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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 08/13/20 through 08/26/20. One of the three allegations investigated was substantiated. Past non-compliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F 689 constitued substandard quality of care. Non-compliance began on 01/17/20. The facility came back in compliance effective 01/21/20. The survey team entered the facility on 08/13/20 to conduct a complaint investigation survey and exited on 08/13/20. The survey team returned to the facility on 08/21/20 to conduct an extended survey and exited on 08/21/20. Additional information was obtained on 08/26/20. Therefore, the exit date was changed to 08/26/20.	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 observation, record review, review of manufacturer's instructions, and staff, resident, Family Nurse Practitioner, and manufacturer	F 689	Past noncompliance: no plan of correction required.	9/9/20

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

Electronically Signed | 09/09/2020

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representative interview, the facility failed to secure the front two wheelchair tie down retractors in a manner to prevent slack in the securement system and prevent a wheelchair from moving during a van transport for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #2). Resident #2's wheelchair fell backwards onto the floor of the van which resulted in Resident #2 striking his head on the van floor and caused a left lateral 8th rib fracture. Resident #2 was taken to the hospital for evaluation and returned to the facility the same day.

Finding included:

The undated manufacturer's instructions for the securement system used in the facility's transport van to secure residents who were seated in wheelchairs during transport was made up of: 4 wheelchair tie downs, 1 occupant lap belt, 1 occupant shoulder belt and floor anchorages. The instructions read in part, "attach tie downs into floor anchorages and ensure they are locked in. Ensure all tie downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs (if present) to take up additional webbing slack."

Resident #2 was admitted to the facility on 01/14/20 with diagnoses that included bilateral above the knee amputations and end stage renal disease. Resident #2 expired at the facility on 05/03/20.

The Nursing Admission Assessment (NAA) dated 01/14/20 indicated, Resident #2 was alert and oriented to person, place, time and situation. The NAA also indicated, Resident #2 was totally

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dependent for transfers.

Resident #3 was admitted to the facility on 01/07/20 with diagnoses that included end stage renal disease. The Admission Minimum Data Set assessment dated 01/14/20 revealed, Resident #3 had moderately impaired cognition. Resident #3 was discharged on 03/03/20.

The facility's Incident Report (IR) dated 01/17/20 at 4:10 and completed by Nurse #1 indicated, the Van Driver (VD) called Nurse #1 to the transport van which was parked outside the facility. The VD stated the front straps on Resident #2's wheelchair unlocked when he drove over the first speed bump in the parking lot which caused his wheelchair to fall backwards. The Nurse observed Resident #2 sitting upright in his wheelchair holding his left flank area and complained of pain in his back, head and between his shoulders. Resident #2 who was alert and verbally responsive stated, his wheelchair fell backwards, and he hit his head and back. Resident #2 was taken to his room and Nurse #1 notified the Family Nurse Practitioner (FNP) of the incident who gave an order for Resident #2 to be sent to the hospital for evaluation. Resident #2 was transferred to the hospital via the Emergency Medical Services (EMS). The IR continued to explain, that Resident #3 was also on the van and stated, they were going slowly over the first bump when the latches released and Resident #2's wheelchair fell straight backwards, then the VD stopped and checked on
Resident #2.

The Administrator interviewed Resident #2 on 01/17/20. The typed interview indicated, Resident

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#2 was asked what happened and Resident #2 replied, that he did not know except that on the way up the driveway his chair flipped. The Administrator asked Resident #2 if he could recall if he and Resident #3 was restrained with the front restraint straps and Resident #2 replied yes, with all the straps including the shoulder harness. The Administrator asked Resident #2 how the ride back to the facility was and the resident stated it was good with no problem. The typed statement was signed by Resident #2.

The Administrator also interviewed Resident #3 on 01/17/20. The typed interview indicated, the Administrator asked Resident #3 what happened and Resident #3 stated they were headed back to the facility when the van went over the speed bump and Resident #2's chair flipped over. The Administrator asked Resident #3 if he could recall if he and Resident #2 was restrained and Resident #3 replied yes, they were both restrained appropriately, and he did not understand why Resident #2's chair flipped. The typed statement was signed by Resident #3.

The Emergency Department (ED) report dated 01/17/20 revealed, Resident #2 was examined for multiple trauma/fall after the transportation van he was riding in went over a speed bump and caused his wheelchair to fall backwards and caused him to hit the back of his head and his left lateral chest wall. Resident #2 complained of pain and denied loss of consciousness. Resident #2 received a computerized tomography (CT) scan w/o contrast of the chest which resulted in a nondisplaced left lateral 8th rib fracture and a head CT w/o contrast that resulted in no acute finding. Resident #2 explained, he had recently been started on a pain medication at the nursing

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home and was given one dose of pain medication while at the hospital before he was discharged back to the nursing home that same day.

During a telephone interview with the Van Driver (VD) on 08/14/20 at 1:05 PM he confirmed, he was driving the facility's transportation van on 01/17/20 when Resident #2 fell backwards in his w/c. The VD explained, he picked Resident #2 and Resident #3 up from dialysis and secured them in the van by way of his normal routine. He stated, he parked Resident #2 behind the passenger side of the van and locked the brakes on his wheelchair then continued to secure the front two tie downs before he secured the back two tie downs. The VD stated, he checked the tie down straps for slack and the wheelchair for stability by rocking the wheelchair back and forth before he applied the seatbelt and shoulder strap. He continued to explain, that when the front two wheels of the van went over the speed bump in the driveway of the facility parking lot, he heard a noise then Resident #2 said he was falling backwards, and the VD pulled the van over to go back to check on Resident #2. The VD found Resident #2 lying on his back still seated in his wheelchair with his seatbelt and shoulder strap in place. The back two tie down straps were secure, but the front two tie down straps had released enough tension to allow the wheelchair to fall backwards. The VD stated, when he asked Resident #2 what happened, he stated his prosthesis must have hit the latches and he fell backwards. The VD explained, Resident #2 was trying to get the wheelchair back in upright position but could not by himself and insisted the VD sit him upright. The VD stated, he called into the facility to inform the Administrator of what happened, and Nurse #1 came out to the van and

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assessed Resident #2 before they sat him upright. He stated, he hooked Resident #2 back up and he moved the van up to the where he usually parked the van while the Nurse stayed in the back of the van with the residents. The VD stated, after the incident the same day he had to reenact the securement process for the Administrator and the Maintenance Supervisor (MS) using Resident #2's wheelchair. He stated, the only explanation he had was that Resident #2's footrests or his prosthesis hit the red release lever on the top of the tie downs when he went over the speed bump which caused enough slack in the front straps and allowed the wheelchair to fall backwards. The VD explained, when he was hired the MS trained him to drive the van which consisted of 3 days of reviewing videos of the securement system, return demonstration of loading and unloading residents and performing the procedures with the MS present. He stated, he had to complete a check off list of procedures before he could drive the van by himself without supervision.

A telephone interview was conducted with Nurse #1 on 08/17/20 at 10:55 AM who confirmed, she was the Nurse who assessed Resident #2 on 01/17/20. The Nurse explained, she was called out to the van which was parked in the van's usual parking spot and observed Resident #2 sitting upright in his wheelchair holding his left side and he complained of pain in his head, back and between his shoulders. The Nurse stated, she notified the FNP who gave her an order to send Resident #2 to the hospital for evaluation and Resident #2 was transported to the hospital by EMS. The Nurse reported, Resident #2 returned the same day with rib fractures. The Nurse explained, the only thing she knew about

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how the incident happened was what the VD reported to her that when the van went over the speed bump Resident #2's wheelchair fell backwards. The Nurse also reported, Resident #3 was also a passenger on the van but did not have any issues related to the incident.

On 08/17/20 at 3:00 PM a telephone interview was conducted with the Maintenance Supervisor (MS) who explained, that he was called to the facility on the afternoon of 01/17/20 because of an incident with the van and Resident #2. The MS stated, he checked the tie downs, and the straps and could not find anything visibly wrong with them. He stated, he then had the VD to reenact the securement procedure using Resident #2's personal wheelchair. He explained, the only thing they could possibly conclude was that the leg rests on the wheelchair rested at the release point which was at the red lever on top of the tie downs and the leg rests could have hit the levers when the van went over the speed bump and caused them to release enough tension on the straps that Resident #2's wheelchair fell backwards. The MS stated, he could not be sure of the exact cause because he was not present when the incident happened. The MS explained, that since they were unable to identify the exact reason for the incident, the facility opted to purchase new tie downs to replace the ones used for Resident #2 and the facility took the van out of service until the new tie downs were installed. He stated, the van was out of service for about 4 days and the facility had to utilize EMS for the transports. He explained, in the meantime they reeducated all the van drivers which included videos, securement process installment and conducting audits that lasted for several months because the facility initiated a self-directed plan of

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correction that was addressed in the monthly Quality Assurance (QA) meetings.

A telephone interview was conducted with the Administrator on 08/18/20 at 9:00 AM. The Administrator confirmed there was an incident on 01/17/20 where Resident #2's wheelchair fell backwards in the facility van while being transported from dialysis. The Administrator explained, as the van was going up the hill into the facility parking lot and went over the speed bump the VD heard a noise and observed a wheelchair had fallen over. The VD stopped the van and went to the back to find Resident #2 in his wheelchair and the wheelchair was lying on its back on the floor of the van. The Resident was still harnessed in his wheelchair with his seatbelt and shoulder strap secured in place. Resident #2 insisted on the VD sitting him upright so the VD, in fear of getting hit by another vehicle because he stopped the van in the road on the hill, assisted Resident #2 to upright position and secured the front straps before he proceeded to the front of the facility. The VD called into the facility to notify the Administrator and the Nurse of the incident. By the time the Administrator had arrived at the van, Resident #2 had already been taken to his room by the VD but Resident #3 was still in the van. The Administrator questioned Resident #3 about the incident and the Resident stated, he did not know what happened because he watched the VD tie Resident #2's wheelchair down with all the tie downs the way he always tied him down and Resident #2 just flipped backwards. Resident #3 added, Resident #2 did not come out of his wheelchair. The Administrator continued to explain, that when he went to Resident #2's room Nurse #1 had already assessed him and he complained of side pain

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and that he hit his head. When the Administrator asked Resident #2 what happened he stated, he did not know but the VD secured him in the correct way, and he was just on the floor. The Administrator stated, about that time the EMS arrived to take Resident #2 to the hospital, where he was evaluated and treated and returned to the nursing home same day. The Administrator explained, that also on 01/17/20 the MS and the Administrator had the VD to demonstrate for them the procedure he used to secure Resident #2 with the tie downs using Resident #2's personal wheelchair but they could not determine a root cause of the incident so they opted to err on the side of caution and replaced the tie downs. The Administrator stated, the van was taken out of service until the new tie downs were replaced. The Administrator added, he completed the summary of investigation and the plan of correction that was put into place on 01/17/20 with the assistance of the Director of Nursing who was no longer employed by the facility.

The Director of Nursing at the time of the incident on 01/17/20 was no longer employed by the facility and unable to be interviewed.

A follow up telephone interview was conducted with the Van Driver (VD) on 08/18/20 at 5:00 PM. The VD explained, that he had misspoken during his first interview when he stated that Nurse #1 came out to the van to check on Resident #2 when the van was parked in the driveway and that the Nurse helped him sit Resident #2 upright in his wheelchair. He stated, it had been a long time since the incident happened and he did not have his notes in front of him when he was asked about the event. The VD stated, he wanted to clarify that Resident #2 insisted that the VD sit

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him upright and he was trying to get up by himself and because had stopped the van in the driveway he was concerned that the van could be hit by another vehicle. Therefore, the VD sit the wheelchair upright and secured the front two tie downs then drove the van up to the building where the Nurse came out assessed Resident #2 before he took him to his room. The VD explained, that after the incident all the van drivers had to go through the whole training process again which included classroom work, videos, demonstration performance and conducting audits for several months afterwards.

During a follow up telephone interview with the Administrator on 08/18/20 at 6:05 PM he acknowledged, he provided via email the detailed Quality Assurance/Process Improvement Plan (QAPI) along with the documentation of proof for the QAPI related to the 01/17/20 incident. The Administrator stated the QAPI continued until the May 2020 Quality Assurance QA meeting and that he was
responsible for compliance.

A telephone interview was conducted with the Family Nurse Practitioner (FNP) on 08/20/20 at 11:35 AM. The FNP explained, her laptop was not available to her at that time of the interview but stated, she remembered the van incident with Resident #2 and requested the IR be read to her. The FNP then confirmed, that Nurse #1 notified her on 01/17/20 because Resident #2 had fallen in the van and was complained of side pain and that he hit his head so she gave Nurse #1 an order to send Resident #2 to the hospital for evaluation. The FNP continued to explain, that Resident #2 had scans at the ED that determined he had rib fractures and since he was already on

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pain medication for his other health conditions, he was given one dose of pain medication for his rib pain in the ED and sent back to the nursing home on the same day. The FNP confirmed, Resident #2 sustained the rib fracture as a result from his fall in the van on 01/17/20.

On 08/20/20 at 4:54 PM the Administrator confirmed in an email that the Van Driver was suspended during the investigation of the incident on 01/17/20.

During a follow up interview with the Maintenance Supervisor (MS) on 08/21/20 at 9:50 AM he explained, the same securement system had been used during his employment. The MS continued to explain, that the last time he inspected the van was 12/11/19 and provided a document that indicated a vehicle safety inspection was conducted on 12/11/19 by the MS who deemed the tie downs were secure to the floor, not frayed, and in good working condition. The MS stated, that he along with the Human Resource Director (HRD) were responsible for reeducation on the securement system and performance procedures for the van drivers and he was also responsible for the routine monitoring and auditing of the van that was outlined in the self-directed plan of correction.

The HRD was unavailable for interview.

An interview was conducted on 08/26/20 at 3:05 PM with a representative of the manufacturer of the securement system utilized by the facility on 01/17/20. The representative explained, the securement system was designed for the tension (slack) from the tie downs to automatically tighten, after they were correctly applied to the

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wheelchair, by rocking the wheelchair back and forth and the only way to release the tension was to manually press the release button on top of the tie downs. Therefore, the representative stated, if the user applied the securement system the correct way the video instructed, the tie downs would not have released the tension that would have allowed the wheelchair to fall backwards.

The facility's corrective actions implemented after the incident to prevent a reoccurrence included the following:

All items listed on this self-imposed action plan have been completed and implemented on 01/17/20 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 01/18/20. The statement was signed by the Director of Nursing and Administrator and dated 01/18/20.

CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:
-01/17/20 Resident #2 was assessed by the Licensed Nurse following a fall in the van.
-01/17/20 Physician was notified, and Resident #2 was transferred to the hospital for evaluation. Resident #2 returned to the facility on 01/17/20 with diagnosis of left lateral 8th rib fracture.
-01/17/20 The van was taken out of use on following the incident until checked out by an approved van dealership to assure straps were functioning properly.
-01/17/20 As a precautionary measure the facility will replace the straps as it may be the contributing factor.
-01/17/20 The van will remain out of service until

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the new straps have been installed.
-01/20/20 The van was checked by an approved dealership and validated that all straps were working properly.
-01/23/20 The new straps were installed in the van and inspected. All were working properly.

IDENTIFICATION OF OTHER RESIDENTS:
-There was one other resident in the van when the incident occurred on 01/17/20. Resident #3 was interviewed by the Administrator on 01/17/20 and he stated he observed the driver attach the straps on his and Resident #2's wheelchair. Resident #3 stated he did not know what happened.
-On 01/17/20 the DON and the HRD interviewed other residents in the facility that were interviewable and had been transported in the facility van within the last 14 days to identify any concerns related to proper securement in the van during the transport process. There were no concerns voiced or identified.

MEASURES FOR SYSTEMIC CHANGE:
-01/17/20 The van will remain out of service until the new straps have been installed as the potential for strap malfunction may have caused the incident.
-01/20/20 and 01/21/20 The facility van drivers were re-educated via the manufacturer's video and return demonstration regarding the use of the van and proper securement of residents and wheelchairs inside the van. No van driver will be permitted to transport residents until the re-education has been completed.
-01/23/20 All van drivers will continue to complete the pre-trip checklist each morning prior to the first transport.
-01/23/20 The Maintenance Director will complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 08/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

a safety inspection of the van twice a month.

HOW CORRECTIVE ACTION WILL BE MONITORED:
-01/23/20 The Maintenance Director and/or Administrator will observe 10 transports a week for 4 weeks then 5 transports a week for 2 months to validate the straps are working functioning properly and properly attached to the wheelchair.
-01/17/20 The Maintenance Director or the Administrator will review the audits monthly to identify any patterns or trends and will adjust the plan to maintain compliance.
-01/17/20 The Maintenance Director or the Administrator will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee.

The Administrator was responsible for compliance.

The date for the decision to QA and monitor was 01/17/20

End of QAPI/POC 05/2020

The Performance Improvement Project (PIP) was a self-imposed action plan for the van was reviewed in the QAPI meeting for May 2020. The interdisciplinary team determined that since no further incidents have occurred, the audit was determined to be satisfactory and no further monitoring was required.

On 08/21/20 at 10:45 AM, during the Extended Survey, an observation was made of the Van Driver (VD) who demonstrated how he connected the securement system to Resident #2's

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wheelchair while the Maintenance Supervisor (MS) was seated in the wheelchair. The VD followed the manufacturer's instructions when he placed all four J hooks, two in the front and two in the back, to the lowest part of the wheelchair connection and rocked the wheelchair back and forth to allow the tie downs to automatically take up the slack in the straps. After the VD applied the seatbelt and shoulder strap, he again rocked the wheelchair back and forth the ensure the wheelchair was unable to move. The VD insisted that he applied the securement system the same way on the day of the incident with Resident #2's wheelchair but could not definitely explain how both of the tie downs released tension at the same time which allowed Resident #2's wheelchair to fall backwards.

On 08/21/20 at 11:10 AM the facility's plan for past noncompliance was validated by the following: 1) Review of in-service training records revealed all five van drivers had been in-serviced on the van's securement system including return demonstrations on 01/20/20 and 01/21/20. 2) Interviews were completed with current van drivers. There was one van driver hired after 01/21/20 who confirmed she received all necessary training that included watching videos, safety inspection of the transportation van, return demonstration of the safe application of the securement system, and demonstration of transporting a resident in the van with the instructor present. 3) The interviews validated the van drivers had undergone training regarding the safe application of the securement system. 4) A review of the facility's audits verified they were completed as specified in their self-imposed action plan. 5) Compliance was achieved on 01/21/20 when all van drivers had been

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F 689	Continued From page 15 reeducated regarding the van securement system.	F 689		