STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185438	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richwood Nursing & Rehab	1012 Richwood Way LA Grange, KY 40031

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 - Actual harm 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** 47567 Based on observation, interview, record review and review of facility policy, it was determined that the facility failed to prevent accidents for one (Resident (R) 19) of twenty-two sampled residents. On [DATE], R19, whose mobility was per wheelchair, fell from the back of a transport van when staff released the safety restraints before assuring that the hydraulic lift was in place. R19 flipped backwards over her wheelchair, falling over 10 feet from the van onto the pavement, landing headfirst. R19 sustained actual harm, including a closed head injury, right and left rib fractures, and cervical spine strain as a result of the accident. The findings include: Review of a facility policy titled, Safety and Supervision of Residents, revised [DATE], revealed resident safety, supervision, and assistance to prevent accidents are facility-wide priorities, and facility employees shall be trained on potential accident hazards, and try to prevent avoidable accidents. Review of a facility policy titled Falls and Falls Risk Managing, revised [DATE], revealed the facility staff will identify interventions related to the resident's specific risk and causes to try and prevent the resident from falling and to try to minimize complications from falling. Review of a facility policy titled, Facility Vehicle Driver Safety Policy, dated [DATE], which was in place at the time of R19's fall, revealed that it did not address the steps that staff were to follow regarding the use of the mechanical lift to ensure a safe exit from the facility van. Closed record review of a Face Sheet revealed R19 was admitted to the facility on [DATE], and discharged to the hospital on [DATE], where she subsequently expired. The resident's diagnoses included Parkinson's Disease, muscle weakness; lack of coordination and abnormalities of gait and mobility. Review of an admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of [DATE], revealed the resident was cognitively intact, based on a Brief Interview for Mental Status (BIMS) score of ,d+[DATE]. Per the MDS, the resident used a wheelchair for mobility, required partial to moderate assistance with transfers. Review of a quarterly MDS, with an ARD of [DATE] revealed R19 was still assessed as cognitively intact, required staff assistance with mobility and used a wheelchair for locomotion. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing progress note, dated [DATE] at 2:33 PM, revealed that while taking R19 to an appointment at a local hospital complex, Certified Nursing Assistant (CNA) 1 was preparing the resident and her belongings to be pushed back on to the van's mechanical lift. Per the note, R19 was attempting to grab her purse and other belongings. CNA1 told R19 to wait while the CNA was gathering up her things. The progress note stated R19 then started propelling herself backwards towards the open back end of the transport van, and the lift was not up at the van floor level. CNA1 told R19 to stop and she would help her, but the resident did not stop propelling herself backwards. CNA1 attempted to reach the resident's wheelchair but could not reach the resident in time and R19 flipped out backwards out of the van onto the parking lot, landing headfirst. Review of R19's Emergency Department Discharge After Visit Summary, dated [DATE], revealed R19's injuries included a closed head injury, left rib fracture, right rib fracture, and a cervical spine strain. The resident did not require surgical intervention for her injuries and returned to the facility the same day. Observation of the surveillance video of the incident, dated [DATE] and timestamped at 12:34 PM, revealed R19 rolling backwards, falling out of the facility's transport van, flipping over her wheelchair backwards and landing headfirst onto the pavement at the 12:35:25 mark. The hydraulic lift gate was observed to be on the ground at the time of the fall. Observation of the van on [DATE] at 10:07 AM revealed that the distance which the resident fell from the bed of the van to the ground was 10 feet, 4 inches. In an interview with R19 's daughter (FM19) on [DATE] at 5:54 PM, she stated she was out of town the weekend of the accident and was notified by the hospital needing permission to take care of her mother because she was the Power of Attorney (POA) and R19 was in and out of consciousness after a fall accident. FM19 stated her mother, who passed away in ,d+[DATE], was foggy on the details of her accident and only remembered being on her back, and then going to the ER. Interview with CNA1, on [DATE] at 10:38 AM, revealed she was taking R19 to a doctor's appointment and they were parked under the porch area of the entrance to the building. CNA1 stated the wheelchairs were hooked up on chains while the residents were being transported in the van. She stated the wheels on the wheelchair were also to be locked. CNA1 stated she had just unlocked the wheels on the wheelchair and unhooked R19 from the safety restraints in the van when R19 started pushing back in her wheelchair. CNA1 stated she told the resident, No, don't do that; however, R19 continued to push back in the wheelchair with her legs as she thought it was time for her to go. CNA1 stated that at this time, the lift was still down on the ground. R19 did not wait for the lift to return up to the van before she rolled back and that was how she fell . CNA1 said she went over to try and grab hold of R19 when she saw the resident begin to fall backwards but did not make it to her in time. CNA1 stated she got out of the van immediately and went and checked on R19. Once she determined the resident was OK, she went inside the building and got some help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In continued interview with CNA1, on [DATE] at 10:38 PM, she stated she called the Administrator and told him what happened with R19. CNA1 added that the Administrator was out of town when it happened, so the Director of Nursing (DON) called her and advised her to send R19 to the emergency room (ER). She stated she stayed at the hospital with R19 afterwards, and she thought that the resident was fine. CNA1 said R19 did state to her she had pain but otherwise was OK and returned to the facility that night after she was treated in the ER. Further interview with CNA1 revealed that she should have waited until the lift was in place before she unlocked the resident's wheelchair wheels. CNA1 stated that she should have looked back and made sure the lift was in place because she was aware of the resident's impulsive behaviors. In an interview with CNA2 on [DATE] at 8:12 PM, she stated she worked at the facility for three years, leaving in ,d+[DATE]. She stated that she was with CNA1 transporting R19 and another resident on the day of the accident. CNA2 stated they got one resident (Resident 20) down out of the van. She stated the van was parked on a slanted slope, so she was trying to safely park Resident 20 she had gotten out of the van by first locking the resident's wheels so that her wheelchair would stay put and not roll away by itself. CNA2 said that as soon as she turned around after securing this first resident, she then saw R19 rolling out the transport van backwards and fall. CNA2 stated when she saw R19 roll out, she thought she saw CNA1 standing in front of her but was unable to tell what CNA1 was doing because she (CNA2) was on the ground off to the side with Resident 20. CNA2 stated she did not recall receiving formal training and CNA1 had been the staff who trained and instructed her on how to operate the hydraulic lift. In an interview with the DON on [DATE] 4:25 PM, she stated that CNA1 called her after the incident and reported it to her. She directed CNA1 to stay with the resident and ensure she was safe. The DON stated R19 frequently went out in the transport van to appointments and was very familiar with the process and how to maneuver getting in and out of the van with the lift and she felt that was most likely why the resident was comfortable with proceeding to exit the vehicle despite CNA1's pleas for the resident to stop and wait for her to assist her. In an interview with the Administrator on [DATE] at 3:02 PM, he stated he was out of town when the incident occurred but got a phone call from staff and was notified of the incident that day. The Administrator stated that, based on what was described to him, the root cause was R19 had anticipated that the lift was coming up quickly and she rolled back, and it was not there. Although the aide told her to stop, instead the resident had kept going. Interview with the Administrator revealed that, prior to R19's fall, their policy and procedures did not detail the steps that staff were to follow when using the mechanical van lift to remove residents from the van, including the need to check that the mechanical lift was in place prior to releasing the resident to exit the van. The facility implemented to following: 1. Record review revealed R19 was evaluated and treated at the ER for injuries received in the accident on [DATE] and discharged back to the facility that evening. In an interview with CNA 1 on [DATE] at 10:38 AM, she stated that she accompanied R19 to the ER and remained there with her until she returned to the facility. 2. In an interview with the Administrator on [DATE] at 3:02 PM he stated that there had been no other incidents of with the transport van. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Review of the facility's allegation of compliance revealed DON and Administrator were educated by the Regional Director of Clinical Services on [DATE]. In an interview with the Administrator on [DATE] at 3:02 PM, he stated he received education from the regional director of clinical services on [DATE]. Additional review and interview with CNA 1 revealed she received training from the facility regarding transportation safety. 4. Review of facility document titled Vehicle Checklist Review revealed the facility checked the vehicle log once a week for 4 weeks then monthly there after.