to previous use of blood thinning medications. Interventions included to protect Resident #11 from falls or injury as much as possible.</p> <p>Review of physician's order dated 02/14/25 revealed Resident #11 had an order for one tablet of Aspirin 81 milligram (mg) tablets every morning for anticoagulation therapy and an order for one tablet of Plavix (antiplatelet medication) 75 mg once daily for a history of a cerebrovascular accident.</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>Review of a nursing note dated 03/19/25 revealed Resident #11 had an appointment scheduled with a pulmonologist on 03/26/25 at 2:00 P.M. The facility was to transport Resident #11 to her appointment with her son to accompany.</p> <p>Review of incident logs from February 2025 to April 2025 revealed on 03/26/25 Resident #11 had an unwitnessed fall on the facility transport van and sustained a bruise.</p> <p>Review of an incident report dated 03/26/25 timed at 5:15 P.M. revealed Resident #11 had an unwitnessed fall during transportation outside of the facility. Transportation Driver #830 reported Resident #11 fell out of the wheelchair during a transport to an outside appointment and Transportation Driver #830 drove her to a nearby hospital to assist with getting Resident #11 off the floor of bus. Resident #11 was taken into the emergency room (ER) for evaluation and admitted. Resident #11 was noted to have a bruise to the top of her scalp. Resident #11 was alert to person and unable to give a description of what had happened. The DON, Resident #11's son, and Resident #11's provider (CNP #885), were notified of the incident.</p> <p>Review of a witness statement dated 03/26/25 for Transportation Driver #830 revealed he had gotten Resident #11 onto the bus at approximately 12:50 P.M. Transportation Driver #830 stated when he loaded Resident #11 in her wheelchair into the bus, she was tilted back so she was hooked up long ways, facing the passenger side of the bus, so she could be comfortably tilted back. Transportation Driver #830 stated he felt the seat belt was in the way and Resident #11's upper body was not going to move anywhere. Transportation Driver #830 applied the four-point wheelchair securing hooks onto the base of her wheelchair. Transportation Driver #830 stated when they arrived at the first appointment, the doctor wanted an x-ray examination completed so they were sent to a local hospital. Transportation Driver #830 stated Resident #11 was re-loaded onto the transportation bus and during transport he heard a noise. Transportation Driver #830 stated he checked his mirrors and observed Resident #11 on the floor of the bus. Transportation Driver #830 stated the hospital was about three minutes away, so he kept driving to the hospital to get help. Upon arrival, Resident #11 was taken into the ER for assessment. Transportation Driver #830 stated he waited at the hospital for approximately one hour until a nurse dismissed him.</p> <p>Review of the hospital trauma and surgical history and physical assessment dated [DATE] timed at 8:54 P.M. revealed Resident #11 presented to the hospital post-fall out of a wheelchair. Resident #11 was traveling on a bus to the doctor's office when she fell out of her wheelchair, striking her face on the floor of the bus. There was no loss of consciousness. A CT scan was completed with findings of 0.4 centimeter (cm) subdural hematoma with trace subarachnoid hemorrhage within the left temporal sulci (groove located on the outer surface of temporal [NAME]). There were noted abrasions to Resident #11's left forehead and nose. Resident #11 had noted history of cerebrovascular incident with noted flaccidity of left upper extremity and left lower extremity. Resident #11 was noted to be on aspirin and Plavix. Resident #11 was admitted to the intensive care unit (ICU) and would have a neurosurgery consultation.</p> <p>Review of hospital imaging results of a CT scan of Resident #11's head dated 03/27/25 at 12:41 A.M. revealed a stable appearance of the left-sided subdural hematoma measuring 2.48 millimeters (mm) in thickness. No new hemorrhage was seen, and an area of chronic infarction was noted.</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>Review of a general note dated 03/27/25 timed at 2:36 A.M. revealed Resident #11 had fallen out of wheelchair during transport to or from an appointment and had hit her head. Resident #11 was noted to be on blood thinners and was sent to the emergency room for evaluation. There had not been an update since shift change.</p> <p>Review of the hospital neurosurgery consult dated 03/27/25 timed at 9:49 A.M. revealed Resident #11 presented with a left middle cranial fossa acute subdural hematoma after fall with face strike. It was noted upon repeat CT scan; Resident #11 was stable with no new neurological deficits. It was noted that Resident #11's wheelchair arm broke and Resident #11 fell onto her face in a transport bus.</p> <p>Review of the undated facility investigative documentation revealed Resident #11 was being transported to an appointment on the facility transportation bus. Resident #11 left the facility on [DATE] and was placed in a tilt-and-space wheelchair she had obtained prior to admission. The wheelchair was inspected by the therapy department on 03/25/25 and found to be in good working order. It was noted Resident #11 was not secured with a lap belt due to being tilted back in the wheelchair. While Transportation Driver #830 was driving the bus, he looked back and observed Resident #11 on the floor of the bus. Transportation Driver #830 was approximately three minutes' drive from a local hospital and drove directly to the hospital ER with Resident #11 remaining on the floor of the bus. Resident #11 was taken into the ER for evaluation. Resident #11 had a CT scan of her head, and a brain bleed was noted. Resident #11 was admitted to a local hospital and returned to the facility on [DATE].</p> <p>Review of Disciplinary Action Form dated 03/27/25 revealed Transport Driver #830 was given a final written warning for a bus competency violation. The form listed Transportation Driver #830 failed to follow proper procedure when securing residents in wheelchairs in the facility transport bus. It was noted that Transportation Driver #830 had previously been trained on proper techniques for securing residents on the transport bus.</p> <p>Review of a social services note dated 03/28/25 timed at 11:02 A.M. revealed Resident #11 was expected to return to facility on 03/28/25.</p> <p>Review of the hospital Discharge summary dated [DATE] at 11:06 A.M. revealed Resident #11 had fallen out of her wheelchair while traveling on a transport bus to her doctor's office and had stuck her face on the floor of the bus. Resident #11 sustained a subdural hematoma and subarachnoid hemorrhage and was treated in the ICU. Resident #11 demonstrated stability of intracranial hemorrhage and was discharged back to the facility on [DATE]. Outpatient neurosurgery follow-up was recommended.</p> <p>Review of a general note dated 03/28/25 timed at 8:41 P.M. revealed Resident #11 returned to facility with all blood thinners discontinued. Resident #11 was not responsive to stimulation upon return.</p> <p>Review of Ad Hoc QAPI Notes dated 03/28/25 revealed Resident #11 was on the facility transportation bus on 03/26/25 and was being transported to hospital for a scan after a doctor's appointment. Resident #11 was in a tilt-in-space wheelchair. During secondary transport for scan, a bolt on Resident #11's wheelchair broke causing the side of the wheelchair to bend off. This resulted in Resident #11 coming out of the wheelchair onto the floor of the transportation bus. It was noted Resident #11's wheelchair was secured using four-point floor latches; however, Resident #11 was not secured using a lap belt due to being in a tilted back position in the wheelchair.</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>Interview on 04/16/25 at 11:15 A.M. with Transportation Driver #830 revealed he had worked at the facility for the last five years. Transportation Driver #830 indicated he had never driven a transport bus prior. Transportation Driver #830 stated he had limited training which included driving a former administrator around the block and verbal instruction on how to load a wheelchair. Transportation Driver #830 indicated he did approximately two resident transports per day. Transportation Driver #830 stated on 03/26/25 he had loaded Resident #11 into the transport bus wrong. Transportation Driver #830 stated he had loaded Resident #11 in her wheelchair facing the passenger side windows of the bus. Transportation Driver #830 stated he felt Resident #11 was in pain while sitting upright in the wheelchair, so he had kept her tilted backwards. Transportation Driver #830 stated he was unable to use the seat belt due to Resident #11's wheelchair being in the tilted back position and positioned facing the passenger side of the bus (instead of forward facing). Transportation Driver #830 stated Resident #11 does not really move anyways so he felt she was secure in the chair despite not using the seat belt. Transportation Driver #830 stated he had applied Resident #11's wheelchair brake and applied four-point hooks to the wheelchair. Transportation Driver #830 indicated while driving to the hospital he heard a noise. He stated Resident #11 was not in her wheelchair when he checked the mirrors, and he saw her lying on the ground of the transport bus. Transportation Driver #830 stated they were approximately two minutes from the hospital, so he kept driving to the ER. Transportation Driver #830 stated the bolt on Resident #11's wheelchair had broken, and Resident #11 was leaning to the left side. Transportation Driver #830 stated the arm of the wheelchair completely bent off and caused Resident #11 to roll out onto the floor of the bus. Transportation Driver #830 stated he had gotten help from EMTs at the hospital and they were able to help her off the floor. Transportation Driver #830 stated Resident #11 did not have any bleeding, and she was not making any noises. Transportation Driver #830 stated Resident #11 just laid on the floor looking uncomfortable and embarrassed until she could be assisted up. Transportation Driver #830 denied any hard braking, speeding, or hard turns when Resident #11 had fallen from her wheelchair. Transportation Driver #830 stated the speed limit was 35 miles per hour and there was traffic near the hospital.</p> <p>Observation on 04/16/25 at 11:20 A.M. with Transportation Driver #830 of the facility transportation bus revealed the bus had three rows of seats with two seats on each side of the bus. There was a space at the back of the bus to secure two residents with wheelchairs. There were four straps with hooks to secure wheelchairs and a shoulder/lap seat belt for each wheelchair space. The equipment was in working order with no frays or tears in the straps. Transportation Driver #830 demonstrated the use of the wheelchair lift located at the back passenger side of the bus. The bus appeared in good working order.</p> <p>Interview on 04/16/25 at 2:16 P.M. with Therapy Director #824 revealed he had done a visual inspection of Resident #11's tilt-in-space wheelchair prior to the transport with no abnormal findings. Therapy Director #824 indicated he had also shown Transportation Driver #830 how to use the tilt-in-space wheelchair. Therapy Director #824 stated Resident #11 had not used the tilt-in-space wheelchair while admitted to the facility as they had been working on her trunk control and strengthening with a standard wheelchair. Therapy Director #824 indicated Resident #11 had not been progressing with a standard wheelchair and the tilt-in-space wheelchair was appropriate for use during transport to her appointment.</p> <p>Interview on 04/16/25 at 2:34 P.M. with the Administrator and RDCS #884 revealed Resident #11's tilt-in-space wheelchair did not return to the facility with her from the hospital. The Administrator indicated there were pictures of the wheelchair.</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>Review of a series of three facility provided photographs, undated, revealed a wheelchair identified by the facility as Resident #11's tilt-in-space wheelchair. In the photographs it was seen the left side arm of the wheelchair was bent towards the back of the wheelchair and the front securing bracket had broken from the frame of the wheelchair. There were two noted brackets to secure the arm to the wheelchair frame.</p> <p>Review of Q'Straint Installation Instructions for Four-Point Wheelchair Securement System undated revealed tiedowns should only be installed so wheelchair passengers were facing forward. Lap belts must always lie against the bony structure of the passenger's body and never infringe on any component of the wheelchair such as armrests, wheels, or frames. Shoulder belts should always be positioned so the belt lies across the center of the passenger's shoulder and extends upward and rearward of the passenger's shoulder.</p> <p>Review of the safety manual for transport van wheelchair secure restraint system titled Doing It Right: A guide to the Proper Use of Sure-Lok Wheelchair Securement and Occupant Restraint Systems undated revealed the correct securement of a wheelchair was extremely important for safety and comfort of the passenger and injury or death could occur due to improper securement. The passenger should be facing the front of the vehicle with the wheelchair centered between the floor tracks or plates. Four straps should secure the wheelchair. A lap belt with a shoulder belt should be used to secure the passenger. The lap belt should be secured across the passenger's pelvic area near hips. The shoulder belt should be secured diagonally across the passenger's upper chest.</p> <p>Review of Invacare Solara 3G Wheelchair User Manual dated 2018 revealed always make sure the wheelchair was stable and engage wheel locks before using reclining option. The wheelchair must be operated by a healthcare professional or assistant when in any tilt position. It was not recommended to transport a wheelchair user in any kind of vehicle while in a wheelchair. It was recommended to complete regular cleaning and inspection of the wheelchair.</p> <p>Review of the facility policy Regularly Scheduled Transportation dated July 2018 revealed the facility would provide transportation using a facility vehicle for medically necessary appointments, activities, and outings. A third-party transportation service could be utilized when indicated.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00164661.</p>		