STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345425	A. BUILDING _____ B. WING _____	04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

(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 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification investigation ending on 04/16/14. Immediate Jeopardy (IJ) was indentified at 483.25. The IJ started on 12/16/13 through 12/17/13. The recertification and extended survey was completed on 04/16/14 and no current deficient practice was identified.	F 000		
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 and resident interviews and record review, the facility failed to secure a resident according to manufacturer's instructions which resulted in 1 of 4 residents reviewed for accidents turning over in his wheelchair during transport (Resident #40). The findings included: The facility provided an undated copy of instructions for use of the Q'Straint system for securing a resident in a wheelchair in a van equipped with four tiedown anchorage points in the van floor. The instructions indicated the	F 323	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/14/2014

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following: The wheelchair should be centered squarely on all four corners of the tiedown anchorage points. Q'Straint belts should first be attached to a solid frame member of the wheelchair on both front corners and then attached to the front anchorage points in the floor. Belts should then be snugged and locked. The procedure should then be repeated for both back corners of the wheelchair and back anchorage points. Back belts should then be snugged and locked. The wheelchair should then be checked for any movement back and forth.

Resident #40 was admitted to the facility on 10/08/13 with diagnoses including dementia with Lewy bodies, peripheral neuropathy, and insomnia. The resident was discharged from the facility on 01/06/14 and returned home. Review of Resident #40's most recent Minimum Data Set (MDS) assessment dated 01/06/14 revealed the resident was moderately cognitively impaired. Resident #40 required extensive assistance with mobility and activities of daily living.

Resident #40's care plan dated 10/30/13 specified he had a potential for falls related to recent history of falls with unsteady gait secondary to Lewy body dementia. The care plan goal was as follows: "Lessen potential for fall related injury until 01/22/14."

A review of an incident/accident report dated 12/16/13 at 8:30 AM revealed Resident #40 was involved in an incident in the facility's transport van. The incident report noted that on the way to an adult day care center, Transporter #1 made a turn and the wheelchair with Resident #40 in it turned over to the left. Transporter #1 stopped the van and noted that Resident #40 was responsive

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and did not appear to be seriously injured. Transporter |#1 noted in the incident report that Resident #40 was alert and denied any pain or injury several times. The report noted that Transporter #1 assisted Resident #40 back into his wheelchair.

Review of Resident #40's closed medical record revealed a nurse's note written on 12/16/13 at 6:08 PM. This note described Resident #40 as being up in his wheelchair and the resident's responsible party was visiting. The resident had voiced no complaints. Resident #40 was placed on the head trauma protocol related to a fall in the facility's van earlier in the day. No problems were noted. Further review of Resident #40's medical record included head trauma protocol documentation. No abnormal assessment findings were noted as a result of the head trauma protocol assessments.

On 04/15/14 at 3:38 PM the Director of Nursing (DON) was interviewed. The DON stated on 12/16/13 at 8:30 AM she was contacted by Transporter #1 and informed Resident #40 had fallen over in his wheelchair while being transported in the van. The DON asked Transporter #1 if the resident was injured. Transporter #1 reported that Resident #40 was alert, denied any pain or injury, and wanted to continue on to the adult day care center rather than return to the facility. The DON instructed the transporter to inform the nurse at the adult day care center about the accident and have her assess the resident on arrival. Resident #40 remained at the adult day care for the day and returned to the facility later that evening. The DON reported that Resident #40 was also assessed after returning to the facility by Nurse

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#1. The DON stated she notified Resident #40's responsible party of the accident in the van shortly after it occurred and she (responsible party) said she would go to the adult day care to check on the resident. The DON stated when Transporter #1 returned to the facility re-training was implemented immediately regarding how to secure a resident in a wheelchair according to manufacturer's instructions.

On 04/15/14 at 4:34 PM an observation was conducted of Transporter #1 returning to the facility with a resident in the facility's transport van. The resident was secured with 4 tiedown straps connected to the van wheelchair restraint system according to manufacturer's instructions.

On 04/15/14 at 4:42 PM Transporter #1 was interviewed. Transporter #1 explained she was transporting Resident #40 to adult day care and was turning on to the street from another street and his wheelchair went onto the left side. Transporter #1 stated Resident #40 was still buckled in and did not come out of the chair until she removed the buckle and removed him from the chair. Transporter #1 stopped the van and called the DON to inform her that Resident #40 had fallen in the van. Transporter #1 stated that the DON had her determine that the resident was conscious with no signs of injury. Resident #40 denied any pain or injuries and was placed back into the wheelchair. Transporter #1 asked Resident #40 if he wanted to return to the facility or continue to adult day care. Resident #40 replied he wanted to go to adult day care. Once they arrived at the adult day care Transporter #1 reported to the nurse Resident #40 had fallen in the van during transport. Transporter #1 returned to the facility and reported the incident to the

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Assistant Administrator. Transporter #1 stated she had knowledge and understanding of how to safely secure a resident in the wheelchair restraint system, but on 12/16/13 she had forgotten to attach the front 2 straps to ensure the residents wheelchair did not move while traveling in the van.

On 04/16/14 at 2:52 PM a follow-up interview was conducted with the DON. The DON stated Resident #40 was assessed by Nurse #1 after returning to the facility. Resident #40 showed no signs of complications related to the fall in the facility's transport van. The DON further stated the facility continued monitoring Resident #40 for 2 days ensuring the resident had not suffered any internal injuries.

On 04/16/14 at 3:53 PM Nurse #1 was interviewed about the assessment of Resident #40 after returning from adult day care on 12/16/13. Nurse #1 described checking Resident #40 from head to toe and he presented no signs of injury. Due to the accident being a fall Nurse #1 placed Resident #40 on the head trauma protocol. The head trauma protocol assessed vital signs, pupil response, temperature and pain. The head trauma protocol also included checking for dizziness and seizure activity to ensure no internal injuries. Nurse #1 stated that Resident #40 presented no signs of internal injury.

On 04/16/14 at 4:53 PM the Assistant Administrator was interviewed. After Transporter #1 returned to the facility the DON informed the Assistant Administrator the van accident had occurred and Resident #40 had suffered no injuries. At this time the DON and the Assistant Administrator started the facility's investigation of

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Resident #40's fall in the facility's van during transport which occurred on 12/16/13. On 12/16/13 Transporter #1 was re-educated on how to secure wheelchairs in the facility's van using "Transit Operational Video" and the "Ride Safe" manual. A demonstration of how to properly secure the 4 tie down straps was reviewed and Transporter #1 performed a return demonstration. Transporter #1 explained to the Assistant Administrator she knew how to secure the 4 tie down straps, but she had just forgotten to secure the front 2 straps on 12/16/13.

On 04/16/14 at 11:56 AM the facility Administrator stated since 12/16/13 the facility had implemented corrective actions to ensure residents were secured during transport on the facility's van according to manufacturer's instructions, indicating past non-compliance from 12/16/13 to 12/17/13. The Administrator specified these corrective actions included the implementation of the following measures:

· Transporter #1 was re-educated/re-trained on proper installation of straps on wheelchairs by Assistant Administrator on 12/16/13.
· Return demonstration was given by Transporter #1 of securing a wheelchair and resident in van on 12/16/13.
· In order to prevent re-occurrence, a new transportation log was created that required the transporte's initials for verification that all four tie down straps were connected securely and safety belt was properly fastened.
· Transporter #1 was retrained by watching "Transit Operational Video" and receiving another copy of "Ride Safe" manual, and was trained on the newly implemented "transporter safety check log," all on 12/16/13.
· Transporter #1 received a written warning for

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violating safety practices that may result in serious injury, as outlined in Employee Handbook

· Transporter #1 was monitored for competency by administrative staff on 12/16/13, 01/15/14, 01/22/14, 03/07/14, 03/20/14, 03/26/14 and 04/10/14.

A. During the outing on 03/20/14 resident #939 (number assigned by facility) stated she felt securely fastened in the van

B. During the outing on 03/26/14 resident #928 (number assigned by facility) stated she felt securely fastened in the van

C. During the outing on 04/10/14 resident #928 (number assigned by facility) stated that she felt securely fastened in the van

· Transporter safety check logs are turned into Assistant Administrator as they are filled for review for ongoing compliance. The proper completion of these forms was discussed at the quarterly Quality Assurance Meetings on 01/21/14 and 04/08/14.

Observations, review of facility documentation, and interviews with staff and residents during the 04/16/14 survey revealed the facility had implemented these corrective actions beginning on 12/16/13 to ensure resident safety when transported in the facility's van. Interviews with the facility's transporter revealed she was provided with instructions on the van's wheelchair restraint system and demonstrated she was knowledgeable on how to properly attach the 4 tie down straps to secure a resident during transport according to manufacturer's instructions. Additionally, observations of the van's wheelchair restraining system revealed it to be in good repair with all equipment in good working order. Review of facility documentation and interviews with the facility's Administrator on 04/16/14 revealed the

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F 323	Continued From page 7 facility implemented monitoring measures to ensure continued compliance beginning on 12/16/13 which included monitoring the facility transporter for competency by the Administrator and Assistant Administrator to ensure residents were secured according to manufacturer's instructions. Transporter #1 was responsible for documenting compliance on the transporter safety check log. The Assistant Administrator was responsible for ensuring compliance on the facility's Quality Assurance (QA) monitoring tool. The Assistant Administrator and Administrator stated they had monitored the facility's QA data information collected by staff since 12/16/13. The Administrator further stated that during the months since the incident in December 2013 no further van accidents had occurred.	F 323		