STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045377	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Southern Hills	701 South Main Street Rison, AR 71665

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. Number of residents sampled: Number of residents cited: Based on record review and interviews, the facility failed to ensure a resident’s wheelchair was properly secured to ensure the resident was safely transported in the facility van for one (Resident #4) of one resident reviewed. The findings include: A review of a Police Incident Report Form indicated that near an address between [town name] and the facility, Certified Nursing Assistant (CNA) #1 was driving the van with two passengers inside: the Activities Director (AD) and Resident #4. While traveling, the wheelchair Resident #4 was seated in suddenly rolled backwards. This caused Resident #4 to bump the back of their head. The resident was transported to the emergency room for evaluation and treatment. A review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/04/2025, revealed Resident #4 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also indicated the resident had diagnoses which included fracture of unspecified part of thigh bone, worn cartilage of the joints, anxiety, diabetes mellitus, and muscle wasting and shrinkage. Resident #4 used a wheelchair or walker for mobility. A review of an Incident and Accidents (I & A) Report with a date of 05/09/2025, revealed Resident #4 was involved in an “unusual occurrence” while on the facility van for a shopping outing with CNA #1 and the AD. A summary of the incident dated 05/09/2025 at approximately 12:15 PM, indicated the Assistant Director of Nursing (ADON) was notified by CNA #1 that on return travel to facility from an outing, Resident #4’s wheelchair tilted back, and the resident’s head hit the lift rack. CNA #1 pulled the facility van to the side of the street and stopped. CNA #1 and the AD assisted the resident back into an upright position. The Director of Nursing (DON) came to the scene of the incident and reported Resident #4 was in the van upon her arrival. Resident #4 was transported to the emergency room for evaluation. A review of a Progress Note dated 05/09/2025 at 9:30 PM revealed Resident #4 hit their head while in the facility van. The resident was sent to the area hospital for evaluation and returned to the facility at 9:30 PM. A body audit completed at the time of return revealed bruising with mild swelling to the left upper arm that was tender to touch, a knot on the back of the head, as well as redness and blanching to sacrum with complaint of mild pain from sitting for extended time at the hospital. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Neuro checks were started at this time. A review of a Body Audit dated 05/09/2025, indicated at 9:30 PM Resident #4 had a knot and swelling to back of their head and bruising to left elbow, left upper arm, and left forearm. A review of an emergency room (ER) General Physician Note dated 05/09/2025, indicated Resident #4 stated they were on the facility transportation bus and their wheelchair tipped backwards. The note revealed an “Obvious bump on lower back part of skull, possible blood collection under the skin to left back bicep, and [Resident #4] reported a headache.” Computed Tomography performed on 05/09/2025 revealed mild back of the head swelling. The ER final diagnoses included head injury, closed, accidental fall, and back of the head swelling due to blood accumulation. Resident #4 was discharged back to facility 05/08/2025 at 5:28 PM. A review of an in-service training sign-in sheet dated 05/07/2025, indicated CNA #1 attended an in-service which covered “correct operation of the lift, correct procedure for loading and unloading a resident utilizing the van lift, correctly securing residents with proper tie down procedures, and manual operation of the lift. The course was named “Correct Lift Operation and Properly Securing Residents” and took place at the facility. A review of an inspection company invoice dated 05/15/2025 indicated the following: - Concern: safety inspection of lift, tiedown straps and belts due to an incident with a resident - Cause: At time of inspection the tiedowns were not in the proposition for transporting a wheelchair. No mechanical issues or damage was found with/on the tiedowns or the lap and shoulder belt assembly when vehicle was inspected. - Correction: Need an in-service training to show proper placement of retractors. Need to replace back tires and front windshield due to safety issues. Review of In-service Education Report titled “When Transporting an Elder Make Sure All the Following Are Observed” dated 05/09/2025 indicated “correct operation of the lift, correct procedure for loading/unloading elder on lift, correct securing of resident with the proper tie down procedures.” CNA #1 and the Maintenance Supervisor signed the in-service report. A review of an In-service Education Report titled “Transportation Van” dated 05/22/2025 indicated a new wheelchair with anti-tippers will be utilized on the van. Residents will not be transported in their personal wheelchair. During an interview on 08/05/2025 at 11:05 AM, Resident #4 indicated CNA #1 strapped the resident’s wheelchair in place and placed the seatbelt over the resident in the facility van before they left the facility. The resident indicated that CNA #1 and the AD were the two employees on the van. Resident #4 indicated on the way back to the facility, suddenly the resident’s head went back, and resident’s head was hit on the lift at the back of the facility van. The resident stated “The whole wheelchair and I went back. I was pinned with my chin to my chest.” The resident reported the employees stopped the van on the side of the road and helped them up. The resident referred to the incident as “a freak accident” and stated they had a “large goose egg big enough to see without feeling on the back of my head and my left shoulder and left arm had large bruising.” (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/2025 at 12:12 PM, the AD indicated on 05/09/2025 Resident #4 went on a shopping outing in the facility van. She reported after shopping at a store, CNA #1 applied the straps onto Resident #4’s wheelchair, securing the resident for the travel back to the facility. She indicated they were about half-way back to the facility when the resident made a verbal sound that caught her attention. The AD reported she looked back, and the resident’s head was against the gate of the lift in the back of the van. The AD reported CNA #1 quickly pulled off the road and they assisted the resident up off the lift. She stated “I don’t even know how it happened. After the accident the wheelchair locks were locked, and all the straps were in place correctly. Shoulder strap and lap belt, each wheel (four) had its own strap and all were in place.” During a phone interview on 08/06/2025 at 11:27 AM, the van inspection company employee verified the repair order safety inspection for the facility van dated 05/15/2025. The van inspection company employee indicated on the invoice Cause: “at time of inspection the tie downs were not in the proposition for transporting a wheelchair” included a typo and the word “proposition” should have read “proper position.” The van inspection company employee indicated straps, or tie downs were also called retractors, and the retractors on the facility van were in the wrong spot, the wrong position. The employee stated “the ratchet straps were parallel to the ones behind it. The two ratchet straps in the back should be closer together so they hold the back of the chair.” The employee reported the way the retractors were positioned in the van could allow a resident to fall side to side or to tip backwards. During a phone interview on 08/07/2025 at 8:16 AM, the van inspection company manager verified the repair order safety inspection for the facility van dated 05/15/2025. The manager indicated on the invoice the Cause: “at time of inspection the tiedowns were not in the proposition for transporting a wheelchair” the word proposition was misspelled and should be proper position and not “proposition”. The manager indicated the tie downs or retractors were not placed in the proper area. The manager reported that when the facility requested the safety inspection following an incident, the facility was instructed to not move anything in the van before the inspection was completed. The manager also reported the facility maintenance man brought the van in and took part in some education on the proper placement of the tie downs. The van inspection company manager stated, “The maintenance man said to me I don’t think we have ever been shown this way”. The manager reported the tiedowns could not have been tight on the wheelchair the way they were positioned. During an interview on 08/07/2025 at 11:21 AM, the Maintenance Director (MD) reported he drove the van back to the facility without passengers after the incident. He reported he took the facility van to be inspected on 05/15/2025. He reported the inspection made recommendations for new tires and a new windshield and the facility did get new tires and a new windshield. The MD stated “The guy checked the straps and said that it was good, he wanted to make sure the tie downs were correctly placed. There were no issues with how they were placed.” The MD verbalized he did not read the printed safety inspection report. He reported the inspector in-serviced him on how to spread out the straps to keep the wheelchair from “wobbling”. He indicated he relayed the in-service to the admin. During an interview on 08/07/2025 at 11:45 AM, the Administrator reported she received a call from the ADON reporting Resident #4 hit their head on the lift of the facility van on the way back from a shopping outing and the van was pulled over on the side of the road. The Administrator indicated she went to the scene and called the ambulance and local sheriff’s office on the way there. The Administrator reported when she got to the van she checked on the resident first. The Administrator (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident #4 was still in the wheelchair and the restraints were in place. The Administrator reported that the resident stated they “adjusted” themselves in the chair. The Administrator reported Resident #4 was transported to the emergency room via ambulance. She reported that the Maintenance Director was called to come pick up the van. The Administrator reported an appointment was made to have the van inspected and the staff were instructed to leave everything as it was and avoid moving anything. The Administrator reported neither she nor any other staff moved anything in the van. She stated the safety inspection indicated “there was no problem with the tract system, there was nothing wrong.” The Administrator stated “I called to get an update from them (inspectors of the van). They said nothing was wrong.” She reported the inspector did say the van needed new tires and a new windshield. The Administrator stated, “it was a ‘freak accident’” and Resident #4 only had a very small knot on the back of [the resident’s] head that was gone the next day. “I really think [Resident #4] leaned back repositioning self and hit head.” During an interview on 08/07/2025 at 4:15 PM the Administrator reported there was not a facility policy for accidents.