

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

PRINTED: 10/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/14/2011
NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 4500 CUMBERLAND ROAD FAYETTEVILLE, NC 28308	
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F 323 SS-J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure safe transport for 1 of 11 (Resident #1) sampled residents transported in a wheelchair in the facility van, that resulted in Resident #1 falling in the floor of the van during transport.</p> <p>Immediate Jeopardy began on 7/5/11 and was identified on 10/13/11 at 12:36 PM. Immediate Jeopardy was removed on 10/14/11 at 1:10PM, when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) the facility was in the process of full implementation and monitoring their corrective action. Findings include:</p> <p>Resident #1 was admitted to the facility on 6/21/11. Cumulative diagnoses included: Right/Left below Knee Amputation (BKA), General Muscle Weakness, Cerebrovascular Accident (Stroke), Dementia, End Stage Renal Disease and Atrial Fibrillation (A-Fib).</p>	F 323	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice – On 7/5/11, patient A.T. was being transported from appointment. During transportation, patient slid from chair. Transportation aide immediately called DON, who advised aide to call 911 since the aide needed assistance in getting the patient back up to the chair and also to rule out possible injury. TITLE</p>	7/5/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Uiki Moore N DON

Director of Nursing 11/9/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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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F 323	<p>Continued From page 1</p> <p>A review of the admission weight worksheet dated 6/21/11 revealed Resident #1's weight was 200 pounds.</p> <p>A review of the admission fall risk assessment form dated 6/22/11 indicated the resident was unable to stand due to a bilateral (both) amputee.</p> <p>The admission Minimum Data Set (MDS) completed on 6/28/11 indicated Resident #1 had short and long term memory problems, and was severely impaired with decision making. He was totally dependant with two plus person's physical assistance for transfer and totally dependent with one person physical assistance with locomotion on/off the unit. The MDS indicated balance during transition and walking did not occur. He was identified with impairment to the lower extremity and used a wheelchair for mobility.</p> <p>A review of the nurse's notes dated 7/5/11 at 10:04 PM revealed Resident #1 sustained a fall within the transportation van while in route back to the facility from dialysis (time of fall not indicated). The resident was transferred from the location (where the resident fell) to the hospital by EMS (Emergency Medical Services) to be evaluated.</p> <p>A review of the emergency room report dated 7/5/11 revealed Resident #1 was diaphoretic, in Atrial Fibrillation (A-Fib) with a pulse of 140, upon EMS arrival at the location. The resident presented to the emergency room with chief complaints of a fall/a-fib. Discharge condition was indicated with a primary diagnosis of A-Fib with RVR (Rapid Ventricular Response) secondary to</p>	F 323	<p>EMS arrived and transported patient to emergency room to assess patient. Patient returned to facility at approximately 10:30 PM on 7/5/11 and without complaints of pain and no injury. 24-hour and 5-day report submitted to state on transportation aide for possible neglect. Transportation aide was suspended in order for investigation to conclude on cause of patient fall. Investigation concluded and did not warrant the termination of the employee and did not substantiate the neglect allegation.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – Facility owned van taken out of use immediately and permanently. Transportation aide assumed role of CNA on the unit. Transportation no longer provided by the facility and is contracted through Victory Transportation, Inc. Families encouraged to transport patients when possible. Completion 7/5/2011</p>	7/5/2011	7/5/2011

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F 323	Continued From page 3 fall) to transport residents to all future dialysis appointments to prevent further fall occurrences. In an interview on 10/11/11 at 11:55 AM, NA #1 (transporter) indicated she had transported residents to/from appointments for the facility for approximately 4 years. She stated she was no longer a transporter for the facility, nor had the facility van been used to transport residents since Resident #1's fall in July 2011. NA #1 added previously (no date given) she had transported Resident #1 twice without any problems, with the resident positioned and securely strapped in the center of the facility van, with no other residents located in the van. NA #1 added upon arrival at the dialysis center there were two residents that needed to be transported back to the facility (Resident #1 and Resident #11). So, she attempted to transport both residents back to the facility at once in the facility van. She stated she positioned Resident #1's wheelchair behind the bench seat with his left side facing the back of the bench seat and his back facing the window of the van, and the other resident was positioned in the center of the van. NA #1 indicated she had never placed Resident #1 in this position before and she had difficulty getting the lap belt to fit properly due to the wideness of the wheelchair and size of Resident #1. She elaborated where Resident #1 was positioned in the van, the belt was not long enough to make a lap-belt (due to size) so she put the lap belt across Resident #1's right shoulder. She also indicated Resident #1 was positioned in the wheelchair with one pillow behind his back, a hoyer pad underneath (butlocks to shoulder) and was sitting on pillows that one would sleep on per quote "I think two pillows." NA #1 stated she secured three points	F 323	Facility transportation needs were reviewed by the QA committee and Victory Transportation was considered for their safety requirements and as a result, Victory provided the following plan for transportation safety. Completion 4/25/2011 Any driver found negligent or not in compliance with company's safety policies and procedures will be immediately terminated In the event of an accident or an emergency the following steps will be taken: If any injury occurs to a patient the driver should immediately call 911, regardless if they can visualize any injuries, and notify health care facility. Wait for law enforcement. Do not move vehicle until authorized by law enforcement or the situation dictates otherwise Report accident to supervisor as soon as possible Provide accident documentation to supervisor upon return to office and file accident record.	4/25/11

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F 323	Continued From page 4 of the lower frame of the wheelchair to the metal hooks bolted to the floor of the van. NA #1 revealed while in route back to the facility when she made a left turn she heard Resident #11 who was positioned in the center of the van state, " He is falling." Upon looking in the rear mirror she indicated she saw Resident #1 's head going downward. Then, she pulled the van over and observed the resident positioned on the floor on his buttocks in front of the wheelchair, with the lap belt positioned under his left arm, across his neck, with his head positioned leaning backward. She added she pushed the button to release the lap belt. Thereafter, NA #1 indicated she called back to the facility and informed what had happened. She stated the Director of Nursing (DON) called her back and instructed her to call 911, NA #1 revealed she then called 911 as instructed and Resident #1 was transported to the hospital to be evaluated. Afterwards, she proceeded back to the facility with Resident #11 in the facility van. NA #1 concluded she felt uncomfortable for two years while transporting large residents/large wheelchairs in the facility van due to the lap belt was not tight enough to support the resident during transport. NA #1 stated she did not report this concern to anyone because she was fearful of losing her job. NA #1 (transporter) added approximately 4 years ago the former Director of Nursing installed seat belts in the facility van himself and verbally indicated to her how to securely strap a gerichair and wheelchair. She indicated she was not asked to do a return demonstration to validate her competency with safely securing a wheelchair or a gerichair in the facility van. On 10/11/11 at 2:45 PM, NA #1 (transporter)	F 323	Unless the driver has been designated by management or the health care facility to be a first aid responder, the driver will not provide first aid. Make the patient as comfortable as possible until medical help arrives. Upon Health Care Facility notification, Nurse Manager, DON or Administrator will notify Responsible party or emergency contact. Measures to be put in place or systemic changes made to ensure practice will not re-occur Facility suspended use of facility owned van immediately and permanently. Completion 7/5/2011 Transportation provided through Victory Transportation, Inc. Victory Transport has the following policies: Completion 4/25/2011 Implementation of a driver reward/incentive program to make safe driving an Integral part of the company Documentation of driver training and responsibilities, including safety strap checklist (done quarterly and prn)	4/25/11 7/5/2011 4/25/2011

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F 323	<p>Continued From page 5</p> <p>demonstrated how she positioned Resident #1 in the facility van on the day of the fall on 7/5/11. During the observation in the facility van, NA #1 stated the wheelchair used for demonstration was smaller than Resident #1's wheelchair. The wheelchair for Resident #1 was positioned behind the bench seat with one's left arm facing the bench seat (parallel to bench seat). The lower frame of the wheelchair was secured to the floor of the facility van at 3 points (left front, right front and right back). The lower back frame of the wheelchair (left side) was not secured to the floor of the van. NA #1 extended a long (single) lap belt that connected from the floor of the van (left side of the wheelchair, near the back wheel) and was positioned behind the wheelchair arm rest, under the left arm, across the chest/right shoulder and connected into a single buckle belt that dangled from the right side of the resident (suspended from the side of the van). The lap belt was observed to be loose and did not provide tightness or resistance if one leaned forward.</p> <p>During an interview on 10/12/11 at 8:10 AM with the Administrator/DON regarding NA #1's employee's file revealed there was no documented skills competency/validation training of transports of residents in the facility van. The administrator indicated she would have the former DON who presently worked at the corporate office; e-mail her a statement regarding NA #1's training (A copy of the training was not provided during the survey investigation).</p> <p>In an interview on 10/12/11 at 8:15 AM, the administrator revealed she was unable to locate the facility's van operational manual for guidance, on how to secure the seat belts in the</p>	F 323	<p>Frequently communicate safety to drivers via email and training sessions</p> <p>Education of drivers upon hire, once per month for 3 months and then quarterly thereafter</p> <p>Upon hire each driver is required to learn how to safely get a patient in and out of the vehicle and how to properly secure the patient in the wheelchair inside the vehicle, and how to use the FE500 Series Systems-Track Applications, which includes the front, and rear tie-downs that are used in securing the wheelchair and the lap and shoulder belt that is used to secure the patient. Victory Transport uses the operation instructions that are recommended by the company SURE_LOK. A copy of the operation instructions is attached.</p> <p>In the event that an incident occurs, Any deficient practice or concern will be addressed at the time of the occurrence. These results will be presented to the Quality Assurance & Assessment committee risk management weekly, and monthly for any additional recommendations. Administrator responsible.</p>	

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F 323	Continued From page 6 van. In an interview on 10/12/11 at 11:55 AM, NA #1 (transporter) indicated it was not unusual for her to transport two residents at one time in the facility van back from dialysis. She added it was the size of Resident #1 that made it difficult for her to secure the resident. NA #1 stated "I had thought the straps were not secure, the straps were not tight, hopefully it will work, we don't have far to go" prior to transport of the resident back to the facility, from the dialysis center. In an interview on 10/13/11 at 8:10 AM, the Administrator and DON revealed the corporate office did not have a copy of the operational manual for the facility's van. The administrator added she discussed with the corporate office after Resident #1's fall, the van needed to be taken out of commission to prevent any potential worse occurrences. In an interview on 10/13/11 at 8:15 AM, NA #1 (accompanied by the administrator) revealed she felt uncomfortable with transport of Resident #1 back from the dialysis center, due to she had never positioned the resident as she did when he fell on 7/5/11 (behind and parallel to the bench seat). She stated the belt straps were loose when the resident was positioned in the van prior to transport back from the dialysis center. Resident #11 could not be interviewed due to the resident no longer resided in the facility. The administrator was notified of the Immediate Jeopardy on 10/13/11 at 12:38 PM. The facility provided an allegation of compliance on 10/13/11 at 5:27 PM. The allegation of compliance	F 323	How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Facility no longer uses facility owned van. Completion 7/5/2011 Transportation provided through Victory Transportation, Inc. Victory Transport has the following policies: Completion 4/25/2011 Implementation of a driver reward/incentive program to make safe driving an integral part of the company Documentation of driver training and responsibilities, including safety strap checklist (done quarterly and prn) Frequently communicate safety to drivers via email and training sessions Education of drivers upon hire, once per month for 3 months and then quarterly thereafter Upon hire each driver is required to learn how to safely get a patient in and out of the vehicle and how to properly secure the patient in the	7/5/11 4/25/11	

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F 323	<p>Continued From page 7</p> <p>Indicated: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 7/5/11, patient was being transported from appointment. During transportation, patient slid from chair. Transportation aide immediately called DON, who advised aide to call 911 since the aide needed assistance in getting the patient back up to the chair and also to rule out possible injury.</p> <p>EMS arrived and transported patient to emergency room to assess patient. Patient returned to facility at approximately 10:30 PM on 7/5/11 and denied pain. 24-hour and 5-day report submitted to state on transportation aide for possible neglect. Transportation aide was suspended in order for investigation to conclude on cause of patient fall. Investigation concluded and did not warrant the termination of the employee and did not substantiate the abuse allegation.</p> <p>How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: Facility owned van taken out of use immediately. Transportation aide assumed role of CNA on the unit. Transportation no longer provided by the facility-owned van, and is contracted through (name of a contracted transportation company). Families encouraged to transport patients when possible. Completion 7/6/2011</p> <p>(Contracted transportation company) provided statement that they can transport 2 Wheelchairs (less than 30 inches) or 1 Geri Chair and 1 small</p>	F 323	<p>wheelchair inside the vehicle, and how to use the FES00 Series Systems-Track Applications, which includes the front, and rear tie-downs that are used in securing the wheelchair and the lap and shoulder belt that is used to secure the patient. Victory Transport uses the operation instructions that are recommended by the company SURE_LOK. A copy of the operation instructions is attached.</p> <p>In the event that an incident occurs, Any deficient practice or concern will be addressed at the time of the occurrence. These results will be presented to the Quality Assurance & Assessment committee risk management weekly, and monthly for any additional recommendations.</p> <p>Chris Thomas, owner of Victory Transport, Inc. will observe driver performance by doing ride-along and reviewing and assessing drivers' safety skills on a quarterly basis. A written summary of the number of ride along's and assessment of driver safety skills will be provided quarterly to Administrator by Chris Thomas.</p> <p>In the event that Victory Transport is unable to transport, County EMS will be contacted to provide transportation.</p>	

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F 323	<p>Continued From page 8</p> <p>Wheelchair (20 in) at the same time. Any resident requiring a wheelchair greater than 30 inches will be transported by County EMS. Completion 10/14/11</p> <p>Patients that require transportation will be assessed on admission and PRN (as needed) using the "Ticket to Ride assessment form" for the appropriate type of transportation. Copy of assessment will be provided to (contracted transportation company). DON or Unit Managers will audit assessment completion, and verify a copy given to (contracted transportation company), and that was transported appropriately based on assessment needs. 2 patients per week X 4 weeks. Audits will be reviewed at weekly risk management meeting and monthly QA (Quality Assurance) X 1. Any deficit practice or concern will be discussed for further recommendations. DON, Unit Manager or House Supervisor responsible. Completion 10/14/2011</p> <p>Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>Facility no longer uses transportation facility owned van. Completion 7/5/2011</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility:</p>	F 323	<p>Patients that require transportation are assessed on admission and PRN using the "Ticket to Ride assessment form" (see attached) for the appropriate type of transportation. Copy of Ticket to Ride will be provided to Victory Transport. Don or Unit Managers will audit Ticket to Ride form completion, and verify a copy given to Victory transport, and that resident was transported appropriately based on assessment needs, 2 patients per week X 4 weeks. Audits will be reviewed at weekly risk management meeting and monthly QA X 1. Any deficit practice or concern will be discussed for further recommendations. Completion 10/14/2011 Don, Unit Manager or House Supervisor responsible.</p>	10/14/2011

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F 323	Continued From page 9 Facility no longer uses facility owned van. Completion 7/6/2011 The allegation of compliance was verified on 10/14/11 at 1:10PM, as evidence by interviews with facility staff/contracted transportation agency staff related to: the maximum size wheelchair a resident could be transported in, the facility procedure for residents who required transport in a wheelchair greater than 30 inches, the facility process for the ticket to ride when transportation arrived at the facility for transport of the residents to appointments. Observations of the pick up process included observing the contracted agency arrival at the facility, pick up the ticket to ride form from the nurses station (prior to transport of the resident). Each nurse 's station had a ticket to ride binder located at each nurse 's station with specific information how the resident was to be transported. The ticket to ride identified the resident, room number, type of transport, any special considerations and a signature by the nurse and initial of the transporter. A copy was given to the transporter upon initial for transport in the presence of the nurse releasing the resident.	F 323			