STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345546	A. BUILDING ______ B. WING ______	C 05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEWOOD HEALTH CENTER	8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615

(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 and complaint investigation survey was conducted from 4/30/18 through 5/4/18. An extended survey was conducted. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) CFR 483.70 at tag F835 at a scope and severity (J) Immediate Jeopardy began on 3/19/18 and was removed on 5/3/18.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to safely transfer a resident off the bus via the lift and failed to have a licensed health care professional assess the patient before standing the resident up after a fall for 1 of 3 sampled residents (Resident #13) reviewed for supervision to prevent accidents. Resident #13 fell back into the bus while attempting to transfer onto the lift and she sustained a bruise to her left upper arm and increased back pain as a result of the fall.	F 689	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider to the allegations or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of Federal and State Law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered an admission that a deficiency existed or	5/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/18/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1

Immediate jeopardy began on 3/19/18 when Resident #13, fell on the bus after attempting to transfer onto the lift. Resident #13 was assisted up by Driver #1 and sustained bruise to the left upper arm and back pain as a result of this fall. Immediate jeopardy was removed on 5/3/18, when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of "D'" (no harm with the potential for more than minimal hard that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective.

Findings included:

The operational manual dated 3/2010 for the Braun century 2 series lift stated that for "standees: lift operating instructions apply to wheelchair passengers and standees. Standees should stand in the center of the platform (fully inside the yellow boundaries) and grip both handrails (if able) when on platform."

Resident #13 was admitted to the facility on 2/13/17 with the diagnoses of repeat falls, diabetes, pain and anemia.

Resident #13 annual Minimum Data Set (MDS) dated 2/7/18 revealed that the resident was cognitively intact. The resident had no moods or behaviors and required supervision with the assistance of one person for bed mobility, transfers, walking in the room, eating, toilet use, personal hygiene and locomotion. The resident required limited assistance with dressing. The resident was steady at all times when moving from the seated to standing positon, walking,

F 689

that additional measures should have been in place at the time of the survey. This serves as this facility□s credible allegation of compliance with state and Federal Regulations.

F689

Resident 13 was assessed on 3/19/18 and x-rays completed on 3/20/18 and then again on 3/26/18 which revealed fractures of undetermined age. Resident number 13□s care plan was updated on 3/20/18. Resident was seen by her physician on 3/22/18. Resident number 13 was interviewed on 3/20/18 and seen again on 5/2/18 and verbalized feelings of being happy with transportation and enhanced protocols initiated on 3/20/18.

All Residents were interviewed on 5/2/18 and expressed satisfaction with transportation and no concerns with drivers or safety concerns were vocalized. All new employees receive new hire training prior to working with residents. The driver has received comprehensive retraining on 03/20/2018 for transferring residents utilizing the transport chair. On 05/02/2018 bus was taken out of service and keys were secured with Facility□s Director. Memo was sent to staff that bus was out of service until further notice. The Cypress of Raleigh will contract with a provider for Rosewood Resident transportation until all training is complete. The facility will make sure that the

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turning around, with surface to surface transfers and moving on and off the toilet. The resident used a walker and was always continent of bowel and bladder. The resident had not had a fall since admission.

A care plan last updated 3/19/18 for falls revealed that resident #13 would be placed in a transport wheelchair to get on bus lift and assisted to a seat on the bus.

An incident report dated 3/19/18 stated that the incident occurred on 3/19/18 at 7:00 PM. The report revealed that the resident had a fall due to equipment failure. Resident #13's vitals were taken. Per the incident report, the event occurred outside the premises at the clubhouse and was a self-reported fall. The incident report stated that the resident was "being assisted to get off the bus according to the member". The incident report also stated the resident was getting off the bus lift ramp. The resident did not have any cognitive impairment. The note on the incident report stated that resident #13 was standing on the bus lift ramp and the lift ramp, instead of going down, went up and threw the member backward and she ended up on the floor and hit her back. No injury was noted at the time of the assessment or pain. The root cause analysis revealed that contributing factors included environmental factors. A skin assessment was completed and no injury was noted at the time of fall but a bruise was noted 2 hours later to the left upper arm. The Director of Nursing (DON) was notified on 3/20/18 at 7:00 AM. The physician was notified on 3/19/18 at 9:00 PM and power of attorney was notified on 3/19/18 at 9:00 PM. The incident report also stated the resident was out for an event at the clubhouse and had an accident on the bus. The

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transportation provider□s contract contains standard safety procedures for resident transport including what to do in case of an accident.

On 05/02/2018 facility implemented enhanced two person transfer method which would include a CNA transferring the Resident through the lift process. On 05/02/2018 the facility implemented the new transfer method. The two step method involves a driver operating the lift while a Resident is seated in the transport chair. A CNA will accompany the resident and rides up on the lift with the Resident after locking the wheels. The safety harness is fastened behind the CNA securing both the Resident and CNA on the lift. Once the CNA holds the yellow handles per the manufacturer□s safety instructions the CNA indicates to the driver that they are ready to be lifted. Once the lift is completed the CNA unlocks the transport chair and wheels the Resident inside. The Resident is then either secured in wheel chair or transferred to a regular seat on the bus. Mandatory in servicing was conducted 05/02/2018 by Administrator and Facility□s Director with transportation staff, activity staff and CNAs on the enhanced two person transport procedures. Approximately 17 staff Residents were in serviced but 100% of nursing and activity staff and drivers will be in-serviced prior to the 14 passenger mini bus being released for use. In addition no staff Resident will be allowed to work until they attend the in-services.

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F 689	Continued From page 3 interventions according to the incident report included (1. Any ambulatory member will be placed in transport wheelchair to get in a lift and put in a seat on bus. 2.) There was ongoing training of staff in transportation department. The incident report also revealed that Resident's #13 X-rays were negative. A nursing note dated 3/19/18 revealed that a "bruise noticed on member's left upper arm and may be caused by the fall member had when she went over to the clubhouse for War World II lecture. According to member, when she was getting off the bus, the lift platform ramps moved upward instead of downward and caused member to fall. Fall on her back and back assessed, no bruises noted and member states: "I known I had a fall but my body does not feel like I had one for now but if I feel the pain at night I will call for medicine." Member declines pain to her left upper arm. Will monitor member through the night if pain occurs then will notify medical doctor for X-rays if needed. Family notified also. Member had 400 milliliters (ml) of fluid and total of the day was 860 ml. Member is currently sleeping with call bell at fingertip and will continue monitor." A skin check dated 3/19/18 revealed that the resident had a bruise to her left upper arm that was reddened and measured 10 centimeters (cm) x 7.5 cm. Review of the resident's Medication Administration Record revealed that Resident #13 received Tylenol (A medication for pain) on 3/20/18 at 10:30 PM for generalized pain with a pain level of 5. Resident #13 also received 50 milligrams of Tramadol (a medication for pain) on	F 689	On 5/3/2018 all drivers were re-in serviced by Facility□s Director using manufacturer□s lift operating instructions as well as a manufacturer□s video training supplement called Braun Ability Commercial Wheelchair Lifts Operators Video on how to use a wheelchair to transfer residents in and out of the bus. All drivers were able to demonstrate competency in using the lift on the 14 passenger mini bus. All community non-clinical staff are being trained on accident response. On 5/2/2018 and 5/3/2018 the Director of Human Resources and the Registered Nursing managers of the homecare department conducted all Rosewood non clinical staff training on emergency response. The training included directions to call for a nurse, 911, on company issued cellphones stay with the Resident and do not to move any Resident. Staff that were not trained on 05/3/2018 were removed from the schedule and were not allowed to return to work until training was complete. A new lift less bus was ordered on 04/03/2018. Effective 05/04/2018 the Facility□s Director will perform lift competency training and evaluations on randomly selected drivers to ensure proper safety procedures while using the lift weekly for three weeks and every other week thereafter until the new bus arrives. Any unsafe practice will immediately be reported to the Administrator and the staff involved will be re-educated on proper	

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3/20/18 at 12:17 PM for back pain, which included signs of "bracing and grimacing" with a pain level of 10.

An X-ray report dated 3/20/18 revealed that the resident had an X-ray of her lumbar spine and revealed that the resident had a Levoscoliotic alignment (a spine abnormality) of the lumbar (lower) vertebrae. The lumbar vertebral bodies showed degenerative osteophyte spurring (boney projections). There was also an osteoporotic compression involving the L2 vertebrae. The age of the compression is old or undetermined.

Another set of X-rays dated 3/26/18 showed an age-indeterminate compression deformity of the lumbar thoracic spine. The conclusion revealed a compression deformity.

The resident was interviewed on 04/30/18 at 10:49 AM. She stated they were not sure if she broke her vertebral or if it was an old fracture. She stated that she had a fall from the bus. She stated that her back was fine now and that it was just a human error. She stated that on 3/19/18, the controller pressed the wrong button on the standing lift and flipped her backwards off. She stated the facility gave her Physical Therapy.

Nurse #1 (nurse on 3/19 from 3:00 PM to 11:00 PM) was interviewed on 4/20/18 at 3:40 PM. She stated residents were going to the clubhouse for a meeting on World War II. She stated that resident #13 told her that she was on the ramp and the ramp went backwards instead of down and threw her back inside of the bus. She stated the resident stated she was standing on the ramp with the walker. She stated the receptionist called the nursing home and asked for a nurse to come

F 689

protocols. The Social Services Coordinator and or designee will receive transportation logs weekly of all Residents that utilized the 14 passenger bus for transportation and will interview at least 50% of Residents. Any concerns will be reported to Administrator for immediate follow-up/investigation. The Administrator will oversee the investigation and ensure that all pertinent information/evidence is gathered.

Quarterly (x 2) safety observations as well as resident interviews will be reviewed and discussed during QAPI meeting. Trends and patterns will be tracked amongst the QAPI Committee for feedback and/or recommendations.

The Administrator will be responsible for ensuring that all corrective measures have been carried out and that appropriate monitoring measures are in place.

Date corrective action was completed: 05/09/2018

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F 689	Continued From page 5 over. When she went there, Resident #13 was sitting in the lobby in a chair at the clubhouse with the receptionist. The nurse stated that she started range of motion and a pain assessment. She stated that she asked the resident if she was in pain and the resident was able to move. She offered to take the resident back (to the nursing home) but the resident stated that she was ok and denied pain. The resident went to the World War II event and when she came back, the nurse stated that she did another full assessment on the resident after the event. The resident got back to the facility around 8:45 PM and the event happened around 7:00 PM. She stated that when she got to the clubhouse, that the bus had already left. She stated she was not sure who was on the bus. She stated she was also not sure who helped the resident up but the receptionist was the one providing her with the information. She stated that she never saw the driver of the bus. The nurse added that they did order an X-ray a day after the event because the resident's family stated that resident #13 may have stated that she was not having pain because she wanted to go to the World War II activity. The day the event occurred, Resident #13 did not have pain but the next 2 days, the resident was complaining of pain in her back. The nurse stated that she was not working the day the resident starting having pain but had heard this. An X-ray was ordered and came back negative. Nurse #1 also stated that the receptionist did not see the event or how the resident got off the bus. The resident only told her that the lift had "thrown her back". She reported the incident to the nurse manager, DON, family and physician and completed an incident report and nursing note. She stated that Resident #13 was alert and oriented to time, person, place, time and situation. The resident	F 689		

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F 689	Continued From page 6 did have a vision deficiency but could ambulate short distances. She stated that for residents who can stand, it is usual for residents to stand in order to use the lift. She stated that the clubhouse was located inside the community right when you enter the gait. The Director of Transportation was interviewed on 5/1/18 at 8:53 AM via phone. He stated that on 3/19/18, Driver #1 was driving from 4:00 PM to 9:00 PM. He said that he heard that resident #13 was on the bus lift and the lift jerked when the resident was on it. He stated that he didn't think that the resident fell but that it just scared the resident. He stated that the incident was reported to him the next day because it occurred in the evening when it happened. The staff member was working less now because of this event. Driver #1 was interviewed on 5/1/18 at 10:00 AM. He stated he was the driver and he had picked the resident up at the nursing home and was getting ready to drop her off and let the lift down. He stated that after the event they (staff) called the nursing home and the resident was ok. He stated that the lift was for residents in wheelchairs and would lifted residents up and down to get on the bus. The resident said she could not use the stairs and the only way to get her on and off the bus was to use the lift. He stated the resident would walk on the lift, be lifted and then walk onto the bus. He stated that she was getting on the lift and was heading to the lift area when she fell backwards inside the bus. He stated that he helped her up and asked her if she was ok. He added that no other residents were on the bus at that time. He stated that the resident was heading towards the lift and her walker was on the lift but she was not yet on it. He stated that there was a	F 689		

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F 689	Continued From page 7 controller to the lift that controlled the lift. The controller could move the lift up, down, flat, and unfold. He stated that the lift was flat when the resident was going to walk on it. He stated that he had the controller in his hand when her walker was on it. He stated that after she fell, he ran in the bus and asked her if she was ok and she said that she was ok. He stated that he lifted her up after she fell and the resident grabbed her walker and continued to walk on the lift. At that point, the resident was placed back on the lift, lifted down and went to the World War II event. He stated he stuck around till the nursing home came but he stated that he wasn't sure who came. He added that it took the nursing home about 5 to 10 minutes to get there. After they said everything was fine, he stated that he left. He stated that the nursing home's golf cart was noted to come to the clubhouse but he stated that he did not talk to any staff from the nursing home and didn't go inside the clubhouse after the incident. The resident just walked in the clubhouse and kept insisting that she was fine and didn't want the nursing home to get involved. He stated that Nursing Assistant #1 was on the bus and insisted that the resident be checked out. He stated that he reported the event to the Director of Transportation the next day because it happened at night. He stated the event happened around 7:25 PM. He stated that he was to contact someone about any kind of fall and that he contacted his director. The Director of Transportation was interviewed again on 5/1/18 at 10:03 AM. He stated that the driver would put residents on the lift. There was a transport chair and any resident transported would sit in the transport chair and the lift would be lowered to the ground. Then the driver would get on the lift behind the resident. If a resident	F 689		

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F 689	Continued From page 8 had a walker, then the walker would be placed on the bus. Then they would put the walker outside of the bus and would lift the member down in the transport chair with the lift and help the resident to the walker. He stated that staff undergo training on the lift when they start here. He said that he didn't think this resident actually fell but heard the lift shook or something. It was not reported to him how the resident was being transported during the incident. If a resident fell then they would have to fill out an incident report and the driver would call him. They would also have to get a nurse from the nursing home to assess the resident if a resident had a fall as they are not allowed to touch the resident. The Administrator stated on 5/1/18 at 2:17 PM that he talked to Resident #13 the day after the event and received a PERS (personal emergency response system) email about the incident. The Corporate Consultant was interviewed on 5/1/18 at 2:17 PM. He stated he thought the resident, driver and other staff members all had a different story. He stated the resident had a history of fractures, was on a many medications and had chronic pain. The Activities Director was interviewed on 5/1/18 at 3:26 PM. She stated that resident #13 and another resident went to the World War II presentation. She stated that she was not here when the resident left for the activity. The bus would have picked up the residents around 7:00 PM or 7:15 PM and the event was about an hour and a half long. The Administrator was interviewed on 5/1/18 at 4:05 PM. He stated he talked to the resident after	F 689		

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F 689	Continued From page 9 the incident and thought they had completed some in-services and would look for them. He stated they also got an X-ray of resident #13 from a nursing standpoint. The Administrator was interviewed on 5/1/18 at 4:47 PM. He stated he interviewed the resident the day after the event and she stated that she was coming back from an activity. He stated that the resident stated that the bus lift was in the up position and she was standing on it when getting off the bus. The resident stated she fell on the bus. He stated that he didn't ask her about pain. He stated that they provided the buses with transport chairs now as they didn't have them before. The administrator stated that he had made a timeline of events that happened for the incident today. The receptionist was interviewed on 5/1/18 at 4:56 PM. She stated that there was World War II lecture and the resident came to the clubhouse around 7:00 PM. The receptionist stated that she was inside the clubhouse building. When the resident got off the tram (she was referring to the bus) another resident stated that the resident fell backwards and hit her head. She stated that the resident walked in the clubhouse and she called the nursing home. The nurse from the nursing home came up and did a complete assessment on the resident. She stated that she could not remember the name of the resident that reported the fall to her. The resident told her that when the door opened and the lift was going down, the lift went up instead of down and she fell. She stated that she sat with the resident for about half an hour and around 7:45 PM, the resident went to the lecture. She stated that the resident was walking with her walker. She stated that she	F 689		

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F 689	Continued From page 10 would have not known that the resident had a fall unless she was told by the other resident. The driver came in the clubhouse after he was done with his rounds and she told him that resident #13 had reported to her that the lift went up instead of down, which caused her to fall. The driver stated that he did not recall this. She stated there was also a nursing aid that was caring for another resident on the bus. She added that the nurse did a thorough job of assessing the resident and no pain was noted. An observation (Driver, Administrator, Corporate consultant, human resources staff were all present) was made on 5/1/18 at 5:15 PM of the "mini bus" (The bus involved in the incident). The bus was E-350 Superduty Ford. A metal piece (ramp) from the lift on the bus was observed to unfold from an upright to a horizontal position when the "unfold" button was pressed when the lift was in the up position and parallel to the bus. The metal flap (ramp) was then observed to fold up and the lift went back down to the ground (for residents to exit onto the bus). The "down" button was pressed and held and the lift dissented down to the ground then the "unfold" button was pressed as the metal ramp would unfold again. The lift appeared to be functioning properly according to the manufacturer's instructions. The lift also had a belt with a latch across it and there was 2 handles on each side of the lift. The lift was controlled via a small electronic hand held remote that the driver used, which was functioning properly. Driver #1 stated on 5/1/18 at 5:15 PM that he would unfold the lift, then the resident would get on the lift and the lift would go down and that he would control the lift via the remote. He stated	F 689		

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F 689	Continued From page 11 that he would tell the resident to "come on" the lift and this resident was standing with the walker. He stated that the only thing the residents have to hold onto is the walker when they get on the lift. He stated resident #13 was coming on the lift and when he turned around and saw her go backwards and saw her on the floor of the bus. He stated he got on the bus and the resident said she was fine and he helped her up. He stated that the resident did not want to go back to the nursing home. The resident then walked back on the lift and was brought back down to the ground with the lift. He stated that there was no issue with the lift going in the wrong direction (up or down) when she fell. He stated that he thought the resident was standing on the 1st metal panel of the lift (the ramp) and the walker was on the lift (he pointed to the middle part of the lift) He stated now they use the wheelchair for residents who have walker and would strap them in the wheelchair, secure them with the seatbelt and that a staff member would ride with the resident on the lift. The Corporate Consultant was interviewed on 5/1/18 at 5:15 PM. He stated they heard there was a nursing assistant present and saw the event. He stated that now the bus had a wheelchair in place for residents that used walkers that it was implemented about a month ago. The Director of Transportation was interviewed again on 5/1/18 at 5:15 PM. He stated that the drivers were in-service on proper use of the lift. He stated that he had documentation of this. He stated there was no incident report filled out for this incident and there should have been but the resident was assessed by the nursing home after	F 689		

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F 689	Continued From page 12 the incident, which may have been why an incident report not been completed. The Human Resources staff member was interviewed on 5/1/18 at 5:15 PM. She stated upon hire and annually that safety training was completed for the drivers. Nursing Assistant #1 was interviewed on 5/2/18 at 10:18 AM. She stated that she was caring for another resident when she was on the bus. She stated that she was standing next to the driver's door outside with the resident she was caring for and resident #13 was waiting for the bus lift inside the bus when she heard something (she demonstrated a loud thump on the table). She stated that she ran inside the bus. Resident #13 was sitting on her buttock and was holding the walker in her hands. The resident's head was not on the ground and the resident was just sitting on the floor of the bus. The resident did not scream or make a noise. The lift was in the up position as it was going to lift the resident down. She stated that the resident could walk. She stated that she didn't hear noises or anything from the lift before the resident fell. The resident had a regular walker with wheels on it. The driver came on the bus too and the resident got up. She stated she was not sure how the resident got up but she thinks it was combination of the resident getting up on her own and help from the driver. Then the resident got back on the lift and it took her down. Then the resident walked on her own into the entry of the clubhouse. The NA stated that she got off the bus and told the resident that she had to be checked out by the nursing home. She stated that she followed the resident inside the clubhouse and she told the receptionist about what had happened to the resident. The resident	F 689		

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did sit down with the receptionist and the receptionist called the nursing home. She stated that she told the receptionist to call the nursing home because Resident #13 needed to be checked out. She stated that she didn't hear a jerking sound or anything from the lift. The driver helped the resident back on the lift and resident #13 stood on the lift to get off the bus. She thought there was a way the resident was secure on the lift but couldn't exactly describe it. After the resident was walking towards the clubhouse, the driver starting helping the other residents that were on the bus. The resident was insisting that she was fine and that she was going to dinner. The resident did not say anything to her about why she fell.

An observation of the "Mini bus" was made on 5/1/18 at 10:55 AM with the Administrator, Corporate Consultant and Director for Transportation. The lift in the bus was observed to go up, down, fold and unfold when the corresponding buttons on the remote were pressed. The buttons on the hand held remote had to be held down continuously in order for the lift to operate when moving up, down, folding and unfolding. The lift did not move when the buttons were not pressed. A safety feature was observed for the lift when the lift was in the up position and the director of transportation was standing on the ramp part of the lift. The lift alarmed when the buttons were pressed on the hand held remote and the lift would not move up or down when the director of transportation was standing on the ramp part of the lift.

The Director of Transportation was interviewed on 5/2/18 at 10:55 AM. He stated when the lift buttons are pressed and held, the lift would go up

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and down but when you stop pushing the buttons on the remote, the lift would not move. He stated that all the buttons worked on the hand held remote. He stated that the ramp of the lift will go up when the down button on the remote is pressed. The lift has a safety function when you are standing on the yellow ramp that keeps the lift from going up or down and will alarm. He stated that there was no way for the lift to go down if the resident was standing on the ramp due to this safety feature. He stated there was no way the lift could have moved if the resident was standing on it as it would have alarmed and locked up. He stated that the belt was used to secure residents that were standing but residents were not allowed to stand on the lift anymore. He stated that he was notified in a "fine" amount of time (the next day) about the incident and that he inspected the lift the next day and tested it. He stated that he did not find any problems with the lift.

The Corporate Consultant was interviewed on 5/2/18 at 10:55 AM. He stated he thought that they had provided everything (information) they were able to provide. He also added that he thought the resident lost her balance and fell backward and was not on the lift.

NA #1 (NA that was a witness to the incident) was interviewed again on 5/2/18 at 11:36 AM. She stated she was standing outside beside the passenger's door near the front of the bus just before the entry door of the bus. She stated that the resident was inside the bus and was not on the ramp or on the lift. She stated that she could see the resident from the window and from the door opening of the bus because there wasn't many seats on the bus and she was tall.

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F 689	Continued From page 15 The Medical Director was interviewed on 5/2/18 at 11:51 AM. He stated that the resident was methodical and brilliant. He stated that the resident took very good care of herself. The resident could not see and had many retinal hemorrhages. He stated the resident was very smart and very alert and oriented. He stated that he was notified promptly about the fall the resident had. He thought that if the resident was having pain after the fall that they would have checked her out. He thought her X-ray showed an L1 partial compression and he had seen her on Thursday. He stated the resident did not have a lot of pain when he saw her and was doing pretty well. He thought the resident was not going to need any kind of procedure for the compression of the spine. He stated that sometimes residents with a compression of the spine would get X-rays completed to see if the compression happened over time or if it was acute. He stated that they did a second set of X-rays to see if the compression was evolving and it wasn't. The second set of X-rays of the spine didn't show that there was an acute process. The resident had osteoporosis, type 1 diabetes, was elderly and had many risk factors could have caused her compression of the spine. He could not recall if the resident had pain medication ordered after the fall. He stated that he did not recall a formal meeting about the incident but had discussed it with staff at the nursing home. He stated he thinks he was notified about falls really promptly. He stated he does not remember recently that the resident had any acute pain. A service manager for the lift company was interviewed on 5/2/18 at 1:47 PM. He stated the lift was made for wheelchairs but people could stand on it too. He stated that you were not	F 689		

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supposed to stand on the lift with a wheelchair but could stand on it with a walker. There was lift belt and handles that should be held onto. The lift belt attached to the lift but would not a snug around the resident.

The resident was interviewed again on 5/2/18 at 2:37 PM. She stated that she was totally blind in her right eye due to a hemorrhage 15 years ago. She stated that she was independent with getting around with the walker but the only thing that she cannot do it put her compression stocking on and the aids helps her. She stated she was standing with the walker and the breaks on the walker were locked. She stated that she was standing on the ramp part of the lift, where you get on, and her walker was also on the ramp part of the lift and she was thrown back. She stated that she was holding onto the walker and it fell back on her as she was holding it. She bruised her left upper arm and her back had a spot where it was bruised. She stated that she had back pain for a short time after the fall; maybe for a couple of weeks. She stated that the driver helped her stand and then got on the lift to get her off the bus then she walked inside the clubhouse. She stated that the nurse from the nursing home came and checked her out. She stated that her blood sugar was not low and she sat in the clubhouse for an hour then watched the World War II lecture. She stated she took some Tylenol (a medication for pain) before she went to bed that night. She stated that she had previously broken her sacrum in 2014. She stated that the last time she rode on the bus, she took the steps to get in the bus and her walker was taken inside the bus.

Nurse #1 was interviewed on 5/2/18 at 3:18 PM. She stated that the resident told her that the ramp

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F 689	Continued From page 17 of the lift threw her back so she put Equipment malfunction on the incident report because she didn't see another option. She stated that she did check the resident's blood sugar when she assessed the resident at the clubhouse. Resident #13 denied pain after the assessment. She stated that when Resident #13 got back from the event, the resident told her that she was not having pain but that her mind remembers what happened. She stated that the resident came back around 8:45 PM to 11:00 PM and the resident could get Tylenol as needed at night. Nurse #1 was interviewed on 5/2/18 at 3:44 PM. She stated that she did not put in the incident report but that resident's #13 blood sugar was 142 when she assessed her at the clubhouse. The administrator was interviewed on 5/4/18 at 1:50 PM. He stated he would expect for any member to be seated on the lift and was properly secured to the chair and to the lift with the appropriate seat belts. He stated that members that can ambulate safety would use the stairs. The NA would not be operating the controls on the lift. If a resident had a fall then he would want non- clinical members to comfort the resident but not to touch or relocate the member and make sure the member was assessed by a clinical staff member. The Director of Transportation should be notified, the nursing home, the director of nursing and himself. In addition, a PERS (Personal Emergency Response System) email should be sent to all department heads. The facility would do a root cause analysis and the status of the resident fall should be assessed and new interventions should be put in place. He stated that they would follow their protocol for incidences and notify the resident's family.	F 689		

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F 689	Continued From page 18 The administrator was notified of Immediate Jeopardy on 5/2/18 at 4:12 PM. On 5/4/18 at 9:31 AM, the facility provided the following credible allegation of Immediate Jeopardy removal. " On 03/19/2018 the bus driver transferred three members to the club house utilizing the community 14 passenger mini bus. Around 7:15 PM, Resident #13 was preparing to get off the bus to go to the club house to attend an activity. Resident was able to ambulate with a walker, however needed supervision during ambulation. According to the member statement, Resident #13 got on the lift with her walker. The resident reported that she was standing on the bus lift ramp and the lift ramp, instead of going down, it went up and threw the resident backward and she ended up on the floor and hit her back. The driver helped the resident to stand up, and walk to the lift with her walker. Then, the driver used the lift to get the resident off the bus before being assessed by nursing professionals to rule out injuries. 1. The root cause analysis: The resident was holding onto the walker instead of the handrails on the lift. The bus driver did not instruct the resident to utilize the yellow hand rails per manufacturer's guidelines. Also the bus driver did not instruct the resident to utilize the safety belt that was present on the lift. The nurse responded to a Personal Emergency Response Call involving Resident #13 and evaluated resident. No suspicious injuries were observed or documented at the time of her initial evaluation and resident requested to continue towards venue. A bruise on the left arm was observed five hours later. Member is at risk for easily bruising	F 689		

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F 689	Continued From page 19 and bleeding due to eliquis use. During the investigation it was determined that the bus driver training (Per manufacturer's instructions) and comprehension was inadequately documented, however it was observed and verbally reported by the Driver responsible for leading training as complete to ensure resident safety during transition from bus to ground on 02/07/2018. The instructions included proper use of handrails and safety belt to ensure member safety. All new employees receive new hire training prior to working with residents. Despite being adequately trained during general new hire orientation on 02/06/2018 on Cypress Safety and Security, the bus driver did not follow community protocols on 03/19/2018 by moving a member prior to nurse evaluation/assessment. The driver has received comprehensive retraining on 03/20/2018 for transferring residents utilizing the transport chair. o The facility did not conduct a thorough investigation to determine root cause of the resident fall and root cause of why the employee moved the resident before waiting for the nurse to arrive to evaluate resident. Due to the incident occurring on the mini bus and the bus transfer protocol being changed on 03/20/2018 administration wrongly assumed that the root cause had been determined and therefore failed to follow facility investigative protocol. 2. On 05/02/2018 bus was taken out of service and keys were secured with Facility's Director. Memo was sent to staff that bus was out of service until further notice. The Cypress of Raleigh will contract with a provider for Rosewood member transportation until all training is complete. The facility will make sure that the	F 689		

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F 689	Continued From page 20 transportation provider's contract contains standard safety procedures for resident transport including what to do in case of an accident. On 05/02/2018 facility implemented enhanced two person transfer method which would include a CNA transferring the member through the lift process. On 05/02/2018 the facility implemented the new transfer method. The two step method involves a driver operating the lift while a resident is seated in the transport chair. A CNA will accompany the resident and rides up on the lift with the member after locking the wheels. The safety harness is fastened behind the CNA securing both the member and CNA on the lift. Once the CNA holds the yellow handles per the manufacturer's safety instructions the CNA indicates to the driver that they are ready to be lifted. Once the lift is completed the CNA unlocks the transport chair and wheels the member inside. The member is then either secured in wheel chair or transferred to a regular seat on the bus. Mandatory in servicing was conducted 05/02/2018 by Administrator and Facility's Director with transportation staff, activity staff and CNAs on the enhanced two person transport procedures. Approximately 17 staff members were in serviced but 100% of nursing and activity staff and drivers will be in-serviced prior to the 14 passenger mini bus being released for use. In addition no staff member will be allowed to work until they attend the in-services. On 5/3/2018 15 of 15 drivers were re-in serviced by Facility's Director using manufacturer's lift operating instructions as well as a manufacturer's video training supplement called Braun Ability Commercial Wheelchair Lifts Operators Video on how to use a wheelchair to transfer residents in and out of the bus. 15 of 15 driver were able to demonstrate competency in using the lift on the	F 689		

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F 689	Continued From page 21 14 passenger mini bus. All community non-clinical staff are being trained on accident response. On 5/2/18 and 5/3/18 the Director of Human Resources and the Registered Nursing managers of the homecare department conducted all Rosewood non clinical staff training on emergency response. The training included directions to call for a nurse, 911, on company issued cellphones stay with the member and do not to move any member. Staff that were not trained on 05/3/2018 have been removed from the schedule and not allowed to return to work until training is complete. 3. A new lift bus has been ordered on 04/03/2018 and is tentatively scheduled to replace the existing 14 passenger bus in July of 2018. Effective 05/04/2018 the Facility's Director will perform lift competency training and evaluations on randomly selected drivers to ensure proper safety procedures while using the lift weekly for three weeks and every other week thereafter until the new bus arrives. Any unsafe practice will immediately be reported to the Administrator and the staff involved will be re-educated on proper protocols. Our Social Services Coordinator and or designee will receive transportation logs weekly of all members that utilized the 14 passenger bus for transportation and will interview at least 50% of members. Any concerns will be reported to Administrator for immediate follow-up/investigation. Quarterly (x 2) safety observations as well as resident interviews will be reviewed and discussed during QAPI meeting. Trends and patterns will be tracked amongst the QAPI Committee for feedback and/or recommendations. 4. The Administrator will oversee the investigation	F 689		

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F 689	Continued From page 22 and ensure that all pertinent information/evidence is gathered. The Administrator will gathers facts, remain objective, ensure timeliness utilizing the 5 W's of Who, What, When Where and Why. The Administrator will use the gathered evidence to summarize the event in an attempt to establish the root cause. 5. The Administrator will be responsible for implementing this credible allegation of removal on 5/3/18. The credible allegation was verified on 5/4/18 at 2:00 PM as evidence by nurses, drivers, and administration interviews regarding in-servicing on use of the lift in the bus, notification and protocol for falls. Licensed and non-licensed staff were interviewed on in- service training how to use and safely get residents on and off the lift on the bus, proper use of the bus lift, and reporting of accidents and incidents. Review of on- going in service records revealed that staff present would receive training who did not receive in servicing prior to working. An observation was made on 5/4/18 at 12:24 PM of the staff properly using the bus lift to transfer an individual.	F 689		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff	F 835	Preparation and/or execution of this Plan	5/9/18

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THE ROSEWOOD HEALTH CENTER	8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615

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interviews, the facility's administration failed to conduct an investigation and determine the root cause analysis for a fall for 1 of 3 residents reviewed for accidents. (Resident #13). The failure of administration to address these concerns led to the inability to implement effective interventions to prevent a reoccurrence.

Immediate jeopardy began on 3/19/18 when Resident #13 fell and an investigation and root cause analysis was not conducted after the fall. Immediate jeopardy was removed on 5/3/18, when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of "D"' (no harm with the potential for more than minimal hard that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective.

Findings included:

This tag is cross referenced to 689:

Based on record review and resident and staff interviews, the facility failed to safely transfer a resident off the bus via the lift and failed to have a licensed health care professional assess the patient before standing the resident up after a fall for 1 of 3 sampled residents (Resident #13) reviewed for supervision to prevent accidents. Resident #13 fell back into the bus while attempting to transfer onto the lift and she sustained a bruise to her left upper arm and increased back pain as a result of the fall.

The Director of Nursing stated on 5/4/18 at 12:19 PM that the nurse would call her for any incident with injury and that she would start an

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of Correction does not constitute an admission or agreement by the provider to the allegations or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of Federal and State Law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered an admission that a deficiency existed or that additional measures should have been in place at the time of the survey. This serves as this facility�s credible allegation of compliance with state and Federal Regulations.

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Resident 13 was assessed on 3/19/18 and x-rays completed on 3/20/18 and again on 3/26/18 which revealed fractures of undetermined age. Resident 13�s care plan was updated on 3/20/18. Resident was seen by her physician on 3/22/18. Resident number 13 was interviewed on 3/20/18 and seen again on 5/2/18 and verbalized feelings of being happy with transportation and enhanced protocols initiated on 3/20/18.

All new employees receive new hire training prior to working with residents. The driver has received comprehensive retraining on 03/20/2018 for transferring residents utilizing the transport chair.

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F 835	Continued From page 24 investigation. If it happened over the weekday, the inter-disciplinary team would do a thorough investigation and would focus on the root cause analysis. The Administrator was interviewed on 5/4/18 at 1:50 PM. He stated that the facility would do a root cause analysis and the status of the resident's fall should be assessed and new interventions should be put in place. He stated that they would follow their protocol for incidences and notify the resident's family. The Administrator was notified of Immediate Jeopardy on 5/2/18 at 4:12 PM. On 5/4/18 at 9:31 AM, the facility provided the following credible allegation of Immediate Jeopardy removal. 1. On 03/19/2018 the bus driver transferred three members to the club house utilizing the community 14 passenger mini bus. Around 7:15 PM, Resident #13 was preparing to get off the bus to go to the club house to attend an activity. Resident #13 was able to ambulate with a walker, however needed supervision during ambulation. According to the member statement, Resident #13 got on the lift with her walker. The resident reported that she was standing on the bus lift ramp and the lift ramp, instead of going down, it went up and threw the resident backward and she ended up on the floor and hit her back. The driver helped the resident to stand up, and walk to the lift with her walker. Then, the driver used the lift to get the resident off the bus before being evaluated by nursing professionals to rule out injuries. The root cause analysis: The resident was holding onto the walker instead of the handrails on the lift. The bus driver did not instruct the resident to utilize the yellow hand rails	F 835	Life Care Services is the management company for The Cypress of Raleigh and The Rosewood Health Center. On 5/2/18 a thorough investigation of the incident which occurred on 03/19/2018 was conducted by the Executive Director, Administrator, Director of Clinical Operations, LCS Nurse Consultants and LCS Director of Survey Compliance which included interviews with the driver, resident #13, and additional witnesses and staff. The Rosewood Health Center had Life Care Services (LCS) corporate resources, to include the Director of Operations Management, Nurse Consultant and Director of Survey Compliance, conduct a review on 05/02/2018 about the standard investigative processes at the Rosewood Health center at the Cypress of Raleigh and identified opportunities for process improvement. The Administrator and Rosewood Nursing Administration were counseled 05/02/2018 by the Director of Operations Management. On 05/02/2018 Administrator and Nursing Administration were re-in serviced on event investigation, which included root cause analysis by Life Care Services corporate resources to include the Director of Operations Management, Nurse Consultant and Director of Survey Compliance on Event Investigation. Rosewood leadership including the Director of Clinical Operations, MDS Nurse, Executive	

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F 835	Continued From page 25 per manufacturer's guidelines. Also the bus driver did not instruct the resident to utilize the safety belt that was present on the lift. The LPN responded to a Personal Emergency Response Call involving Resident #13 and evaluated resident. No suspicious injuries were observed or documented at the time of her initial evaluation and resident requested to continue towards venue. A bruise on the left arm was observed five hours later. Member is at risk for easily bruising and bleeding due to eliquis use. During the investigation it was determined that the bus driver training (Per manufacturer's instructions) and comprehension was inadequately documented however it was observed and verbally reported by the Driver responsible for leading training as complete to ensure resident safety during transition from bus to ground on 02/07/2018. The instructions included proper use of handrails and safety belt to ensure member safety. All new employees receive new hire training prior to working with residents. Despite being adequately trained during general new hire orientation on 02/06/2018 on Cypress Safety and Security, the bus driver did not follow community protocols on 03/19/2018 by moving a member prior to nurse evaluation. The driver has received comprehensive retraining on 03/20/2018 for transferring residents utilizing the transport chair. The facility did not conduct a thorough investigation to determine root cause of the resident fall and root cause of why the employee moved the resident before waiting for the nurse to arrive to evaluate resident. "Due to the incident occurring on the mini bus and the bus transfer protocol being changed on 03/20/2018 administration wrongly assumed that the root cause had been determined and therefore failed to follow facility investigative protocol.	F 835	Director, Administrator and Nursing Supervisors participated in a mandatory in service conducted by LCS Nurse Consultant on 05/03/2018 on the proper completion and review of Fall Scene Investigation report. Anyone unable to attend the mandatory in service was not allowed to work until they had completed mandatory in servicing. It is the practice of the Rosewood Health Center to investigate all Resident related accidents. All incidents/accidents involving transport will initiate an investigation immediately Any instances of a Rosewood Resident accident will be consistently investigated in order to determine root cause. The changes made will ensure that the Facility will consistently conduct a root cause analysis as a part of its investigative process. The Administrator will gathers facts, remain objective, ensure timeliness utilizing the 5 W□s of Who, What, When Where and Why. The Administrator will use the gathered evidence to summarize the event in an attempt to establish the root cause. The Administrator or designee will review all incident/accident reports to ensure forms are fully completed and a thorough root cause analysis is also completed. Executive Director of the community will provide oversight of the Administrator to ensure that incidents are being investigated. The Executive Director will	

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F 835	Continued From page 26 On 5/2/18 a thorough investigation of the incident which occurred on 03/19/2018 was conducted by the Executive Director, Administrator, Director of Clinical Operations, Nurse Consultants and Director of Survey Compliance which included interviews with the driver, resident #13, and additional witnesses and staff. The Rosewood Health Center had Life Care Services (LCS) corporate resources, to include the Director of Operations Management, Nurse Consultant and Director of Survey Compliance, conduct a review on 05/02/2018 about the standard investigative processes at the Rosewood Health center at the Cypress of Raleigh and identified opportunities for process improvement. We found that event investigation needs to be consistently completed regardless of the location of the incident. Any instances of a Rosewood member accident will be consistently investigated in order to determine root cause. The changes made will ensure that we will consistently conduct a root cause analysis as a part of our investigative process. Those were the missed steps that occurred in the investigative process. Administration prematurely determined corrective action without doing a root cause analysis. 2. It is the practice of the Rosewood Health Center to investigate all member related accidents. All incidents/accidents involving transport will initiate an investigation immediately. The Administrator and Rosewood Nursing Administration were counseled 05/02/2018 by the Director of Operations Management. Life Care Services is the management company for The Cypress of Raleigh and The Rosewood Health Center. On 05/02/2018 Administrator and Nursing Administration were re-inserviced on event	F 835	audit incident/accident reports for 60 days. Any incomplete incident/accident reports will be investigated. Quarterly (x 2) audit results will be reviewed and discussed during QAPI. Trends and patterns will be tracked amongst the QAPI Committee for feedback and/or recommendations. The Administrator will be responsible for ensuring that all corrective measures have been carried out and that appropriate monitoring measures are in place. Date corrective action was completed: 05/09/2018	

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F 835	Continued From page 27 investigation, which included root cause analysis, by Life Care Services corporate resources to include the Director of Operations Management, Nurse Consultant and Director of Survey Compliance on Event Investigation. Rosewood leadership including the Director of Clinical Operations, MDS Nurse, Executive Director, Administrator and Nursing Supervisors will participate in a mandatory in-service conducted by LCS Nurse Consultant on 05/03/2018 on proper completion and review of Fall Scene Investigation report. Anyone unable to attend the mandatory in-service will not be allowed to work until they have completed mandatory in-servicing. 3. Administrator or designee will review all incident/accident reports to ensure forms are fully completed and a thorough root cause analysis is also completed. Executive Director of the community will provide oversight of the Administrator to ensure that incidents are being investigated. The Executive Director will audit incident/accident reports for 60 days. Any incomplete incident/accident reports will be investigated. Quarterly (x 2) audit results will be reviewed and discussed during QAPI. Trends and patterns will be tracked amongst the QAPI Committee for feedback and/or recommendations. 4. The Administrator will be responsible for implementing this credible allegation of removal on 5/3/18. The credible allegation was verified on 5/4/18 at 2:00 PM as evidence by administration interviews regarding in-servicing on incident/accident notification, protocols for falls, investigating accidents/incidents and determining the root	F 835		

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F 835	Continued From page 28 cause analysis of a fall. Review of on- going in service records revealed that staff present would receive training who did not receive in servicing prior to working.	F 835		