STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365813	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorn Glen Nursing Center	5414 Hankins Road Middletown, OH 45044

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** 43062 Based on observations, record review, review of Emergency Medical Services (EMS) report, review of emergency room (ER) records, review of hospital records, staff interviews, review of personnel record, review of job descriptions, and review of facility policy, the facility failed to ensure residents were free from accidents while being transported by the facility's bus. This affected one (#25) of the three residents reviewed for accidents. The facility census was 64. Findings include: Review of the medical record for Resident # 25 revealed the resident was admitted to the facility on [DATE] and discharged to the hospital on 10/25/24. Diagnoses included major depressive disorder, cerebral infarction (stroke), dementia, anxiety, chronic kidney disease, morbid obesity, congestive heart failure (CHF), essential primary hypertension, pneumonia, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had impaired cognition and was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 04/27/24 for Resident #25, revealed the resident was at risk for falls due impaired cognition, vertigo and prior falls. Her interventions included assisting with toilet use, bariatric bed, Dycem to wheelchair, call light in reach, and monitor medications. The care plan revealed no documented evidence of being updated when the resident fell on [DATE] while being transported on the facility bus. Review of the cardiologist visit note dated 10/24/24 at 11:15 A.M. for Resident #25, revealed the resident was seen in the office for a follow-up and evaluation on her biventricular implantable cardioverter defibrillator (BiV ICD) (a small, battery-powered device that helps treat heart failure by improving heart function and preventing dangerous heart rhythms), nonrheumatic tricuspid valve regurgitation, primary hypertension and paroxysmal atrial fibrillation. The resident's vital signs were normal and the resident was scheduled for transesophageal echocardiogram on 11/15/24. follow up visit on 11/15/24 for a transesophageal echocardiogram (a non-invasive ultrasound procedure that allows a doctor to see the heart's structure and function) and was to follow-up with the heart failure clinic on 11/26/24. (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	Review of a nurse's progress note dated 10/24/24 at 1:15 P.M. and recorded as a late entry on 10/25/24, for Resident #25, revealed the resident was being transported back to the facility from a medical appointment in the facility owned transport bus. Maintenance Supervisor (MS) #204 was driving bus and Certified Nurse Assistant (CNA) #202 accompanied the resident for the transport. During the return transport, MS #204 had to slam on the brakes to avoid hitting a car that pulled in front of them. This caused Resident #25 to fall from her wheelchair into the floor landing on her knees and then onto her stomach with her legs under her wheelchair. MS #204 immediately pulled over and CNA #202 checked the resident for any signs of trauma. MS #204 and CNA #202 assisted Resident #25 from the floor and back into her wheelchair. Upon return to the facility, the Director of Nursing (DON), two staff nurses, and two CNAs took Resident #25 to her room to assess her. Resident #25 stated a truck hit them, and she fell out of her chair. Resident #25 was assessed and there were no new skin injuries, no obvious swelling or trauma, range of motion (ROM) was within normal limits and blood pressure was 101/55 millimeters of mercury (mmHg), pulse 62 beats per minute, oxygen saturation was 84 percent (%) on two liters per minute (LPM) of oxygen. Review of the facility's investigation dated 10/24/24 at 1:15 P.M. for Resident #25 and authored by the DON, revealed the resident was being transported back to the facility from an appointment via the facility owned transport bus and being driven by MS #204 and CNA #202 was accompanying the resident. During the journey back to the facility, MS #204 had to slam on the brakes to avoid a car turning in front of them which caused the resident to fall from her wheelchair onto her knees and then onto her stomach with her legs under the wheelchair. Resident #25 stated a truck hit them and she fell out of her chair. MS #204 pulled over immediately and they checked on the resident for any signs of trauma and none were found. MS #204 and CNA #202 lifted the resident from the floor of bus, back into her wheelchair and drove back to the facility. Upon returning to the facility, the DON, two nurses and two CNAs took the resident to her room and put her in the bed to assess her. The assessment revealed there were no new skin injuries, no obvious swelling or trauma and range of motion was within normal limits. The resident's vital signs were as follows: blood pressure 101/55 mmHg, pulse 62 beats a minute, oxygen saturation of 84 % on two LPM of oxygen via nasal cannula The immediate intervention was to send Resident #25 to the hospital for an evaluation for possible injuries. The investigation revealed the resident's wheelchair was secured to the bus; however, the resident was not secured in the wheelchair with the vehicle's seat belt. Review of a nurse progress noted dated 10/24/24 at 2:00 P.M. and recorded as a late entry on 10/25/24 for Resident #25, revealed the resident had a brief period of unresponsiveness and staff performed a sternal rub which was effective. Blood pressure was 52/39 mm/Hg (very low), pulse was 61 beats per minute, temperature was 98.3 degrees Fahrenheit (F), and oxygen saturation was 62 % (very low) . A non-breather mask (a mask that delivers a high concentration of oxygen) was applied with five liters per minute (LPM) of oxygen and a breathing treatment was administered. The staff notified the nurse practitioner (NP) who ordered the resident to be sent to the emergency room (ER). The team called 911 and EMS arrived at 2:00 P. M. The head of bed was raised to 45 degrees and the crash cart was at bedside. Resident #25 was admitted to the hospital with a diagnosis of hypotension related to cardiovascular disease. (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 EMS report dated 10/24/24, revealed EMS arrived at the facility at 2:02 P.M. for Resident #25 complaining of head pain related to injuries after a fall from her chair and shortness of breath. EMS found Resident #25 sitting up in her bed and appeared to be in respiratory distress with a nasal cannula in place. The staff reported the resident was being transported in the bus when she fell out of her wheelchair when the driver hit the brakes. The driver returned the resident to the nursing home and the staff got the resident back in bed when the resident became unresponsive. The staff reported the resident's oxygen saturation dropped to the 60's and the resident was hypotensive. EMS found the resident alert, oriented and stated she fell out of her wheelchair and hit her head and knee. The resident complained of pain at a six (pain scale from zero [no pain] to ten [extreme pain] on top of her head with a small hematoma noted to the top of head. The resident's blood pressure was 107/42 mmHg upon arrival and dropped to 86/57 mmHg during transport to the hospital. The resident was transported to the ER with no additional concerns. Review of the ER note dated 10/24/24 at 2:36 P.M., revealed Resident #25 arrived in the ER related to a motor vehicle accident (MVA) and shortness of breath. The resident was being transported back to her nursing facility in the facility van, when it suddenly slammed on its brakes and may or may not have hit another vehicle and the resident was thrown from the wheelchair in the van. The transporters got her back into her seat, but when she arrived back at the nursing facility she was unresponsive and did not have a pulse. Information was being relayed to the ER staff by the daughter of the resident who was not on scene. The resident arrived awake and answered questions but confused (baseline). An assessment revealed atraumatic without any gross deformity and no hematomas. The resident had no acute fractures or injuries after multiple radiographic images were completed. The resident initially arrived with a normal blood pressure but declined quickly and had to be upgraded to a trauma. The resident was admitted to the hospital for ascites, cardiogenic shock, acute on chronic respiratory failure with hypoxia and no evidence of traumatic abnormalities. The resident discharged back to the facility on [DATE] Review of the hospital's admission History and Physical dated 10/24/24 at 5:36 P.M., revealed Resident #25 was at her cardiologist's office earlier in the day when she was returning with medical transport, and they got in a motor vehicle accident and the resident was thrown from her wheelchair and hit the wall. The transporters put her back in the wheelchair and continued to her extended care facility (ECF) where the patient was found unresponsive and hypotensive. The resident remained hypotensive and unresponsive until a bilevel positive airway pressure (BIPAP) was placed and the resident woke up but remained hypotensive. A trauma workup was performed, and resident was fond to have no fractures, injuries or other causes for her sudden hypotension and cardiac which appeared to be cardiogenic shock. Resident #25 had a history of severe tricuspid regurgitation and having right sided heart failure and the resident was admitted to the intensive care unit. Resident #25 had a large volume overload with significant ascites. The resident had recent paracentesis at the end of September 2024 and would benefit from another procedure. The resident was at her cardiologist's officer earlier in the day and was noted to have significant volume overload but was not in any acute distress and unclear if the accident precipitated cardiogenic shock The resident was cleared by trauma and will be monitored closely as she denied any pain and unclear if thrown during the accident. (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 a witness statement dated 10/24/24 and authored by MS #204, revealed he was driving the bus on State Route 63 heading towards the facility when a car cut in front of the bus and then emergency braked for a traffic light that turned yellow and to avoid a collision with the vehicle, the bus came to abrupt stop. The resident slid out her wheelchair and onto the floor of the bus. The right leg was bent under her and the left was out front but bent at the knee. MS #204 put on the emergency hazard lights and helped the aide in getting the resident back into the wheelchair. MS #204 continued driving to the nursing home and made a report to the DON and the Administrator. Review of an updated witness statement by CNA #202 and narrated by the DON and Administrator, revealed MS #204 appeared to be driving too fast, when he had to stop hard for a red light, and when CNA #202 looked back, Resident #25 had fallen out her wheelchair. CNA #202 indicated the wheelchair was buckled in but the over-the-shoulder belt for the resident was never attached. The resident landed in front of her chair with her legs under the wheelchair and her head close to the seat in front of her and face down in the floor. CNA #202 and MS #204 helped the resident back into the wheelchair and we started talking about lunch. Resident #25 stated she was hungry and denied any pain. CNA #202 stated they did not hit another vehicle. CNA #202 noted she had the resident's daughter's phone number and was messaging her to ask how the resident was doing when she went to the hospital. Review of an Inter Disciplinary Team (IDT) note dated 10/28/24 at 11:24 A.M. and recorded as a late entry for Resident #25, revealed the IDT met to discuss the resident's fall. The resident was sent to the hospital to be evaluated. The hospital reported all scans were clear with no injuries or trauma. The resident was admitted for hypotension related to cardiovascular disease and was still out of the facility. All staff involved in facility transportation were re-educated and checked off for competency in bus safety policy and procedure. Review of a nurse's progress note dated 11/08/24 at 10:47 A.M. for Resident #25, revealed the resident returned to the facility by stretcher. The nurse went to the room and oriented the resident to the room and the family was present. The resident's oxygen concentrator was set up and applied to the resident, vitals were obtained and range of motion was normal for resident. Interview on 11/27/24 at 10:54 A.M. with the Director of Nursing (DON) revealed Resident #25 had an appointment on 10/24/24 with her cardiologist and was being transported in the facility bus by MS #204 and CNA #202. The DON stated she was in her office with CNA #203 when she heard the facility bus was out front and Resident #25 had a fall from her wheelchair while being transported. The DON stated MS #204 told her Resident #25 had a fall from her wheelchair onto the van floor. The DON stated Resident #25 required a Hoyer lift for all transfers and she questioned MS #204 and CNA #202 on how they got Resident #25 from the floor of the van and back into her wheelchair. The DON relayed the staff lifted the resident up by her arms and legs and placed her back in the wheelchair. The DON stated she would have expected for the resident to be properly assessed for any injuries prior to the staff putting the resident back in the chair and driving her back to the facility. The DON stated nursing and CNA staff got Resident #25 in her bed to be assessed when she went unresponsive. The DON stated the team called 911 and the resident was discharged to the hospital and remained in the hospital due to cardiac issues until she was readmitted on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MS #204 on 11/27/24 at 11:15 A.M. revealed he transported Resident #25 to a medical appointment on the facility's bus along with CNA #202 on 10/24/24. MS #204 stated on the return trip, he had to stop suddenly, and Resident #25 fell out of her wheelchair. MS #204 stated he secured Resident #25's wheelchair to the bus; however, he didn't secure Resident #25 in the wheelchair. MS #204 stated Resident #25 slid from her wheelchair, and she landed in a praying position leaning on the seat in front of her. MS #204 stated CNA #202 asked the resident if she was hurt and when she reported she was not hurt, he and CNA #202 lifted the resident from the floor and placed her back in the wheelchair. MS #204 stated he continued on driving back to the facility. MS #204 when he got back to the facility, he was wheeling the resident inside when the DON was at the front desk, and he told her about the incident. MS #204 stated he was never been trained in how to secure a resident on the bus prior to this incident. Observation of the facility bus on 11/27/24 at 11:30 A.M. with MS #204, revealed Resident #25 was in a wheelchair and when he placed her in the bus, she was placed behind the last affixed row of seats on the driver's side of the bus. MS #204 demonstrated how he secured the resident's wheelchair to the bus by using four tie-down straps which hooked into the wheelchair and into anchors permanently affixed to the floor of the bus. MS #204 also demonstrated how he should have secured the resident to her wheelchair by using the shoulder and lap system designed for their bus. MS #204 stated he forgot to secure the seat-belt strap which went over the resident's shoulder and lap and secured into the tie-downs. MS #204 verified resident was not properly secured in her wheelchair when the incident occurred. Interview with CNA #202 on 11/27/24 at 1:30 P.M. revealed she was accompanying Resident # 25 while being transported to a medical appointment on 10/24/24. CNA #202 stated the bus suddenly stopped and when she looked back, the resident slid out of her wheelchair and her legs were under her and her cheek was against the seat in front of her. CNA #202 stated she had never accompanied a resident while being transported to an appointment and MS #204 was responsible for securing Resident #25 in the bus. CNA #202 verified Resident #25 was not properly secured in her wheelchair with a seat belt. CNA #202 stated she and MS #204 grabbed an arm and a leg of Resident #25 and placed her back into her wheelchair. CNA #202 stated she had told MS #204 to slow down while exiting the highway on the off ramp prior to the incident. CNA #202 stated she did not receive any prior training related to how to transport or secure a resident on the transport bus. Interview with the Administrator on 11/27/24 at 3:21 P.M., revealed he was not the Administrator when this incident happened. The Administrator stated he was reviewing files on the desk when he discovered the bus incident involving Resident #25. The Administrator stated he asked MS #204 to demonstrate exactly what happened when Resident #25 fell on the bus on 10/24/24. The Administrator stated he discovered Resident #25 was not properly secured in her wheelchair when the incident occurred. The Administrator verified MS #204 and CNA #202 placed the resident back in her wheelchair and drove the resident back to facility. The Administrator stated the staff made a judgement call. Review of the personnel file for MS #204 revealed a final written warning dated 11/14/24 for failure to obey safety rules. The personnel file revealed no documented evidence that MS #204 received any prior training related to transporting residents in the facility vehicles. Review of the job description dated and signed by MS #204 on 10/06/22 revealed no documentation related to transporting residents in the facility vehicles. (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 personnel file for CNA #202 revealed a final written warning dated 11/14/24 for failure to obey safety rules. The personnel file revealed no documented evidence CNA #202 received any prior training related to transporting residents in the facility vehicles. Review of the job description dated and signed by CNA #202 on 08/23/24 revealed no documentation related to transporting residents in the facility vehicles. Review of the facility policy titled, Transportation, dated 08/02/24, confirmed it is the policy of the facility to arrange and ensure transportation is provided for doctors and specialist appointments if the resident does not have family, friend, or responsible party available for transport. Residents will be evaluated for cognitive impairment and the need to be escorted by staff to the appointment. Staff providing transpiration for residents will receive bus/van competency training. This deficiency represents non-compliance investigated under Complaint Number OH00160174.