STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. BUILDING _____ B. WING _____	**06/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK HELENA, LLC	**116 NOVEMBER DRIVE HELENA, AR 72342**

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 -** Immediate jeopardy **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** Complaint # (AR 708) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure the transport staff consistently utilized the Vehicle Anchorages for the 4-Point Wheelchair Securement System in accordance with the manufacturer's instructions, and that all transport staff members were properly trained on them to prevent a fall with a serious injury for 1 (Resident #1) of 3 (Residents #1, #2 and #3) sampled residents who utilized a wheelchair during transport in the facility van. This failed practice resulted in past noncompliance at the level of actual harm to Resident #1 who was anchored incorrectly in her wheelchair on the van and fell out of wheelchair during transportation resulting in the resident being airlifted to a Hospital Trauma Center for treatment of [REDACTED]. Resident #1 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); was totally dependent for bed mobility, transfers, and activities of daily living (ADLS); was always incontinent of bowels and bladder; required a wheelchair for mobility; and was totally dependent for locomotion off the unit. a. The manufacturer's instructions titled Installation Instruction Vehicle Anchorages and Accessories for 4-Point Wheelchair Systems provided by the Administrator on 6/1/2020 at 1:50 p.m. documented, .Introduction . Q'Straint's 4-Points wheelchair and occupant systems, when used as recommended, provide the safest means of transportation for wheelchair passengers unable to transfer from their wheelchairs when traveling in motor vehicles . Each component has been designed, engineered and tested to work as one comprehensive system . We highly recommend the use of lap and shoulder belts to reduce possibility of head and chest impacts with vehicle components . b. The Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, And Exploitation of Residents in Long Term Care Facilities, Division of Medical Services, (DMS) Form 762 dated 5/9/2020 at 3:15 p.m. documented, .Date and Time . 5/9/2020 at 3:15 p.m. .Date and Time of Discovery . 5/9/2020 at 3:15 p.m. .(Resident #1) was on her way back from [MEDICAL TREATMENT] with driver (Certified Nursing Assistants (CNA) #1) and passenger (CNA #2) are suspended until investigation is completed on the Facility Van. The staff hit their brakes at the stop sign and (Resident #1) fell out of the wheelchair. Staff called the facility and Assistant Director of Nursing (ADON) was told to take (Resident #1) to the emergency room (ER) . (ADON) met staff at the ER with (Resident #1). One CNA got to go back with (Resident #1). We received a phone call about 5:10 p.m. that (Resident #1) was being airlifted to (Name) Trauma Center . c. The Summary of Incident Report on DMS Form 731 dated 5/29/2020 at 2:45 p.m. documented, .(Resident #1) was pushed on the Van per staff . (CNA #1) was inside. She locked the wheelchair and then locked the straps in the front . then the seat belt was placed across abdomen . then (CNA #2) locked the straps in the back. At 3:15 p.m., transportation (CNA #1) and (CNA #2) were coming back from [MEDICAL TREATMENT] with resident. While driving, (CNA #1) made it to the stop sign. When (CNA #1) pushed on the break to stop, resident slid out of the wheelchair. (CNA #1) put van in park, then got in the back of the van to see what was wrong with (Resident #1). (CNA #1) noted that legs were under resident. (CNA #1) and (CNA #2) moved the wheelchair to get access of (Resident #1) . (CNA #1) noted that the (resident's) legs were under the resident. The wheelchair was still in the upright position and the resident was sitting on the foot petal. The CNAs called the facility and there was no answer at 3:23 p.m. and then called at 3:25 p.m. ADON and was told to take resident to the ER (emergency room). Waiting on results from Hospital X-rays. (CNA #1 and CNA #2 have been suspended until the investigation is over . d. The hospital x-ray report dated 5/9/2020 at 16:41 (4:41 p.m.) provided by the Administrator via e-mail on 5/29/2020 at 3:06 p.m. documented, .CT (Computed Tomography) of Bilateral Upper Legs without IV (intravenous) Contrast . Findings . There are comminuted and moderately displaced and impacted fractures of both distal femoral Metadiaphysis with no intra-articular extension. Associated soft tissue swelling and hematoma is noted adjacent to the fracture sites . e. On 6/1/2020 at 1:39 p.m., the Administrator was asked, Have all the employees that drive / ride on the facility van been trained / in-serviced on the Van? She stated, We have in-serviced everyone now. We had an in-service on 5/9/2020 and gave everyone certificates. There were no in-services prior to the incident. There is a notebook in the Van also that the employees are supposed to fill out before transporting a resident, but it has not been completed since November 2019. The DON stated, We have talked to the staff about one of them sitting in the back of the van with the resident while transporting them. That's why we sent two staff members on the van. The Administrator was asked, Do you have any documentation of informing the staff to sit in the back with the resident? She stated, No, we don't have it documented anywhere prior to 5/9/2020. The Administrator was asked, Did the facility re-assess the residents that use wheelchairs for transport in the facility van? The Administrator stated, No we didn't. The Administrator was asked, How are you monitoring to ensure that it doesn't happen again? The Administrator stated, We are monitoring the residents that are being transported via facility van. I go out and check the residents and make sure they are secured correctly before they leave. This was implemented after the incident. We had no monitoring prior to the incident on 5/9/2020. She was asked, Did you do a return demonstration on securing the residents in the van? She stated, Yes, we did in the in-service on 5/9/2020. The Administrator was asked, What do you feel like happened that resulted in this resident falling out of her wheelchair? She stated, I feel like the CNAs did not anchor the back wheels on the wheelchair. Both of them said the back wheels came up off the floor of the van, and if the shoulder strap and the lap belt had been secured correctly, there is no way she would have fallen out of the wheelchair. We haven't been able to talk to the resident to see if she could tell us what happened because she is still in the hospital. f. On 6/1/2020 at 2:17 p.m., CNA #6 was asked, Have you had any concerns with residents' wheelchairs? She stated, No ma'am. I haven't. She was asked, Do you ever drive the van or ride on the van when a resident is transported? She stated, Yes, I do. She was asked, Where do you sit on the van? She stated, I sit in the back with the resident. She was asked, Who secures the resident on the van? She stated, We both do. One does the back and the other one does the front. We strap them in the seat belt, then we put the strap across the shoulder, and one belt around their waist. g. On 6/1/2020 at 2:21 p.m., CNA #3 was asked, Have you had any concerns with residents' wheelchairs? She stated, No ma'am, I haven't. She was asked, Do you ever drive the van or ride on the van when a resident is transported? She stated, No. I haven't ridden on or driven the van. She was asked, Have you had any training on the facility van? She stated, Yes, they trained us all on the sure-loc safety issues on the van. We watched a video. I have never actually anchored a wheelchair down with a resident in it. h. On 6/1/2020 at 3:15 p.m., the Administrator was asked for the facility security logs checklist before transports, and wheelchair repair logs, and how often wheelchairs are checked for safety? She stated, The safety log hasn't been filled out since 2019. I don't have a policy and procedure for the van, only checks for oil changes and tires if needed. The transport staff should be filling out a checklist daily whenever they transport a resident. There are no logs for wheelchair checks, only maintenance randomly checks them. We haven't monitored wheelchair transports. i. On 6/1/2020 at 5:56 p.m., the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Administrator was asked, Should the staff always check for safety prior to transporting resident? She stated, Yes ma'am, they should have. She was asked, Should a safety check be performed on wheelchairs in a timely manner? She stated, Yes, they should be. She was asked, Should all staff drivers and riders be in-serviced and trained on safety measures for the facility van? She stated, Yes, they should. j. A facility form titled Wheelchair Tiedown Strap, Belt and Anchorage Maintenance provided by the Administrator on 6/4/2020 at 4:46 PM via email documented, .Inspect strap and belt assemblies frequently . Any defects such as strap / belt cuts, fraying, or malfunctioning, call for replacement of the entire strap / belt assembly . Floor anchorage pockets must be cleaned and not worn, bent, or otherwise damaged . (prohibiting proper strap / belt attachment). If there is any sign of damage, wear, abnormal condition, or improper operation of straps, belts, strap / belt, hardware (hooks, keepers, latch plate, receptacle), or floor pockets, discontinue use and replace components immediately . 2. The facility initiated corrective action immediately after the van incident on 5/9/2020 by implementing the following: a. .All staff was in-serviced on 5/9/2020 and 5/10/2020 with the Sure-Loc System for strapping down wheelchair securely with return demonstrations. b. All 56 residents that ride in the van will be observed prior to leaving facility to ensure they are securely placed in van and staff will check equipment before placing resident in the van to make sure it is working properly and will do monitoring log. Designee will check the check-off list weekly to ensure staff is checking-off daily. c. Staff will be re-in-serviced on the Van Procedure and Maintenance starting 6/1/2020 and Transportation Staff will be in-serviced by 6/2/2020 on doing check-off daily on van equipment to ensure safety of residents and will document when they have. Any negative findings will be reported to the Administrator / Designee. d. All negative findings will be corrected immediately and reported to the Administrator and Designee will report to QA (Quality Assurance) three times a week .