STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	09/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(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 A recertification survey was conducted from 09/05/2017 through 09/09/2017. Past-noncompliance was identified at: CFR 483.25 at tag F309 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) The tags F309 and F323 constituted Substandard Quality of Care. Past-noncompliance for tags F309 and F323 began on 08/30/2017. The facility corrected the deficient practice at tags F309 and F323 effective 8/31/2017. An extended survey was conducted. The facility is currently out of compliance and need a plan of correction for tags F241, F242 and F371.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to toilet residents upon request to three of three residents	F 241	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of	10/4/17

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

Electronically Signed | 09/22/2017

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F 241	Continued From page 1 reviewed for dignity (Resident ' s #53, 173 and #62). Findings included: 1. Resident #53 was admitted to the facility on 12/16/2016 with diagnoses to include hemiplegia, overactive bladder and chronic loose stools. The quarterly Minimum Data Set (MDS) assessment dated 8/23/2017 assessed her to be cognitively intact with verbal behaviors noted. The resident required extensive, one person assistance with bed mobility, transfers, toileting, and hygiene. The MDS assessed her as frequently incontinent of bowel and bladder. An interview was conducted with Resident #53 on 9/6/2017 at 11:47 AM. She reported that the staff would not assist her out of bed when they were feeding the dependent residents. She further reported she had difficulty controlling her bowel movements and frequently had incontinent, liquid stools in bed because the staff would not get her up to the bathroom. She concluded by reporting that she didn ' t like having incontinent stools in bed and she felt upset because she couldn ' t control her bowels, and staff knew that she had loose stools after breakfast. Nursing assistant (NA) #1 was interviewed on 9/7/2017 at 9:00 AM. She reported she was frequently assigned to provide care for Resident #53. She reported that dependent residents were served meals first so they could be fed before the other residents got their meals. The NA went on to explain that if a resident needed to use the toilet during the time that staff were feeding the dependent residents, the NA would ask a nurse on the floor to assist, but the NA would not stop	F 241	correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. The director of nursing met with the affected residents in the CMS-2567 and discussed their preferences. The residents all agreed individually to toilet prior to meals if they needed. This was conveyed to staff through in-servicing. For residents that have the ability to be affected, all staff were in serviced on resident rights including, but not limited to, the freedom to toilet depending on their preference of when. If CNAs are feeding dependent residents, nurses must step up to toilet the resident. If they are in a med pass or other obligation that prevents their assistance, they should identify the person or persons that can offer assistance. Management will conduct quarterly interviews with a random selection of residents that include similar residents that could be effected. If any issues are identified, it will be immediately corrected through in-serving or other sensitivity training deemed most appropriate to address the issue. To ensure on-going compliance, the director of nursing or the clinical care competency coordinator will attempt to interview 3 residents that are cognitively	

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F 241	Continued From page 2 feeding to assist a resident to the bathroom. She further reported that all nursing assistants on the hall were assigned to feeding dependent residents and no nursing assistants were assigned to answer call lights during meals. Nurse #1 was interviewed on 9/7/2017 at 9:12 AM. She reported that she was familiar with Resident #53. Nurse #1 further reported if a resident required assistance to use the bathroom while the nursing assistants were feeding dependent residents, the nurses would assist residents on the hall, if the nurses were not in the middle of a medication pass. Nurse #2 was interviewed on 9/8/2017 at 10:34 AM. He reported he worked all areas of the facility, and was familiar with Resident #53. He reported some female residents did not want a male nurse to assist with toileting and Resident #53 did not want him to assist her. He conveyed he would find another nurse to assist a resident to toilet, if they did not want him to assist them. He concluded by reporting he would not interrupt the feeding of dependent residents for a nursing assistant to assist another resident to toilet. The Unit Manager was interviewed on 9/8/2017 at 10:45 AM. She reported there were a large number of dependent residents who required total assistance to eat a meal. She reported that due to the large number of dependent residents, all nursing assistants assigned to the 500/600 hall assisted the dependent residents with meals. She then reported that no nursing assistants were assigned to answer lights during meals. She also described that if a resident wanted to get out of bed before a meal, the nursing assistants would have to choose between that resident and a dependent resident to assist out of bed. She also	F 241	aware of their toileting needs and the ability to request assistance regardless of the timing to ensure their dignity is preserved for 2 weeks. This follow-up will then for 2 residents for 2 additional weeks and then on a PRN basis. The director of nursing will then interview 2 residents a month for the next 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. This will be in addition to any quarterly interviews or in-serving conducted. This plan of correction and follow-up will be monitored by our QA committee in October, November and December or until substantial compliance is achieved to ensure we have appropriate corrective action.	

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reported that the nursing assistants offered toileting to residents prior to meals. She concluded by sharing the facility did not pause meals for dependent residents to provide toileting, but nurses and supervisors were available to assist to answer call bells on the halls.

The Director of Nursing was interviewed on 9/9/2017 at 9:50 AM. She reported that it was her expectation that if nursing assistants were busy feeding dependent residents, the nursing staff would pitch in or call management to assist in the care of residents on the hall.

2. Resident #173 was admitted to the facility on 9/15/2016 with diagnoses to include hypertension, osteoarthritis and edema (swelling). The most recent quarterly MDS dated 7/4/2017 assessed the resident to be cognitively intact. The resident required extensive, one person assistance with bed mobility, transfers, toileting, and hygiene and was assessed as frequently incontinent of bowel and bladder.

Resident #173 was interviewed on 9/8/2017 at 3:30 PM. She reported she had called for assistance to use the bed pan during meals and had to use her incontinence brief to urinate because the staff had not assisted her. She denied she had been incontinent of stool, but shared that she was able to hold her bowel movements, which caused her physical and emotional discomfort. She reported she would take a laxative at 3:00 PM and would need to have a bowel movement between 4:00 PM and 5:30 PM and sometimes she had to hold her bowel movement because staff were not available to assist her onto the bedpan. She

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concluded that it was upsetting when she called for assistance and was not assisted by the staff.

NA #1 was interviewed on 9/7/2017 at 9:00 AM. She reported that dependent residents were served meals first so they could be fed before the other residents got their meals. The NA went on to explain that if a resident needed to use the toilet during the time that staff were feeding the dependent residents, the nursing assistants would ask a nurse on the floor to assist, but the NA would not stop feeding to assist a resident to the bathroom. She further reported that all nursing assistants on the hall were assigned to feeding dependent residents and no nursing assistants were assigned to answer call lights during meals.

Nurse #1 was interviewed on 9/7/2017 at 9:12 AM. Nurse #1 reported if a resident required assistance to use the bathroom while the nursing assistants were feeding dependent residents, the nurses would assist residents on the hall, if the nurses were not in the middle of a medication pass.

Nurse #2 was interviewed on 9/8/2017 at 10:34 AM. He reported he worked all areas of the facility. He reported some female residents did not want a male nurse to assist with toileting. He conveyed he would find another nurse to assist a resident to toilet, if they did not want him to assist them. He concluded by reporting he would not interrupt the feeding of dependent residents for a nursing assistants to assist another resident to toilet.

The Unit Manager was interviewed on 9/8/2017 at 10:45 AM. She reported there were a large

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F 241	Continued From page 5	F 241		

number of dependent residents who required total assistance to eat a meal. She reported that due to the large number of dependent residents, all nursing assistants assigned to the 500/600 hall assisted the dependent residents with meals. She then reported that no nursing assistants were assigned to answer lights during meals. She also described that if a resident wanted to get out of bed before a meal, the nursing assistants would have to choose between that resident and a dependent resident to assist out of bed. She also reported that the nursing assistants offered toileting to residents prior to meals. She concluded by sharing the facility did not pause meals for dependent residents to provide toileting, but nurses and supervisors were available to assist to answer call bells on the halls.

The Director of Nursing was interviewed on 9/9/2017 at 9:50 AM. She reported that it was her expectation that if nursing assistants were busying feeding dependent residents, the nursing staff would pitch in or call management to assist in the care of residents on the hall.

3. Resident #62 was admitted to the facility on 9/1/2016 with diagnoses to include atrial fibrillation, congestive heart failure and cardiac pacemaker status. The quarterly MDS dated 7/4/2017 assessed the resident to be moderately cognitively impaired and she required extensive, one person assistance with bed mobility, transfers, toileting, and hygiene. She was assessed as having occasional bladder incontinence and was continent of bowels.

An interview was conducted with Resident #62 on 9/8/2017 at 3:19 PM with a family member

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present. The resident reported if she had to use the toilet and it was meal time, she was told by staff she would have to wait. She further reported she had requested to toilet during meals and had been told "no" by staff, which caused her anxiety. The family member agreed with the report of Resident #62 and stated she had heard staff refuse to assist her mother to the toilet during meals.

NA #1 was interviewed on 9/7/2017 at 9:00 AM. She reported that dependent residents were served meals first so they could be fed before the other residents got their meals. The NA went on to explain that if a resident needed to use the toilet during the time that staff were feeding the dependent residents, the nursing assistants would ask a nurse on the floor to assist, but the nursing assistants would not stop feeding to assist a resident to the bathroom. She further reported that all nursing assistants on the hall were assigned to feeding dependent residents and no nursing assistants were assigned to answer call lights during meals.

Nurse #1 was interviewed on 9/7/2017 at 9:12 AM. Nurse #1 reported if a resident required assistance to use the bathroom while the nursing assistants were feeding dependent residents, the nurses would assist residents on the hall, if the nurses were not in the middle of a medication pass.

Nurse #2 was interviewed on 9/8/2017 at 10:34 AM. He reported some female residents did not want a male nurse to assist with toileting. He conveyed he would find another nurse to assist a resident to toilet, if they did not want him to assist them. He concluded by reporting he would not

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F 241	Continued From page 7 interrupt the feeding of dependent residents for a nursing assistant to assist another resident to toilet. The Unit Manager was interviewed on 9/8/2017 at 10:45 AM. She reported there were a large number of dependent residents who required total assistance to eat a meal. She reported that due to the large number of dependent residents, all nursing assistants assigned to the 500/600 hall assisted the dependent residents with meals. She then reported that no nursing assistants were assigned to answer lights during meals. She also described that if a resident wanted to get out of bed before a meal, the nursing assistants would have to choose between that resident and a dependent resident to assist out of bed. She also reported that the nursing assistants offered toileting to residents prior to meals. She concluded by sharing the facility did not pause meals for dependent residents to provide toileting, but nurses and supervisors were available to assist to answer call bells on the halls. The Director of Nursing was interviewed on 9/9/2017 at 9:50 AM. She reported that it was her expectation that if nursing assistants were busy feeding dependent residents, the nursing staff would pitch in or call management to assist in the care of residents on the hall.	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments,	F 242		10/4/17

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F 242	Continued From page 8 and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to give a resident a choice regarding the time she wanted to get out of bed for the day for one of three residents reviewed for choices (Resident ' s #53). Findings included: Resident #53 was admitted to the facility on 12/16/2016 with diagnoses to include hemiplegia, overactive bladder and chronic loose stools. The quarterly Minimum Data Set (MDS) assessment dated 8/23/2017 assessed her to be cognitively intact with verbal behaviors noted. The resident required extensive, one person assistance with bed mobility, transfers, toileting, and hygiene. The MDS assessed her as frequently incontinent of bowel and bladder. An interview was conducted with Resident #53 on 9/6/2017 at 11:47 AM. She reported that the staff would not assist her out of bed before breakfast, which was her preference. An observation was made of Resident #53 on 9/7/2017 at 8:42 AM. The resident had turned on her call bell to request getting out of bed. The	F 242	For the resident affected, on 9/19/17, the director of nursing met with Resident #53 to determine when she wanted to get out of bed. Though it was difficult to identify a time, staff will be sensitive to allow her to dictate when she would like to get up in the mornings. For residents that have the ability to be affected, staff interviewed 7 cognitively intact residents and all of their preferences were being met. However, they were encouraged if that ever changed, to let a nurse know so the facility could honor that wish. In addition, on 9/20/2017, all staff were in-serviced on the need to respect resident□s choices by allowing them to indicate when they wanted to receive certain services related to activities of daily living. Management will conduct quarterly interviews with a random sample of residents to ensure this and other dignity concerns are not present and if so, it will be immediately corrected through in-servicing of staff to ensure all residents□ dignity is respected.	

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F 242	Continued From page 9 nursing assistant (NA) #1 answered the call light at 8:45 AM and was heard telling Resident #53 she could not get out of bed until after breakfast, it was her shower day. An interview was conducted with Resident #53 on 9/7/2017 at 8:54 AM. She reported she wanted to get out of bed, and was told because it was her shower day, she had to wait in bed until it was time to shower. She reported she felt that she didn ' t have a choice for when she wanted to get out of bed and that made her feel frustrated. Nursing assistant (NA) #1 was interviewed on 9/7/2017 at 9:00 AM. She reported she was frequently assigned to provide care for Resident #53. She reported a change in procedures in the morning for providing care had been implemented recently and Resident #53 was upset she couldn ' t get out of bed when she wanted. NA#1 explained that Resident #53 was unhappy that other residents were getting out of bed for breakfast and she was not. Nurse #1 was interviewed on 9/7/2017 at 9:12 AM. She reported that she was familiar with Resident #53. Nurse #1 reported that usually on scheduled shower days, Resident #53 would stay in bed until it was time to shower. She was not aware the resident wanted to get out of bed. The Unit Manager was interviewed on 9/8/2017 at 10:45 AM. She reported the NA on the hall have the option of getting a dependent resident up for the day prior to breakfast, or a resident who can feed themselves, but if the NA chooses to get an independent resident up before breakfast, the dependent residents will need to be fed in bed. The Unit Manager was asked if the aides were deciding for the residents the time they were	F 242	To ensure on-going compliance, the director of nursing or the clinical care competency coordinator will attempt to interview 3 residents that are cognitively aware of their toileting needs and the ability to request assistance regardless of the timing to ensure their dignity is preserved for 2 weeks. This follow-up will then for 2 residents for 2 additional weeks. The director of nursing will then interview 2 residents a month for the next 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. All new hires will be in-serviced as part of orientation and all staff will be in-serviced on dignity of our residents annually This plan of correction and the results of these audits will be reviewed by the QA committee in October, November, and December or until substantial compliance is achieved to ensure we have appropriate corrective action.	

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F 242	Continued From page 10 gotten out of bed in the morning and the Unit Manager answered "yes", but then clarified by reporting that if a resident did not want to get out of bed for the day before breakfast, they were not gotten up. The Director of Nursing was interviewed on 9/9/2017 at 9:50 AM. She reported that it was her expectation that if nursing assistants were busy feeding dependent residents, the nursing staff would pitch in or call management to assist in the care of residents on the hall.	F 242		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is	F 309		9/22/17

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F 309	Continued From page 11 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews with resident, family, facility staff, contracted van transportation driver and owner, and record review, the facility failed to ensure that a resident was assessed by medical professionals before he was lowered to the floor of the van after he slid forward in his wheelchair. The resident slid forward in the wheelchair and his knee hit the back of the driver seat. The resident experienced some lower back pain and right knee pain and needed pain medication. This was evident in 1 of 1 sampled resident (Resident # 264). Findings included: The contract between the transportation company and the facility dated 10/1/2016 was reviewed and it was noted there were no statements in the contract regarding emergency procedures for the transportation van staff to follow, no specifications of training for transportation van staff. Resident #264 was admitted to the facility on 7/17/2017 with diagnoses of atrial fibrillation, congestive heart failure, end stage renal disease and diabetes with neuropathy. The resident ' s	F 309	Past noncompliance: no plan of correction required.	

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admission minimum data set (MDS) of 7/24/2017 revealed the resident was cognitively intact. The resident had no problem with short and long term memory and was independent in making decision of tasks of daily living. The resident required extensive, one-person assistance with bed mobility, ambulation, and extensive two-person assistance with transfers. The resident height was 77 inches and he weighed 300 pounds. The resident had no impairment of upper or lower body range of motion and required one person assistance to move from sitting position to standing. He was unable to ambulate without one person assistance.

A review of the care plans for Resident #264 found a plan in place dated 8/3/2017 related to the fall risk due to impaired mobility, medication effects, history of falls and medical diagnoses end stage renal disease and neuropathy. Interventions in place to include to remind resident to call for assistance and to maintain the environment free of clutter and safety hazards.

A review of the resident ' s medical record revealed he was scheduled for dialysis treatments three times per week. Resident #264 was scheduled to be transported by the contracted transportation van company from the dialysis center to the facility on 8/30/2017.

The Administrator for the facility was interviewed on 8/30/2017 at 2:13 PM. He reported the facility transported residents to appointments using its own transportation van. Also, the facility had a contract with a private van company to transport residents to appointments.

Resident # 264 was interviewed on 9/7/2017 at

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PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

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10:41 AM. He reported on 8/30/2017 at approximately 4:15 PM he was returning from dialysis to the facility. He reported the driver (Driver #1) of the contracted transportation van, did not secure his wheelchair wheels when she loaded him into the van. He reported the driver did not secure him with a lap belt or shoulder belt once he was in the van. The resident reported that while driving on Highway 74 West, the driver hit the brakes and he slid forward in the wheelchair and was bracing himself on the back of the passenger seat and the driver ' s seat. When this happened, driver #1 stopped the van in the middle of traffic on Highway 74 W to attempt to assist him back into the wheelchair, but was unable to scoot him back in the wheelchair and he was unable to assist due to weakness. Resident #264 instructed her to pull the van over out of traffic and she pulled into restaurant ' s parking lot.

Resident #264 reported that bystanders in the parking lot of a restaurant assisted driver #1 to release the lock on the wheels of Resident #264 ' s wheelchair and he was lowered to the floor of the van by the bystanders and the driver called the owner of the van. Resident #264 stated he did not fall out of the wheelchair, he was lowered to the floor of the van because they couldn ' t lift him back into the wheelchair. The resident called his wife at 4:26 PM and the wife arrived on the scene at approximately 4:45 PM. The wife reported that the driver of the van had not called EMS and the wife called EMS. The resident reported that the EMS arrived approximately 5 minutes after his wife called them and they assisted him off the floor of the van to a stretcher and transported him to the hospital ' s emergency department.

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Resident #264 reported he was evaluated and no bones were fractured, but he had a contusion with abrasion to the right tibia, left knee laceration and left forearm laceration. The resident reported he returned to the facility from the emergency department on 8/30/2017 about 9:30 PM.

The resident and his wife were interviewed on 9/7/2017 at 12:00 PM. The wife reported that when she arrived at the incident, Emergency Medical Services (EMS) had not been called. She placed the call to EMS and they arrived within five minutes.

Driver #1, who was an employee of the contracted van company, was interviewed on 9/7/2017 at 4:18 PM via phone call. She reported, on 8/30/17, she picked Resident #264 up from his dialysis treatment and secured his wheelchair with the safety straps to the floor of the van. She reported the (black) seatbelt that was special made for restraining residents in the wheelchair and it was not operational. She used the factory installed seatbelt (tan seatbelt intended for restraining residents sitting in van seat) to secure Resident # 264 who was sitting in a wheelchair.

Driver #1 reported she was heading west on Highway 74 and traffic was dense. She hit the brakes hard to avoid hitting a car in front of her and when she did, Resident #264 stated, "I think I ' m coming out of my seat." She looked back and Resident #264 had slid forward in his wheelchair and was bracing himself with his hands on the back of the passenger and driver seats. Driver #1 reported she pulled into a restaurant parking lot and asked for help from two bystanders. The bystanders assisted her to release the straps on the wheelchair wheels and lower Resident #264

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to the floor of the van. She reported that the factory installed seatbelt had come undone. She then reported she used her own cell phone to call the owner of her company to report the incident. She reported the owner had offered to come with a stretcher for transport back to the facility, but the resident did not want him to come. The resident wanted Driver #1 and the bystander to attempt to push him back into the wheelchair, but when they couldn ' t get him back into the wheelchair, Resident #264 requested to be lowered to the van floor and transported back to the facility. Driver #1 reported she could not drive back to the facility with the resident on the floor of the van and he called his wife from his phone. When Resident #264 ' s wife arrived at the restaurant parking lot, she called for an ambulance. EMS arrived and transported the resident to the hospital.
Driver #1 was interviewed again on 9/8/2017 at 11:42 AM. She reported she did not call 911 because she had been instructed to call the owner for minor incidents and to call 911 only if the resident was injured or in distress, "like a stroke or something."

When asked about the training she had received, Driver #1 reported that she had ridden in the van with a trainer for several days and she took some notes, but did not receive written training materials or an employee handbook. She concluded by sharing she had handwritten a statement for the incident and the owner had a copy.
An undated handwritten statement written by Driver #1 was reviewed. The statement described the series of event of the incident on 8/30/2017 that happened during Resident #264 transportation and included her name and the

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date of the incident. The statement described the series of events as they happened.

The statement read, in part:

" ... Traffic is heavy on Highway 74 so by the time I come through the light near (drug store), I ' m in the left lane and traffic is so congested and I hit my brakes and then (Resident #264) says ' I believe my chair is tilting. I feel like I ' m going to come out or something. ' So I then put my emergency lights on and get over to pull into (restaurant) parking lot. At this time I ' m asking (Resident #264) is he alright, ' I ' m going to pull here to check you out to make sure your (sic) ok. ' When I get out to open the side door to check him, I seen (Resident #264) hands on the back of the chairs of the van as if he was trying to push his weight back to the back of his chair. I called for help ... Some guy in a truck came to assist me. I then called (owner of transportation van) to explain the situation. ... (Owner of transport van) asked if (Resident #264) would like him and his guys to come transport him with the stretcher. (Resident #264) said, ' If you are close then that ' s fine, but if not maybe EMS if they (Driver #1 and bystander) can ' t pull me back in the chair. ' (Owner of transportation van) said he would call (facility) and call (me) right back. So me and the (bystander) try our best to push him back. (Resident #264) then says ' No, I don ' t believe you guys are going to do it because I can ' t help you push back my weight is coming down more. ' I get his chair unbuckled to lower him onto the floor. At this same time (Resident #264) was saying he has too much pressure on his leg. ... I got the full chair undone and I pulled it out of the van. (Owner of transport van) was then calling me back asking how was everything and he was on

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his way. (Resident #264) then said ' No, we don ' t need (Owner) to come I feel ok like this, just take me to (facility) laying here. ' I told (Resident #264) I ' m sorry, but that ' s not safe I cannot take you like this. (Resident #264 then yelled ' Well tell him to call EMS or you call, well better yet give me my phone so I can call my wife. ' Resident #264 called his wife and then told Driver #1 he wanted EMS called to check out his leg. By then (Resident #264 ' s) wife had arrived and was yelling ' call EMS ' . I try telling the wife what ' s going on and she brushed me off saying ' I don ' t wanna (sic) hear it, why haven ' t EMS arrived. ' ...I then said, ' I ' m so sorry I was following the guidelines and my boss was sending help our way. ' ...EMS (arrived) there ... load(ed) (Resident #264) into the (ambulance). ..."

The owner of the transportation company was interviewed on 9/7/2017 at 1:50 PM. He reported that he was called by the driver of the van after she had braked hard and Resident #264 slipped forward out of his wheelchair. The owner reported he offered to come to the van to assist the driver to put the resident back into the wheelchair, but the resident did not want him to come to the incident. He told the driver he would call the facility and would call her back with further instructions. He further reported he called the facility to report the incident to the administrator on 8/30/2017 at approximately 4:45 PM. He explained the procedure for drivers was to call the office/him to report minor incidents, and to call EMS if the resident is injured or in distress.

The EMS record dated 8/30/2017 was reviewed. The time of the call received was 4:33 PM on 8/30/2017. The EMS was dispatched at 4:33 PM and was on the scene at 4:38 PM. The EMS

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record further noted transport of Resident #264 to the hospital emergency room at 5:03 PM on 8/30/2017. It was recorded Resident #264 had a fall and was found lying on his left side in the rear of a wheelchair van. Resident #264 was complaining of right knee pain and the EMS did not note deformities or swelling during the assessment.

The hospital emergency department notes were reviewed dated 8/30/2017 at 5:13 PM. The physician notes indicated Resident #264 was experiencing pain in his left lower back and right knee. The resident was medicated and expressed some relief of the pain. The hospital record described his skin with multiple superficial abrasion on forearms (old), no head trauma, left lateral paraspinal tenderness to palpation, the right lower leg effusion noted and bilateral pedal edema, and no neurological deficit observed.

The x-ray report dated 8/30/2017 at 6:16 PM from the hospital was reviewed and it revealed no acute fracture or dislocation of the right knee.

A review of the facility nursing notes dated 8/30/2017 at 11:13 PM noted resident was alert and oriented and without signs or symptoms of pain. The resident reported during the interview that he was sore from the accident and did not receive a dialysis treatment on 9/6/2017 because he was too sore to travel to the dialysis center. The Administrator for the facility was interviewed on 8/30/2017 at 2:13 PM. He stated he was notified of the incident on 8/30/2017 at about 4:45 PM after the owner of the transportation company called the facility. He conveyed his knowledge of the incident, the resident had an injury and was desiring to go to the emergency room.

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On 9/9/2017 at 8:46 AM, the administrator provided the following corrective action with compliance date of 8/31/2017.

On August 30 at approximately 4:45 PM, facility staff notified the administrator of an incident with the van. It was relayed by the caller, the passenger was involved in an incident and was desiring to go to the emergency department (ED). The administrator directed them to immediately call 911.

The administrator texted the owner of the company and requested to get the details and to meet the following morning. In the meantime, using the said company was suspended.

At 7:23 p.m. on 8/30/2017 the administrator called the spouse to see if he could gain any information regarding the incident. She passed the phone to the resident. The conversation offered the administrator a perspective from the resident ' s point of view. The resident stated he did not feel the back of his chair was strapped properly. He also stated the shoulder restraint was in poor repair for the past three weeks and the driver stated she has told (the owner) them to get it fixed. He stated no over the shoulder strap was used but a lap restraint was. In front of (a restaurant), he stated she slammed on brakes and the chair tipped over putting him on the floor. He hit his knee in the incident and wanted to go to the hospital. The administrator asked for screen shots of any calls placed so he could recreate the incident to the best of his ability but the wife was unable to do so.
On 8/30/17 allegedly the wife contacted EMS to help transport the resident to the ED for

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evaluation and possible treatment. The resident was found to have no injuries and was transported back to the facility by EMS later in the day.

On August 31, 2017 at 9:35 a.m., the administrator met with the owner and the driver. During the conversation, the administrator shared his desire to determine exactly what occurred in order to prevent such an occurrence in the future. The driver denied the resident came out of the chair rather the chair tipped up (similar to a 45 degree angle) and as he slid down, his knee(s) was pressed against the driver seat. She cannot recall if a seatbelt was used. She stated she turned her hazard lights on, pulled over in the (restaurant) parking lot and got a bystander to help. She then followed company protocol and phoned the owner of the company.

Though our van driver was not involved, the van driver demonstrated proper securing of a wheelchair according to policy on the morning of 8/31/2017 and was retrained by the administrator on the aspects of safely transporting our residents. She has never had any incidents as a van driver. She was also reminded by the administrator it is the desire of the facility for her to call 911 regardless of the severity of any incident in which the van is involved in. She was also instructed not to move the resident unless they are clearly in a dangerous position or situation. If physical damage is present, regardless of extent, the van should not be moved until administrator is contacted and the van is assessed.

To ensure ongoing compliance, the facility will not deviate from its regular inspection by the

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administrator or maintenance director of both its van, driver training and periodic and random assessments of passengers beings secured to our van by the administrator or maintenance director. This has proven to be highly effective and has assisted us in maintaining full compliance with state and federal regulations. The driver will be reminded during annual retraining by the administrator or maintenance director and informally of our on-going desire for 911 to be contacted as soon as any incident occurs regardless of the severity and not to move the resident unless they are clearly in a dangerous position or situation. Only the passenger can refuse treatment directly with 911 personnel. Though we have no immediate plans of utilizing outside transports, if this need were to change in the future, the facility will require proof of their training which must be equivalent to our own internal training, proof the vehicle is in proper working condition, immediate notification of 911 regardless of severity and this would supersede their own company policy, and proof of periodic training of the drivers and van assessments.

The QA committee will monitor the on-going compliance of our driver and his/her training with respect to F309 as well as any future events monthly for the next 12 months and then as needed.

The corrective action was validated on 9/9/2017 by reviewing the following:

The facility administrator reported the contract with the transportation company had been terminated.
The driver of the van had been suspended on 9/1/2017 and she would be terminated when the

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F 309	Continued From page 22 investigation was completed. The program worksheet dated 8/31/2017 with the signature of the facility driver and the Administrator was reviewed. The facility driver was instructed by Administrator on the procedures to follow after an incident. The Administrator documented 911 was to be contacted after any incident, regardless the severity, and the van was not to be driven until Administration had audited the van for safety.	F 309		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323		9/22/17

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F 323	Continued From page 23 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with resident, family, facility staff, contracted van transportation driver and owner, and record review, the facility failed to ensure a resident was transported from the dialysis center to the facility in a safe manner. The resident slid forward in the wheelchair and his knee hit the back of the driver seat. The resident experienced some lower back pain and right knee pain and needed pain medication. This was evident in 1 of 1 sampled resident (Resident # 264). Findings included: The Q ' straint manufacturer ' s user instructions for the transportation van were reviewed and the instructions stated, in part: A. Secure the wheelchair by placing wheelchair facing forward; attach tie-down hooks into floor anchorages and ensure they are locked in; attach the four tie-down hooks to solid frame members or weldments near seat level. Ensure tie-downs are fixed at approximately 45 degrees and are with angles shown in Figure 2; Do not attach hooks to wheels, plastic or removable parts of wheelchair; ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs to take up additional webbing slack. B. Secure passenger: attach lap belts: use integrated stiffeners to feed belts through openings between seat backs and bottoms, and/or armrests to ensure proper belt fit around	F 323	Past noncompliance: no plan of correction required.	

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occupant; on the aisle side, attach belt with female buckle to rear tie-down pin connector ensuring buckle rests on passenger ' s hips; on the window-side, attach belt with male tongue to rear tie-down pin connector and insert into female buckle; attach shoulder belt: extend shoulder belt over passenger ' s shoulder and across upper torso and fasten pin connector onto lap belt; ensure belts are adjusted as firmly as possible, but consistent with user comfort.

C. Warnings: lap and shoulder belt should not be held away from passenger ' s body by wheelchair components or parts such as the wheelchair ' s wheels, armrests, panels or frame; occupant belts should always bear upon the bony structure of the passenger ' s body and be worn low across the front of the pelvis with the junction between lap and shoulder belts located near passenger ' s hip.

The contract between the transportation company and the facility dated 10/1/2016 was reviewed and it was noted there were no statements in the contract regarding emergency procedures for the transportation van staff to follow, no specifications of training for transportation van staff and no specifics regarding maintenance and upkeep of the van or transportation safety equipment.

Resident #264 was admitted to the facility on 7/17/2017 with diagnoses of atrial fibrillation, congestive heart failure, end stage renal disease and diabetes with neuropathy. The resident ' s admission minimum data set (MDS) of 7/24/2017 revealed the resident was cognitively intact. The resident had no problem with short and long term memory and was independent in making decision of tasks of daily living. The resident required

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extensive, one-person assistance with bed mobility, ambulation, and extensive two-person assistance with transfers. The resident height was 77 inches and he weighed 300 pounds. The resident had no impairment of upper or lower body range of motion and required one person assistance to move from sitting position to standing. He was unable to ambulate without one person assistance.

A review of the care plans for Resident #264 found a plan in place dated 8/3/2017 related to the fall risk due to impaired mobility, medication effects, history of falls and medical diagnoses end stage renal disease and neuropathy. Interventions in place to include to remind resident to call for assistance and to maintain the environment free of clutter and safety hazards.

A review of the resident ' s medical record revealed he was scheduled for dialysis treatments three times per week. Resident #264 was scheduled to be transported by the contracted transportation van company from the dialysis center to the facility on 8/30/2017.

The Administrator for the facility was interviewed on 8/30/2017 at 2:13 PM. He reported the facility transported residents to appointments using its own transportation van. Also, the facility had a contract with a private van company to transport residents to appointments.

Resident # 264 was interviewed on 9/7/2017 at 10:41 AM. He reported on 8/30/2017 at approximately 4:15 PM he was returning from dialysis to the facility. He reported the driver (Driver #1) of the contracted transportation van, did not secure his wheelchair wheels when she

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loaded him into the van. He reported the driver did not secure him with a lap belt or shoulder belt once he was in the van. The resident reported that while driving on Highway 74 West, the driver hit the brakes and he slid forward in the wheelchair and was bracing himself on the back of the passenger seat and the driver ' s seat. When this happened, driver #1 stopped the van in the middle of traffic on Highway 74 W to attempt to assist him back into the wheelchair, but was unable to scoot him back in the wheelchair and he was unable to assist due to weakness. Resident #264 instructed her to pull the van over out of traffic and she pulled into restaurant ' s parking lot.

Resident #264 reported that bystanders in the parking lot of a restaurant assisted driver #1 to release the lock on the wheels of Resident #264 ' s wheelchair and he was lowered to the floor of the van by the bystanders and the driver called the owner of the van. Resident #264 stated he did not fall out of the wheelchair, he was lowered to the floor of the van because they couldn ' t lift him back into the wheelchair. The resident called his wife at 4:26 PM and the wife arrived on the scene at approximately 4:45 PM. The wife reported that the driver of the van had not called Emergency Medical Services (EMS) and the wife called EMS. The resident reported that the EMS arrived approximately 5 minutes after his wife called them and they assisted him off the floor of the van to a stretcher and transported him to the hospital ' s emergency department.

Resident #264 reported he was evaluated and no bones were fractured, but he had a contusion with abrasion to the right tibia, left knee laceration and left forearm laceration. The resident reported

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he returned to the facility from the emergency department on 8/30/2017 about 9:30 PM.

The resident and his wife were interviewed on 9/7/2017 at 12:00 PM. The wife reported that when she arrived at the incident, EMS had not been called. She placed the call to EMS and they arrived within five minutes.

An interview was conducted on 9/8/2017 at 4:20 PM with the resident and his wife. Resident #264 denied the van driver had applied any restraint to him and had only locked down the wheels of the wheelchair for transport. The resident had been told the black shoulder/lap restraint was broken by the driver and he recalled her stating " ... no use in me giving this to you, it ' s broke."

Driver #1, who was an employee of the contracted van company, was interviewed on 9/7/2017 at 4:18 PM via phone call. She reported, on 8/30/17, she picked Resident #264 up from his dialysis treatment and secured his wheelchair with the safety straps to the floor of the van. She reported the (black) seatbelt that was special made for restraining residents in the wheelchair and it was not operational. She used the factory installed seatbelt (tan seatbelt intended for restraining residents sitting in van seat) to secure Resident # 264 who was sitting in a wheelchair.

Driver #1 reported she was heading west on Highway 74 and traffic was dense. She hit the brakes hard to avoid hitting a car in front of her and when she did, Resident #264 stated, "I think I ' m coming out of my seat." She looked back and Resident #264 had slid forward in his wheelchair and was bracing himself with his hands on the back of the passenger and driver seats. Driver #1

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reported she pulled into a restaurant parking lot and asked for help from two bystanders. The bystanders assisted her to release the straps on the wheelchair wheels and lower Resident #264 to the floor of the van. She reported that the factory installed seatbelt had come undone.

She then reported she used her own cell phone to call the owner of her company to report the incident. She reported the owner had offered to come with a stretcher for transport back to the facility, but the resident did not want him to come. The resident wanted Driver #1 and the bystander to attempt to push him back into the wheelchair, but when they couldn ' t get him back into the wheelchair, Resident #264 requested to be lowered to the van floor and transported back to the facility. Driver #1 reported she could not drive back to the facility with the resident on the floor of the van and he called his wife from his phone. When Resident #264 ' s wife arrived at the restaurant parking lot, she was very upset and called for an ambulance. Emergency Medical Services (EMS) arrived and transported the resident to the hospital.

Driver #1 was interviewed again on 9/8/2017 at 11:42 AM. Driver #1 reported she had used the tan, factory installed seatbelt to secure Resident #264 by connecting the tan belt to the Q-straint and had not attempted to use the black wheelchair seatbelt "because it was not working and I had told (the owner) it wasn ' t working." Driver #1 further stated she thought the tan belt disconnected from the Q-straint connection when she pressed the brakes during the 8/30/2017 incident. She reported she did not call 911 because she had been instructed to call the owner for minor incidents and to call 911 only if

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the resident was injured or in distress, "like a stroke or something."

When asked about the training she had received, Driver #1 reported that she had ridden in the van with a trainer for several days and she took some notes, but did not receive written training materials or an employee handbook. She was asked to demonstrate securing passengers in wheelchairs after watching the procedure. She concluded by sharing she had handwritten a statement for the incident and the owner had a copy.

An undated handwritten statement written by Driver #1 was reviewed. The statement described the series of event of the incident on 8/30/2017 that happened during Resident #264 transportation and included her name and the date of the incident.

The statement read, in part,

"First I lifted his two leg rest(s) before I pushed (him) up the ramp. I then pushed him up the ramp into the van and as I positioned him in the locking area, I then locked his wheelchair wheels on both sides. Next I straped (sic) his two back strapes (sic) to his chair to secure the back of his chair. Onced (sic) I finished the back I then went around to my side door and straped (sic) the two front strapes (sic) down to secure the front of the chair. When finished with that I straped (sic) his shoulder and waist belt. ... Traffic is heavy on Highway 74 so by the time I come through the light near (drug store), I ' m in the left lane and traffic is so congested and I hit my brakes and then (Resident #264) says ' I believe my chair is tilting. I feel like I ' m going to come out or

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something. ' So I then put my emergency lights on and get over to pull into (restaurant) parking lot. At this time I ' m asking (Resident #264) is he alright, ' I ' m going to pull here to check you out to make sure your (sic) ok. ' When I get out to open the side door to check him, I seen (Resident #264) hands on the back of the chairs of the van as if he was trying to push his weight back to the back of his chair. I called for help ... Some guy in a truck came to assist me. I then called (owner of transportation van) to explain the situation. ... (Owner of transport van) asked if (Resident #264) would like him and his guys to come transport him with the stretcher. (Resident #264) said, ' If you are close then that ' s fine, but if not maybe EMS if they (Driver #1 and bystander) can ' t pull me back in the chair. ' (Owner of transportation van) said he would call (facility) and call (me) right back. So me and the (bystander) try our best to push him back. (Resident #264) then says ' No, I don ' t believe you guys are going to do it because I can ' t help you push back my weight is coming down more. ' I get his chair unbuckled to lower him onto the floor. At this same time (Resident #264) was saying he has too much pressure on his leg. ... I got the full chair undone and I pulled it out of the van. (Owner of transport van) was then calling me back asking how was everything and he was on his way. (Resident #264) then said ' No, we don ' t need (Owner) to come I feel ok like this, just take me to (facility) laying here. ' I told (Resident #264) I ' m sorry, but that ' s not safe I cannot take you like this. (Resident #264 then yelled ' Well tell him to call EMS or you call, well better yet give me my phone so I can call my wife. ' Resident #264 called his wife and then told Driver #1 he wanted EMS called to check out his leg.) By then (Resident #264 ' s) wife had arrived and was yelling ' call

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EMS ' . I try telling the wife what ' s going on and she brushed me off saying ' I don ' t wanna (sic) hear it, why haven ' t EMS arrived. ' ...I then said, ' I ' m so sorry I was following the guidelines and my boss was sending help our way. ' ...EMS (arrived) there ... load(ed) (Resident #264) into the (ambulance). ..."

The owner of the transportation company was interviewed on 9/7/2017 at 1:50 PM. He reported that he was called by the driver of the van after she had braked hard and Resident #264 slipped forward out of his wheelchair. The owner reported he offered to come to the van to assist the driver to put the resident back into the wheelchair, but the resident did not want him to come to the incident. He told the driver he would call Pruitt and would call her back with further instructions. He further reported he called the facility to report the incident to the administrator on 8/30/2017 at approximately 4:45 PM. He explained the procedure for drivers was to call the office/him to report minor incidents, and to call EMS if the resident is injured or in distress. The owner concluded by reporting Driver #1 was suspended during the investigation and would be terminated.

An observation of securing a wheelchair for transport in the contracted transportation van was completed at 10:41 AM on 9/8/17. The facility administrator, the owner of the transportation van and Driver #2 were present. Driver #2 was an employee of the contracted transportation van, but was not the driver of the resident during the incident on 8/30/2017; Driver #1 had been suspended by the contracted company and was not available to perform the demonstration.

A standard 20 inch wheelchair was used for the

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observation. The administrator reported that the wheelchair Resident #264 used in the facility was a 22 inch wide wheelchair. Driver #2 demonstrated securing the Q-straps that hooked to the wheels and then locked into the floor of the van. It was noted there were three seatbelts in the rear of the van: a red lap belt, a black shoulder/lap belt and a factory installed tan seatbelt that the owner of the van reported was used for seated passengers and not for passengers in wheelchairs. The driver demonstrated applying the red waist belt across the wheelchair and fastening it into the Q-straps on the floor of the van and stated the straps would hold the resident in place. The driver then took the black waist and shoulder restraint that was attached at the same point as the tan seatbelt and she brought it across the wheelchair and through the wheels to hook into the Q-strap. The driver explained there were 8 points of safety to secure the resident in place. The owner of the van reported that he was not aware the black seatbelt was not functioning and had not been informed by Driver #1 about this fact.

During the interview on 9/8/2017 at 11:42 AM, Driver #1 was asked if she had used the red lap belt that was observed in the demonstration described above. Driver #1 stated "What red lap belt?" The driver said that the only seatbelts on that van the day of the incident on 8/30/17 were the tan one that came with the van and the black seatbelt (shoulder and waist belt). She further stressed the black seatbelt was not functioning and she used the tan seatbelt only to secure the resident in his wheelchair.

The EMS record dated 8/30/2017 was reviewed. The time of the call received was 4:33 PM on

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8/30/2017. The EMS was dispatched at 4:33 PM and was on the scene at 4:38 PM. The EMS record further noted transport of Resident #264 to the hospital emergency room at 5:03 PM on 8/30/2017. It was recorded Resident #264 had a fall and was found lying on his left side in the rear of a wheelchair van. Resident #264 was complaining of right knee pain and the EMS did not note deformities or swelling during the assessment.

The hospital emergency department notes were reviewed dated 8/30/2017 at 5:13 PM. The physician notes indicated Resident #264 was experiencing pain in his left lower back and right knee. The resident was medicated and expressed some relief of the pain. The hospital record described his skin with multiple superficial abrasion on forearms (old), no head trauma, left lateral paraspinal tenderness to palpation, the right lower leg effusion noted and bilateral pedal edema, and no neurological deficit observed.

The x-ray report dated 8/30/2017 at 6:16 PM from the hospital was reviewed and it revealed no acute fracture or dislocation of the right knee.

A review of the facility nursing notes dated 8/30/2017 at 11:13 PM noted resident was alert and oriented and without signs or symptoms of pain. The resident reported during the interview that he was sore from the accident and did not receive a dialysis treatment on 9/6/2017 because he was too sore to travel to the dialysis center.

The Administrator for the facility was interviewed on 8/30/2017 at 2:13 PM. He was notified of the incident on 8/30/2017 at about 4:45 PM after the owner of the transportation company called the

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facility. He conveyed his knowledge of the incident, the resident had an injury and was desiring to go to the emergency room. The facility Administrator performed audits on the facility transportation vans on 8/30/2017 at 9:23 PM and found no issues with the safety of the facility van. Driver #1 met with the Administrator and the owner of the transportation van on 8/31/2017 at 9:35 AM. Driver #1 demonstrated securing a wheelchair into the van and took a statement from Driver #1. The statement the Administrator received from Driver #1 differed from the statement he received from Resident #264. He further reported he had inspected the contracted transportation van on 8/31/2017 and all seat belts appeared to be in working order. The Administrator provided a written account of the incident.

A Quality Assurance document dated 8/30/2017 prepared by the Administrator was reviewed. The document reported the Administrator had been notified of an incident on 8/30/2017 at 4:45 PM by (unnamed) caller and the Administrator instructed the caller to call EMS immediately. A meeting was arranged with the owner of the transportation company and Driver #1 by the Administrator on 8/31/2017. The Administrator inspected the facility vans on 8/30/2017 at 9:21 PM and "found it to be in good repair with no imperfections with the straps or other ancillary equipment that would be necessary for safe transport." Driver #1 provided a statement in which she shared the resident did not fall out of his chair, but rather tipped forward at a 45 degree angle and slid forward with his knees pressed to the back of the driver seat. Driver #1 proceeded to explain she had pulled the van over into a restaurant parking lot and enlisted the assistance of a bystander.

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The Administrator further documented that he reviewed the background checks, drug test, training records and driver credentials for Driver #1. The correct demonstration by Driver #1 to secure a wheelchair to the floor of the transportation van during the demonstration on 831/2017 was noted by the Administrator. The factory installed black seatbelt in place for wheelchair passengers locked when sudden pressure applied to it, as intended, per the documentation by the Administrator. It was also noted Driver #1 had reported the presence of an additional seatbelt, but that it was broken and she didn ' t use it, instead she used the tan seatbelt to secure the resident.

On 9/9/2017 at8:46 AM, the administrator provided the following corrective action with compliance date of 8/31/2017.

On August 30 at approximately 4:45 PM, a facility staff notified the administrator of an incident with the van. It was relayed by the caller, the passenger was involved in an incident and was desiring to go to the emergency department (ED). The administrator directed them to immediately call 911.

The administrator texted the owner of the company and requested to get the details and to meet the following morning. In the meantime, using the said company was suspended.

At 7:23 p.m. on 8/30/2017 the administrator called the spouse to see if he could gain any information regarding the incident. She passed the phone to the resident. The conversation offered the administrator a perspective from the resident ' s point of view. The resident stated he

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did not feel the back of his chair was strapped properly. He also stated the shoulder restraint was in poor repair for the past three weeks and the driver stated she has told (the owner) them to get it fixed. He stated no over the shoulder strap was used but a lap restraint was. In front of (a restaurant), he stated the driver slammed on brakes and the chair tipped over putting him on the floor. He hit his knee in the incident and wanted to go to the hospital. The administrator asked for screen shots of any calls placed so he could recreate the incident to the best of his ability but the wife was unable to do so.

On 8/30/17 allegedly the wife contacted EMS to help transport the resident to the ED for evaluation and possible treatment. The resident was found to have no injuries and was transported back to the facility by EMS later in the day.

At 9:21 p.m., on 8/30/2017 the administrator inspected his own van and found it to be in good repair with no imperfections with straps or other ancillary equipment that would be necessary for a safe transport. The document used for the administrator ' s review was a document developed and provided by his corporation to ensure a very thorough and detailed review of any automobile used to transport residents.

On August 31, 2017 at 9:35 a.m., the administrator met with the owner and the driver. During the conversation, the administrator shared his desire to determine exactly what occurred in order to prevent such an occurrence in the future. The driver denied the resident came out of the chair rather the chair tipped up (similar to a 45 degree angle) and as he slid down, his knee(s)

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was pressed against the driver seat. She cannot recall if a seatbelt was used. She stated she turned her hazard lights on, pulled over in the (restaurant) parking lot and got a bystander to help. She then followed company protocol and phoned the owner of the company. During this meeting, the administrator reviewed the background checks, drug test, training records, driver credentials, etc. to ensure the driver had been properly vetted and trained in accordance with state and federal regulations that govern skilled nursing facilities. This review revealed compliance with all local, state and federal regulations.

The administrator and both representatives from the company went outside for a demonstration of what occurred. The driver recalled the representative of the dialysis company stating how hard it was to push the resident ' s wheelchair - implying something was wrong with it. The administrator assessed the wheelchair and found it in good repair without any noted concerns including the wheels or anything that would make it difficult to maneuver. With the same wheelchair and van involved, the driver demonstrated through simulation pushing the chair onto the rear ramp and stated the resident was trying to help by "scooting" forward in a rocking motion with both feet on the leg rests. Upon pushing the chair to the front of the van, the driver demonstrated securing the rear of the chair first before coming around and securing the front of the chair on points located under the chair. After this, she (the driver) stated she would apply the seatbelt.

During the observation, the administrator noted what appeared to be a factory installed, tan

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seatbelt in place. The driver provided a demonstration with a black seat belt that connected to the Q strap. The administrator pulled the tan seatbelt all the way out and verified it was in good working order and "grabbed" when sudden pressure was applied as it was intended. She stated they would use the black seatbelt for wheelchair bound residents but it was broken. During the demonstration, the administrator could not determine any aspect broken and she was unable to show it. The owner said they were in the process of replacing the van. According to the owner, the tan seatbelt is not designed for wheelchair transports thus the installation by the conversion company of the black seatbelt and attachments.

After the observation and simulations, the administrator and owner discussed the situation and the variances between the stories.

Beyond the investigation, the administrator performed quality assurance checks on the facility ' s only van and observed the transport driver securing a resident. The administrator observed 5 wheelchairs of those scheduled for transport and found them all in working order with no issues. These were standard wheelchairs issues to residents upon admission.

Though our van driver was not involved, the van driver demonstrated proper securing of a wheelchair according to policy on the morning of 8/31/2017 and was retrained on the aspects of safely transporting our residents. She has never had any incidents as a van driver. Furthermore the administrator reviewed the weekly van checks since June 2017 and found them to be in compliance with regulations and company policy.

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He noted no issues in light of this event during her review of these documents.

To ensure ongoing compliance, the facility will not deviate from its regular inspection of both its van, driver assessments of passengers beings secured to our van. These assessments of securing passengers will be at least annually but then as needed based upon a random sample and if any event occurs. These random assessment currently includes the administrator or maintenance director accessing the van without warning to ensure any passenger secured is done so in compliance with corporate standards as well with state and federal regulations. This has proven to be highly effective and has assisted us in maintaining full compliance with state and federal regulations. For the purpose of this plan for compliance, we will inspect 1 transfer a month for 3 months, and then PRN. As such, we do not plan to use this or any other transport company to assist with transports. If residents elect to utilize such services, it will be the policy of the facility to require the resident to sign out just as they would if they were being transported in their own car. The facility will no longer coordinate or contract with outside vendors. However, if this need were to arise in the future, the facility will require proof of their training which must be equivalent to our own internal training, proof the vehicle is in proper working condition, immediate notification of 911 regardless of severity and this would supersede their own company policy, and proof of periodic training of the drivers and van assessments.

The facility currently holds monthly QA meetings and the QA committee will monitor our on-going compliance at each meeting for the next 12

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months and then as needed. If any event occurs this oversight will be specific to that event as well as our on-going compliance with state and federal regulations.

The corrective action was validated on 9/9/2017 by reviewing the following:

A pre-trip checklist was reviewed dated 8/30/2017 at 6:41 PM and completed by the facility administrator for a facility owned van. The form noted the securement station was properly equipped with four securement straps. The lap belt and a shoulder belt, all straps and belts were in good working condition without defects. All floor anchorages were clear of dirt/debris and allowed for proper system fitting attachment. A clean, dry container in the vehicle was in place to allow for storage of the system when not in use. The vehicle was equipped with web/belt cutter for use in an emergency evacuation. A complete system operational instructions in either printed or decal form were located within the vehicle compartment to serve as a reference.

A pre-trip checklist was reviewed dated 8/31/2017 at 10:06 AM and completed by the facility administrator for the contracted transportation van. The administrator noted the securement station was properly equipped with four securement straps. The lap belt and a shoulder belt, all straps and belts were in good working condition without defects. All floor anchorages were clear of dirt/debris and allowed for proper system fitting attachment. A clean, dry container in the vehicle was in place to allow for storage of the system when not in use. The vehicle was equipped with web/belt cutter for use in an emergency evacuation. A complete system

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F 323	Continued From page 41 operational instructions in either printed or decal form were located within the vehicle compartment to serve as a reference.	F 323		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the male dietary staff failed to wear beard guards to cover facial hair during meal service for 3 of 4 male dietary staff observed. Findings included:	F 371	On 9/6/2016, the Dietary Manger applied a beard guard as well as all male staff members with beards or other facial hair. On 9/14/2017, all male staff with beards were in-service on the need for them to	10/4/17

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F 371	Continued From page 42 The noon meal was observed on 9/5/2017 in the dependent dining room and 500/600 hall dining room. The observation occurred between 12:18 PM and 1:28 PM. Dietary Aide (DA) #1 was observed serving food for dependent dining room on 9/5/2017 at 12:23 PM. It was noted he had a beard and moustache. He was not wearing a beard guard. DA #2 was observed handling drinks and delivering plates to residents, as well as assisting residents in the 500/600 hall dining room on 9/5/2017 at 12:23 PM. It was noted he had a beard and moustache. He was not wearing a beard guard. The dietary manager (DM) was observed delivering food to the 500/600 halls dining room. It was noted he had a beard and moustache. He was not wearing a beard guard. 9/5/2017 12:31 PM the DM delivered hair nets to DA #1 and #2, and they applied to cover facial hair. DA #1 was interviewed on 9/5/2017 at 12:23 PM and he stated he was not aware he had to wear a beard guard while serving food. He further stated he was not certain where to locate a beard guard to wear. DA #2 was interviewed on 9/5/2017 at 12:23 PM and he stated he did not know where to locate a beard guard. The DM was interviewed on 9/5/2017 at 12:31 PM. He reported he did not have beard guards in stock, but the staff would use the hair nets until he could order the beard guards and they were	F 371	wear beard guards while on duty in any food prep area. (This does not include the dietary manager□s office.) As part of our orientation process, all future male dietary employees will be instructed to wear a beard guard while in the food prep or delivery areas or be free of facial hair. To ensure on-going compliance, the registered dietician or administrator will observe 2 meals deliveries for 2 weeks, then at least 1 meal delivery for the next for the next two weeks to ensure all male staff members with facial hair are wearing beard guards. The wearing of bear guards will be monitored as part of our quarterly audits for sanitation and periodically during unannounced rounds. The results of these and outside inspections will be taken to the quality assurance committee. This plan of correction and follow-up will be monitored by our QA committee next month (October) and on a PRN basis going forward.	

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F 371	Continued From page 43 delivered. The DM was interviewed again on 9/6/2017 at 8:37 AM. He reported he had found beard guards in storage. The DM stated he had not worn beard guards because he didn ' t know the facility stocked the beard guards. He reported he performed many different tasks in the kitchen and did not wear a beard guard.	F 371		