STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255228	A. BUILDING _____ B. WING _____	C 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA REHABILITATION AND HEALTHCARE CENTER	200 DR MARTIN LUTHER KING JR DRIVE CLEVELAND, MS 38732

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification and complaint survey for MS #19658 at the facility from 10/25/22 through 10/28/22. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation.The SA substantiated MS #19658 for incident and accidents and cited F689. The SA also cited regulatory deficiences at F584 and F919. The census at the time of the survey was 65. The facility was certified for 75 beds.	F 000		
F 689 SS=E	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 observation, staff and resident interview, policy review and record review, the facility failed to prevent the likelihood of an injury related to a fall, during a van transport, as evidenced by failure to use chest and lap seat belts for three (3) of four (4) residents reviewed for van transport. Resident #11, Resident #25, and Resident # 41. Findings include: Resident #41	F 689	1. Resident #41 was assessed by the Director of Nurses on 10/1/22; no injuries noted. CNA/Van Driver was suspended on 10/1/22 and removed from transporting for not following policy and procedures. On 10/3/22 the Maintenance Director educated CNA/Van Driver #2 on proper securing and strapping of straps across residents and return demonstration conducted. Observational audits of resident transfers were conducted on 10/3/22 and 10/4/22 by the Maintenance	11/22/22

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

Electronically Signed | 11/16/2022

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F 689	Continued From page 1 Review of the facility policy titled, "Driver and Vehicle Safety Policy," revised 2015, revealed, "...Seat belts are worn at all times ... Residents are properly secured at all times." Record review of the facility incident report revealed Resident #41 had an incident on 10/1/22 when he fell out of his wheelchair while riding in the nursing facility's transport van from an appointment at the dialysis unit. The investigation noted that the resident was not injured, the Van Driver was noted to have reported that Resident #41 was not buckled in safely with a chest or lap seat belt, to avoid the fall. A telephone interview on 10/26/22 at 4:00 PM, with the Former Van Driver for Resident #41's incident, revealed the resident fell from the wheelchair when she abruptly hit the brakes, because he was not wearing a chest or waist safety belt. She revealed she had not been trained by the Maintenance Director on how to use the seat belts for the residents during transport, and had not been told to use the seat belts on the residents during transport. She noted she was only told to buckle the wheelchairs down so they would not move. She revealed she was not trained on how to buckle residents in until after Resident #41 fell out of the wheelchair on 10/1/22. An interview with the Director of Nursing (DON) on 10/26/22 at 4:10 PM, revealed she completed the investigation for the incident of Resident #41's fall on 10/1/22 and the former van driver informed her she did not use a seatbelt on Resident #41 during the transport. She revealed the Former Van Driver noted she only buckled the wheelchair	F 689	Director to ensure proper securing of straps were used; no negative issues identified. 2. All residents who can transport on the van have the potential to be affected. 3. CNA/Van Driver #2 was assigned to full time transporting on 10/3/22. CNA/Van Driver #2 was educated on proper strapping of residents during transporting on 11/11/22 by the Administrator. In-servicing 2 of 2 Van Driving Staff was educated on securing straps across residents on 11/14/22 by the Administrator. 4. Beginning the week of 10/31/22, the Maintenance Director or designee will conduct 3 audits weekly to ensure CNA/Van Driver is securing straps across residents properly for 4 weeks and monthly for two months and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement Committee on 11/15/22 for review and recommendation and then monthly for three months. The Administrator is responsible for on-going monitoring and compliance.	

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down and did not use the chest and lap seat belt by her documentation in the "Record of Interview" dated 10/5/22.

An interview on 10/26/22 at 4:30 PM, with the Administrator revealed the findings of the investigation of the fall incident for Resident #41 on 10/1/22. The former van driver did not buckle Resident #41 in the wheelchair with a chest or lap seat belt which would have avoided the fall. She revealed the former van driver did not follow proper protocol to safely secure residents. She did not follow the transport policy and she did not follow the safety check off that she completed on 4/18/22 regarding properly loading and securing a resident prior to transport. The Administrator revealed the user's manual that had instructions about the seat belt use was always on the transport van with the drivers. The Administrator revealed the fall incident for Resident #41 provided the likelihood for possible injury due to being transported without the use of a chest and lap safety belt.

Record review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 9/15/2022, revealed Resident #41 has a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #41 is cognitively intact.

Record review of the statement written by the previous van driver, dated 10/1/22, revealed, " ... (Formal Name of Resident #41) fell forward out the wheelchair ... Both parts of his chair was locked."

Record review of the statement from the facility incident report revealed the findings of the fall

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incident for Resident #41, from the Administrator, with no date, revealed, " ... (Formal name of previous van driver) CNA/Van Driver was removed from transporting for not following policy and procedure."

Resident #25

An interview on 10/26/22 at 4:40 PM, with Resident #25 revealed she has used the nursing facility's transport van to go to dialysis appointments and did not remember a safety belt being put across her waist or chest. Resident #25 expressed the wheelchair was locked down in 2 areas, but she had never been offered a chest or lap seat belt.

Record review of the Face Sheet for Resident #25 revealed she was admitted to the facility on 10/14/22, with diagnoses of End Stage Renal Disease, Nontraumatic Ischemic Infarction of Muscle, Left Lower Leg, Other Lack of Coordination, and Dependence on Renal Dialysis.

Record review of Resident #25's most recent BIMS score of 14 indicated she is cognitively intact.

Resident #11

An interview on 10/26/22 at 4:45 PM with Resident #11 revealed she was transported to the dentist in the nursing facility's transport van and was not buckled in across the chest nor the waist with a safety belt. Resident revealed she was transported on the van to an appointment before and did travel with the former and present van driver.

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Record review of the Face Sheet for Resident #11 revealed she was admitted to the facility on 9/14/18, with diagnoses of Other Lack of Coordination, Difficulty in Walking, Not Elsewhere Classified, and Unspecified Osteoarthritis, Unspecified Site.

Record review of Resident #11's most recent BIMS score of 15 indicted her cognition is intact.

An interview on 10/26/22 at 5:15 PM with the present van driver revealed she was the back-up driver to the former van driver and was also a ride along Certified Nurse Aide (CNA) to assist with transports. She stated she was not trained on the use of the chest and waist seat belts for resident transports until after the fall incident for Resident #41 on 10/1/22. She revealed she had not witnessed a chest or waist seat belt being used by the former van driver when she had to ride along to assist with resident transports.

An interview on 10/27/22 at 8:30 AM, with the Maintenance Supervisor revealed he was the one responsible for training all van drivers on the process of safely loading a resident for transport and about seat belt safety in transport. He stated he did train the present van driver and the former van driver before they assumed the transporter position.

Record review of the Face Sheet for Resident #41 revealed he was admitted to the facility on 9/9/22 with diagnoses of End Stage Renal Disease, Difficulty in Walking, Not Elsewhere Classified, Muscle Weakness (Generalized), and Dependence on Renal Dialysis.

Record review of the check off titled, Securing

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Residents in Van - Competency Demonstration," dated 4/18/22, for the former van driver, revealed, " ... Belts should be adjusted so that they firmly, yet comfortably, keep the passenger secured. ... Belts should be kept low at the passenger's pelvic zone (near the hip) rather than over the abdominal area or over the arm rests. ... Ensure that shoulder straps cross diagonally across the upper chest of the passenger."

Record review of the check off titled, Securing Residents in Van - Competency Demonstration," dated 4/16/22 and signed by the present van driver, revealed, " .. Belts should be adjusted so that they firmly, yet comfortably, keep the passenger secured. ... Belts should be kept low at the passenger's pelvic zone (near the hip) rather than over the abdominal area or over the arm rests. ... Ensure that shoulder straps cross diagonally across the upper chest of the passenger."

Record review of the check off titled, Securing Residents in Van - Competency Demonstration," dated 10/3/22, for the present pan driver, revealed, " ... Belts should be adjusted so that they firmly, yet comfortably, keep the passenger secured. ... Belts should be kept low at the passenger's pelvic zone (near the hip) rather than over the abdominal area or over the arm rests. ... Ensure that shoulder straps cross diagonally across the upper chest of the passenger."

Record review of the transport van's operation manual, pages 37-38 revealed, "Seatbelts ... Warnings Always drive and ride with the seatback upright and the lap belt snug and low across the hips. ...All occupants of the vehicle, including the driver, should always properly wear their

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F 689	Continued From page 6 seatbelts, even when an airbag supplemental restraint system is provided. Failure to properly wear your seatbelt could seriously increase the risk of injury or death. ... Fastening the seatbelts. The front outermost and rear safety restraints in your vehicle are a combination lap and shoulder belts. ... 1. Insert the seatbelt tongue into the proper buckle (the buckle closest to the direction the tongue is coming from) until you hear a snap and feel it latch."	F 689		