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F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 12/3/18 through 12/7/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/20/18 and was removed on 12/5/18. An extended survey was also conducted. No deficiencies were cited as a result of the complaint investigation.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		1/4/19

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

Electronically Signed | 12/28/2018

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F 657	Continued From page 1 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews the facility failed to invite residents and responsible parties to participate in care plan meetings regular care plan meetings for 1 of 1 sampled residents (Resident #64) reviewed for care plan participation. The findings included: Resident #64 was admitted to the facility on 3/17/17. His diagnoses included sepsis, cellulitis and pressure ulcer. A review of the quarterly Minimum Data Set (MDS) dated 10/9/18 revealed Resident #64 was cognitively intact. He had no behavioral symptoms or rejection of care. He required total assistance with all activities of daily living. On 12/3/18 at 2:18 PM during an interview with Resident #64 he stated he had not attended a care plan meeting and had not received an invitation to attend a care plan meeting. He added he did not know anything about his plan of care . A record review of Resident #64 computer chart on 12/3/18 at 3:30 PM revealed there were no Multidisciplinary Care Plan conference forms. On 12/5/18 at 11:45 AM Social Services (SS) staff #1 stated she was responsible for sending	F 657	F657 Corrective action for residents found to be affected by the alleged deficient practice: The Interdisciplinary team held a care plan conference with Resident #64 on 12/14/18 with his mother attending via phone conference. Identification of other residents having the potential to be affected by the alleged deficient practice: The MDS nurses completed an audit on 12/12/18, for the current facility residents, to validate that care plan conferences were held with residents and/or resident representative. There were 67 residents that did not have a Multidisciplinary form completed, as evidence of a care conference being held or attendance of the resident and/or resident representative, following completion of a comprehensive and/or quarterly assessment. The Interdisciplinary team (IDT), will complete care conferences by 1/04/19, and document attendance by the resident and/or the resident representative using the Multidisciplinary Care Conference Form in the electronic	

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F 657	Continued From page 2 care plan invitation letters to the family and if a resident was cognitively intact she would give the letter to the resident or she would verbally invite the resident. SS #1 said the MDS nurse provided her with a calendar of the residents who were scheduled for a care plan meeting and she would complete the invitation letters. She stated Resident #64 did not attend his meetings. She said she documented the meetings under the Assessment tab on the form titled Multidisciplinary Care Plan. A review of completed MDS documents for Resident #64 revealed he had an annual MDS on 3/21/18 and a quarterly MDS on 5/23/18, 7/9/18 and 10/9/18. On 12/7/18 at 11:58 AM MDS nurse #1 stated she provided the calendar to the SS person who then notified the families and residents of the care plan meetings. She also stated SS #1 was responsible to document the care plan meeting in the resident's medical record. MDS #1 reviewed the calendar and stated Resident #64 was not listed on the October calendar because he went to the hospital. She added he went to the hospital on 9/14/19 and returned on 9/20/18. MDS #1 stated the MDS was completed on 10/9/18 so he may not have been in the facility when she made the calendar. She stated she forgot to put him back on the calendar. While reviewing her records MDS nurse #1 stated they usually have a care plan meeting with each quarterly assessment. She said Resident #64 was on the calendar in July so he should have had a care plan meeting on 7/9/18 and he should have been on the calendar in May. She observed he was on the May calendar but there was no care plan meeting.	F 657	medical record. Measures implemented to ensure that the deficient practice will not recur: The DON and Administrator completed in service education on 12/12/18, for the Social Service Director (SSD) and the MDS nurses regarding Updating assessment calendars to include newly admitted residents and readmission of residents; sending letters to resident and/or resident representative, inviting to care plan conferences; documentation in resident record to include invite sent and resident and/or resident representative attendance. The education will be provided to newly hired SSD and/or MDS nurses during orientation. The MDS nurses will develop a calendar to include upcoming comprehensive and quarterly assessments including new admissions and readmitted residents. The calendar will be given to the SSD and the SSD will send a letter to the resident and/or resident representative inviting them to a care plan conference. The IDT will complete the Multidisciplinary Care Conference Form in the electronic medical record when the care conferences are held and will include documentation regarding resident and/or resident representative attendance. Monitoring to assure continued compliance: The Administrator and/or the DON will review calendar weekly and audit 5 residents weekly for 4 weeks, then 10 residents monthly for 2 months, that are scheduled for care plan review, to validate	

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F 657	Continued From page 3 On 12/7/18 MDS #1 provided a note of the last care plan meeting for Resident #64. The date of the medical record note was 2/22/18. She stated this was the last care plan conference. The note revealed the resident, SS, the Director of Nursing (DON), the Assistant Director of Nursing and the physician were present. The note also stated Resident #64's mother was on attendance by telephone. During an interview with the DON on 12/7/18 at 2:30 PM she stated she expected care plan conference meeting to be conducted at least quarterly for Resident #64.	F 657	that care plan conferences were held, Multidisciplinary Care Conference form completed with documentation of attendance of the resident and/or resident representative. The Administrator will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The Administrator will review the plan during monthly QAPI and will continue audits at the discretion of the QAPI committee	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, physician, nurse practitioner, and staff, interviews the facility failed to evaluate a resident's condition by a licensed professional before moving the resident and subsequently assess the resident upon the resident's return to the facility for 1 of 1 sampled residents following a fall in the transportation van. (Resident #68)	F 684	F 684 Corrective action for residents found to be affected by the alleged deficient practice: Resident #68 returned from a dental appointment on 11/20/18. Nurse #1 stated that resident #68 voiced shoulder pain upon return from appointment and she medicated him with his ordered pain medication, as he had received a	1/4/19

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F 684	Continued From page 4 Findings included: Resident #68 was admitted to the facility on 2/12/15. His active diagnoses included neurogenic bladder, hyperlipidemia, depression, calculus of the kidney, metabolic encephalopathy, repeated falls, and chronic kidney disease. Review of a wheelchair van policy signed by Van Driver #1 on 12/1/17 revealed Van Driver #1 was educated to ensure residents were appropriately secured with a seat belt prior to any transport. The education also covered what to do in case of a fall during transport. In case of a fall during transport the driver is to immediately call 911, notify the Administrator and Director of nursing of the situation, and never move the resident, to include body parts and/or attempt to transfer resident back to the chair. Review of Resident #68's most recent minimum data set assessment dated 10/19/18 revealed he was assessed as cognitively intact. He was documented to have no moods or behaviors. Resident #68 was independent with bed mobility, and locomotion on and off unit. He required limited assistance with transfers. Resident #68 had impairment to both lower extremities and used a wheelchair as a mobility device. Review of Resident #68's care plan dated 10/29/18 revealed he was care planned to be at risk for falls related to poor balance, poor communication and comprehension, psychoactive drug use, and an unsteady gait. The goal was for staff to maximize safety through interventions listed for Resident #68. The interventions included to encourage Resident #68 to ask for assistance and anticipate his needs,	F 684	cortisone shot in that shoulder on 11/13/18, due to shoulder pain. On 11/23/18, The Director of Nursing (DON) was informed about the alleged van incident that occurred on 11/20/18. The DON initiated an investigation on 11/23/18, notified the Nurse Practitioner and received an order for X-ray of the shoulder. X-ray results were obtained on 11/24/18, and showed degenerative joint disease, which was not a result of a fall. The Physician was made aware of the results on 11/24/18, with no new orders given Identification of other residents having the potential to be affected by the alleged deficient practice: The Director of Nursing (DON) completed an audit on 12/27/18, of current facility residents that have had incidents from 11/01/18 through 12/26/18, to validate that residents were assessed for injury following an incident. Residents identified as having an incident were assessed by the licensed nurse following an incident, with appropriate treatment rendered as necessary. Measures implemented to ensure that the deficient practice will not recur: The DON and/or the Staff Development Coordinator (SDC) completed in service education for the nursing staff on 12/05/18, regarding Assessment of residents for injury following an incident. No staff who were absent or PRN (pro re nata) will be allowed to return to the floor and resident care until this	

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F 684	Continued From page 5 observe Resident #68 and record and report all unsafe conditions and situations, and monitor his neuro status and assess for a change in his level of consciousness. Review of a progress note dated 11/20/18 at 12:49 PM revealed the Unit Coordinator documented Resident #68 returned from his dental appointment with nothing written on the consult sheet. No further documentation was found for 11/20/18. Review of a weekly skin assessment for Resident #68 dated 11/21/18 revealed the resident was assessed to have no new skin abnormalities noted. Review of a physician visit/communication note dated 11/23/18 revealed Resident #68 had right neck and arm pain and numbness. Resident #68 reported pain with right shoulder motion and right arm pain. A prednisone injection was given to the right shoulder. Review of a progress note dated 11/23/18 at 9:34 PM revealed Nurse #2 documented she spoke to Nurse Practitioner #1 regarding Resident #68's right shoulder pain. An order was received to obtain an x-ray of Resident #68's right shoulder. Review of a radiology report dated 11/24/18 revealed the results of Resident #68's right shoulder x-ray revealed the joint was in alignment but there was narrowing of the joint space due to mild degenerative changes. Review of a progress note dated 11/24/18 at 10:34 AM revealed Physician #1 was in the facility and reviewed Resident #68's right shoulder x-ray	F 684	training/education has been completed. This education will be included with new hires as part of the new hire training process. Monitoring to assure continued compliance: The DON will audit 5 residents weekly for 4 weeks then 10 residents monthly for 2 months, to validate that residents were assessed for injury following an incident. The DON will review the audits to identify patterns/trends and will adjust the plan as necessary for continued compliance. The DON will review the plan during monthly QAPI and will continue audits as the discretion of the QAPI committee.	

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results. The results from the x-ray were mild degenerative joint disease of the right shoulder, no fracture or dislocation were noted, and no new orders were given.

Review of a written statement by Resident #68 dated 11/23/18 taken by the Director of Nursing revealed Resident #68 stated he was coming back from his appointment in the wheelchair van. He stated the driver did not strap him in and he slid right on the floor. Resident #68 stated he messed his arm up and they had just put a cortisone shot in his arm. He told the Director of Nursing he went down on his right elbow.

During an interview on 12/3/18 at 11:47 AM Resident #68 stated he fell about a month ago in the transportation van because the seat belt was not placed across him. He stated the van driver did not call anyone for assistance at that time and it took the driver a long time helping Resident #68 back into the wheelchair. The resident stated Van Driver #1 then placed the seatbelt on him correctly. He stated the van driver then brought him back to the facility. He stated he mentioned the incident to a staff member but did not remember who. He stated the facility did an x-ray on him but there were no breaks in his bones. Resident #68 stated he had shoulder pain after the fall. He stated he did not know who was notified of his fall in the van in the facility and no one assessed him when he returned.

During an interview on 12/4/18 at 8:12 AM Resident #68 stated he told the Unit Coordinator at the desk that he fell in the van on 11/20/18 as soon as he was brought into the facility after the incident. He further stated he told the Unit Coordinator at that time he had right shoulder and

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arm pain because of the fall in the van. He stated the Unit Coordinator told him she had to get in touch with the doctor. He stated after he told her he went back to his room and no staff members performed an assessment on him at that time. He stated about three days later he had an x-ray done on his right arm and shoulder. He further stated he did not know what the results of the x-ray were, and he did not remember who else he told about the fall in the van. He further stated his right arm and shoulder were still a little sore. He concluded before the van accident he did have a cortisone shot in his right shoulder and the pain could have been a result of the injection and he was not sure if the pain and soreness came from the fall or the shot.

Review of a written statement dated 11/23/18 by Nurse #1 who worked with Resident #68 on 11/20/18 on second shift revealed Resident #68 came to her at the medication cart and asked for a pain pill. Resident #68 then stated his Responsible Party had the transporter fired because he did not use a seat belt. Nurse #1 clarified that Resident #68's shoulder was hurting and gave him a pain pill. The nurse stated she understood Resident #68 had a history of generalized pain. The nurse did not understand when the incident had occurred. The nurse stated he was propelling himself in his wheelchair without difficulty.

During an interview on 12/4/18 at 10:53 AM Nurse #1 stated during her shift on 3 to 11, prior to thanksgiving, Resident #68 came to her while she was at her medication cart and said his shoulder was hurting. She stated she would get him his pain medication and while he was waiting he stated his Responsible Party had gotten the

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van driver fired. She stated she then made conversation with Resident #68 and stated, "oh, really?" Resident #68 then told her the van driver did not have him seat belted during transport. She further stated she was not aware of when the concern happened and took it as him giving a casual conversation because he spoke as if it happened in the past. She stated she did not report the conversation to anyone else in the facility or perform a fall assessment because he was casually chatting and did not say it had happened that day. She stated she gave him his as needed pain medication. She further stated because he did not verbalize it had happened that day or recently and he had been self-propelling himself around the facility going about his daily routine she did not notify anyone about the comment until the Director of Nursing requested a statement from her later that week.

Review of a written statement dated 11/23/18 by the Unit Coordinator responsible for resident appointments and transportation revealed Resident #68 did say something about the van driver getting fired when he returned from the appointment, but he did not say anything about a fall. She concluded the Responsible Party who was with Resident #68 did not report the fall to her.

During an interview on 12/4/18 at 8:39 AM the Unit Coordinator stated she handled the appointments and transportation of residents. The Unit Coordinator stated Resident #68 left the facility on 11/20/18 around 7:30 AM She stated he did not mention anything about his appointment or anything unusual on 11/20/18 when he returned to the facility from his dental appointment around 12:15 PM. She stated Van

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Driver #1 did not inform her about anything as well. She stated she could not remember which day it was, but later that same week, Resident #68 came to the desk and said something about Driver #1 getting fired. Before she could respond or ask a question her attention was pulled away by either a phone call or another staff member needing assistance. She stated when she returned he was gone and did not approach her about the concern again. She stated he had not said anything about it to her since. She stated on 11/23/18 the Director of Nursing called her at home questioning her if Resident #68 had said anything about a van incident. She further stated she told her he had mentioned the van driver had been fired but no further information had been given. She further stated that was the first time she had heard about an incident with the van transport on 11/20/18.

During an interview on 12/6/18 at 10:33 AM Van Driver #1 stated while transporting the resident he was approaching a stop light which turned to yellow and he stated he did not press the breaks any harder than a normal stop. At that point he looked at the rear-view mirror and saw that Resident #68 was about to come out of his chair and pulled into the closest parking lot. He stated Resident #68 slide forwards and partially out of the wheelchair. He stated the Responsible Party was sitting in the front seat at this time. He stated it took about five to seven minutes to get him back into the wheelchair as he had to lift Resident #68 back up into the seat. He further stated he then tightened Resident #68's seat belt. Van Driver #1 then called the Van Company Owner and informed him of what had happened. He stated the Van Company Owner told him the seat belts should have been fastened more securely

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on the resident and terminated his employment at that time. Van Driver #1 stated he then dropped off Resident #68 at the facility and did not inform anyone in the facility of the incident. He further stated he had been trained how to lift the resident back into the seat if they were partially out of the wheelchair and Resident #68 did not fall all the way to the floor of the van which was why he did not have to contact emergency medical services.

During an interview on 12/3/18 at 12:40 PM Resident #68's Responsible Party stated she had traveled with Resident #68 in the van to his appointments twice. She stated on 11/20/18 Van Driver #1 forgot to place the seatbelts on Resident #68 and she did not notice the concern. The Responsible Party stated the wheelchair was braced in tight, but the seatbelt strap was not on Resident #68 and a stop light changed to red, the car in front of them stopped quickly, and Van Driver #1 put on the breaks causing Resident #68 to fall out of the wheelchair. She stated he slid out of the chair across the foot rests and landed on his back with his legs out in front of him. She stated Van Driver #1 then got in the back with Resident #68 and tried to help him get back up in his chair since Resident #68 did not have much use of his legs. She stated the driver asked Resident #68 if he was okay and Resident #68 said yes. She stated Van Driver #1 and Resident #68 struggled for a while trying multiple ways to get him back in his chair. She stated Resident #68 attempted to help the driver get him back up in the chair by holding the chair's arm rests and pushing up while Van Driver #1 lifted Resident #68 by his pants and his legs to get him back into the chair. She stated they had a hard time getting him back up into the chair and it took about ten minutes for the driver to get Resident #68 back

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into his wheelchair. Once the driver got him in his wheelchair he placed the seatbelts on him. She stated the driver then took the resident in to the facility. She further stated she did not go in with them. She further stated she came to the facility a few days later to sign some paperwork and mentioned Resident #68 had fallen on to the floor of the van during transportation to the Director of Nursing. She stated the Director of Nursing was not aware of the fall when she told her about it.

During an interview on 12/3/18 at 3:06 PM the Van Company Owner stated he did remember on 11/20/18 a resident was being transported to or from an appointment and Van Driver #1 had called him and said that Resident #68 had an incident. The staff member did not clarify if Resident #68 had hit the floor. He further stated he asked the driver if the resident was hurt and the driver said the resident had not sustained any injuries and had already placed the resident back in his wheelchair. The Van Company Owner stated if a resident fell from the wheelchair to the floor during transportation it was his expectation Van Driver #1 immediately call 911 and not attempt to move the resident. He stated Van Driver #1 did not clarify with him if the resident touched the floor of the van or not. He further stated because of the incident he told the staff member to take the resident where he needed to go, and then he was fired. The Transport Company Manager stated he did not inform the facility of the incident because the driver led him to believe there were no injuries because of the incident. He concluded he did not believe the van driver informed the facility either.

During an interview on 12/4/18 at 9:07 AM the Director of Nursing stated on 11/23/18 Resident

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#68's Responsible Party was in the facility to sign some consent forms and happened to mention there was an incident on 11/20/18. The Director of Nursing stated she had not been informed of the incident prior to the Responsible Party bringing it to her attention at that time. The Responsible Party stated Resident #68 was being transported back from his dentist appointment and the van driver had to stop short and Resident #68 slide from his wheelchair to the floor of the van. She stated the Responsible Party told her they struggled to get him back into his chair. She stated after learning of the incident on 11/23/18 Nurse #2 on 3 to 11 shift contacted the on call Nurse Practitioner #1 and informed her of the incident and the report of shoulder and arm pain for Resident #68. A mobile x-ray was ordered on 11/23/18 and performed on 11/24/18 which returned negative for any concerns besides the already identified degenerative joint disease of the right shoulder. She further stated no injuries were identified as a result of the incident once the facility was made aware on 11/23/18.

During an interview on 12/4/18 at 11:32 AM the Director of Nursing stated Nurse #1 worked with Resident #68 on 11/20/18 during the 3 to 11 shift. She further stated when Nurse #1 was informed of the incident by Resident #68 it was her expectation the nurse would have investigated more and report the concern to her Unit Coordinator and she did not believe the nurse did so because the nurse did not think it was an incident.

During an interview on 12/5/18 at 8:10 AM the Administrator stated the Director of Nursing came to him on 11/23/18 after she spoke with the Responsible Party of Resident #68 and informed

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him of what the Responsible Party had shared with her. He further stated he would expect to be notified if any situation arose during transportation of a resident that could have compromised the safety of the resident and it was not done.

During an interview on 12/6/18 at 7:46 AM Physician #1 stated he knew Resident #68 very well. He further stated Resident #68 had complained of right shoulder pain for at least a month prior to 11/13/18 and denied any injury to his arm and shoulder. The pain had been reported to him as gradually getting worse for Resident #68. The physician stated the pain had been on going prior to the incident on 11/20/18 and he had received a cortisone shot in his right shoulder on 11/13/18 from the orthopedic clinic after a referral for shoulder pain. He stated on 11/24/18 Resident #68 had a right shoulder x-ray which he reviewed and found only mild degenerative joint disease as a significant finding. The physician stated mild degenerative joint disease would not be caused from a fall but was a gradual disease process. They physician stated there were no other substantial findings from the x-ray and concluded Resident #68 did not sustain any injuries from any alleged fall on 11/20/18. The Physician concluded if Resident #68 did sustain a fall to the floor in the van, Driver #1 should have contacted emergency medical services and not moved Resident #68 himself, however Resident #68 did not sustain any injuries.

During an interview on 12/6/18 at 9:44 AM the Director of Nursing stated it was her expectation if Resident #68 did sustain a fall in the van on 11/20/18 that Van Driver #1 would notify emergency medical services according to the van company's policy and not attempt to move the

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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, record review and resident, family, physician and staff, interviews the facility failed to secure 1 of 1 sampled residents in the transportation van according to manufacturer's recommendations while being transported back to the facility from a medical appointment by the facility's contracted transport company (Resident #68). Resident #68 slid from his wheelchair to the floor of the transportation van during transport and was not injured. Immediate Jeopardy began on 11/20/18 when Resident #68 was being transferred from an appointment by the facility contracted transport company. The resident was not secured according to manufacture's instructions in the wheelchair during transportation and slid to the van floor without injury when Van Driver #1 stopped at a stop light. Immediate jeopardy was removed on 12/5/18 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for	F 689	Free from Accident/Injury Corrective action that will be accomplished for Tag 689 Resident #68 currently resides at Ridgewood Rehabilitation Center and has no injury related to alleged incident 11/20/2018 of not being secured and allegedly falling from wheelchair while in a Contract Transportation company transport vehicle. Owner of the company, of the Contract Transportation company has in-serviced 100% of all transportation drivers who operate the wheelchair lift van to ensure appropriate connection of belt device completed by 11/25/2018. Provider has in-serviced 100% of all transportation drivers who operate the wheelchair lift van to ensure appropriate connection of belt device, this was completed through manufacturer video and slide show and verbal instruction and review of key points. No damage or malfunction of the device was noted. Upon revisit on	1/4/19

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F 689	Continued From page 15 more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: During observation on 12/5/18 at 1:30 PM the manufacturer's instructional video for the locking mechanism used by the facility's contracted van company related to the correct securement of residents for transportation was watched. According to the video, the rear wheelchair locking straps were to be anchored behind the wheelchair to the inside of the wheels which avoided placing stress on the anchor straps. The rear anchors for the seat belt were to be placed behind the wheelchair inside the wheelchair strap anchors and wheels to avoid placing stress on the anchor straps. The video also stated the lap belt was never to be placed around the wheelchair's arm rests and instead was to run between the arm rest and seat back of the wheelchair. Resident #68 was admitted to the facility on 2/12/15. His active diagnoses included neurogenic bladder, depression, calculus of the kidney, metabolic encephalopathy, repeated falls, and chronic kidney disease. Review of Resident #68's most recent minimum data set assessment dated 10/19/18 revealed he was assessed as cognitively intact. He was documented to have no moods or behaviors. Resident #68 was independent with bed mobility and locomotion on and off unit. He required limited assistance with transfers. Resident #68 had impairment to both lower extremities and used a wheelchair as a mobility device.	F 689	12/5/2018 it was observed that the driver did not apply the devices appropriately. Because of the above observation all transport persons were again trained by Owner on 12/5/2018. This training included a step by step demonstration by the owner of the company in the van, along with return demonstration. No personnel will be allowed to provide transportation until they have received re-in-service training. Additionally, each wheelchair vehicle has been provided a printed illustration of the directions. Nine other residents who were transferred during that week of alleged incident were interviewed on 11/25/18 and reported no other incidents or injuries related to transportation. All incidents and accidents are to be reported to the administrator, director of nursing(DON), or nursing supervisor immediately via cell phone. The administrator, Director of Nursing (DON), or nursing supervisor will be responsible for investigating any incidents/accidents. Identification of other residents: All residents that are transported are at risk for this alleged deficient practice. All transportation service aides who operate a wheelchair lift van were provided in-service education the transportation company owner to prevent reoccurrence to this resident or any other resident. This was completed by or on November 25, 2018. Upon revisit on 12/5/2018 it was observed that the driver did not apply the devices appropriately. Because of the above observation all transport persons	

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F 689	Continued From page 16 Review of Resident #68's care plan dated 10/29/18 revealed he was at risk for falls related to poor balance, poor communication and comprehension, psychoactive drug use, and an unsteady gait. The goal was for staff to maximize safety through interventions listed for Resident #68. The interventions included to assist the resident to bed to provide care, observe Resident #68 and record and report all unsafe conditions and situations, and monitor his neuro status and assess for a change in his level of consciousness. Review of a progress note dated 11/20/18 at 12:49 PM revealed the Unit Coordinator documented Resident #68 returned from his dental appointment with nothing written on the consult sheet. No further documentation was found for 11/20/18. Review of a written statement by Resident #68 dated 11/23/18, taken by the Director of Nursing revealed Resident #68 stated he was coming back from his appointment in the wheelchair van. He stated the driver did not strap him in and he slid right on the floor. Resident #68 stated he messed his arm up and they had just put a cortisone shot in his arm. He told the Director of Nursing he went down on his right elbow. During an interview on 12/3/18 at 11:47 AM Resident #68 stated he fell about a month ago in the transportation van because the seat belt was not placed across him. Resident #68 stated he did not notice he was not wearing a belt until he fell because he was used to being in a wheelchair. He further stated his Responsible Party was with them in the front passenger's seat	F 689	were again trained by transportation company owner on 12/5/2018. This training included hands on application and return demonstration using the video and manufacturer□s instructions. No personnel will be allowed to provide transportation until they have received re-in-service training. All licensed staff members were contacted by the Director of nursing and Assistant Director of Nursing and had not been made aware of any trends or patterns involving any other resident which had not been previously reported. No other residents were affected by this alleged deficient practice. This was completed on December 5, 2018. Measures for system change: Director of Nursing (DON) and Administrator were provided in-services to the reporting and investigation of any incident reported by staff, resident, visitor by Regional Director of Operations on 12/5/2018. Administrator and Director of Nursing in-serviced all department manager staff currently working. The department managers provided training to their staff currently working. All staff who were not present will be unable to return to work until they have received in-service training. The training included 1) Appropriate and immediate notification of any incident or knowledge of any incident of any resident on or off premise to the director of nursing, administrator and/or unit coordinator. 2) Investigation of any incident or knowledge of any incident at the time of occurrence will be completed by the administrator, director of nursing	

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F 689	Continued From page 17 and it was around noon. Resident #68 stated he was on his way back from the doctor's office and the van stopped at a stoplight and he slide forward out of the wheelchair and his bottom hit the wheelchair's foot rests and his arms hit the floor on both elbows and he came to rest on his back. He further stated then Van Driver #1 pulled over into a parking lot. Resident #68 continued stating Van Driver #1 came into the back of the van with him and began to help him back into his chair. He stated the van driver did not call anyone for assistance at that time and it took the driver a long time helping Resident #68 back into the wheelchair. He stated the van driver then brought him back to the facility. He stated he mentioned the incident to a staff member but did not remember who. He stated the facility did an x-ray on him but there were no breaks in his bones. Resident #68 stated he had shoulder pain after the fall. He stated he did not know who was notified in the facility of his fall in and no one assessed him when he returned. During an interview on 12/4/18 at 8:12 AM Resident #68 stated he told the Unit Coordinator at the desk that he fell in the van on 11/20/18 as soon as he was brought into the facility after the incident. He further stated he told the Unit Coordinator at that time he had right shoulder and arm pain because of the fall in the van. During an interview on 12/6/18 at 10:33 AM Van Driver #1 stated following the appointment on 11/20/18 he had placed Resident #68 in the van and secured the wheelchair. He further stated he then left the shoulder and lap belt slack on Resident #68 because he knew Resident #68 had a heart problem and Van Driver #1 did not want to have the belt tight across Resident #68's chest	F 689	and/or unit coordinator. No facility staff who were absent or PRN (pro re nata) staff will be allowed to return to work until this training/education has been completed. Systematic change to prevent reoccurrence will be that all contracted transportation services will include language within the contract to contact the facility immediately if an incident occurs. This language includes any incident involving injury must be immediately called to the administrator or Director of Nursing. Owner of the company requires a company provided cell phone be on the vehicle at all times. All staff members will report all incidents or accidents with or without injury to the nurse, administrator or Director of nursing. Upon receipt of this notification, alleged incident/accident will be fully investigated in accordance with the facility policy re: Incident/Accident Investigation. This new systematic change was implemented by the Regional Director Operations on 12/05/18. Director of Nursing (DON), and Administrator were in serviced by Regional Director of Operations on 12/05/18. Administrator and Director of Nursing in-serviced all department directors on 12/05/18. All Department directors in-serviced all staff currently working. No staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. This education and information will be included with all new hires as part of the new hire training process.	

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and waist. While transporting the resident he was approaching a stop light which turned to yellow and he stated he did not press the brakes any harder than a normal stop. At that point he looked at the rear-view mirror and saw that Resident #68 was about to come out of his chair and pulled into the closest parking lot. He stated Resident #68 slide forward and partially out of the wheelchair. Van Driver #1 stated Resident #68's buttocks was no longer in the seat of the wheelchair and the lower portion of Resident #68's back was resting on the front edge of the seat of the wheelchair with the seat belt and lap belt across his chest holding his upper body on the chair. He stated the outside of Resident #68's feet and his ankles did come in contact with the floor of the van, but no other body part of Resident #68 touched the floor. He stated the Responsible Party was sitting in the front seat at this time.

During an interview on 12/3/18 at 12:40 PM Resident #68's Responsible Party stated she had traveled with Resident #68 in the van to his appointments twice. She further stated the two appointments were for Resident #68 to go to the dentist. She stated on 11/20/18 Van Driver #1 forgot to place the seatbelts on Resident #68 and she did not notice the concern. The Responsible Party stated the wheelchair was braced in tight, but the seatbelt strap was not on Resident #68 and a stop light changed to red, the car in front of them stopped quickly, and Van Driver #1 put on the brakes causing Resident #68 to fall out of the wheelchair. She stated he slid out of the chair across the foot rests and landed on his back with his legs out in front of him. She stated she was in the front passenger's seat and did not see the fall but turned around when she heard the noise of his fall and saw Resident #68 on the floor of the

How corrective actions will be monitored: Administrator, Director of Nursing or other staff who have received training through manufacturer training video on how to properly secure a resident in the wheelchair van shall conduct random visual audit of 5 resident transports per week x 1 month, then 5 times per month times 3 months and report to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. Administrator and Director of Nursing will monitor all incident and accidents of residents weekly, ensuring that appropriate investigation and intervention of any incidents that occur is performed. This information will be reported to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. Director of Nursing or Assistant director of nursing will conduct random audits of nursing personnel, inquiring to the knowledge of accidents reported by residents, staff, and/or visitors which have not been communicated. This will be completed 5 times per week X 1 week and 5 times per month X 3 months and report to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. This will be monitored by the administrator. Credible allegation and all elements were in place on 12/5/2018.

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van. She stated she told Van Driver #1 to pull over into a parking lot near them and he did. She stated Van Driver #1 then got in the back with Resident #68 and tried to help him get back up in his chair since Resident #68 did not have much use of his legs. She stated the driver asked Resident #68 if he was okay and Resident #68 said yes. Once the driver got him in his wheelchair he placed the seatbelts on him. She stated Van Driver #1 knew he had made a mistake and was quiet for a while as he continued to drive back to the facility. After some time had passed, the driver told them he was going to call his boss. She stated he then called his boss while driving back to the facility and she heard him tell his boss Resident #68 was not strapped in to the wheelchair. After the phone call the driver hung up and told them he was fired and that it was his fault for not placing the seat belt on Resident #68. She stated the driver then took the resident in to the facility. She further stated she did not go in with them. She stated no one had contacted her about the incident in the facility. She further stated Resident #68 had started complaining more about his shoulder and arm on his right side. She further stated she came to the facility a few days later to sign some paperwork and mentioned Resident #68 had fallen on to the floor of the van during transportation to the Director of Nursing. She stated the Director of Nursing was not aware of the fall when she told her about it. She stated she did not remember what the Director of Nursing's response was to the fall, and the Responsible Party had not heard anything about the fall since then.

Review of a written interview performed by the Director of Nursing dated 11/23/18 revealed the Director of Nursing performed a telephone

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interview with the facility's contracted Van Company Owner. The Van Company Owner stated he was aware of an incident with the resident and driver. He reported the driver told him the resident slipped to the front of the wheelchair because he (the driver) did not adjust the strap. The Van Company Owner told the Director of Nursing he terminated the driver for not adjusting the strap. The interview concluded that the facility was not notified because the Van Company Owner did not think the resident fell and stated the driver said he did not hit the floor or hit his head.

During an interview on 12/3/18 at 3:06 PM the Van Company Owner he did remember on 11/20/18 a resident was being transported to or from an appointment and Van Driver #1 had called him and said that Resident #68 had an incident. He stated Van Driver #1 hit the brakes because a car in front of him had stopped and Resident #68 slid halfway out of the chair. The driver did not clarify if Resident #68 had hit the floor. He further stated the driver told the manager that he had not adjusted the shoulder and lap belts tightly enough which allowed the resident to slide halfway out of the chair. He further stated the van belts had two straps, one which went over the resident's shoulder and one that went across the resident's lap. He further stated had the driver adjusted the belts to the correct tightness, Resident #68 would not have slid out of the wheelchair and it was Driver #1's fault that the resident slid out of the chair. He further stated he asked the driver if the resident was hurt and the driver said the resident had not sustained any injuries and had already placed the resident back in his wheelchair. He stated staff were repeatedly trained on how to correctly apply

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the safety belts on residents when they are being transported and he had no idea why the driver did not correctly apply the safety belts and there was no excuse for not applying them appropriately. He further stated the van was inspected by the Transport Service Manager and there were no issues identified with the van. The Van Company Owner stated he did not inform the facility of the incident because the driver led him to believe there were no injuries because of the incident. He concluded he did not believe the van driver informed the facility either.

Review of a written statement dated 11/23/18 by the Unit Coordinator responsible for resident appointments and transportation revealed Resident #68 did say something about the van driver getting fired when he returned from the appointment, but he did not say anything about a fall. She concluded the Responsible Party who was with Resident #68 did not report the fall to her.

During an interview on 12/4/18 at 8:39 AM the Unit Coordinator stated she handled the appointments and transportation of residents. The Unit Coordinator stated Resident #68 left the facility on 11/20/18 around 7:30 AM. She stated he did not mention anything about his appointment or anything unusual on 11/20/18 when he returned to the facility from his dental appointment around 12:15 PM. She stated Van Driver #1 did not inform her about anything as well. She stated she could not remember which day it was, but later that same week, Resident #68 came to the desk and said something about Driver #1 getting fired. She further stated the contracted van company did not contact the facility and inform them about the van incident

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and she had not discussed the incident with the van company. She further stated it was her expectation that the van company would notify her of any incidents during transportation of residents regardless if the incident resulted in an injury or not. The Unit Coordinator stated if a van incident occurred and a resident slid halfway out of his chair or sustained a fall, the van driver should immediately contact the facility. She stated she was the primary contact for the transport company at the facility. She stated she would then notify the Director of Nursing and the Administrator. She further stated Resident #68 did not inform her about any pain or concerns on 11/20/18 and the van driver gave her the paperwork from the doctor's office and did not inform her about any incidents in the van. She stated Resident #68's Responsible Party did ride in the van to the appointment on 11/20/18.

Review of a written statement dated 11/23/18 by Nurse #1 who worked with Resident #68 on 11/20/18 on second shift revealed Resident #68 came to her at the medication cart and asked for a pain pill. Resident #68 then stated his Responsible Party had the transporter fired because he did not use a seat belt. Nurse #1 clarified that Resident #68's shoulder was hurting and gave him a pain pill. The nurse stated she understood Resident #68 had a history of generalized pain. The nurse did not understand when the incident had occurred. The nurse stated he was propelling himself in his wheelchair without difficulty.

During an interview on 12/4/18 at 10:53 AM Nurse #1 stated during her shift on 3 to 11, prior to thanksgiving, Resident #68 came to her while she was at her medication cart and said his

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shoulder was hurting. She stated she would get him his pain medication and while he was waiting he stated his Responsible Party had gotten the van driver fired. She stated she then made conversation with Resident #68 and stated, "oh, really?" Resident #68 then told her the van driver did not have him seat belted during transport. She further stated she was not aware of when the concern happened and took it as him giving a casual conversation because he spoke as if it happened in the past. She stated she did not report the conversation to anyone else in the facility or perform a fall assessment because he was casually chatting and did not say it had happened that day. She stated she gave him his as needed pain medication. She further stated because he did not verbalize it had happened that day or recently, and he had been self-propelling himself around the facility going about his daily routine, she did not notify anyone about the comment until the Director of Nursing requested a statement from her later that week.

During an interview on 12/4/18 at 9:07 AM the Director of Nursing stated on 11/23/18 Resident #68's Responsible Party was in the facility to sign some consent forms and happened to mention there was an incident on 11/20/18. The Director of Nursing stated she had not been informed of the incident prior to the Responsible Party bringing it to her attention at that time. The Responsible Party stated Resident #68 was being transported back from his dentist appointment and the van driver had to stop short and Resident #68 slide from his wheelchair to the floor of the van. She stated the Responsible Party told her they struggled to get him back into his chair. The Responsible Party told the Director of Nursing that the driver was fired and did not share any

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further information about the incident. The Director of Nursing stated she then called the contracted transportation company and spoke with the Van Company Owner who told her that Resident #68 slipped to the front of the wheelchair because Driver #1 did not adjust the strap. She further stated she was told by the Van Company Owner he did not notify the facility because he did not think the resident had fallen, hit the floor, or hit his head. She further stated if there was any incident during transport of a resident where the resident had a risk for injury because a van driver did not appropriately secure the resident, especially if it warranted the van driver being fired, it was her expectation the van company notify her of the incident. She further stated after the incident on 11/20/18 it was her expectation that either the van driver or the owner of the company would have notified the facility of the incident. She stated on 11/21/18 a routine skin assessment was performed on Resident #68 by the facility and no concerns were identified at that time. She stated after learning of the incident on 11/23/18 Nurse #2 on the second shift contacted the on-call Nurse Practitioner #1 and informed her of the incident and the report of shoulder and arm pain for Resident #68. A mobile x-ray was ordered on 11/23/18 and performed on 11/24/18 which returned negative for any concerns besides the already identified degenerative joint disease of the right shoulder. She further stated no injuries were identified as a result of the incident once the facility was made aware on 11/23/18. The Director of Nursing stated they suspended any further transportation of residents by the Medical Transport company on 11/23/18 while the transport company completed in services with all their staff. The suspension was lifted on 11/26/18. She stated

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audits of the transportation were initiated on 11/26/18.

During an interview on 12/4/18 at 11:32 AM the Director of Nursing stated Nurse #1 worked with Resident #68 on 11/20/18 during the second shift. She further stated when Nurse #1 was informed of the incident by Resident #68 it was her expectation the nurse would have investigated more and report the concern to her Unit Coordinator and she did not believe the nurse did so because the nurse did not think it was an incident.

During an interview on 12/3/18 at 3:41 PM the Transport Service Manager stated following the incident on 11/20/18 he serviced the van that was used to transport Resident #68 and identified no concerns with any of the safety features including the seat belts and wheelchair anchoring straps. He concluded the incident was a result of user error by Van Driver #1.

Review of a progress note dated 11/23/18 at 9:34 PM revealed Nurse #2 documented she spoke to Nurse Practitioner #1 regarding Resident #68's right shoulder pain. An order was received to obtain an x-ray of Resident #68's right shoulder.

Review of a radiology report dated 11/24/18 revealed Resident #68's right shoulder's joint was in alignment but there was narrowing of the joint space due to mild degenerative changes. There were no shoulder fractures, separations, or dislocations observed.

Review of a progress note dated 11/24/18 at 10:34 AM revealed Physician #1 was in the facility and reviewed Resident #68's right shoulder x-ray

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results. The results from the x-ray were mild degenerative joint disease of the right shoulder, no fracture or dislocation were noted, and no new orders were given.

During an interview on 12/6/18 at 7:46 AM Physician #1 stated he knew Resident #68 very well. He further stated Resident #68 had complained of right shoulder pain for at least a month prior to 11/13/18 and denied any injury to his arm and shoulder. The pain had been reported to him as gradually getting worse for Resident #68. The physician stated the pain had been on going prior to the incident on 11/20/18 and he had received a cortisone shot in his right shoulder on 11/13/18 from the orthopedic clinic after a referral for shoulder pain. He stated on 11/24/18 Resident #68 had a right shoulder x-ray which he reviewed and found only mild degenerative joint disease as a significant finding. The physician stated mild degenerative joint disease would not be caused from a fall but was a gradual disease process. The physician stated there were no other substantial findings from the x-ray and concluded Resident #68 did not sustain any injuries from any alleged fall on 11/20/18.

During an interview on 12/5/18 at 8:10 AM the Administrator stated the Director of Nursing came to him on 11/23/18 after she spoke with the Responsible Party of Resident #68 and informed him of what the Responsible Party had shared with her. He stated he then went and interviewed the nine resident who had been transported that week and discovered no residents had any concerns about their transportation that week. The Administrator then stated he suspended transportation with the contracted company on 11/23/18 and then continued his contact with the

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transportation company to coordinate getting all the documentation of the in serviced staff members at the contracted transportation company. This was completed on 11/25/18 and transportation was resumed on 11/26/18. He stated he watched the training video about the appropriate way to secure a resident into a transportation van about a year ago. He stated the Director of Nursing and the Unit Coordinator had not been in serviced on how to appropriately secure a resident into a transportation van prior to monitoring the transportation starting 11/26/18. He further stated there were no in services provided to facility staff regarding the need to follow up on statements such as the ones Resident #68 made to staff members on 11/20/18 and 11/21/18. He further stated he would expect to be notified if any situation arose during transportation of a resident that could have compromised the safety of the resident.

During an interview on 12/4/18 at 3:45 PM the Director of Nursing stated the Unit Manager and herself had not been in serviced about the appropriate way to secure a resident in the transportation van. She concluded none of her staff had received any in services related to following up on resident statements that they had not been secured appropriately in a van or about reporting such concerns to their supervisors and performing an assessment.

During an interview on 12/5/18 at 8:52 AM the Unit Coordinator who monitored the transportation on 11/26/18 stated she had not been in serviced on how to appropriately secure a resident in a transportation van. She stated she was the only staff member present when performing the observation on 11/26/18 and she

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observed that all straps were placed properly, and the resident was observed to be secure in the van to the best of her knowledge.

During an interview on 12/5/18 at 2:20 PM Van Driver #2 stated he had worked for the transportation company for 8 years. He further stated he had been in serviced on the correct way to transport residents in vans including how to secure residents for transport. He stated this training took place on 11/25/18.

During observation on 12/5/18 at 2:36 PM Van Driver #2 was observed securing the Administrator in the transportation van. Van Driver #2 placed the rear wheelchair anchors on the outside of the wheelchair wheels. The anchor straps were then secured to the wheelchair frame causing the straps to wrap around the wheels of the wheelchair on both sides placing stress on the straps. Van Driver #2 then placed the seat belts on the administrator. The lap belt was observed to wrap around the left arm rest. The rear anchors for the lap belt was observed to be secured on the outside of the wheelchair wheels and wheelchair rear anchors. This caused the lap belt straps to wrap around the wheelchair wheels placing stress on the belt straps.

During an interview on 12/5/18 at 2:40 PM Van Driver #2 stated he had finished securing the administrator in the van as he would secure a resident for transportation. Upon observing the lap belt secured around the left arm rest, Van Driver #2 stated the seat belt should not be around the arm rest and instead placed through the opening between the arm rests and the seat back. Upon being questioned about the placement of the wheelchair and seat belt

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anchors, Van Driver #2 stated the anchors could be moved to the correct positions and that they were not correct as the straps should not wrap across the wheelchair. When asked the reason he did not adjust the seat belts and anchors correctly he stated he did not have a reason as it was for demonstration.

During an interview on 12/5/18 at 2:50 PM the Administrator stated it was his expectation that Van Driver #2 would have demonstrated the correct way to secure a resident in the transportation van according to manufacturer's instructions.

The Administrator was notified of the immediate jeopardy on 12/5/18 at 12:30 PM. On 12/6/18 at 1:52 PM the facility provided the following credible allegation of compliance for immediate jeopardy removal:

"Free from Accident/Injury

Corrective action that will be accomplished for Tag 689
Resident #68 currently resides at Ridgewood Rehabilitation Center and has no injury related to alleged incident 11/20/2018 of not being secured and allegedly falling from wheelchair while in a Contract Transportation company transport vehicle. Owner of the company, of the Contract Transportation company has in-serviced 100% of all transportation drivers who operate the wheelchair lift van to ensure appropriate connection of belt device completed by 11/25/2018. Provider has in-serviced 100% of all transportation drivers who operate the wheelchair lift van to ensure appropriate connection of belt device, this was completed through manufacturer

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video and slide show and verbal instruction and review of key points. No damage or malfunction of the device was noted. Upon revisit on 12/5/2018 it was observed that the driver did not apply the devices appropriately. Because of the above observation all transport persons were again trained by Owner on 12/5/2018. This training included a step by step demonstration by the owner of the company in the van, along with return demonstration. No personnel will be allowed to provide transportation until they have received re-in-service training. Additionally, each wheelchair vehicle has been provided a printed illustration of the directions. Nine other residents who were transferred during that week of alleged incident were interviewed on 11/25/18 and reported no other incidents or injuries related to transportation.

All incidents and accidents are to be reported to the administrator, director of nursing (DON), or nursing supervisor immediately via cell phone. The administrator, Director of Nursing (DON), or nursing supervisor will be responsible for investigating any incidents/accidents.

Identification of other residents:

All residents that are transported are at risk for this alleged deficient practice. All transportation service aides who operate a wheelchair lift van were provided in-service education by?? the transportation company owner to prevent reoccurrence to this resident or any other resident. This was completed by or on November 25, 2018. Upon revisit on 12/5/2018 it was observed that the driver did not apply the devices appropriately. Because of the above observation all transport persons were again trained by transportation company owner on 12/5/2018. This training included hands on application and return demonstration using the video and

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manufacturer's instructions. No personnel will be allowed to provide transportation until they have received re-in-service training.
All licensed staff members were contacted by the Director of nursing and Assistant Director of Nursing and had not been made aware of any trends or patterns involving any other resident which had not been previously reported. No other residents were affected by this alleged deficient practice. This was completed on December 5, 2018.
Measures for system change:
Director of Nursing (DON) and Administrator were provided in-services to the reporting and investigation of any incident reported by staff, resident, visitor by Regional Director of Operations on 12/5/2018. Administrator and Director of Nursing in-serviced all department manager staff currently working. The department managers provided training to their staff currently working. All staff who were not present will be unable to return to work until they have received in-service training. The training included 1) Appropriate and immediate notification of any incident or knowledge of any incident of any resident on or off premise to the director of nursing, administrator and/or unit coordinator. 2) Investigation of any incident or knowledge of any incident at the time of occurrence will be completed by the administrator, director of nursing and/or unit coordinator. No facility staff who were absent or PRN (pro re nata) staff will be allowed to return to work until this training/education has been completed.
Systematic change to prevent reoccurrence will be that all contracted transportation services will include language within the contract to contact the facility immediately if an incident occurs. This language includes any incident involving injury

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must be immediately called to the administrator or Director of Nursing. Owner of the company requires a company provided cell phone be on the vehicle at all times. All staff members will report all incidents or accidents with or without injury to the nurse, administrator or Director of nursing. Upon receipt of this notification, alleged incident/accident will be fully investigated in accordance with the facility policy re: Incident/Accident Investigation. This new systematic change was implemented by the Regional Director Operations on 12/05/18. Director of Nursing (DON), and Administrator were in serviced by Regional Director of Operations on 12/05/18. Administrator and Director of Nursing in-serviced all department directors on 12/05/18. All Department directors in-serviced all staff currently working. No staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. This education and information will be included with all new hires as part of the new hire training process.

How corrective actions will be monitored: Administrator, Director of Nursing or other staff who have received training through manufacturer training video on how to properly secure a resident in the wheelchair van shall conduct random visual audit of 5 resident transports per week x 1 month, then 5 times per month times 3 months and report to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. Administrator and Director of Nursing will monitor all incident and accidents of residents weekly, ensuring that appropriate investigation and intervention of any incidents that occur is

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F 689	Continued From page 33 performed. This information will be reported to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. Director of Nursing or Assistant director of nursing will conduct random audits of nursing personnel, inquiring to the knowledge of accidents reported by residents, staff, and/or visitors which have not been communicated. This will be completed 5 times per week X 1 week and 5 times per month X 3 months and report to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. This will be monitored by the administrator. Credible allegation and all elements were in place on 12/5/2018." The credible allegation for Immediate Jeopardy removal was validated on 12/6/18 at 3:09 PM, which removed the Immediate Jeopardy on 12/5/18, as evidenced by staff interviews, in-service record reviews, and observation. The in services included information on, following up on resident statements about accidents in and out of the facility, need for assessment following any reported incidents, and training on how to appropriately secure a resident for transport.	F 689		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14	F 809		1/4/19

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F 809	Continued From page 34 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to offer a substantial snack to the residents when the time between the evening meal and breakfast was greater than 14 hours. The findings included: During an interview with the dietary manager on 12/5/18 at 3:28 PM she stated snacks were delivered to each wing every evening at 8:00 PM. She said the 3 snacks trays included oatmeal cream cookies, orange peanut butter nabs, vanilla wafers, chocolate chip cookies, sugar cookies and graham crackers. She added that no beverages were included because the nursing staff had water or juice on the medication cart for the residents. The Dietary Manager also stated some residents did received specific snacks assigned individually to certain particular residents. An observation of the bedtime snacks delivered on 12/5/18 from 7:45 PM until 9:30PM revealed two snack carts were delivered with one cart for each of the two nursing stations in the facility. One cart contained: 5 oatmeal cookies, 4 oatmeal	F 809	Corrective action for residents found to be affected by the alleged deficient practice: There were no specific residents identified during survey process. The Dietary Manager (DM) and Administrator met with the Resident Council on 12/28/18 and 1/02/19, to discuss with them a change in meal times for breakfast and evening meals, in order to provide meals no more than 14 hours between meal times. The Resident Council agreed on meal times for breakfast to begin at 7am and evening meal to begin at 5pm. Identification of other residents having the potential to be affected by the alleged deficient practice: Current facility residents have the potential to be affected by the alleged deficient practice of more than 14 hours between the evening meal and breakfast meal, without being offered a substantial snack.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD LIVING & REHAB CENTER	1624 HIGHLAND DRIVE WASHINGTON, NC 27889

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F 809	Continued From page 35 cream pies, 5 packages nabs, 5 package graham crackers with 2 crackers in each and 8 containers of fruit juice. The second cart contained: 5 oatmeal cookies, 1 carton of Low Fat milk and 5 packages of graham crackers. This cart also contained additional snacks which were labeled for specific residents. Three of these labeled snacks were observed to be 2 packages saltine cracker with 2 slices cheese. Two other individually labeled snacks included a package of graham crackers with a container of fruit juice. There was also one Styrofoam container that contained pureed meat, creamed potatoes, and pureed vegetables. It was labeled for a specific resident. This Styrofoam container was put in the refrigerator to hold "in case this resident gets hungry during the night." On 12/5/18 at 8:15 PM Nursing Assistant (NA) #1 was interviewed. She stated she knocked on the resident ' s door and asked the residents if they wanted a snack. On 12/5/18 at 8:23 PM NA #2 was interviewed. She reported she begins to pass out snacks between 8:00 PM and 9:00 PM. She said she passed out the snacks labeled for specific residents then takes the cart of snacks back to the nursing station where the remainder of the snacks were there in case a resident asked for a snack. NA #3 was interviewed on 12/5/18 at 8:333 PM. She stated she delivered the resident specific snacks to those residents who had their name on the snack. She said the rest of the snacks were left in the area near the nursing station "in case someone wants something".	F 809	Measures implemented to ensure that the alleged deficient practice does not recur: The Dietary Manager (DM) and Administrator met with the Resident Council on 12/28/18 and 1/02/19, to discuss with them a change in meal times for breakfast and evening meals, in order to provide meals no more than 14 hours between meal times. The Resident Council agreed on meal times for breakfast to begin at 7am and evening meal to begin at 5pm. The Dietary Manager (DM) adjusted meal times on 12/29/18, for breakfast and evening meal so there will be no more than 14 hours between meal times. The DM and/or Director of Nursing or Staff Development Coordinator (SDC) completed education on 1/02/19, for the dietary staff and nursing staff regarding the change in meal times. Monitoring to assure continued compliance: The Dietary Manager and/or Administrator will observe and document meal times for evening and breakfast meals 3 times a week for 4 weeks, then twice a week for 2 months, to validate that meal times does not exceed more than 14 hours between evening and breakfast meals. The DM will review audits/documentation to identify patterns/trends and will adjust plan as necessary. The DM will review plan in monthly QAPI and audits will continue at the discretion of the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 809	Continued From page 36	F 809		

NA #4 was interviewed on 12/5/18 at 8:47 PM. NA #4 stated he delivered the snacks that had resident names labeled on them. He said some of the other residents would ask for something and he would retrieve it from what was left on the cart. He added some residents will wake up and ask for a snack or some juice and that would be retrieved from the cart. He stated there were always snacks left on the cart.

Nurse #5 was interviewed on 12/5/18 at 8:59 PM. She reported that some snacks were labeled with specific residents ' names on them. She stated staff passed out the snacks that were labeled for the specific resident. The other snacks were left at the nursing station "in case someone asks for something." She stated there were usually some extras snacks left on the cart.

During an interview with the Administrator on 12/7/18 at 2:30PM he stated he was not aware that there was greater than 14 hours between the dinner meal and breakfast so he was not aware of the need for a substantial snack or what items would make a substantial snack.