STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045350	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COURTYARD GARDENS HEALTH AND REHABILITATION CENTER	2701 TWIN RIVERS DRIVE ARKADELPHIA, AR 71923

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** Based on observation, record review, and interview, the facility failed to ensure residents were secured in the van prior to moving the van and failed to ensure law enforcement and the facility were notified prior to leaving the area of the accident to ensure that the resident was properly assessed for injury for 1 (Resident #5) of 2 (Resident #1 and #5) sampled residents who were transported in the van from 7/20/2020 - 7/27/2020. This failed practice resulted in past non-compliance at the level of immediate jeopardy which caused or could have caused serious harm, injury or death to Resident #5, when the resident's wheelchair turned over when the van driver moved the van prior to securing the resident and then moving the resident back into the wheelchair and taking the resident back to the facility without notifying the facility immediately when the accident occurred. This failed practice had the potential to affect 7 residents who were transported in the facility van from 7/20/2020 to 7/27/2020 according to the list provided by the Administrator on 8/3/2020. The Administrator was notified of the past immediate jeopardy on 7/31/2020 at 2:15 p.m. The findings are: 1. Resident #5 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) documented the resident was severely impaired in cognitive skills for daily decision maker per a Staff Assessment for Mental Status (SAMS); and required extensive assistance of 1 person for transfers, limited assistance with locomotion, wheelchair was normally used for mobility; and received [MEDICAL TREATMENT] services in the last 14 days. a. An In-service sheet dated 7/17/20 documented (Name of Company) In-Service Training Sign-In Sheet Presented by (name of company) Instructor: (name). Course: Correct lift Operation/Properly Securing Residents. Items covered: correct operation of the lift, correct procedure for loading/unloading resident on lift, manual operation of the lift, vehicle height and ensuring proper clearance for any type awning, covered driveway, parking garage, etc , properly securing oxygen tank in floor mounted oxygen tank holder. Van Driver #1 signed the in-service sheet. b. An Incident and Accident report dated 7/31/20 documented, Incident Location: Out of Facility/During Transport. Incident Description: Resident was being picked up from [MEDICAL TREATMENT]. While in the van going up the hill from [MEDICAL TREATMENT], resident flipped backwards causing resident to fall out of chair. Resident Description: I was in my wheelchair and the wheelchair flipped backwards and I fell out. Immediate Action Taken Description: Resident was re-secured in his wheelchair and van. He was brought back to the facility for evaluation by a nurse. Injury type: Abrasion Location back of head. Injury Type skin tear right forearm, left hand. Level of Pain: 2 Level of Consciousness: Alert Mobility: Wheelchair bound. Notes 7/27/20 Received new order from MD (Medical Doctor) to send to ER (emergency room) for CT (Computerized Topography) of head/neck. In-serviced van driver one-on-one on securing resident properly and double checking that protocol was followed. 7/28/20 CT of head and neck were negative. This nurse checked resident this morning and no new findings noted at this time. Will continue to monitor. c. A DMS (Division of Medical Services) -762 documented Resident was being picked up from [MEDICAL TREATMENT] on 7/27/20 at approximately 3:30 PM. Van driver stated as she was going up the steep hill at [MEDICAL TREATMENT] the resident fell over backwards in his wheelchair. Van driver pulled over to check on resident. she noted a superficial skin tear to his arm. Van driver asked resident if he was ok and resident stated he was fine. Van driver assisted resident upright. secured his wheelchair and proceeded to the facility. Van driver took resident to his room then came and reported it to the DON and Administrator. Van driver stated it was her fault for not securing resident properly. Stated there was a long line of vehicles waiting to pick up other [MEDICAL TREATMENT] patients and she felt pressured to get out of their way. The van driver (#1) is back-up transportation and not our main van driver. she is our full time Activities Director. (Van Driver #1) was suspended pending investigation. reprimanded. brought back to facility as Activities Director only and is NOT to drive the van at any time. All other van drivers (full-time and back-up) were re-inserviced on the van. watched the Q-Straint video and made aware that any incident involving a commercial. passenger van must immediately call the police department and report. d. A physician's orders [REDACTED]. e. A physician's orders [REDACTED]. f. A physician's orders [REDACTED]. g. A physician's orders [REDACTED]. h. On 7/31/2020 at 10:25 a.m., the resident was being strapped in the facility van. There was a bandage on his left wrist dated 7/31/20, and 3 bandages on the right forearm with a date of 7/31/20. i. On 7/31/20 at 10:40 a.m., the Administrator was asked to state what exactly happened. She stated, the backup van driver who is actually the Activities Director was picking the resident up from [MEDICAL TREATMENT]. I guess there was a long line of vans, so she was in a hurry and did not secure the resident properly. There is a hill at [MEDICAL TREATMENT], so she said when she was going up the hill the resident fell back. She came here took him to his room and immediately told us what happened. She has been with us for years and this is her first incident, so we suspended her from driving the van at any time. She is only the activities director now. We had all the van drivers re-in serviced and had them watch a couple videos. The resident is okay. He has a couple of skin tears to his arms and a hematoma to the back of his head, we did a CT and neuro checks to be sure. Every time we ask the resident if he is okay or has any complaints, he says he is fine. We even went around and asked other residents if they had any issues with the van drivers and they all said No. j. On 7/31/20 at 10:59 a.m., Van Driver #1 was interviewed and asked what happened. She stated, Monday when I went to pick my residents up from [MEDICAL TREATMENT]. There is always a line of truck and cars and other vans. I went to pick up (Resident #5) and (another resident). I got (Resident #5) on first then (resident name). I started hooking (Resident #5) up and didn't finish buckling him up properly because (other resident) was fussing so I went and got (other resident) on and got her hooked up properly. Then I got out, let the lift down, let it back up and closed the doors. I proceeded to get out the way of the rest of the people. I proceeded to go up the hill from the [MEDICAL TREATMENT] covered portico, once I started to go up the hill (Resident #5's) chair tilted back and turned over. So, I pulled around to the front parking lot, parked the van, got out, let the lift down, got on and asked (Resident #5) if he was okay. He said yeah but he had these little skin tears on his left hand and right forearm and elbow from falling back. I proceeded to assist him in getting up after I got the wheelchair back straightened up. I then asked him again if he was okay and he stated yeah. Once I got him back in the wheelchair, I got him good and secured that time. I used some wipes to wipe the blood that was bleeding on his arms. I asked him again are you sure you're alright and he said yes. I came back to the facility assisted him and (other resident) off the van, came in and got their temps (temperatures). Another CNA (Certified Nursing Assistant) assisted (other resident) back to her room and I assisted (Resident #5) to the nurse on the east side. Once I got done talking to the nurse, I went immediately to (Administrator) office and (Director of Nurses) was in there and I told them exactly what had happened. Me and the DON went back down to see (Resident #5) and he was still at the nurse's station with the nurse receiving treatment. She was asked, Why did you not call the facility when it happened? She stated, I don't know, it scared me to death. I was just trying to get the resident back up into a comfortable position. I've been here since 2003 and this is the first time an accident like this has ever happened. She was asked, Why didn't you secure him? She stated, I got in such a hurry I guess, with all the traffic behind us. I guess I was nervous and got in a

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) hurry and was just trying to get out of the people's way. She was asked, Have you been trained on how to properly secure residents? She stated, Yes. She was asked, Did you have any follow up training through the years? She stated, We had a training a week or 2 weeks before this happened. She was asked, During the training what did you do? She stated, The instructor that came he just redid the training that he already did. None of the wheelchairs are the same so you have to hook them up a certain way. She was asked, Did you have to do return demonstration during that training? She stated, No. He just showed us how to do it. 2. The facility removed the immediate jeopardy and corrected the failed practices on July 27 and 28, 2020 as evidenced by the following: a. On July 27, 2020 at 4:00 p.m., Van Driver #1 reported incident to Administrator and Director of Nursing (DON). The DON assessed resident. The Administrator inspected the van. The DON and Administrator were interviewed along with the van driver and the surveyor took a statement. The Administrator reprimanded and suspended the employee pending investigation. The DON called the Medical Director and received orders for CT of head (negative). A body audit, neuro checks, and I&A {Incident and Accident) was initiated. At 4:22 p.m. the Administrator notified the police department. At 4:25 the DON, Marketing Director, and Nurse Consultant interviewed the resident. At 4:30 p.m., the DON, Administrator, and Marketing Director spoke with the resident's sister. Cognitive residents with recent transfers were interviewed with statements being collected. In-services began to all authorized facility van drivers to include watching of Q straint DVD prior to driving the van stressing the importance of securing properly, checking and double checking prior to transportation. Also, reminded any/all commercial, passenger incidents must be reported to the police department immediately and not to move the resident or van. Notify Administrator/DON/Designee immediately. b. On July 28, 2020 at 5:40 a.m., the DON at facility to ensure in-servicing was done prior to driving the van. The Administrator reported to The Office of Long Term Care (OLTC) and the remaining interviews/statements from cognitive residents collected. c. A statement provided by the Administrator dated July 31, 2020 documented, . As the Administrator of (facility), I routinely inspect the facility van and also observe the van driver(s) loading, securing and unloading the residents on and off the van. My office is in close conjunction of the portico where the van drives up to load and unload residents. I frequently go out to open doors, greet residents or assist in any way, while I am assisting I observe for safety and compliance. Any issues are addressed and corrected immediately. signed by the Administrator. 3. A form titled Transportation Services documented, OLTC Reg. 323. If resident/elder do not meet the medical necessity for ambulance transportation and the resident/elder's family does not wish to transport them, the facility will provide reasonable transportation for the resident/elder to the hospital, medical clinics or dentists' offices. If resident/elder is wheelchair bound, the facility will lift them into the van with a wheelchair lift according to manufacturers' guidelines and will secure them in the van for safety with straps according to manufacturers' guidelines. All resident/elders must wear a seatbelt when in the facility van .