

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Gosnell Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Moody Street Gosnell, AR 72315	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interviews, record review, observations, and document review, the facility failed to prevent an accident that caused serious injury during a van with lift transfer due to not following the manufacturer's guidelines for the lift and training for 1 (Resident #199) of 1 resident reviewed for accidents. This deficient practice resulted in Resident #199 sustaining a left ankle fracture on 09/10/2024, and a suspected fracture to the sacrum.</p> <p>The findings are:</p> <p>On 09/17/24 at 11:09 AM, during an interview with [NAME] President of Operations regarding incident he confirmed Certified Nurse Aide #1 (CNA #1) assisted with unloading Resident #199. CNA #1 failed to confirm the lift gate was up and ready for the transfer which caused the fall. CNA #1 was suspended until the end of the facility investigation, then terminated.</p> <p>On 09/17/24 at 11:11 AM, Director of Nursing (DON) interviewed regarding the incident on 09/10/2024 involving Resident #199. When asked what her immediate action was following the incident, she confirmed she assessed Resident #199 then sent the resident to the nearest emergency department for an evaluation and treatment. She confirmed provider and family were notified.</p> <p>On 09/17/24 at 11:31 AM, Resident #199 was interviewed regarding incident. Resident stated, I was just sitting there in the van waiting to be taken back in and all of a sudden I was falling backwards. It happened very quick. My body was all catawampus, and was like a V, my legs came up to my body. Resident confirmed pain level was controlled with current treatment.</p> <p>On 09/17/24 at 02:04 PM, Maintenance Director was interviewed regarding mechanical actions/demonstration of lift on the 2018 van. Staff demonstrated the process of loading and unloading residents in wheelchairs. He demonstrated the warning threshold plate working properly (safety mechanism to warn the gate is not up).</p> <p>During an interview on 09/17/24 at 2:30 PM, CNA #7 stated she returned from assisting the first resident into the building and came back to assist CNA #1 with the last resident (Resident #199). The lift gate was down from the first transfer, and stated as she approached the van, she saw Resident #199 fall from the van in the wheelchair, and then CNA #1 fell out of the van soon after. CNA #7 confirmed she completed re-training on about 09/12/2024.</p> <p>On 09/17/24 at 2:40 PM, the Maintenance Director was interviewed regarding the van transport wheelchair training 01/16/2024. He confirmed CNA #1 was present for the class. Maintenance Director confirmed he attended the re-training for van transfers on 09/12/2024.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/17/24 at 02:44 PM, the Administrator was interviewed regarding the incident involving Resident #199. The Administrator confirmed CNA #1 did not follow the manufacturer's guidelines or the training, which CNA #1 last completed on January 16, 2024.</p> <p>On 09/17/24 at 03:27 PM, CNA #1 was interviewed regarding the incident on 9/10/2024. She stated, I assisted [CNA #7] in undoing the floor strap for the other resident. CNA #7 took the other resident inside the building, and I was in the process of undoing the floor strap for Resident #199 and preparing to transfer the resident. I said okay, and then I heard CNA #7 say okay, so I thought that meant she was ready and the lift was up, so I proceeded to push the resident to the edge, then both of us fell and that's when I knew the gate was not up. When asked if she looked to see if the gate was lifted, she stated, I am too short to see over the resident in the wheelchair. When asked about safety mechanism to alert gate is not up, CNA #1 stated, Are you talking about the beeping? It always beeps regardless of if it's up or down. CNA #1 stated, My last transfer training was at least two years ago. When asked if CNA #1 had worked as a transporter before her other roles, she stated, Yes, I used to be a transporter, then I switched to HR [Human Resources] about 6 years ago, but I was filling in doing transports.</p> <p>On 09/17/24 at 12:17 PM, the surveyor reviewed video footage of the incident that happened on 09/10/2024 at approximately 12:30 PM. The video shows the return of the transport van with two residents, CNA #1 and CNA #7. One resident was unloaded from the transport van without incident by CNA #7 and taken inside the facility. The gate remained lowered. CNA #1 was seen holding the wheelchair, facing the resident, both are located at the rear exit. As CNA #7 walked out of the front door, she walked toward the back of the van and noticed CNA #1 was struggling to hold the wheelchair/resident inside the back of the van. CNA #7 approached the van to assist but was unable to prevent the resident from falling out of the van. Resident #199 fell approximately 24 (measured from floor of van to base of the lift lowered). Resident #199's legs spread outward in opposite directions. The resident remained seated inside the wheelchair. CNA #1 also fell out of the back of the van, and partially landed on the left portion of the wheelchair, struck Resident #199's left leg/foot, pressing the resident's foot against the left foot pedal of the wheelchair. This action potentially caused the fracture to the left ankle. Resident #199 also sustained a suspected fracture to the sacrum (low back area).</p> <p>Reviewed the undated, Operator's Manual for the facility's wheelchair lift. Under the section labeled operation notes, vehicle loading and unloading, it read, The platform must be fully raised (at floor level) and the inner roll stop (bridge plate) must be properly positioned when loading or unloading passengers in or out of vehicle. It is the responsibility of the lift attendant to ensure the platform, and the inner roll stop are properly positioned at floor level when loading and unloading passengers.</p> <p>Review of training provided to CNA #1 on van transfers including the most recent dated 01/16/2024. The training acknowledgement was signed, and the signature matches other signatures in CNA #1 employment file. Other attendees of the van transfer training on 01/16/2024 confirmed CNA #1 was present for that training.</p> <p>A requirement for training included each of the transport staff to demonstrate proper loading and unloading techniques with a focus on understanding all safety measures. Transport staff were required to demonstrate proper operation of the transport van equipment to the instructor.</p> <p>Reviewed facility undated policy titled Accidents and Incidents - Investigating and Reporting Policy and the Facility Van/Vehicle Usage, undated policy which was consistent with the facility's</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Completed: 09/11/2024 and ongoing.</p> <p>The facility implemented a plan for retraining all transport staff which was completed on several different dates, but the final transport staff member completed the training on 09/13/2024. The staff watched the manufacturer training video linked below:</p> <p>https://youtube.com/watch?v=vDLdUXcotEc&si=LgpoAUyOrtwuHRJV</p> <p>The transport staff completed training along with demonstration of the skills of loading and unloading a resident in a wheelchair. Training also included safety measures for safe transportation of residents. This training will be ongoing.</p>		