STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465101	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurricane Health and Rehabilitation	416 North State Street Hurricane, UT 84737

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 - 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** 45490 Based on interview and record review, it was determined that for 1 of 7 sampled residents, the facility did not ensure each resident received the supervision and assistance devices necessary to prevent an accident. Specifically, Resident 3 was not properly secured when transported in a facility vehicle and the resident subsequently slid out of their wheelchair and sustained a femur fracture. Resident Identifier: 3. In response to the incident involving Resident 3, the facility identified the quality deficiency and developed a corrective action plan. At the time of the complaint survey, it was determined the facility had implemented corrective measures and met the requirements of F689. Due to the facility's corrective measures, the noncompliance was determined to be past-noncompliance. The facility's corrective action plan, which was developed and implemented by 4/23/24, included the following measures: a. On 4/22/24, the date of the incident involving Resident 3, the facility entered into an agreement with an organization to implement and provide training and new protocols to transport facility residents. The organization utilized by the facility had experience manufacturing wheelchair securement's and occupant restraint systems for transporting individuals with special needs. All staff who performed transportation services for the facility were reeducated on proper securement of residents during transport, which included training videos produced by the contracted organization. Transportation staff attested to the completion of the training by signing training records. Transportation staff were then required to complete a post-training test. b. On 4/22/24, all staff members who performed transportation services were required to read and sign the Fleet Safety Program book. c. On 4/23/24, staff members were interviewed regarding safety during transportation. Administrative staff also interviewed residents to determine if there were additional concerns about safety during transportation. d. The facility's Quality Assurance Performance Improvement (QAPI) Committee approved the updated driver safety training program and implemented the following QAPI activities: (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 - Actual harm Residents Affected - Few	-The transportation supervisor will audit the transport of each driver daily for 2 weeks, followed by audits on 3 random days of the week for 1 week, with an audit 1 day per week for 1 week. The transportation supervisor will perform ongoing random audits. -The transportation supervisor or designee will validate transportation driver's pre and post-securement, documenting the results every week for 4 weeks then bi weekly for 2 weeks, and 3 random audits every month thereafter. -The transportation supervisor will report any trends or concerns to the QAPI committee for review for 90 days. Any discrepancies will be addressed at time of discovery. Findings Include: Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included diabetes mellitus type 2, hypotension, muscle weakness, a need for assistance with personal care, and difficulty in walking. On 4/22/24 at 4:28 PM, the facility electronically submitted a Form 358: Facility Reported Incident Initial Report (Form 358) to the Survey State Agency (SSA). The facility reported that on 4/22/24 at 1:00 PM, Resident 3 sustained injuries while being transported in a facility van by Transportation Driver (TD 1). On the Form 358, the facility documented that TD 1 explained, a car stopped right in front of him and he had to slam on his brakes. The resident [resident 3] slid out of her chair hit both of her knees and is feeling pain in both knee's (sic). The facility documented that Resident 3 was evaluated by a facility RN, emergency medical services (EMS) was called, and the resident was transported to the emergency room of a local acute care hospital. On 4/24/24, the facility electronically submitted a Form 359: Follow-up investigation report (Form 359) to the SSA. In their investigation, the facility reported that TD 1 explained that he neglected to put the lap belt on Resident 3 when transporting the resident back from an appointment. The facility documented that TD 1 further explained that he harnessed all four points of Resident 3's wheelchair, but he missed the lap belt strap. A review of resident 3's medical record was completed on 7/30/24. Facility staff completed a quarterly Minimum Data Set (MDS) assessment of Resident 3. The Assessment Reference Date was 4/3/24. As part of the MDS assessment, a facility staff member conducted a Brief Interview for Mental Status (BIMS), for which Resident 3's score was 11. Per the Centers for Medicaid Services (CMS) MDS 3.0 Resident Assessment Instrument Manual, a BIMS score of 11 represents moderately impaired cognition. Facility staff also assessed Resident 3 as requiring substantial to maximum assistance with mobility and that the resident used a wheelchair. On 4/22/24 at 12:26 PM, a facility nurse documented a Nursing Note in Resident 3's medical record. The nurse documented that Resident 3 had a fall in the transport van while returning from a doctor's appointment. The nurse documented that Resident 3 had an injury to her left knee and that the resident was sent to the emergency room . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/24/24 at 9:06 AM, a facility nurse documented a Nursing Note in Resident 3's medical record. The nurse documented that as Resident 3 was being transported to the facility, the resident was propelled out of the wheelchair, hitting the front seats. The nurse documented Resident 3 sustained a right leg injury and was transported to an acute care hospital. The nurse documented that an x-ray revealed Resident 3 sustained a right femur fracture. Note: Based on hospital radiology reports, Resident 3 sustained a left femur fracture. On 5/1/24 at 5:27 PM, a facility nurse documented a Nursing Note in Resident 3's medical record that the resident had readmitted to the facility. The nurse also documented Resident 3 had a large left arm bruise, two left hip sutures, one left knee suture, and that Resident 3 was to have weight bearing as tolerated. Resident 3's medical record included the resident's hospital discharge documentation that was dated 5/1/24. Per the hospital discharge documentation, upon Resident 3's presentation to the emergency room for the evaluation of the resident's left knee pain, x-ray results revealed the resident an acute left distal femoral shaft fracture. Resident 3 was initially hospitalized in the intensive care unit for close monitoring and treatment. On 7/30/24 at 11:28 PM, an interview was conducted with the Transportation Supervisor (TS). TS stated that on 4/22/24, TD1 called the facility to inform them that a resident had slid from the wheelchair during transport because TD 1 had to break hard. TS stated the incident occurred on the road just next to the facility. TS stated on 4/22/24, when the transportation van entered the parking lot, he was present along with a physical therapist, a nurse and the operations manager. TS stated when the van door was opened, it was apparent the resident had not been secured properly and the lap belt was not on. He stated Resident 3 was in notable pain and paramedics were called. On 7/30/24 at 1:48 PM, an interview was conducted with the facility's Operations Manager (OM). The OM explained that on 4/22/24, the day of incident involving Resident 3, the facility immediately updated and revised their process for ensuring transportation staff were trained and monitored. The OM stated the facility retained all prior training and included an observed daily check off for every transport to ensure the transportation driver did not forget anything before the facility van moved. The OM stated the onboarding process included new training on how to secure residents in the transportation van, as well as a post-training examination. The OM also stated that if an employee, who had been used to transport residents, had not provided transportation services within the previous 30 days, an observed check off would be required to ensure the drivers skills remained acceptable.