

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  Woodview Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  1630 3rd Avenue Northeast Ardmore, OK 73401	

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 - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34333</p> <p>Based on observation, record review, and interview the facility failed to ensure adequate safety measures during transportation to prevent accidents for 2 (#1 and #4) of 2 sampled residents reviewed for accidents.</p> <p>The administrator identified two residents who had experienced accidents during transportation in the past six months.</p> <p>An undated Facility Process to Authorize Company Vehicle Drivers policy, read in part, All persons who drive any company owned vehicle, including vans, ARE REQUIRED to be an authorized driver under the company's current auto insurance policy .The employee being considered must be [AGE] years of age or older .The facility will request a Motor Vehicle Record in the employee's name .The facility is to manage their list of drivers to include providing in-service training to transport.</p> <p>1. Resident #1 had diagnoses which included chronic kidney disease, diabetes, and bilateral below the knee amputation.</p> <p>A quarterly assessment for Resident #1, dated 12/31/24, showed the resident was moderately cognitively impaired. The assessment showed the resident required assistance with activities of daily living.</p> <p>A progress note, dated 01/28/25 at 12:28 p.m., showed Resident #1 arrived to the facility via transport van from dialysis. The note showed the transport driver reported the resident was sitting in their wheelchair with the seatbelt on, and due to a dog running in front of the van, the transporter had to push on their brakes. The note showed when the transport driver pushed on the brakes, the resident fell out of their wheelchair onto the floor, hitting their face on a plastic crate that was sitting in front of the wheelchair. The note showed the nurse entered the transport van and observed the resident lying in a supine position and was noted with a laceration to the left side of their nose, extending to the cheek area. The nurse noted a hematoma to the left side of the resident's head with bleeding due to hitting their face on the plastic crate. The note showed first aid was provided and the resident denied losing consciousness. The note showed nursing staff positioned the resident to a sitting position and arrangements were made to have the resident transported to the emergency department for evaluation.</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 - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An emergency department provider note, dated 01/28/25 at 2:38 p.m., showed Resident #1 received a computed tomography (CT) of the head with a diagnosis of subacute appearing mildly displaced bilateral nasal bone fractures, with no acute intracranial abnormality. The note showed final diagnoses of closed head injury, facial laceration, and abrasion of nose.</p> <p>On 02/12/25 at 9:15 a.m., Resident #1 was interviewed in their room regarding the injury they sustained during transport in the facility van. The resident stated they were doing pretty good and had recently had five sutures removed from a laceration sustained during the accident. The resident reported being strapped in their wheelchair, but fell forward out of the wheelchair and hit their head. The resident stated they were not fearful and felt safe traveling in the facility van. The resident denied any previous incidents during transportation.</p> <p>On 02/12/25 at 9:25 a.m., transport driver #1 reported they were driving the facility van when Resident #1 fell from their wheelchair. The driver stated they had stopped at a stop sign, made a turn, and a dog was in the road. The driver stated they had barely started accelerating after a complete stop, but pushed on the brake to avoid the dog. The driver reported Resident #1's wheelchair was secured to the floor of the van and stayed in place. The driver reported the resident also had a seatbelt around their waist and shoulder, but slipped through them. The driver reported the resident always leaned forward somewhat in their wheelchair, but perhaps did not have the seatbelt and harness tight enough that day. The driver was asked if anything like this had happened before and they stated the same thing happened with Resident #4 several months previous. The driver reported Resident #4 was also an amputee and did not have the shoulder strap in place at the time of the incident.</p> <p>2. Resident #4 had diagnoses which included diabetes, chronic pain, osteoarthritis, and peripheral vascular disease.</p> <p>An incident report for Resident #4, dated 08/28/24 at 2:17 p.m., showed facility transport picked up the resident from an appointment. The report showed per the driver, a car stopped in front of the transport van causing the transporter to press on the brakes abruptly. The report showed the resident was sitting in their wheelchair with seatbelts on and flew forward out of the wheelchair. The report showed the director of nursing assessed the resident and they were sent to the emergency department for evaluation.</p> <p>In-service records, dated 08/29/24, showed transport staff received wheelchair restraint training and occupant securement demonstrations.</p> <p>A care plan for Resident #4, dated 01/14/25, showed the resident had a left above knee amputation and should be positioned for comfort with physical support as necessary.</p> <p>On 02/12/25 at 9:35 a.m., transport driver #1 reported the transport van had seatbelts and shoulder harnesses in place when the accident happened with Resident #4. The driver reported Resident #4 was wearing a seatbelt, but not wearing the harness because they had no idea what the harness was used for. The driver reported they had not been in-serviced on harnesses at the time of the incident. The driver reported after the accident with Resident #4, all of the transport drivers received in-service training on the use of seatbelts and harnesses.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 02/12/25 at 9:42 a.m., the facility transport van was observed to have seatbelts and shoulder harnesses in place. Transport Driver #1 demonstrated how the belts and harnesses were utilized to secure wheelchairs and residents during transport.</p> <p>On 02/12/25 at 10:15 a.m., Resident #4 reported they were not sure what happened when they fell from their wheelchair in the facility van. The resident stated they knew they were strapped in with a seatbelt and could not remember anything in particular that caused them to fall. The resident reported they were evaluated at the emergency department, but had no injury. The resident reported they have taken several trips in the facility van since the accident and they felt safe when being transported.</p> <p>On 02/12/25 at 11:54 a.m., corporate staff #1 reported when the accident with Resident #4 happened in August 2024, they had transport staff watch videos related to proper use of the harnesses. They stated a demonstration was done for staff in the facility van and then the transport staff did a return demonstration.</p> <p>On 02/12/25 at 12:04 p.m., transport staff #2 reported they had training a few months ago on seatbelts and harnesses. They stated when the incident happened with Resident #1 in January, corporate staff #1 and another staff member did a demonstration to make sure all of the transporters knew how to properly fasten the belts and harnesses. They stated they all took turns getting in the wheelchair and each of the transporters practiced putting the seatbelts and harnesses on, as well as removing them and rolling the wheelchair out of the van. They stated corporate staff #1 watched them load a resident a few days ago to ensure it was done properly.</p> <p>On 02/12/25 at 12:14 p.m transport staff #3 reported the transporters had seatbelt/harness training with videos and demonstrations in August 2024. They stated the most recent in-service in January was with corporate staff #1 in which they did a demonstration with the seatbelts and harnesses, then had each transporter do a return demonstration. They reported a nurse or aide observed them at least a couple of times a week when loading and securing residents in the van. They reported they had never had an accident with a resident and stated they were aware Resident #1 did not like the shoulder harness and was known to slide it off their shoulder during transport.</p> <p>On 02/12/25 at 1:00 p.m., in-service documentation was provided which included the following training for transport drivers:</p> <ul style="list-style-type: none"> <li>a. 08/28/24 - Van Seatbelt Safety,</li> <li>b. 08/29/24 - Van Safety,</li> <li>c. 08/29/24 - Wheelchair Restraint Training with videos,</li> <li>d. 01/29/25 - Defensive Driving/Van Safety, and</li> <li>e. 02/03/25 - Harness Use in Van/Proper Use of Safety Harness.</li> </ul> <p>(continued on next page)</p>

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