DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANCHESTER REHAB AND HEALTHCARE CENTER	312 SOLLEY DRIVE BALLWIN, MO 63021

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible by failing to properly secure the resident's wheelchair to all of the locking mechanisms used to hold the resident's wheelchair in place during transport to another facility (Resident #1). This failure resulted in the wheelchair to fall/flip over backwards during a turn with the resident still in his/her wheelchair. The resident sustained a small gash in the back of his/her head which required first aid to stop the bleeding. The census was 53. The Administrator was notified on 11/7/24, of the past non-compliance. On 10/25/24, the facility initiated an investigation, interviewed staff, completed an evaluation of the van with no concerns, and provided video education to the driver related to review of all straps and proper securement of residents for transportation. The deficiency was corrected on 10/25/24. Review of the facility's Vehicle and Driver Safety Program, showed: -The purpose of this policy is to ensue the safety of those individuals who drive company vehicles,	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom O Levi | TITLE: Administrator | (X6) DATE: 11/19/24

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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their passengers, and the public. Vehicle accidents are costly to our company, but more importantly, they may result in injury to you or others. It is the driver's responsibility to operate all vehicles in a safe manner and to drive defensively to prevent injuries and property damages;
-Definitions:
-Company Vehicle: Includes any car, van, SUV (Sport Utility Vehicle), truck, or other motorized transport owned by the company;
-Driver: Shall include employees designated to perform duties that require operating a company vehicle;
-Rules:
-All drivers and passengers operating or riding in company vehicles must wear seat belts;
-All drivers must ensure that a proper vehicle restraint system in used for all passengers in wheelchairs;
-Report any mechanical difficulties or repair needs immediately to the Administrator;
-Driving Safely
-Starting:
-Conduct pre-trip inspection;
-Wear seatbelts at all times;
-Authorized Employees:
-Agree to abide by all Vehicle and Driver Safety Policies;
-Conduct a pre-trip inspection before any first daily use;
-Ensure all vehicle occupants wear seatbelts before moving the vehicle;
-Ensure all wheelchairs are tied down securely and resident is secure in the chair before moving the vehicle;
-Participate in driver training programs;
-Training: All employees authorized to operate company-owned or leased vehicles will

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participate in initial and ongoing driver-safety training.

Review of the facility's investigation, dated 10/25/24, showed:
-On 10/25/24 at approximately 11:15 A.M. the Administrator was notified by the Activity Director of an incident involving a resident during transportation. Resident was fidgeting with the straps that secure the wheelchair and resident fell backward, hitting his/her head on the floor of the van. The driver immediately pulled into a parking lot, Activity Director completed first aid as resident sustained a small laceration to the back of his/her head. Driver (Maintenance Worker A) completed trip to receiving facility. Driver and Activity Director returned to the facility and evaluation of van was completed;
-Initial interventions:
-Staff interviews completed:
-Activity Director's investigation statement, dated 10/25/24, showed:
-Doing a ride along transport leaving the facility and taking a resident to another facility. While transporting, the resident fell backwards and hit his/his head on the van floor. We (Maintenance Worker A and Activity Director) pulled the van over in a safe place. Activity Director and Maintenance Worker A assessed the resident and upon assessment of the resident, he/she had a small gash on the back of his/her head. Activity Director looked over the resident's head. She assessed the resident, stopped the bleeding, and called the ambulance. They also called the resident's family. When the ambulance came to the scene, the bleeding was stopped. The ambulance only took the resident because he/she was on blood thinner (medications that prevent blood clots);

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-Maintenance Worker A's investigation statement, dated 10/25/24, showed:
-Today left the facility to take a resident to another facility. Before leaving, we (Maintenance Worker A and Activity Director) used all straps on all four wheels along with seatbelt to strap the resident in. Maintenance Worker A and Activity Director secured the resident and proceeded to drive to the new facility. Five minutes away from our destination, the wheelchair flipped and the resident was in the back of the van, due to he/she had flipped out of the wheelchair. We immediately pulled over, got out of the van and helped the resident back into his/her chair. We noticed blood, so we pulled the chair in the up-right position, (the chair) still caught in the strap. Once he/she was back in (the chair), the ambulance was called. The Activity Director, who was with me administered care. The resident seemed to be fine. The paramedics did take the resident to the hospital. Family was called. Report was given to the other facility about what took place and returned to the facility;
-Evaluation of van completed with no concerns;
-Education with Driver (Maintenance Worker A);
-Review of education document, dated 10/25/24, showed:
-Video (FaceTime) education conducted with the Regional Director of Plant Operations with Maintenance Worker A on review of all straps and proper securement of residents for transportation;
-No signature of Maintenance Worker A and/or Regional Director of Plant Operations on the training document;
-No education/re-education of Activity Director noted;
-Findings: There were not any malfunctioned items discovered during the evaluation of the van. All straps were functional;

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-Conclusion: On 10/25/24, resident was being transported to another facility. This individual sustained a fall in the van with a minor scrape to the head. Staff immediately pulled into a parking lot and provided first aid; all proper entities notified. The van was returned to the facility where an inspection was completed with no faulty equipment identified. At this time, we were unable to determine the cause of the fall.

Review of Maintenance Worker A's Transportation Safety Competency, dated 9/27/24, showed:
-Instructor/Trainer: Administrator;
-Reason for Competency: Orientation;
-Task:
-Uses of seat belts at all times: Goal Met was checked;
-Safely Securing a resident in van/bus: Goal Met was checked:
-Ensure resident is seated properly in the wheelchair before loading in van/bus: Goal Met was not checked;
-When securing resident/wheelchair, uses proper technique: Goal Met was not checked;
-Floor straps secured properly: Goal Met was not checked;
-Ensures wheelchair is secure, including wheelchair locks being engaged: Goal Met was not checked;
-Seatbelt is safely secured: Goal Met was not checked.

Review of Resident #1's medical record, showed:
-Admission date: 10/17/24;
-Diagnoses included nondisplaced simple supracondylar fracture (a break in the upper arm bone (humerus) just above the elbow where the bones are still aligned) without intercondylar

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fracture (a break in the condyles, which are the thickened areas at the ends of bones where they meet other bones) of right humerus, subsequent encounter for fracture with routine healing, muscle weakness, generalized.

Review of the resident's Baseline Care Plan, dated 10/17/24, effective date 10/18/24, showed:
Falls:
-Problem(s): At risk for falling
-Goals: Maintain safety from falls. Will not experience any injuries related to falling;
-Interventions: Observe for unsafe actions and intervene.

Review of the resident's progress notes, dated 10/25/24 at 10:44 A.M., showed:
-Nursing note: Resident discharged to a different skilled facility and the current facility provided transportation;
-No documentation related to the resident falling in the van.

Review of the resident's emergency room discharge note, date 10/25/24 at 2:05 P.M., showed:
-Clinical Impressions:
-Fall from wheelchair, initial encounter;
-Abrasion to scalp, initial encounter;
-Anticoagulated (treated with anticoagulants, medications that prevent blood clot).

During an interview on 11/7/24 at 1:14 P.M., Maintenance Worker A said he assisted with transportation sometimes. He couldn't say if the facility really had a transporter, but the Activity Director did most of the transporting. He said the Activity Director was CPR (Cardiopulmonary Resuscitation - is an emergency lifesaving

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procedure performed when the heart stops beating) certified, but he was not. Maintenance Worker A said the last time he transported a resident, there was an accident whereby the resident fell out of his/her wheelchair in the van. He and the Activity Director strapped the resident in the way he was shown. About five minutes away from the destination, the long seatbelt came undone or broke, he wasn't sure. The resident fell backwards in his/her wheelchair. They pulled the van over and stopped. There was blood on the resident's head. They tried to turn the wheelchair upright with the resident in it, but realized part of the chair was still strapped in. They pulled the resident out of the wheelchair and carried him/her out of the van by placing hands underneath the resident's arms and legs. Afterwards, they unstrapped the wheelchair, pulled it out of the van, and put the resident back in his/her wheelchair. There was a small gash in the back of the resident's head. The Activity Director gave the resident first aid to stop his/her head from bleeding. The ambulance and police were called. The ambulance took the resident to the hospital as a precaution because he/she was on blood thinners. Maintenance Worker A said it was really sad. He drove that day against his better judgement, and he strapped the resident in like they showed him.

During an interview on 11/7/24 at 2:04 P.M., the Activity Director said she transported a resident to another facility, but couldn't remember his/her name. The date was 10/25/24. She said that was the only resident transported that day. She was CPR certified but didn't have any in-service training on how to strap residents in wheelchairs in facility vehicles. The resident was strapped in the van prior to driving off from the facility. She

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said while they were driving, Maintenance Worker A moved from one lane to the next and when he did that, the resident went backwards in the wheelchair. After the resident fell backwards, she told Maintenance Worker A to go to a safe place, which was a parking lot, to pick the resident up. They pulled over, both unbuckled their seatbelts, exited the van, and preceded to enter the van through the double doors. The resident was still laying back in the wheelchair on the van floor. She said the resident wasn't secured anymore. The seatbelt came undone from the securing latch on the floor. She told Maintenance Worker A they would try to sit the resident upright in the wheelchair inside the van but that didn't work. They grabbed the resident's legs and upper part of his/her body and scooted him/her towards the door and then out of the van. Once they got out of the van, they saw the resident had hit the back of his/her head. There was a small gash. There was blood on the van ramp. The resident was talking and said he/she had fell. The Activity Director got the first aid kit. She called the Administrator and told her what happened. The ambulance, police, and the resident's family were called/notified.

During an interview on 11/7/24 at 2:32 P.M., the Administrator said the Activity Director was there as a ride along for assistance and only Maintenance Worker A had transportation safety competence training. The resident was going to another facility. The Activity Director called the Administrator and said the resident had fallen backward in his/her wheelchair in the van and cut his/her head. The Administrator said the Activity Director didn't give her a reason for why the wheelchair fell back. The resident's seatbelt came undone, maybe the resident pushed the button. She didn't know because the van was

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new (2023). She expected the resident to be transported safely and be free from accidents. She said the Regional Maintenance Director checked the vehicle after the accident. Maintenance Worker A and Activity Director were not the regular transporters. The Activity Director did ride alongs once in a while.

During an interview on 11/7/24 at 3:08 P.M., Maintenance Worker A said he locked the seatbelt across the resident's chest, locked the wheelchair, and attached the wheelchair to the hooks that come from the floor in the van for the front and back wheels of the resident's wheelchair. He said attaching it that way was supposed to keep the wheelchair from moving. He said his boss's boss, the Regional Director of Plant Operations, took him to the van to make sure it was right. He showed the Regional Director of Plant Operations where he had strapped the wheelchair and the Regional Director of Plant Operations said that was right. Maintenance Worker A said he didn't know what happened and that had never happened before. He wasn't sure if the resident hit the mechanism or not, but they had driven about 15 minutes before the wheelchair fell backwards. Maintenance Worker A said he had no formal training and said he watched and went by what the Activity Director did to strap the resident in on her side. Then that's what he did. He said the Activity Director was replacing the regular driver until he/she came back from leave. Maintenance Worker A said the video in-service education was on the proper way to secure straps to the wheelchair. It was a FaceTime Video call, and his boss's boss told him once the resident was strapped in to pull on the straps to make sure they were secure. Maintenance Worker A said the

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Regional Director of Plant Operations did not walk him out to the van or check his work for competency. The day the resident fell, he strapped his/her wheelchair in on one side and the Activity Director strapped the other side. Maintenance Worker A said he was just the driver. He said the straps, seatbelts, and ratchets were ok. The Administrator went out after the incident to see what they did to secure the wheelchair. He said the Administrator let him and the Activity Director secure her in a wheelchair inside the van. Maintenance Worker A said the Administrator said it seemed to be ok.

During an interview on 11/7/24 at 3:49 P.M., the Maintenance Supervisor said the van received maintenance on 10/25/24. He said there was nothing wrong with the seatbelts or the seatbelts' locking mechanisms and there was nothing wrong with the locking latches on the floor in the van. He didn't know of any training Maintenance Worker A had received. The Maintenance Supervisor said Maintenance Worker A was with the Activity Director when the incident happened. The vehicles received monthly maintenance and if there were any problems with the vehicles, staff would let him know.

During an interview on 11/7/24 at 3:58 P.M., the Administrator said the original transporter was out on leave. The Administrator said she had the Regional Director of Plant Operations on FaceTime, and he walked Maintenance Worker A through securing the straps from the wheelchair to the van while transporting. Right now, the facility used a vendor for transportation. They were not using the facility vehicle for transportation until the regular driver returned back from leave. The Administrator said she

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F 689	Continued From page 10 couldn't determine a cause for the incident. She didn't expect what happened to the resident to be in his/her progress notes/medical records because he/she was discharged from the facility. She didn't re-educate the Activity Director because she was just a ride along. She expected all drivers, whether permanent or temporary assignment, to be competent and follow the facility's vehicle policy. She said competency was done during orientation and annually, as needed. She expected staff to follow the policy and inspect the vehicle daily prior to first use of the day. MO00244174	F 689		