Received 8/18/11

PRINTED: 08/12/2011
FORM APPROVED
OMB NO. 0938-0391

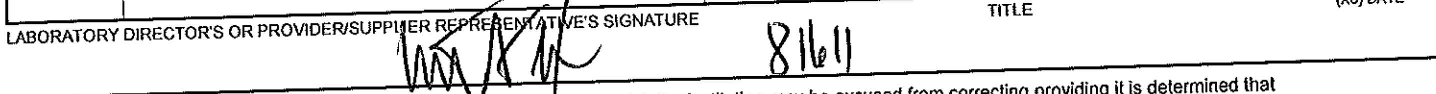
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345132	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 07/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DR GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff, EMT, (Emergency Medical Technician), resident interviews and record review, the facility failed to secure the resident and resident ' s wheelchair in the facility ' s van to ensure safe transport resulting in a fall with injury for 1 of 1 sampled resident (#3). Findings included: A review of the medical record for Resident #3 indicated the resident was admitted on 1/10/07 and re-admitted on 6/15/11. The culmulative diagnoses included: diabetes, chronic osteomyelitis, schizoaffective disorder, aftercare involving internal fixation device left knee (left knee replacement). A review of the Care Plan dated 6/15/11 indicated the resident required assistance /potential to restore or maintain maximum function of self-sufficiency for all ADL ' s, (activities of daily living) related to: impaired mobility and physical limitations. A review of a significant change in condition MDS	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 8/16/11



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.

JB

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F 323	Continued From page 1 (Minimum Data Set) dated 6/21/11 indicated resident #3 was cognitively intact, and required extensive assistance for locomotion and required total assistance for transfers. On 7/27/11 at 10:30AM Resident #3 was interviewed about the accident that happened on 6/3/11. She stated that the driver of the van had " locked me down " (indicating he moved around her in the van, placing the straps from the floor to the wheelchair.) On interview, Resident #3 was positioned in the middle of the van in her wheelchair when suddenly the driver put on the brakes. Resident #3 stated the straps were frayed, worn and old looking. The interview continued to reveal that a belt broke throwing Resident #3 out of her wheelchair. She hit her head and bumped her knee and hips. She hit her right thumb and received three stitches in it. She stated her left arm was bruised. Resident #3 believed the wheel chair flipped on top of her and she was on the floor of the van, face down behind the van driver ' s seat. The van driver called for an ambulance and when they arrived they took the wheel chair off of her and placed her back into the wheelchair. She continued to state she was taken to the hospital on a strectcher and was x-rayed. Resident #3 continued that she was sent back to the nursing home with a lot of pain in her head and left knee. On Monday, (6/6/2011), she asked to talk to the doctor. The doctor called for x-rays and the results found a fracture. She was sent to the hospital that night where the fracture of her hip was identified. Resident #3 further commented that no one in the nursing home had come to talk to her about the accident. She further stated she had been in the van since the accident and noticed new straps were	F 323		

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F 323	Continued From page 2 installed. On 7/27/11 at 12:43 PM a phone interview was conducted with the van driver who was involved with the accident on 6/3/2011. He stated he had been a transport driver since February, 2011. He continued to state that he had been inserviced about his duties in the nursing home when he was hired. On 6/3/11 (before lunch) the van driver was transporting Resident #3 to a doctor ' s appointment. He continued to reveal the signal light turned caution and the car in front of the van stopped suddenly and he stopped suddenly to avoid hitting the car in front of him. The interview continued to reveal Resident #3 fell out of her wheelchair. He continued to state that Resident #3 landed behind the driver ' s seat, face down on the floor. The van driver then described the van having 4 straps (2 in front of the wheelchair and 2 in back of the wheelchair). He stated the 4 straps are strapped to the wheelchair, 2 in front and 2 in back and the seat belt was the problem. He stated he was not sure if the seat belt was hooked or not. The van driver stated the seat belt was not on Resident #3 when she fell. He stated he was not sure if he failed to hook the seat belt or it came loose. " I have transported [Resident #3] many times and there were no problems. " The van driver continued the interview about how some of the wheelchairs have to be strapped differently because of the way the straps are. He stated some wheelchairs have to be strapped down in front like you normally do (locking the 2 straps in front of the wheelchair to the floor). The van driver continued to explain that the problem was with Resident #3 ' s wheelchair. He stated that because of the of the way it (the wheelchair) was made, the front of the wheelchair had to be	F 323		

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F 323	Continued From page 3	F 323		

strapped down normally (2 in front of the wheelchair) and the back straps had to be wrapped around the crossbar of the wheelchair in back, in order for the straps to tighten up. He clarified that he wrapped the straps around the wheelchair on the back crossbars instead of securing the straps to the wheelchair which are then secured to the floor of the van. " The back straps were too long but the rachett straps in the front were secured. "

On 7/27/11 at 11:20 AM, Nursing Assistant (NA) #7 that was in the van with Resident #3 at the time of the incident was interviewed. NA #7 stated Resident #3 was in the middle of the van between herself and the driver. NA #7 was in the front passenger seat. NA #7 stated, " I do not check for proper strapping as it was not part of my job description. The van driver was rushing to be on time for [Resident #3 ' s] appointment. The van was coming down the street when the light turned red and the van driver had to stop quickly to avoid hitting the car in front of him. When the van driver stopped [Resident #3] fell out of her wheel chair. The wheelchair stayed in the same position and [Resident #3] fell to the back of the driver ' s seat on her stomach. " NA #7 told the driver to call the DON (director of nurses) and she called the ambulance. NA#7 continued, " The ambulance came before the DON and they (EMTs) picked [Resident #3] up off the floor and put her back into the wheelchair and asked if she was ok and asked her to go to the hospital, but [Resident #3] refused. When the DON, administrator and the [supply/scheduler #8] arrived they talked to [Resident #3] and talked her into going to the hospital to be checked. The ambulance driver put her in the ambulance on a

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F 323	Continued From page 4 stretcher and took her to the hospital. " On 7/29/11 at 11:15 AM a phone interview was conducted with the Emergency Medical Technician (EMT) that was called to the scene of the accident on 6/3/2011. The EMT stated that Resident #3 was in the van, lying on the floor face down, behind the driver ' s seat when they arrived at the van. " The wheel chair was up-right attached with straps to the front only. The wheelchair was not secure enough as there were no straps attached in the back, only in the front. [Resident #3] stated she was not wearing her seatbelt because it hurt her stomach and there were no shoulder straps in the van. " The EMT continued, " The van driver told me that the straps in the back were too long and he could not secure them to the floor and he knew that was a problem. " The EMT stated the force of the van stopping so quickly threw Resident #3 out of the wheel chair. On 7/27/11 at 1:00 pm an interview with the Facilities Director (FD) # 14 revealed: " I saw the van about 3:30 pm - 4 pm on 6/3/11. The administrator gathered people who had anything to do with driving the van, or ride with the residents in the van. He coordinated with the sister facility to instruct our group on how to properly transport a resident from the beginning to the end. The straps that were on the van were replaced because the administrator had experience with a better type. " (At this time an observation of all the old straps that were in the van was completed and there were no old seat belts in the box). The FD stated the seat belts were left in the van. We (surveyor and the FD) went to the van and an observation of the seat	F 323		

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F 323	Continued From page 5 belts appeared to be new (no wear, very shiney). The FD further stated; " The rachett type straps have been replaced with a newer type that are easier to use. The shoulder straps were not in the van at the time of the incident. Shoulder straps have been installed since then. The FD continued to state; " In the clean up I found a brand new shoulder strap that was never installed so we ordered a matching one. I informed the administrator that there were no shoulder straps installed in the van at the time of the incident. I think whoever did the initial investigation already knew about the shoulder straps not being installed. The only way this may of happened in my opinion was the van driver may have been rushed, because he is a time sensitive person and wants to keep all the appointments on time. " On 7/27/11 at 10:45 AM an interview was conducted with the Administrator. He stated, " [Resident #3] fell out of her wheel chair which was strapped in appropriately (referring to all 4 straps were secured to the wheelchair). " He continued to state that when the driver came to red light, a car swerved from the right lane in front of him and caused the resident to fall out of the wheelchair due to the quick stop. The interview continued to reveal that when he (Administrator) arrived at the scene, the EMT's had already picked up Resident #3 and placed her back into the wheel chair. " [Resident #3] was sent to the hospital on a stretcher and they sent her back to the facility with no apparent injuries. " The Administrator further stated that three days later Resident #3 complained of pain and the mobile x-ray came to the facilty on Monday (6-6-11) and it was determined she had a fracture. (he was not sure what type of fracture). He further stated	F 323		

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F 323	Continued From page 6 that Resident #3 was transported to the hospital at that time. On 7/28/11 at 1:35 pm a re-enactment of Resident #3 being put in the van in her wheel chair was completed. The new driver, NA #18 for the van, completed the procedure. There were 3 surveyors, the Administrator and VP of Operations observing. Resident #3 stated, "these are not the seat belts I had on as these are new. The seat belt I had on was frayed. " The Administrator stated, "these are the same seat belts that were on the van when [Resident #3] was transported." The VP of Operations also stated, " [Resident #3] is in is the same wheelchair she was in the day of the accident. " On 7/28/11 at 2:00 pm an interview with the supply clerk #8 stated; " The wheel chair the resident has now is not the wheel chair she was in the day of the accident. She now has a 20 inch wheel chair, previously she had an 18 inch wheel chair. The new wheelchair has side bars on the back where the back straps are hooked which go to the floor and the 18 inch wheel chair had (an observation of an18 inch wheel chair) cross bars on the bottom. " The invoice for the new wheel chair was received and it was dated 7/21/11. (the date was the ship date - and invoice date). The administrator was notified of the immediate jeopardy on 7/27/11 at 3:30 pm. The facility provided a corrective action plan on 7/29/11 at 11:40 am. PLAN OF CORRECTION FOR VAN INCIDENT OF 6/3/2011	F 323		

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F 323	Continued From page 7 A. Corrective action for the affected resident: - The van driver called the facility at 10:20AM on 6/3/11 to report an incident with the named resident. Based on the interviews of the resident, van driver and second staff member during the transport the resident fell out of the wheelchair. It was not known if the seatbelt was fastened correctly during the transport. The van came to a sudden stop at the intersection of (street names.) The van driver had already called 911 and the resident was checked by the driver and certified aide in the van. - The primary physician was notified of the van incident for this resident at 10:25AM by the DON. Physician was in the facility at the time of the van driver call. The resident is her own responsible party. - The Administrator notified the Regional Vice President (RVP) of the incident on 6/3/11 at 10:25 AM. Corrective action was initiated with the Administrator at that time. - At 10:30 AM the DON, Administrator and Supply Clerk arrived at the scene of the incident. The DON completed an assessment of the resident and resident denied any pain and refused to go to the hospital. - At 10:35 AM the resident was convinced by the DON to go to the hospital via EMS. - At the hospital the resident was treated and released with no mention of knee injury or acute pain. The named resident returned to the facility at 2:00 PM on 6/3/11.	F 323		

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F 323	Continued From page 8 - The RVP notified the nursing consultant for this facility of the van incident on 6/3/11 at 3:00 PM for any further prevention/interventions that may have been required. B. Corrective action for residents who the potential to be affected: - The facility van was brought back to the facility on 6/3/11 at 10:55AM, by the supply clerk, who was trained on August 21, 2009. Her training included per the " Resident Transportation Audit " : Chose and used appropriate placement of tie downs and safety belts, Secured wheelchair, Geri-chair, rock n go chair in van, Secured resident(s) into the secured chair during transport to include use of physical restraints and/or enablers or positioning devices per individualized plan of care, Correct Van lift operation and safety demonstrated, Van seat belts utilized for resident(s), Use of cellular phone demonstrated (Van must be stopped when using), verbalize: Incident/accident reporting procedures Vehicle accident reporting procedures, Resident Emergency procedures, No smoking policy enforced, were transport procedures performed correctly? After returning the van to the facility parking lot, the Administrator, Maintenance Director, DON and van driver checked the seat belt and tie downs. These were inspected and found to be in proper working order and good condition. - The van was removed from service by parking it in the facility parking lot, locking the van, and the Administrator collected all van keys. The van keys were maintained by the Administrator in his office, secured in a locked drawer.	F 323		

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F 323	Continued From page 9 - Van Driver was suspended on 6/3/11 at 11:00 AM, pending investigation outcome. The driver was not allowed to drive the van back to the facility. - No residents were transported by the only facility van, (name of owner) owns and operates, until the investigation of the incident and retraining had been completed. Arrangements for resident appointments were made using outside sources (sister facility transports). - The facility van did not operate again until 6/6/11 at 9:30AM. The outcome of the investigation of the van incident revealed the seat belt was not clicked into the buckle completely. - Upon use of the van on 6/6/11 at 9:30AM, the Administrator used the Audit Tool " QI Audit Tool of Van Transports of Residents " to ensure the driver (Supply Clerk) secured the resident ' s wheelchair and seatbelt properly before leaving the facility. The Administrator and the Supply Clerk left the facility with the resident. The Supply Clerk received training during the 100% inservices for retraining of the drivers (Maintenance Director and Supply Clerk) and the administrative nursing staff DON (director of nurses), SDC,(staff development coordinator), MDS (minimum Data Set) nurses and day shift supervisor) began on 6/3/11 at 11:30 AM and were completed on 6/3/11 at 3:00 PM. The inservice training was provided by the Transportation Supervisor at a sister facility and was overseen by the Administrator. The areas of the inservice included Proper procedure for resident transportation, proper procedure, proper straps and proper hooks. How to secure the	F 323		

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F 323	Continued From page 10 wheelchair correctly and the resident in the chair correctly. - Upon return of the resident to the facility, the DON, (who was trained on 6/3/11 by the Administrator on how to use the Audit Tool " QI Audit Tool of Van Transports of Residents ") used the Audit Tool " QI Audit Tool of Van Transports of Residents " to check the resident/employee for proper securing of the wheelchair and the seatbelt and employee seated in appropriate designated seat. - C. Measures put in place to ensure deficient practice will not occur: - A pair of black shorter tie down straps from stock supply was used to replace the grey tie down straps in the van that secure the wheelchair to the floor of the van on 6/3/11. These new straps were checked by the Administrator and Maintenance Director to ensure safety and proper operation on 6/3/11 at 1:00 PM. These were replaced during the inservice training for the van drivers, and nursing administrative staff members. - The seatbelt was inspected by the Administrator, Maintenance Director and DON and was found to be in good working order and condition on 6/3/11 at 1:00 PM. - On 6/6/11 the shoulder strap was implemented as an extra precautionary measure for securing the residents during transports. Additionally, two (2) more shoulder straps were purchased on 6/13/11 and installed on 6/13/11, to allow more than one (1) resident to transport at a time. The	F 323		

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F 323	Continued From page 11 facility has a third set of tie down straps in the event more than two (2) residents will be transported in the van. - A 100% inservices for retraining of the drivers (Maintenance Director and Supply Clerk) and the administrative nursing staff (DON, SDC, MDS nurses and day shift supervisor) began on 6/3/11 at 11:30 AM and were completed on 6/3/11 at 3:00 PM. The inservice training was provided by the Transportation Supervisor from a sister facility which included return demonstrations. This Transportation Supervisor was trained on 1/11/11 on the following: " Resident Transportation Audit " : Chose and used appropriate placement of tie downs and safety belts, Secured wheelchair, geri-chair, rock n go chair in van, Secured resident(s) into the secured chair during transport to include use of physical restraints and/or enablers or positioning devices per individualized plan of care, Correct Van lift operation and safety demonstrated, Van seat belts utilized for resident(s), Use of cellular phone demonstrated (Van must be stopped when using), verbalize: Incident/accident reporting procedures Vehicle accident reporting procedures, Resident Emergency procedures, No smoking policy enforced, were transport procedures performed correctly? " The inservices for retraining by the Transportation Supervisor from a sister facility, were overseen by the Administrator who is certified in the " Sure-lok " training. This included presentation of information and the return demonstrations. The areas of the inservice included Proper procedure for resident transportation, proper procedure, proper straps and proper hooks. How to secure the wheelchairs (which include hemi, standard,	F 323		

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F 323	Continued From page 12 medium, and large) correctly and the resident in the chair correctly. The facility does not utilize electric wheelchair, geri chairs and/or scooters in the van for transportation. - Additional retraining was provided by the Administrator to emphasize the importance and severity of not following proper procedures for transportation. The retraining was provided during van driver skills checks and nursing administration skills checks on 6/3/11 to the Maintenance Director, Supply Clerk, DON, SDC, MDS nurse and dayshift Supervisor. The Administrator is certified in " Sure-Lok " training. - A 100% inservice training was given completed by 6/7/11 for certified nursing assistants, med aides, nurses and activity director and assistant, who would accompany as the second person on transportation. The inservice sheet titled " Complete In-Service Training Report with Staff Attending " included the following topics: where to sit (in the back seats) with the resident and to assist the resident, you may not get out of the van, or leave the facility until the resident and the wheelchair have been checked for proper securing to prevent accidents. The payroll roster was utilized to ensure 100% of the certified nursing assistants, med aides, nurses and activity director and activity assistant received the training. The training was provided by the SDC, Administrator and DON to all three shifts. - No newly hired certified nursing assistant will be allowed to ride as the second person in the van. The list of staff who have been trained to be the second person on the van is kept by the	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 Administrator, DON and Schedule Coordinator. -- Van Driver was suspended on 6/3/11 at 11:00 AM, pending investigation outcome. The van driver did not drive the van at any time after the van incident. Upon completion of the investigation the van driver was terminated on 6/7/11. - A new form " QI Audit of Van Transports of Residents " was implemented on 6/6/11 to verify that all residents were secured appropriately in the van prior to leaving the facility and upon return to the facility with each transport. The Administrator, Maintenance Director, Supply Clerk, and/or the Administrative Nursing Staff will be responsible for these audits. - D. How the facility plans to monitor to ensure solutions are sustained. - The authorized van drivers as of 6/6/11 were the Maintenance Director, the Supply Clerk and the Administrator. Beginning 6/6/11 audits were completed using the " QI Audit of Van Transports of Residents " for each transport from the facility and upon return to the facility. The date, time, resident name, if the wheelchair was tied down correctly, (i.e. seat belt is pulled around the waist of the resident and hooked into the buckle; the wheelchair tie down straps are attached to the rail system located in the van floor; the shoulder strap is attached to the upper inside of the van, pulls down across the resident ' s chest area and attaches into the seat belt. This forms a three (3) point securing system of the resident in the wheelchair and van.), was the seat belt on the resident, was a second staff member necessary	F 323		

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
	345132	A. BUILDING ______ B. WING ______	C 07/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DR GREENSBORO, NC 27406

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F 323	Continued From page 14 on the transport, and the signature of the Administrator, Maintenance Director, Supply Clerk or Administrative Nursing staff member performing the audit were recorded. - At the monthly QI meeting held on 6/7/11 with the Medical Director, Administrator, DON, SDC and MDS nurse in attendance, it was decided the " QI Audit of Van Transports of Residents " would continue daily with each transport until the next QI meeting date of 7/5/11. No issues had been observed with any transports as of this date. - At the monthly QI meeting held on 7/5/11 with the Administrator, DON, MDS nurse, SDC and Dietary Manager in attendance, it was decided the " QI Audit of Van Transports of Residents " would continue daily with each transport until the next QI meeting date of 8/2/11. The reason for continuation of these audits was to verify that a newly hired van driver would be audited for safety and compliance using the QI Tool. This was with the recommendation of the RVP to continue the audits on an ongoing basis. Findings will be reported at the quarterly Executive QI Committee meeting. No issues had been observed with any transports as of this date. - As part of the preventative maintenance program, the Monthly audits will be ongoing using the " Safety Inspection - Facility Auto " for safety checks of van equipment of seat belts, tie downs to verify they are in good working order, have been done by the Maintenance Director. For the June audit, dated 6/15/11 under comments, the seat belts were checked as " yes " for being in " good repair " and " new shoulder straps " and floor straps was written by the Maintenance	F 323		

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
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F 323	Continued From page 15 Director. These audits will continue to be completed on a monthly basis by the Maintenance Director. - Any issues/concerns related to van transports or securing of residents for transports will be referred on the day of occurrence, to the Regional VP and/or Corporate Nursing Consultant. The Administrator will be responsible for oversight of any concerns for resolution and/or interventions as deemed necessary. Weekend operation of the van will be by primary van driver. Relief drivers include the Maintenance Director, Supply Clerk or Administrator. - The results of the audits conducted will be forwarded by the Administrator/DON to the monthly QI Committee for review of potential trends or patterns, for follow up action as deemed appropriate and to determine the need for and/or frequency of monitoring to maintain continued compliance. The Executive QI Committee will review the audits on a quarterly basis as an ongoing preventative safety measure. Validation of the Plan of Correction was done on 7/29/11. Interviews were held with nursing and administrative staff which revealed they had attended recent in-services regarding resident transportation, proper hooks and proper straps. The wheel chair must be secured properly prior to the van moving. Inservices were held on riding with residents present stating that an approved person must sit in the back seats provided with the resident (s). A list was provided with the staff approved person (s) that is allowed to accompany residents on the facility van. Staff was able to express the new interventions that had been put into place.	F 323		

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
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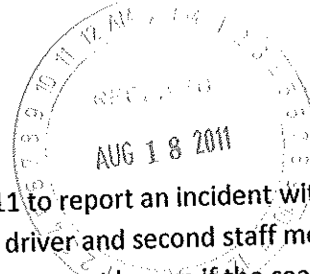
F 323	Continued From page 16 NA #7 revealed in an interview on 7/27/2011 at 11:20 AM she was inserviced the same day as the incident (6/3/2011). The new procedure is for the aide accompanying the driver to sit in the back seat closer to the resident. Someone from nursing is to come out and check the straps before the van leaves the facility. On 7/29/11, record review was made of the staff in-service records and new forms. On 7/29/11, completed audits were reviewed. On 8/8/11 at 1:33 pm an interview conducted with the Administrator who revealed he did not know the name of the original straps that were in the van at the time of the accident on 6/3/11. He did not have any written material about the original straps or who the manufacturer was.	F 323		

PLAN OF CORRECTION FOR VAN INCIDENT OF 6/3/2011



A. Corrective action for the affected resident:

- The van driver called the facility at 10:20AM on 6/3/11 to report an incident with the named resident. Based on the interviews of the resident, van driver and second staff member during the transport the resident fell out of the wheelchair. It was not known if the seatbelt was fastened correctly during the transport. The van came to a sudden stop at the intersection of Friendly Avenue and Washington Street. The van driver had already called 911 and the resident was checked by the driver and certified aide in the van.

- The primary physician was notified of the van incident for this resident at 10:25AM by the DON. Physician was in the facility at the time of the van driver call. The resident is her own responsible party.

- The Administrator notified the Regional Vice President (RVP) of the incident on 6/3/11 at 10:25 AM. Corrective action was initiated with the Administrator at that time.

- At 10:30 AM the DON, Administrator and Supply Clerk arrived at the scene of the incident. The DON completed an assessment of the resident and resident denied any pain and refused to go to the hospital.

- At 10:35 AM the resident was convinced by the DON to go to the hospital via EMS.

- At the hospital the resident was treated and released with no mention of knee injury or acute pain. The named resident returned to the facility at 2:00 PM on 6/3/11. (See hospital emergency report: attachment #1)

- The RVP notified the nursing consultant for this facility of the van incident on 6/3/11 at 3:00 PM for any further prevention/interventions that may have been required.

B. Corrective action for residents who the potential to be affected:

- The facility van was brought back to the facility on 6/3/11 at 10:55AM, by the supply clerk, who was trained on August 21, 2009. Her training included per the "Resident Transportation Audit": Chose and used appropriate placement of tie downs and safety belts, Secured wheelchair, geri-chair, rock n go chair in van, Secured resident(s) into the secured chair during transport to include use of physical restraints and/or enablers or positioning devices per individualized plan of care, Correct Van lift operation and safety demonstrated, Van seat belts utilized for resident(s), Use of cellular phone demonstrated (Van must be stopped when using), verbalize: Incident/accident reporting procedures Vehicle accident reporting procedures, Resident Emergency procedures, No smoking policy enforced, were transport procedures performed

correctly? After returning the van to the facility parking lot, the Administrator, Maintenance Director, DON and van driver checked the seat belt and tie downs. These were inspected and found to be in proper working order and good condition.

- The van was removed from service by parking it in the facility parking lot, locking the van, and the Administrator collected all van keys. The van keys were maintained by the Administrator in his office, secured in a locked drawer.

- Van Driver was suspended on 6/3/11 at 11:00 AM, pending investigation outcome. The driver was not allowed to drive the van back to the facility.

- No residents were transported by the only facility van, Greenhaven Healthcare and Rehab owns and operates, until the investigation of the incident and retraining had been completed. Arrangements for resident appointments were made using outside sources (sister facility transports).

- The facility van did not operate again until 6/6/11 at 9:30AM. The outcome of the investigation of the van incident revealed the seat belt was not clicked into the buckle completely.

- Upon use of the van on 6/6/11 at 9:30AM, the Administrator used the Audit Tool "QI Audit Tool of Van Transports of Residents" to ensure the driver (Supply Clerk) secured the resident's wheelchair and seatbelt properly before leaving the facility. The Administrator and the Supply Clerk left the facility with the resident. (See attachment 12) The Supply Clerk received training during the 100% inservices for retraining of the drivers (Maintenance Director and Supply Clerk) and the administrative nursing staff (DON, SDC, MDS nurses and day shift supervisor) began on 6/3/11 at 11:30 AM and were completed on 6/3/11 at 3:00 PM. The inservice training was provided by the Transportation Supervisor at a sister facility and was overseen by the Administrator. The areas of the inservice included Proper procedure for resident transportation, proper procedure, proper straps and proper hooks. How to secure the wheelchair correctly and the resident in the chair correctly. (See attachment #3)

- Upon return of the resident to the facility, the DON, (who was trained on 6/3/11 by the Administrator on how to use the Audit Tool "QI Audit Tool of Van Transports of Residents") used the Audit Tool "QI Audit Tool of Van Transports of Residents" to check the resident/employee for proper securing of the wheelchair and the seatbelt and employee seated in appropriate designated seat. (See attachment 12)

C. <u>Measures put in place to ensure deficient practice will not occur:</u>

- A pair of black shorter tie down straps from stock supply was used to replace the grey tie down straps in the van that secure the wheelchair to the floor of the van on 6/3/11. These new

straps were checked by the Administrator and Maintenance Director to ensure safety and proper operation on 6/3/11 at 1:00 PM. These were replaced during the inservice training for the van drivers, and nursing administrative staff members.

- The seatbelt was inspected by the Administrator, Maintenance Director and DON and was found to be in good working order and condition on 6/3/11 at 1:00 PM.

- On 6/6/11 the shoulder strap was implemented as an extra precautionary measure for securing the residents during transports. Additionally, two (2) more shoulder straps were purchased on 6/13/11 and installed on 6/13/11, to allow more than one (1) resident to transport at a time. The facility has a third set of tie down straps in the event more than two (2) residents will be transported in the van. (Attachment #2)

- A 100% inservices for retraining of the drivers (Maintenance Director and Supply Clerk) and the administrative nursing staff (DON, SDC, MDS nurses and day shift supervisor) began on 6/3/11 at 11:30 AM and were completed on 6/3/11 at 3:00 PM. The inservice training was provided by the Transportation Supervisor from a sister facility which included return demonstrations. This Transportation Supervisor was trained on 1/11/11 on the following: "Resident Transportation Audit": Chose and used appropriate placement of tie downs and safety belts, Secured wheelchair, geri-chair, rock n go chair in van, Secured resident(s) into the secured chair during transport to include use of physical restraints and/or enablers or positioning devices per individualized plan of care, Correct Van lift operation and safety demonstrated, Van seat belts utilized for resident(s), Use of cellular phone demonstrated (Van must be stopped when using), verbalize: Incident/accident reporting procedures Vehicle accident reporting procedures, Resident Emergency procedures, No smoking policy enforced, were transport procedures performed correctly?" The inservices for retraining by the Transportation Supervisor from a sister facility, were overseen by the Administrator who is certified in the "Sure-lok" training. This included presentation of information and the return demonstrations. The areas of the inservice included Proper procedure for resident transportation, proper procedure, proper straps and proper hooks. How to secure the wheelchairs (which include hemi, standard, medium, and large) correctly and the resident in the chair correctly. (See attachment #3) The facility does not utilize electric wheelchair, geri chairs and/or scooters in the van for transportation.

- Additional retraining was provided by the Administrator to emphasize the importance and severity of not following proper procedures for transportation. The retraining was provided during van driver skills checks and nursing administration skills checks on 6/3/11 to the Maintenance Director, Supply Clerk, DON, SDC, MDS nurse and dayshift Supervisor. The Administrator is certified in "Sure-Lok" training. (See attachment #4a and 4b)

- A 100% inservice training was given completed by 6/7/11 for certified nursing assistants, med aides, nurses and activity director and assistant, who would accompany as the second person on

transportation. The inservice sheet titled "Complete In-Service Training Report with Staff Attending" included the following topics: where to sit (in the back seats) with the resident and to assist the resident, you may not get out of the van, or leave the facility until the resident and the wheelchair have been checked for proper securing to prevent accidents. The payroll roster was utilized to ensure 100% of the certified nursing assistants, med aides, nurses and activity director and activity assistant received the training. The training was provided by the SDC, Administrator and DON to all three shifts. (See attachment #5)

No newly hired certified nursing assistant will be allowed to ride as the second person in the van. The list of staff who have been trained to be the second person on the van is kept by the Administrator, DON and Schedule Coordinator. (See attachment #6)

-- Van Driver was suspended on 6/3/11 at 11:00 AM, pending investigation outcome. The van driver did not drive the van at any time after the van incident. Upon completion of the investigation the van driver was terminated on 6/7/11. (See attachment # 11)

- A new form "QI Audit of Van Transports of Residents" was implemented on 6/6/11 to verify that all residents were secured appropriately in the van prior to leaving the facility and upon return to the facility with each transport. The Administrator, Maintenance Director, Supply Clerk, and/or the Administrative Nursing Staff will be responsible for these audits. (See Attachment #7)

D. <u>How the facility plans to monitor to ensure solutions are sustained.</u>

- The authorized van drivers as of 6/6/11 were the Maintenance Director, the Supply Clerk and the Administrator. Beginning 6/6/11 audits were completed using the "QI Audit of Van Transports of Residents" for each transport from the facility and upon return to the facility. The date, time, resident name, if the wheelchair was tied down correctly, (i.e. seat belt is pulled around the waist of the resident and hooked into the buckle; the wheelchair tie down straps are attached to the rail system located in the van floor; the shoulder strap is attached to the upper inside of the van, pulls down across the resident's chest area and attaches into the seat belt. This forms a three (3) point securing system of the resident in the wheelchair and van.), was the seat belt on the resident, was a second staff member necessary on the transport, and the signature of the Administrator, Maintenance Director, Supply Clerk or Administrative Nursing staff member performing the audit were recorded.

- At the monthly QI meeting held on 6/7/11 with the Medical Director, Administrator, DON, SDC and MDS nurse in attendance, it was decided the "QI Audit of Van Transports of Residents" would continue daily with each transport until the next QI meeting date of 7/5/11. No issues had been observed with any transports as of this date. (See attachment #8)

- At the monthly QI meeting held on 7/5/11 with the Administrator, DON, MDS nurse, SDC and Dietary Manager in attendance, it was decided the "QI Audit of Van Transports of Residents" would continue daily with each transport until the next QI meeting date of 8/2/11. The reason for continuation of these audits was to verify that a newly hired van driver would be audited for safety and compliance using the QI Tool. This was with the recommendation of the RVP to continue the audits on an ongoing basis. Findings will be reported at the quarterly Executive QI Committee meeting. No issues had been observed with any transports as of this date. (See attachment #9)

- As part of the preventative maintenance program, the Monthly audits will be ongoing using the "Safety Inspection – Facility Auto" for safety checks of van equipment of seat belts, tie downs to verify they are in good working order, have been done by the Maintenance Director. For the June audit, dated 6/15/11 under comments, the seat belts were checked as "yes" for being in "good repair" and "new shoulder straps" and floor straps was written by the Maintenance Director. These audits will continue to be completed on a monthly basis by the Maintenance Director. (See attachment #10)

- Any issues/concerns related to van transports or securing of residents for transports will be referred on the day of occurrence, to the Regional VP and/or Corporate Nursing Consultant. The Administrator will be responsible for oversight of any concerns for resolution and/or interventions as deemed necessary. Weekend operation of the van will be by primary van driver. Relief drivers include the Maintenance Director, Supply Clerk or Administrator.

- The results of the audits conducted will be forwarded by the Administrator/DON to the monthly QI Committee for review of potential trends or patterns, for follow up action as deemed appropriate and to determine the need for and/or frequency of monitoring to maintain continued compliance. The Executive QI Committee will review the audits on a quarterly basis as an ongoing preventative safety measure.