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F 000	INITIAL COMMENTS A complaint survey was conducted from 10/3/18 through 10/5/18. Immediate Jeopardy was identified at CFR 483.25 for tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/1/18 and was removed on 10/5/18. A partial extended survey was conducted.	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 observations, staff interviews, and record reviews, the facility failed to follow the van lift manufacturer ' s recommendations for lowering a resident who is wheel chair bound to the ground with the Transportation Aide on the ground and the resident ' s wheel chair in the correct position with the wheel chair brakes locked for 1 of 4 sampled residents (Resident #1) reviewed for accidents. While being assisted to exit the facility ' s transport van, Resident #1 fell backwards in the wheel chair onto the platform of the van ' s lift. Resident #1 was immediately transported to the hospital where she was diagnosed with a head contusion. The facility also failed to secure each wheelchair-bound resident with a safety shoulder belt and lap belt during	F 689	The facility failed to follow the manufacturer's recommendations for using the van lift for residents being transferred in the van. The facility did not have both the lap belt and shoulder belt for each resident that was transferred over in the van. 1) Resident #1 was immediately transported to Wake Baptist Hospital after the accident occurred. CAN#1 was withheld from all responsibilities while a full investigation of the accident was initiated. The van was locked out/tagged out on 10/1/2018. Resident #1 was discharged from the hospital several hours later with a contusion but	11/2/18

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

Electronically Signed | 10/24/2018

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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F 689	Continued From page 1 transportation, as evidenced by 1 of 4 sampled residents (Resident #2) reviewed for accidents. Immediate jeopardy began on 10/1/18 when Resident #1 fell backwards in her wheel chair while staff assisted her to exit the facility ' s transport van using the van ' s lift and she hit her head on the lift ' s platform. Immediate jeopardy was removed on 10/5/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for finding #2 and for the facility to complete staff training and monitor its corrective action to ensure appropriate interventions are put into place to safely transport residents. Findings included: A review of the manufacturer ' s van lift manual included the following statements (page 23): "The attendant must always be certain the wheelchair passenger or standee is properly positioned on the platform (fully inside yellow boundaries) and the wheelchair brakes are locked when a passenger is on the lift platform. The lift passenger must keep hands, arms and all other body parts within the lift occupant area and clear of all moving parts." Page 23 of the lift manual also included the following statement: "The passenger must be positioned in the center of the platform to prevent side-to-side load imbalance. The lift attendant (operator) should not ride on the platform with the passenger." Page 24 of the lift manual included a black boxed "Warning" which	F 689	"well-appearing" according to the hospital's discharge note. At the time she was discharged from the hospital she was accompanied by her family to a different nursing facility. 2) Any other residents that use the facility transportation are at risk for F689 Accident Hazards/Supervision/Devices. The facility began utilizing a commercial carrier to transport residents until the plan is fully implemented. 3) The Facility Transportation Vehicle policy and procedure was updated beginning 10/1/2018 and completed 10/4/2018. The policy includes a comprehensive background check including driving record from the DMV and age verification, use of manufacturer's videos for training, a Transport Driver Skills Assessment, a Transport Safety Observation protocol and includes monthly checks by the trainers at each facility and daily safety checks by the drivers of the transport vehicle. Accordius Health has determined the large transport vehicles such as the one involved in this accident will be staffed by two persons to support the safe on-boarding and un-boarding of residents. This additional staff will function to stand on the ground at the side of the lift gate to provide extra assurance of safety. Safety belts have been ordered that will be secured on wheelchairs when they are placed on the van for transport. A corporate subject matter expert completed training with manufacturer's standards as of 10/25/2018. He now holds a two-year certification awarded by the Q-Strain	

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F 689	Continued From page 2 read: "Whenever a passenger is on the platform, the: · Passenger must be positioned fully inside yellow boundaries · Wheelchair brakes must be locked · Inner roll stop and outer barrier must be UP Failure to follow these rules may result in serious bodily injury and/or property damage." 1. Resident #1 was admitted to the facility on 6/7/18 from another nursing home or swing bed. Her cumulative diagnoses included end stage renal failure requiring hemodialysis, a history of a right above knee amputation (AKA), and right hemiplegia (paralysis on one side of the body). A review of Resident #1 ' s most recent quarterly Minimum Data Set (MDS) dated 7/26/18 revealed the resident had intact cognitive skills for daily decision making. No behaviors nor rejection of care were reported. Section G of the MDS indicated the resident required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of being totally dependent on staff for locomotion off the unit (with physical assist of one) and requiring supervision only for eating. The resident used a wheelchair for mobility. Review of an Incident Report (last revised on 10/3/18 at 11:08 AM) detailed an incident which occurred out of the facility during transport on 10/1/18. It reported Transportation Aide #1 called the facility ' s Administrator and stated Resident #1 had fallen off of the van lift when the transportation aide tripped and fell off of the back of the van lift. The report indicated no injuries were observed at the time of the incident; no witnesses were found to the incident. Resident	F 689	Manufacturer and proper operation and securing methods. Using the Train the Trainer model, the facility has chosen two Maintenance team members to receive training directly from the corporate subject matter expert who will then be able to oversee an certify all drivers and transportation aides for the facility. No person will be permitted to operate the transportation vehicle until they have completed this training. Current drivers will have completed training by November 2, 2018. New drivers will complete the full training process before operation of the vehicle. Until all drivers that operate the van have completed training, a commercial vehicle will be used. 4) The Maintenance Director will randomly select 5 opportunities a week to observe securing, on-boarding, and off-boarding using the Transportation Safety Observation Report for 30 days and then 3 times a week for 60 days, with continued monitoring thereafter. These observation forms will be reviewed by the Maintenance Director and Administrator on a weekly basis to look for room for improvement. This data is then presented in monthly QAPI and will be discussed, looking for any room for improvement. 5) The Administrator is ultimately responsible for this corrective action which will be fully implemented by November 2, 2018.	

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#1 was taken to the hospital Emergency Department (ED) immediately after the fall.

A review of the Hospital Records for Resident #1 revealed she was brought to the hospital by an ambulance service and seen at the ED on 10/1/18 at 12:04 PM for triage. The initial ED notes indicated the resident presented less than one hour after having a fall her from wheelchair. At the time of the evaluation, Resident #1 complained of moderate pain in her left shoulder. The resident was diagnosed with a head contusion and discharged to another facility on 10/2/18.

An interview was conducted on 10/3/18 at 12:20 PM with Transportation Aide #1. Transportation Aide #1 was identified as the staff member who transported Resident #1 to the dialysis center on 10/1/18 and was involved in the incident when the resident fell on the lift. This transportation aide reported she began working at the facility in the spring of 2018 as a Nursing Assistant (NA). She reported having previous work experience transporting residents and transitioned over to working with transportation at this facility approximately two months ago. The transportation aide reported she initially began driving an older facility van belonging to the facility before a new van was put into service 6 weeks ago (on 8/17/18). Transportation Aide #1 stated she picked up this new van from a sister facility and drove it back to the facility. The transportation aide reported the only training she received on the new van was, "I got the key and they showed me where the brake was."

The interview conducted on 10/3/18 at 12:20 PM with Transportation Aide #1 continued as she

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detailed events surrounding Resident #1 ' s fall on 10/1/18. The transportation aide reported she had transported Resident #1 and Resident #2 together in the van to the dialysis unit around 10:30 AM on 10/1/18. She stated both of the residents were transported in wheelchairs, with Resident #1 using a bariatric wheelchair. Each wheelchair was fastened with 4 floor anchors to the floor of the van. Resident #1 rode on the left side (driver ' s side) of the van and was also secured with a safety shoulder and safety lap belt. Resident #2 rode on the right side of the van. After arriving at the dialysis center, Resident #2 was taken off of the van using the van lift and brought into the dialysis center by Transportation Aide #1. To unload Resident #1, the transportation aide unfastened the resident ' s safety shoulder and safety lap belt and released the floor anchors for the wheel chair. Transportation Aide #1 then proceeded to back the resident ' s wheelchair onto the lift while standing behind the wheelchair on the van ' s lift platform. Once on the platform, she locked the resident ' s wheelchair brakes. The transportation aide began to lower the lift as she stood on the platform behind Resident #1 ' s wheelchair. She stated the van lift stopped when the resident ' s left foot applied pressure onto the inner roll stop on the lift (a safety feature of the lift which prohibits operation of the lift when it senses weight). Transportation Aide #1 reported she then released the brakes on Resident #1 ' s wheelchair so she could pull the wheelchair back further to ensure the resident ' s foot was no longer triggering this safety sensor. As she did this so, she tripped over the back flap on the end of the lift (the outer barrier). Transportation Aide #1 reported she was able to stay on her feet as she hit the ground and continued to hang onto the

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resident ' s wheel chair. The transportation aide reported the wheel chair tipped backwards with the resident still seated in the chair. She stated both the resident and the wheel chair landed on the lift, "kinda hanging over." After landing, Resident #1 ' s head was reported to be on the edge of the lift and she was on her back while still partially sitting in the wheel chair. The transportation aide stated an unidentified man was in the parking lot loading up people on another transport van. This man responded when she called out for help and he went into the dialysis center to get help for her. When asked, the resident stated she hurt at the base of her neck. Staff from the dialysis center called 911 for an ambulance and Transportation Aide #1 reported she called the facility to inform them of the accident. When the ambulance came, the paramedics transferred the resident to a stretcher and transported her to the hospital for evaluation and treatment. Transportation Aide #1 reported the facility ' s Administrator called and told her to wait for someone to come and bring the van back to the facility. The transportation aide reported she has not driven the facility ' s van since that time because the Administrator told her she had to be oriented before she could drive again. Transportation Aide #1 stated, "That should have been done before I started driving." The transportation aide reported this morning (10/3/18) the facility initiated a transportation orientation for her with the Maintenance Director as her trainer. Among other activities that morning, the transportation aide stated she watched a video "for the first time" on the use of the new van lift.

An interview was conducted on 10/3/18 at 1:19 PM with the Maintenance Director. During the

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interview, the Maintenance Director reported the facility ' s other maintenance employee (the maintenance assistant) usually provided training on the transportation of residents. However, since the maintenance assistant was off on this date, the Maintenance Director began the training for Transportation Aide #1 himself. When asked who trained him on the new van and the van lift, he stated no one had trained him on this van. However, the Maintenance Director reported the new van was basically the same as their old van except the lift was on the back of the van instead of on the side. He reported the straps (referring to the safety shoulder and safety lap belts) were the same. Upon inquiry, the Maintenance Director stated he had reviewed the details of Resident #1 ' s fall on the van lift with Transportation
Aide #1. The Maintenance Director was asked if there were differences between how the lift was supposed to be used and how the transportation aide reported using it when Resident #1 fell on 10/1/18. Upon this inquiry, the Maintenance Director stated the transportation aide was not supposed to be standing on the lift platform when it was being operated. He also reported that from what he understood, the resident ' s wheelchair brakes were not locked at the time of the fall. The Maintenance Director stated, "That ' s an accident waiting to happen."

A demonstration was conducted on 10/3/18 at 1:38 PM by Transportation Aide #1 of Resident #1 ' s fall on the transportation van lift. Resident #1 ' s bariatric wheelchair was used for the demonstration conducted by the transportation aide. Transportation Aide #1 demonstrated how she was standing on the van lift platform while she operated it and began to lower the wheelchair

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passenger to the ground. When the safety sensor on the inner roll stop was triggered by a foot touching this floor panel, the lift stopped (approximately 16" above ground level). Transportation Aide #1 released the brakes on the wheelchair to move the chair further back on the lift and re-enacted how she tripped on the outer barrier of the lift while holding on to the wheelchair. The wheelchair was again described as having landed on the lift with the passenger coming to rest on her back while still in the wheelchair.

An interview was conducted on 10/3/18 at 1:57 PM with the facility ' s Administrator. During the interview, the Administrator reported a re-enactment of the incident was done on 10/1/18 with Transportation Aide #1 and the van was been checked over by maintenance. She reported there were with no operational issues/concerns found with the van itself. She stated, "It was clearly an accident to us because she (Transportation Aide #1) tripped over backwards when trying to help the resident." The Administrator stated the facility has not used the facility ' s van since Resident #1 ' s fall occurred on 10/1/18. She reported the facility was temporarily using a transportation service to meet the residents ' transportation needs. The Administrator also stated, "We are making sure before the drivers go back on the van we have an evaluation check list that we are in the process of creating."

A follow-up interview was conducted on 10/3/18 at 2:27 PM with the Administrator. During the interview, the Administrator was asked how Transportation Aide #1 was trained to provide transportation for residents prior to the incident on

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10/1/18. The Administrator responded by stating that every driver was trained, "on manufacturer instructions." When asked what this included, the Administrator reported the written vehicle manual was in the van for review. The Administrator added that Transportation Aide #1 received two days of training when she first started driving the facility ' s van. The first day of this training involved Transportation Aide #1 observing Transportation Aide #2, and the second day involved Transportation Aide #3 observing Transportation Aide #1. The Administrator stated she utilized "a basic sign off that the driver is comfortable." This sign off consisted of asking both the trainee and the person who observed her if they were "comfortable" before the trainee began transporting people on her own.

Telephone interviews were conducted on 10/3/18 at 3:46 PM and 10/4/18 at 12:17 PM with Transportation Aide #2. During the interviews, Transportation Aide #2 stated he began working with transportation at the facility in November 2017 and currently worked on an as needed (PRN) basis. When asked what training he received prior to transporting residents, he stated he did a "ride along" on 3 occasions with Transportation Aide #3. When asked, Transportation Aide #2 reported he was trained to stand on the ground when operating the van lift for a wheelchair resident.

Multiple unsuccessful attempts were made to contact Transportation Aide #3 for a telephone interview. There was no answer and no message could be left to request a return phone call. Transportation Aide #3 was reported to be a PRN staff member, but has not worked with the new van since it was put into service at the facility on

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8/17/18.

A video from the manufacturer of the van lift was viewed on 10/3/18 at 5:10 PM. The video depicted wheelchair passengers being lowered from the van to the ground with the lift operator standing on the ground. The video provided instructions to position the wheelchair in the center of the lift platform (with the brakes locked) prior to lowering the lift.

Follow-up telephone interviews were conducted on 10/3/18 at 6:19 PM and 10/4/18 at 4:40 PM with Transportation Aide #1. During the interviews, the transportation aide was asked to detail the transportation training (specifically related to the ride-alongs) provided at the facility. Transportation Aide #1 stated she rode with Transportation Aide #3 on one trip in the old van (approximately 15 minutes long). Two or three days later, she reported going on one ride along (one trip only) with Transportation Aide #2 for approximately 15-30 minutes. She reported she drove the old van back to the facility on that day but had no hands on training with the residents. From that point on, Transportation Aide #1 stated she transported residents on her own. When the transportation aide was asked if she was observed to load and/or unload a resident from the transport van prior to assuming the transportation responsibilities, she stated she was not. When asked if she signed any paperwork related to training upon starting the transport position, she stated she did not. The transportation aide reported she did not have a transportation check off training sheet until today (10/3/18).

An interview was conducted on 10/4/18 at 9:42

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AM with the Vice President (VP) of Clinical Operations. The VP reported Transportation Aide #1 had extensive training on transportation in a previous job. However, when asked if the facility should have verified the transportation aide ' s competency prior to her transporting residents, the VP stated, "Absolutely...and she should have done a return demo (demonstration)." When asked if there was any documentation of Transportation Aide #1 ' s training conducted prior to the incident on 10/1/18, the VP pointed to the documentation provided by the facility and stated, "Obviously not."

A telephone interview was conducted on 10/4/18 at 3:50 PM with a representative of the van lift ' s manufacturer. Upon inquiry, the representative stated the lift manufacturer did not recommend anyone stand on the lift with a wheelchair passenger during operation of the lift. The representative reported this information was included in the lift manual and an electronic copy of the lift manual was provided by the manufacturer for review.

On 10/4/18 at 5:45 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 10/5/18 at 6:23 PM. The allegation of compliance indicated:

Credible Allegation for F689:

Accordius Health at Clemmons
10/5/2018
Credible Allegation of Removal of Immediate Jeopardy

Part One:
The facility acknowledges that on October 1,

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2018 at approximately 10:15 am, resident number one (1) was injured during an accident that occurred while disembarking resident number 1 from the facility ' s transport van. The probable citation identifies 1) improper use of seatbelts and safety harnesses and 2) the allowance of having a second person on the lift gate potentially creating a positioning issue that contributed to the accident and inconsistent with manufacturer ' s recommendations.

Resident number 1 was immediately transported to and treated at Wake Forest Baptist Hospital where she was discharged several hours later with a contusion but "well appearing" according to the hospital ' s discharge note. At the time she was discharged from the hospital she was accompanied by her family to a different nursing facility.

Immediate and subsequent investigation began on October 1, 2018 at approximately 11:00 am, when the administrator dispatched Richard, Maintenance Supervisor, to the dialysis center where the fall had occurred. The initial investigation included checking the integrity of the van and its components, and returning the van in lock out tag out to the facility. Once back at the facility, the investigation evolved including statements and reenactments of the event. The transporter placed herself on the end of the ramp between the wheelchair and the panel and attempted to lower the lift. When it would not move the transporter checked and realized the resident ' s foot was making contact with the inner panel. In order to move the chair back she stepped out, released the brake and as she was moving the chair back enough to remove contact, she tripped over the real panel and, without losing her balance, landed at ground level. In the

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process the chair went with her. The transporter was able to control the speed and velocity of the tipping to a point, but the chair did overturn and the resident did land on the ramp. During a conversation on 10/4/18 between corporate clinical with the manufacturer about having a second person on the ramp, the representative said they cannot recommend a second person because of weight variations as the lift gate holds a maximum of 800 pounds safely. However, though she expressed that they know it happens frequently and the restriction is related to weight on the lift, she declined to offer anything in writing.

The allegation around improper use of seatbelts is not connected to this event. During the surveyors investigation a statement was made that there were only enough seatbelts to properly secure one passenger. Because there were occasions during which two passengers were transported, the deduction is that passengers were transported without complete seat belt. Management was unaware the seatbelts were missing or that anyone was being transported incompletely secured. It should be noted that the 4 point seat restraints and the shoulder harness were present for a second passenger but the lap belt portion was not there. The Maintenance Supervisor replaced these as of 10/4/18.

Part Two:

All residents who are transported on the facility ' s van are at risk of similar events. To assure no such event will occur the facility has instituted the following plan:

· The facility immediately, at 12:30 pm on 10/1/18, stopped transporting residents and took

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the van out of commission to abate the immediate jeopardy assuring that no resident was still at risk and allowing the facility to begin the process of evaluating, revising and implementing a revised company policy. Our contracted licensed medical transporter, [Company Name], will continue to provide all resident non-emergency transportation until the facility has completed the process and the plan is fully implemented. [Company Name], representative [Name] has reported to the Administrator that [Company Name] meets the safety standards for driving and has provided the facility with their safety check sheets on 10/5/18. Each has been reviewed by the Administrator and corporate clinical director on 10/5/18.

· At the time of the incident (10/1/18 approximately 10:15 am), the Transportation Aide was instructed to wait for assistance from the Maintenance assistant who was sent from the facility to check the van to make sure there were no operational issues with the van or the lift. The maintenance assistant brought the van and the aid back to the facility arriving shortly after 12:30 pm. The maintenance assistant found all mechanical and functional aspects of the van and the lift system to be in working order.

· An analysis of the incident was initiated immediately and included a thorough inspection of the scene, re-enactment of the Transportation Aide ' s account of what transpired. The transport vehicle was locked-out/tagged out until checked by the Maintenance Director who arrived at the facility approximately 6:30 pm. Equipment failure was ruled out as a contributing factor to the fall. Even so, lock-out/tag out continues through this investigation and implementation of the quality improvement plan.

· The Transportation aide was immediately

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removed from her transport duties.

· All equipment in the van was checked for function on 10/1/18 by the maintenance director.

Involved staff in the incident was interviewed by the Administrator, The Regional Director of Clinical Services and the Regional Director of Reimbursement beginning on 10/1/18 and continuing through 10/3/18. Follow up documentation of the injured resident was received.

· An Emergency QAPI meeting was held on 10/2/18 to review findings of the investigation which began on 10/1/18, the moment the event took place; and to evaluate the transportation process. Participants of the QAPI meeting included: The Director of Nursing, the Business Office Manager, the Dietary Manager, the Housekeeping Supervisor, the MDS Coordinator, an RN Supervisor and the Administrator. The meeting included discussion about the facts and circumstances of the accident with the QAPI committee decided 1) retraining of the transport driver/C NA, 2) looking for potential contributing factors such as footwear or clothing items, 3) assuring that all drivers understand the special parameters and requirements for proper wheelchair placement on the lift, 4) Discussion of whether anti-tippers might have stabilized the chair, and 5) residents be interviewed about their own experiences while being transported and whether or not they felt fearful 6) to keep the van out of commission until a plan could be fully revised and implemented.

· Evaluation and revision of the Facility Transportation Vehicle policy and procedure by the Vice President of Clinical Services was begun on 10/1/18. The plan was finalized at 11:30 am on 10/4/18 with a specific plan for full implementation

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prior to again transporting residents utilizing the facility van. Implementation was underway as of 10/1/18. Based on new training and credentialing requirements included in this plan as well as additional equipment which has been ordered, the facility intends to resume use of the facility van on or about 10/15/18 if all standards have been met and the Corporate Compliance team has reviewed and approved the status of the plan. To assure the facility does not place any resident at risk, Triad Safe Choice remains in place.

· Policy revisions include: 1) no transport aid (facility staff) will ride the lift gate with the resident either up or down and will be trained to stand next to the gate (on the ground unless otherwise indicated by manufacturer ' s instructions to provide support and stability as may be needed during operation. 2) All safety harnesses and seat belts have been evaluated for safety, effectiveness and compliance with operation manual instructions. Additional equipment has been added to the van allowing the full securing of any individual who would be transported 3) additional individual wraparound belts have been ordered for use on each individual wheelchair during transport and onboarding and off-boarding. This belt will secure the resident to the chair while on the lift gate during the time when the vehicle wall and floor mounted securing devices cannot be used.

· The revised policy includes additional background information to be collected and verified for each driver, use of both the manufacturer ' s lift operations manual and the manufacturer ' s videos for training, a Transport Driver Skills Assessment, a Transport Safety Observation protocol and both Daily and Monthly Safety Check protocols (checklists).

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· To assure training is conducted accurately, a team of two specific trainers have been assigned. Both are experienced Maintenance Directors who have worked with van transport extensively. Each is using the manufacturer ' s operations manual and training videos as well as policy and its components to establish a "train the trainer" format. Each building will have a trainer who has been through training with this team so that procedures are consistent and policy is adhered to.

· As the facility may use two different vans of vastly different size and capability, the large transport vehicles such as the one involved in this accident will be staffed by two persons for the purpose of safe on-boarding and off-boarding of residents. The facility ' s transport van will remain out of commission until the entire plan is fully implemented (on or about 10/15/18 and the full approval of the Corporate Compliance team.)

· No resident will be transported on the facility van until the Compliance team has declared the plan is complete (on or about 10/15/18). No person will drive or operate the van until the Compliance team has determined the implementation is complete.

Part Three:

On 10/3/18, the maintenance director began re-training the transporter C NA on the safe and proper use of the lift gate including proper onboarding and off-boarding, proper placement of the chair on the lift gate, proper positioning of the transport aide, proper securing of the wheelchair, proper use of the vehicle mounted securing system, the new element of using a wraparound seatbelt for each wheelchair occupant. Effective 10/1/18, and ongoing, Individual training will be

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completed by the Maintenance Director including Transport Driver Skills Assessment, prior to any individual being permitted to operate the van and will require completion of the Transportation Safety Observation Report prior to any resident being transported. Full training and competency evaluation by the Maintenance Director will be completed then on an annual basis thereafter and anytime there is a change in process, a risk is identified, or a change in condition occurs.

On 10/4/18 the Maintenance Director began training the transporter(s) on the use of the Pre-Trip Inspection, the Transportation Vehicle Monthly Safety Inspection.

Before the facility van is brought back into use, proposed drivers will receive, study and sign for the Facility Transportation Vehicle Policy and Procedure Accordius Health. This is the policy that guides the process to be followed. It is expected that each potential driver will understand this policy and be prepared to follow it in its entirety.

Part Four:

The safety committee (The Maintenance Director, Housekeeping Supervisor, Dietary Manager, Staff Development, DON and Administrator) will review the "Pre-Trip Inspections" and the Transportation Vehicle Monthly Safety Inspection forms (see addendum included at the end of this document) as well as driver Skills Assessments and Transport Observation Reports (see addendum included at the end of this document) on a monthly basis. The committee will review as well any and all close-calls, incidents or events that occur related to the use of the facility van as they

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occur and on at least a monthly basis. The report of this review will be presented at QAPI on an ongoing basis beginning with the October QAPI meeting. The purpose of this presentation is to seek opportunities to improve the process and the safe operation of the facility van.

The Regional and Corporate Team will review all reports of events and occurrences to ensure policies and procedures are adhered to as well as to look for opportunities to continue process improvement for the safety of residents. The Corporate Compliance Committee and the Regional Team will oversee this plan and its implementation to support ongoing success.

Prior to allowing the van back into service and the driver to load or transport, the maintenance director will complete a Transportation Safety Observation Record and a Pre-Trip Inspection and observe on-boarding and off-boarding. The maintenance director will review at random three times each week for 6 weeks then at random 2 times per week for 3 months. Thereafter the maintenance director will observe at random on a weekly basis ongoing. All data collected during these observations will be recorded on an audit tool which will be presented during QAPI for review.

Date of Removal Request:
Accordius Health at Clemmons requests consideration for removal of Immediate Jeopardy effective 10/5/2018 at 12:30 pm, the time the van was taken out of service for transportation of residents.

The facility ' s credible allegation of Immediate Jeopardy removal was validated on 10/5/18 at

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5:20 PM. On 10/3/18 from 12:40 PM through 10/5/18 at 5:20 PM, transportation aides and the Maintenance Director working at the facility were interviewed in regards to the training initiated at the facility. An outside transportation vehicle was observed on multiple occasions as it was utilized to transport the facility ' s residents. The Facility Transportation Vehicle Policy and Procedure Accordius Health, Transport Driver Skills Assessment, a Transport Safety Observation protocol and both Daily and Monthly Safety Check protocols (checklists) initiated by the facility were reviewed as part of the validation process.

2. Resident #2 was admitted to the facility on 9/14/18 from the hospital. Her cumulative diagnoses included end stage renal failure requiring hemodialysis and a history of epileptic seizures.

A review of Resident #2 ' s admission MDS dated 9/21/18 revealed the resident had severely impaired cognitive skills for daily decision making. No behaviors nor rejection of care were reported. Section G of the MDS indicated the resident required extensive assistance for all of her ADLs, with the exception of being totally dependent on staff for locomotion. The resident used a wheelchair for mobility.

A review of Resident #2 ' s medical record revealed no incidents/accidents were reported for this resident since her admission to the facility.

An interview was conducted on 10/3/18 at 12:20 PM with Transportation Aide #1. Transportation Aide #1 was identified as the staff member who transported Resident #1 and Resident #2 to the dialysis center on 10/1/18. The transportation

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aide reported she began working at the facility in the spring of 2018 as a Nursing Assistant (NA). She reported having previous work experience transporting residents and transitioned over to working with transportation at this facility approximately two months ago. The transportation aide reported she initially began driving an older facility van belonging to the facility before a new van was put into service 6 weeks ago (on 8/17/18). Transportation Aide #1 stated she picked up this new van from a sister facility and drove it back to the facility. The transportation aide reported the only training she received on the new van was, "I got the key and they showed me where the brake was."

The interview conducted on 10/3/18 at 12:20 PM with Transportation Aide #1 continued as she reported transporting both Resident #1 and Resident #2 together in the facility ' s van to the dialysis unit around 10:30 AM on 10/1/18. She stated both of the residents were transported in wheelchairs, with Resident #1 using a bariatric wheelchair. Each wheelchair was fastened with 4 floor anchors to the floor of the van. Resident #1 rode on the left side (driver ' s side) of the van and was also secured with a safety shoulder and safety lap belt. Resident #2 rode on the right side of the van. The transportation aide reported Resident #2 did not have a safety shoulder belt or lap belt in place during the transport. She stated only one seat belt worked on the van for a wheelchair passenger because there was a missing part for the second lap belt on the facility ' s van. Once the transport van reached the dialysis center, Resident #2 was the first resident taken off of the van and was brought into the dialysis center without incident. Transportation Aide #1 reported she had not driven the facility ' s

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van since 10/1/18 because the Administrator told her she had be oriented before she could drive again. Transportation Aide #1 stated, "That should have been done before I started driving." The transportation aide reported this morning (10/3/18) the facility had her begin a transportation orientation with the Maintenance Director as her trainer.

Telephone interviews were conducted on 10/3/18 at 3:46 PM and 10/4/18 at 12:17 PM with Transportation Aide #2. During the interviews, Transportation Aide #2 stated he began working with resident transportation at the facility in November 2017. When asked what training he received prior to transporting residents, he stated he did a "ride along" on three occasions with Transportation Aide #3. The transportation aide reported Transportation Aide #3 showed him how to secure the seat belts on the old van. He stated Transportation Aide #1 figured out how to use the seat belts on the new van and had shown him. When asked if he was involved with the training provided to Transportation Aide #1, he stated he was not. During the interviews, Transportation Aide #2 was asked how many wheelchair passengers could be transported in the new van at one time. He answered "one." The transportation aide reported he did not transport more than one wheelchair passenger because only one resident could wear a seat belt at any one time.

A follow-up telephone interview was conducted with Transportation Aide #1 on 10/3/18 at 6:19 PM. During the interview, the transportation aide was asked to confirm there was only one working seat belt available for a wheelchair passenger on the new transport van. The staff member stated

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that was correct. Although there were two seat belt straps that anchored to the van (both on the left side of the van), one was missing a part (the lap belt itself) and could not be used. During the interview, the staff member was asked to detail the transportation training (specifically related to the ride-alongs) provided at the facility. Transportation Aide #1 stated she rode with Transportation Aide #3 on one trip in the old van (approximately 15 minutes long). Two or three days later, she reported going on one ride along (one trip only) with Transportation Aide #2 for approximately 15-30 minutes. She reported she drove the old van back to the facility on that day, but had no hands on training with the residents. From that point on, Transportation Aide #1 stated she transported residents on her own. When asked if she signed any paperwork related to training upon starting the transport position, she stated she did not. The transportation aide reported she did not have a transportation check off training sheet until today (10/3/18).

An interview was conducted with the Administrator on 10/4/18 at 7:15 AM. Inquiry was made as to whether the Administrator was aware that while two wheelchair passengers had been transported together in the new van at one time, there was only one functional shoulder belt/lap belt for a wheelchair passenger in the van. The Administrator stated "No." She reported if she had been aware of this, she would not have allowed the van to transport two wheelchair passengers at one time. The Administrator reported she would expect all wheelchair passengers to be secured by a safety shoulder belt/lap belt at all times while traveling in the van. She stated this was "a safety issue."

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Accompanied by the facility ' s Administrator, Corporate Consultant, and Maintenance Director, a demonstration was conducted by Transportation Aide #1 on 10/4/18 at 9:15 AM of the safety precautions taken to secure a wheelchair and its passengers for transport in the facility ' s van. The transportation aide used 4 floor anchors in the van to secure a wheelchair in place on the left side (driver ' s side) of the van. Transportation Aide #1 was then asked to demonstrate how the shoulder belt and lap belt were applied to the wheelchair passenger. She showed how an "extender" and a "lap belt" (2 separate pieces) were attached to one of the two straps anchored to the left side van. She explained how both pieces needed to be used for both standard and bariatric wheelchairs to secure the passenger with a shoulder belt and lap belt. The transportation aide was then asked to demonstrate how she secured a shoulder belt/lap belt for the second wheelchair passenger riding on the right side of the van. In response, the transportation aide reported she could only use the 4 floor anchors to secure the second wheelchair. When asked how she used a seat belt for the second wheelchair passenger (such as Resident #2 on 10/1/18), Transportation Aide #1 reported she did not use one because the van did not come with all of the necessary pieces required to use a second seat belt.

An interview was conducted on 10/4/18 at 9:25 AM with the facility ' s Administrator. During the interview, the Administration acknowledged that based on the information obtained from Transportation Aide #1 ' s demonstration, only one wheelchair passenger could be transported at a time with the equipment currently available in the van.

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F 689	Continued From page 24 On 10/4/18 at 2:00 PM, the corporate Vice President (VP) of Clinical Operations reported a box containing additional manuals (including one on use of the shoulder belts/lap belts) and a second "extender" piece for the belts was found in the new van. On 10/4/18 at 2:45 PM, an interview was conducted with the maintenance assistant as he was observed to be carrying an opened box out to the van. The maintenance assistant reported the facility had just received the box containing additional shoulder and lap belts for the new van. At that time, the Administrator, Director of Nursing (DON), Maintenance Director, and maintenance assistant provided a demonstration (conducted by the maintenance staff) to show how the second "extender" piece found in the van could be used to secure a resident in a wheelchair during transport. As demonstrated, only a strap across the resident ' s waist could be put into place (without a shoulder belt). A review of the manufacturer information (provided by the facility) on the securing of a wheelchair passenger was conducted. An interview was conducted with the VP of Clinical Operations on 10/4/18 at 3:30 PM. During the interview, the VP reported her understanding from the manufacturer ' s information was that both the lap belt and a shoulder belt needed to be used in order to appropriately secure a wheelchair passenger in the van during transport.	F 689		