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	345083	A. BUILDING _____ B. WING _____	C 09/20/2019

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E 000	Initial Comments An unannounced Recertifiction survey was conducted on 09/16/19 through 09/20/19. The facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID# OGQN11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 09/16/19 through 09/20/19. There were two allegations investigated and one was substantiated but not for the named resident. Past non-compliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F 689 constituted substandard quality of care. Non-compliance began on 04/03/19. The facility came back in compliance effective 04/12/19. An 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 resident, staff and manufacturer	F 689	Past noncompliance: no plan of	

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

Electronically Signed | 10/07/2019

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representative interviews, and record review and review of manufacturer's instructions, the facility failed to secure all four of the transport van's wheel chair tie-down retractors in a manner to prevent slack in the securement system and prevent a resident's wheel chair from moving during a van transport for 1 of 6 residents reviewed for supervision to prevent accidents. Resident #42's wheelchair flipped backwards toward the left side and he struck his head on the van floor. Resident #42 had a portable oxygen tank in a mesh-bag holder behind his wheelchair. Transport Aide (TA) #1 assisted Resident #42 into an upright position in his wheelchair after Resident #42 complained of difficulty breathing prior to the resident being assessed by a licensed medical professional. Resident #42 obtained a laceration and hematoma to the back of the head, discoloration to right hand and left forearm and skin tear to left elbow. Resident #42 was taken to the hospital for evaluation and returned to the facility on the same day.

Findings included:

The manufacturer's instructions for the securement system used by the facility's transport van to secure residents who were seated in wheelchairs during transport read in part, "the following parts make a complete wheelchair/passenger securement system: 4 wheelchair tie-down retractors, 1 occupant lap belt, and 1 occupant shoulder belt and a mounting hardware. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs to take up additional webbing

correction required.

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slack."

A document entitled "Resident/Patient Van Transport Checklist" dated 8/30/18 and signed by TA #1 revealed this checklist was used as a training tool and included the following statement regarding securing the patient: Make final check to ensure proper tension of tie-down straps.

Resident #42 was admitted to the facility on 4/11/18 with diagnoses of chronic obstructive pulmonary disease (COPD) and end-stage renal disease (ESRD). A review of the annual Minimum Data Set (MDS) dated 3/12/19 revealed Resident #42 was cognitively intact, required limited physical assistance with transfers and received oxygen therapy and dialysis. The quarterly MDS dated 9/3/19 revealed Resident #42 was cognitively intact and required limited physical assistance with transfers.

The facility's "Occurrence Report" dated 4/3/19 indicated Resident #42 fell backwards toward the left side in his wheelchair while being transported in the facility van. Resident #42 had a 0.5 x 0.5 cm (centimeter) laceration to the back of mid scalp, a 1 x 1 cm hematoma to the back of the head, a 3 x 2 cm skin tear to the left elbow, a 5.5 x 4 cm discoloration to the left forearm and a 1.5 x 1 cm discoloration to the right hand.

The Emergency Department (ED) report dated 4/3/19 revealed Resident #42 was examined after a fall out of his wheelchair. Resident #42 had a

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history of end-stage renal disease and was on dialysis, and COPD. He stated that his breathing was at baseline and only complained of headache. Resident #42 was initially sent for a Computerized Tomography (CT) but he stated that he cannot have a CT without anti-anxiety medications. After treatment with (anti-anxiety medication), Resident #42 again refused to have a CT because he felt he could not breathe laying flat. He again stated that this was his baseline. He did not want to do the CT. After discussion of the risk of refusing CT of his head and cervical spine which included intracranial hemorrhage and death, Resident #42 stated he understood and signed the AMA (against medical advice) form.

An interview with Resident #42 on 9/17/19 at 4:10 PM revealed he remembered what happened on 4/3/19 during the van incident. Resident #42 stated he got picked up by Transport Aide (TA) #1 from dialysis when after one block, the van turned right and accelerated then "the front two straps didn't hold, and my wheelchair flipped backwards." He further stated he hit his head on the van floor. He said he couldn't remember how TA #1 strapped his wheelchair on the van and he did not pay any attention to it. He confirmed that he requested TA #1 to assist him to an upright position after his wheelchair flipped backwards because he was having trouble breathing. TA #1 called 911 and the EMT (emergency medical technician) arrived within 5 minutes.

An interview with TA #1 on 9/17/19 at 4:36 PM confirmed she was driving the transport van on 4/3/19 when Resident #42 fell backwards to the left side with his portable oxygen in a mesh-bag

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holder behind him. TA #1 stated she picked Resident #42 up from dialysis and strapped Resident #42's wheelchair on the van like she normally did. She attached the two front straps first and then went towards the back of his wheelchair. While she was attaching the two back straps, Resident #42 leaned forward towards the left seat in the van to place his lunchbox and folder on the seat. TA #1 indicated this might have caused the front straps to get some slack. TA #1 further stated that after attaching the two back straps, she did not go back to the front straps and re-check to see if the front straps became loose. She did not wiggle the wheelchair or re-check the tension of the straps because she didn't think she had to because she had already locked all four straps. She could not remember being told to make a final check to ensure proper tension of the tie-down straps during her last van transport training. When she made a right turn, she heard Resident #42 and his wheelchair, looked in the rear-view mirror and saw Resident #42's wheelchair was flipped backwards. TA #1 stopped the van, turned the hazard lights on, called 911 and checked on Resident #42. Resident #42 was complaining of having difficulty breathing and wanted TA #1 to get him up off the van floor. She told Resident #42 she was not supposed to get him up off the van floor until checked by the EMT but Resident #42 insisted to be gotten up off the floor. TA #1 got Resident #42 upright in his wheelchair. Resident #42 requested her to turn on the van air conditioner. TA #1 stated while making her way to the front of the van, she noticed the two front straps were unhooked from the wheelchair but were still extended. She stayed with Resident #42 until the EMT arrived and took Resident #42 to the

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hospital.

There were no other residents on the van at the time of Resident #42's fall.

An interview with the Maintenance Director on 9/17/19 at 4:55 PM revealed he inspected the wheelchair securements used for transporting Resident #42 on 4/3/19 and found them to be in working order. He further stated even though he did not find anything wrong with the straps, he went ahead and replaced them with a new set of the same model on 4/3/19. He said he wasn't present at the incident so he cannot say exactly what happened, but his impression was that the straps weren't fastened correctly, and the incident happened due to an "operator error."

A telephone interview was conducted with the Staff Development Coordinator (SDC) on 9/19/19 at 9:37 AM. The SDC stated training for all staff driving the facility van involved watching a video made by the company which manufactured the securement straps, return demonstrations of wheelchair securement, a road test, and practice loading and unloading a resident. TA #1 was the main van driver at the facility and was a nurse aide (NA) before she became employed with the facility. TA #1's road test was done when she was originally signed off on driving the van. TA #1 was in-serviced on van operation and wheelchair transport on 6/28/17 and 8/30/18 for van safety. The SDC further stated without looking at the training record, she could not confirm if making a final check to ensure proper tension of tie-down straps was included in the 8/30/18 training but the

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SDC stated she expected the van drivers to rock or wiggle the wheelchairs back and forth after securing all four straps to re-check for tension on the straps.

A telephone interview with a representative from the manufacturer of the wheelchair securement device on 9/18/19 at 9:19 AM revealed all wheelchair securement devices were designed to be used with 4 points of securement. The representative stated if all 4 securement devices were used correctly, it would be highly unlikely the wheelchair could tip backwards. She also stated if the actual tie-down of the wheelchair was in place and all straps were locked, any movement (side to side or front to back) from the wheelchair, whether the wheelchair was locked or unlocked, will not likely cause the straps to loosen up. She confirmed that someone moving to one side to place something on a seat was very unlikely to loosen the front straps or knock off the safety straps.

An interview with the Director of Nursing (DON) was conducted on 9/18/19 at 9:37 AM. The DON confirmed there was an incident on 4/3/19 where Resident #42 fell backwards in his wheelchair while being transported from dialysis in the facility van. The DON further stated an investigation was begun and TA #1 was suspended following the incident. As part of the investigation, the DON, Administrator, Maintenance Director and TA #1 re-enacted the entire occurrence with Resident #1's wheelchair. The Corporate Safety Manager inspected the wheelchair securements and other devices in the facility van and all the devices were functioning properly. In her opinion,

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what happened was that Resident #42 pulled his wheelchair up and caused some slack in the front straps which eventually caused the straps to get unhooked from Resident #42's wheelchair when TA #1 made the right turn. She said she expected TA #1 to have made a final check to ensure proper tension of the tie-down straps.

An interview with the Administrator on 9/18/19 at 10:55 AM revealed her investigation determined Resident #42's securement straps must have gotten loose after Resident #42 reached over to his left side. The Administrator stated that based on the re-enactment and her interviews with Resident #42 and TA #1, they could not find anything wrong with what TA #1 did but they decided to suspend TA #1 during the investigation. But she did expect TA #1 to have made a final check to ensure proper tension of the tie-down straps as indicated in the van training checklist. She further stated the facility switched over to the automatic retractable straps on 5/23/19 due to a corporate decision. The Administrator provided a summary of the investigation and Quality Assurance/Process Improvement Plan (QAPI) that was put into place following the incident on 4/3/19.

The facility provided the following QAPI with the plan of correction date of 4/12/19.

-The facility self-identified an opportunity with transportation services related to the training of transportation attendants regarding safety precautions, utilization of required safety restraints, and emergency management following an accident.

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-The Quality Improvement Plan dated 4/4/19 had a problem statement that read van driver did not complete final check on securement straps to make sure they were tight for a resident transporting in van. This resulted in resident turning over backwards. The root causes of the incident were determined to be questionable strap failure or slack of straps, resident's movement in wheelchair from side to side and van driver not completing final check of straps. Barrier was education of staff.

-The Maintenance Director changed the previous van straps with a new set of van straps of same type on 4/4/19.

-Starting on 4/5/19, Resident #42 was transported while riding in the passenger seat at the back of the driver's seat in the van or on the front passenger seat in the facility car. Resident #42 was secured using the regular seatbelt in either facility van or facility car.

-Facility van drivers were re-inserviced on van safety and procedures by the Staff Development Coordinator and the Corporate Safety Manager. The re-training included van lift operation, securing residents with the 4 restraint belts per manufacturer's guidelines, watching a video of proper placement of securement straps by the manufacturer of the securement straps and return demonstrations. Education began on 4/4/19 and was completed on 4/12/19. Facility van drivers performed all safety procedures correctly on return demonstration.

-Inspection of all wheelchairs including brakes, arm rests, backs and seats was completed by

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Housekeeping on 4/5/19. Any issues identified during the inspection were corrected.

-Monitoring of the facility approved van drivers started on 4/8/19. The drivers performed transportation demonstration and check off for all transports for 2 weeks from 4/8/19 to 4/22/19, 5 residents x 4 weeks from 4/22/19 to 5/21/19 and 2 residents x 4 weeks from 5/21/19 to 6/18/19. The audit was completed by the Staff Development Coordinator who stated there were no problems during the audit period. The monitoring was completed on an audit tool titled "Van Check Off." The SDC or approved staff member observed the approved van driver securing the residents in their wheelchair while in the van for their scheduled transports. The observations were completed to confirm the approved van drivers were strapping the residents' wheelchair with all 4 restraint belts per manufacturer's guidelines and making a final check after securing all 4 straps. The monitoring tool of the residents that require transportation in the facility van were discussed during Quality Improvement (which included the discussion/review of an identified issues/concerns and recommendations for corrective actions) meetings Monday to Friday, and the monitoring tool was further reviewed during the weekly Quality Assurance meetings. The QI was completed on 6/20/19 and the Staff Development Coordinator was responsible for collecting and presenting with back up from the DON and/or designee.

-The "What to do in Case of an Accident" form dated 4/8/19 was added to the training for all approved van drivers that included a resident was not to be moved until evaluated by a medical

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professional, and the form was laminated and placed in a visible and readily available location in the wheelchair van for the van drivers to refer to during transports. All van drivers completed training on what to do in case of an accident on 4/12/19 by the Staff Development Coordinator.

-New retractable safety belts which secured the wheelchair to the floor of the van were ordered on 4/11/19 and replaced in the facility van by the Maintenance Director on 5/23/19. Corporate decided to replace all straps from manual to automatic retractable type.

The QAPI was validated on 9/19/19 and concluded the facility implemented an acceptable corrective action plan on 4/12/19 once all authorized drivers were trained. The facility provided documentation that included transport drivers' training on transportation safety that included how to properly secure a resident in a wheelchair and perform return demonstrations. Staff interviews also confirmed they were trained if an accident occurred during a resident transport to not move the resident until they have been assessed by a licensed professional.