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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/11/2020 thru 12/14/2020. Event ID#89EN11. 2 of the 4 complaint allegations were substantiated resulting in deficiencies. 2 of the 4 complaint allegations were not substantiated.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to ensure 1 of 3 residents reviewed for discharge had a safe place to go after leaving the facility. (Resident #2) The findings included: Resident #2 was admitted to the facility on 10/29/2020 with diagnoses of coronary artery disease, deep venous thrombosis and asthma. The admissions Minimum Data Set (MDS) dated 11/04/2020 had Resident#2's cognition as moderately impaired, requiring extensive assistance with transfers, dressing and toilet use. The resident was independent with eating and personal hygiene. She required limited assistance	F 624	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	12/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/29/2020

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

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with bed mobility.

Resident # 2's comprehensive care plan dated 10/29/2020 had focuses including Activity of daily living self-care performance deficit due to limited mobility, Limited range of motion, had impaired cognitive function/dementia or impaired thought processes, resolved positive for COVID-19, has altered respiratory status/difficulty breathing due to Chronic Obstructive Pulmonary Disease (COPD).

Discharge planning notes dated 11/25/2020 read: "Discharge Planner (DP) spoke with the resident's family member notified him of upcoming discharge date set for 12/09/20. The family member had no concerns but wanted to make sure that before the resident was discharged that she would be able to get up and go to the bathroom by herself. DP explained she would notify therapy of that. DP also explained to the family member that the equipment or services needed for the resident would be set up before discharging home. Review of the discharge notes further revealed Resident # 2's family member was experiencing medical issues and had concerns about being able to care for Resident # 2 if she was discharged home under his care. According to the discharge notes, the family member expressed these concerns to the facility Discharge Planner."

The Discharge planning notes dated 12/3/2020 read: "DP along with patient Physical Therapy (PT) spoke with family member regarding his concerns for the resident's discharge. The family member stated that he got his Peripheral Inserted Central Catheter(picc) line taken out and that in 6 more days he will be able to bear more weight on

F 624

F624

How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 2 was readmitted back to the facility on 12/11/2020 until further discharge planning could be conducted.

How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice.

The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The administrator educated at the discharge planning director and assistant on reevaluating the discharge plan when the home support system has changed by completing the community skills checklist (which addresses equipment needs, education needs, home visit and caregiver support) at the time of the change. Should a patient be found to not have an adequate support system and still wish to discharge adult protective services will be notified prior to discharge. This was completed December 12th 2020. The administrator or designee will audit all discharge plan changes weekly in morning meeting x 4 weeks, biweekly x 4 weeks and monthly x 1.

How the facility plans to monitor its

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his foot, but he must take it easy. The family member's concern is that the resident will tell the staff she will do things but then not do them at home. PT explained to family member that the resident is capable of walking and minimum assistance for transfer. PT discussed with family member about setting up a virtual visit so that he can see what the resident can do. The family member was agreeable to virtual visit and states it's not that he did not want the resident to go home, he just wants her to be confident that when she goes home, she can do the things she has been working on."

Review of the Physician order dated 12/08/2020 revealed the resident was to be discharged home on 12/10/2020 with family member.

Discharge planning notes dated 12/9/2020 read: "DP received voice message from family member stating that he will no longer be available the rest of the day. DP attempted to call, and no answer and left voice mail that patient was scheduled to discharge home. The resident would like to go home but facility would like to verify that the family member was home before discharging the resident as she was expressing not having keys to the house. DP expressed that they would need a call back and if there were any concerns about the discharge to contact facility about alternative plans."

Discharge planning progress notes dated 12/10/2020 read: "The DP spoke with the resident in the morning and she was persistent that she wants to go home. DP explained to her that her discharge would be Against Medical Advice (AMA) as they knew she needs some assistance, but the family member did not want to help her.

F 624

performance to make sure that solutions are sustained. The results of the audits will be reported to the QAPI committee quarterly x 1 for analysis of patterns, trends, or need for further systemic changes.

Date of compliance for all plan of corrections is December 14th, 2020

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The resident stated that it was her house and the family member can move out if he did not want her there, but she would like transportation to go home. The resident stated she did not want to stay at the facility."

Nurse note dated 12/10/2020 read: "Resident # 2 was be discharged home AMA with instruction about what an AMA means. Resident # 2 was persistent about wanting to go home. She stated not wanting to stay in the facility any longer. Resident # 2 was able to demonstrate personal catheter care but needed assistance with the clip. Resident # 2 stated the family member would be able to assist her with the clip. Resident # 2 showed proper peri-care and understanding of the importance to stay clean and the risk of infection. Resident # 2 signed the AMA paperwork. Medications were sent home with resident upon discharge."

Discharge Planning (DP) progress notes date 12/11/2020 read: "DP along with Director of rehab (DOR) contacted family member due to family member reporting that he had concerns regarding Resident # 2. Team spoke with the resident and family member on speaker phone to try to address any concerns. Family member stated that since Resident # 2 went home, she had remained in reclining chair and did not want to get up. DP asked the resident why she did not get up, the resident stated that she did not need to get up yet. DP asked the resident if she felt that she needed to come back to the facility, the resident stated that she didn't know she had not been home long enough to tell. The family member stated that he had offered to assist his mother, but she did not want to get out of her recliner. The

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family member said that he had asked the resident if she needed to get up for bowel movement and states the resident said that she hasn't had to use the restroom. The family member stated that his concern is that he has a follow up appointment and he is unsure if they will put another PICC line in and that he expects them to increase his weight bearing. DP asked if Resident # 2 wanted to return to facility at this time the resident stated "I guess so" the family member stated he wanted her home, but he needs to find out what is going to happen at the appointment first. DP asked the family member and the resident if they needed to set up transport to get her back to the facility, the family member stated that he could get the resident up and bring her to the facility."

Nurse notes dated 12/11/2020 read: "The family member arrived at facility with the resident in personal truck. The family member met by nursing with wheelchair. DP and DOR discussed previous conversation that they had over the phone. The family member stated that he just needed to find out on Monday how his foot is healing and that way he would be able to know how much assistance he would be able to provide. The family member showed DP along with DOR that currently he has no PICC line and it was removed and hopes that the wound closes and he won't need another PICC line. The family member states that he wants the resident at home and that they help each other. The family member stated that he could see that the resident is able to assist him as he transferred her. States that he was able to get down the stairs with just holding his hands around her waist to let her know he was there. "

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Nurse notes dated 12/11/2020 read: "The resident was readmitted to facility in the afternoon after being dropped off by son. The resident was alert and oriented. Resident was able to make her needs known to staff. No complaints of pain. The resident was continent of bowel. Foley catheter was in place for urine. Foley was draining yellow urine. Respiratory evaluation indicated the following vitals: Temperature 97.7, Pulse oxygen was 99."

During an interview on 12/11/2020 at 1:15 PM, the DP reported the resident discharged home AMA on 12/10/2020 due to the resident insisting she wanted to go home despite the family member refusing to help the resident once she was discharged home. Home Health was set up before the resident was discharged home. DP added the Home Health was to go to check on the resident on 12/12/2020. "DP further reported the Adult Protection Services (APS) was notified about resident discharging home AMA on 12/10/2020. DP added the resident was readmitted back to the facility on 12/11/2020 after the family called back the facility expressing he wanted the resident to be readmitted back to the facility due to the resident not willing to get up to the chair all night and family member not willing to assist the resident use the bathroom and provide the resident with food.

During an interview on 12/11/2020 at 1:30 PM, Nurse # 1 who discharged Resident # 2 indicated Resident # 2 on 12/10/2020 was picked up at the facility by the staff of a transportation service. Nurse # 1 indicated Resident # 2 demonstrated personal catheter care but needed assistance with clip. She further reported the discharge instruction was given to the resident who

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verbalized understanding of discharge instructions. She reported the resident signed AMA form before leaving the facility.

During an interview on 12/11/2020 at 2:00 PM, the family member reported before the resident was discharged home, he had informed the facility that he could not take care of the resident including catheter care due to his health. The family member reported the resident was discharged on 12/10/2020 to her home which they share, and she sat on the recliner chair all night. The family member reported on 12/11/2020, the resident was readmitted back to the facility. The family member indicated he was not going to take care of

Observation of the resident on 12/11/2020 at 3:00PM revealed the resident sitting on the bed and visibly upset. Resident #2 was in a low bed. she reported she was tired of staying at the facility and she wanted to go back to her house. She further reported the family member was going to take care of her even though he kept telling the facility staff that he will not take care of her.

During an interview on 12/11/2020 at 3:30 PM, the Administrator revealed Resident # 2 was informed about the family member not wanting to take care of her at home after discharging from the facility. She reported Resident # 2 insisted she wanted to go home indicating the family member will take care of her even though he says otherwise. Administrator added that Resident # 2 signed herself AMA knowing the family member had said he will not take care of her at home. She further stated before Resident # 2 was discharged home, the DP should have made a

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F 624	Continued From page 7 home visit to make sure the resident's home was safe. The DP should have also made sure the resident had an adequate support system even if the resident wanted to be discharged home AMA. Administrator also indicated prior to the resident being discharged home, the Adult protection Services should have been notified.	F 624		
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, resident, family, Physician and staff interviews the facility's contracted transportation driver (Van Driver #1) failed to secure the resident with the seat belt before transporting her back to the facility after her dialysis appointment for 1 of 4 sampled residents (Resident #1). Resident #1 fell out of her wheelchair and landed on the floor of the transportation van after Van Driver #1 had to stop suddenly to avoid being hit by another vehicle. As a result of not using the seat belt, she sustained right maxillary (face) contusions, fractures of the right inferior and superior pubic ramus (pelvis bone), questionable Hematoma (localized bleeding outside of blood vessels, due to either disease or trauma, including injury or surgery) to right wrist, and nondisplaced fracture at the proximal shaft of the fourth metacarpal (ring	F 689	Past noncompliance: no plan of correction required.	12/23/20

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F 689	Continued From page 8	F 689		

finger).

Findings included:

Review of Van driver #1's signed transportations safety policy dated 09/08/2020 read, "Each driver must complete the training video before locking down anyone to the vehicle for transport. Clients must be restrained to the vehicle and chairs properly, according to the training video, at all times during transport. All drivers must check off safety checklist with each transport."

Review of the safety checklist/verification form listed a space to document the Resident/client name, date, time, facility employee and drivers initial. The checklist required a checkmark for: wheelchair straps, seatbelt, leg-rest and wheelchair pad for each resident/client.

Resident #1 was admitted 11/07/2019 with diagnoses including End Stage Renal Disease (ESRD) and Morbid Obesity. The annual Minimum Data Set (MDS) dated 10/01/2020 had Resident #1 coded as moderately cognitively impaired needing extensive assistance with activities of daily living (ADL). The resident was also coded as having had dialysis.

During a telephone interview with Resident #1 on 12/11/2020 at 8:13 PM, Resident #1 stated all she remembered was the van stopping and her falling out of her wheelchair onto the floor of the van. Resident#1 also stated her seat belt was not buckled and she was in a lot of pain.

During a telephone interview with Family Member #1 on 12/11/2020 at 7:32 PM, Family Member #1 stated on 12/02/2020, she was at the dialysis

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F 689	Continued From page 9 center after Resident #1 received her treatment and saw Van Driver #1 having problems trying to buckle her seatbelt. Van driver #1 stated he was having a hard time buckling her seatbelt. Family Member #1 also stated she did not see if the seat belt was fastened when she left the dialysis center. She left, went home and received a call from the DON stating Resident #1 was in an accident, fell out of her wheelchair and would be going to the Emergency Department (ED) because her right side was hurting. Family member #1 also stated the Director of Nursing (DON) told her Van driver #1 said he had to slam on the brakes to avoid getting hit by another vehicle and Resident #1 fell out of the wheelchair. Family member #1 further stated Family member #2 went to the facility on 12/03/2020 for a meeting with the Administrator, Van driver #1 and others to discuss what happened and how it happened and at that time, Van driver #1 stated Resident #1 slipped out of the wheelchair. During an interview with the Admissions Coordinator (AC) on 12/11/2020 at 4:01 PM, the AC stated she saw the transport van, at the entrance of the facility at approximately, 4:10 PM, on 12/02/2020, parked on the side where the bricks are for about 4-5 minutes. The AC also stated she was making copies and looked out the window and watched him then pull up to the front door and he asked the Receptionist if he can get some help. During an interview with Receptionist on 12/11/2020 at 4:07 PM, the Receptionist stated at 4:15 PM she saw the driver pulled up in the transportation white van and stated he needed help, right away. The Receptionist stated she reported it to the Director of Nursing (DON).	F 689		

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A progress note written by the DON dated 12/02/2020 read, "Resident was observed lying flat on her back in the transport van. Wheelchair was located behind her. Upon assessment, resident was calm and able to state name, date of birth, and family members' names. Stated she had pain in her right leg and unable to move at this time. No visible injury to her right leg. Swelling noted to the right side of her forehead. Resident was able to move upper extremities. No open areas noted. Emergency Medical Services (EMS) called immediately to transfer to Emergency Department (ED) for evaluation. Dr. notified."

During an interview with the DON on 12/11/2020 at 3:47 PM, the DON stated on 12/02/2020 at approximately 4:15-4:30 PM the Receptionist told her that Van driver #1 needed help with Resident #1 because she had fallen on the van floor, due to him having to stop fast to avoid another vehicle hitting him at the light in front of the facility. When the DON arrived at the van, she found Resident #1 on her back, with redness noted to her right side of her face. Resident #1 was assessed, and members of her nursing staff came out to assist. The DON asked them to stay with Resident#1, so she could call 911 and the family. Resident #1 was not moved because she was a mechanical lift resident and they suspected her head was hit in the accident. The Emergency Medical Services (EMS) came but could not get her on the stretcher, so the fire department came and were able to get her in the ambulance and she was taken to the ED. The DON stated the van driver reported to her, Resident #1's seat belt popped off.

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F 689	Continued From page 11 During an interview with Nurse #1 on 12/11/2020 at 4:14 PM, Nurse #1 stated she was alerted by one of the people that worked in the front office on 12/02/2020. She was told Van driver #1 was outside stating Resident #1 had been hurt, there was some sort of accident and they needed nurses outside. So, she went outside to the transportation van and found Resident #1 laying on her back, her head was facing towards the back of the van. She was complaining of some right-sided pain. She noticed some swelling to the right cheek. Van driver#1 said somebody had pulled out in front of him, he had to slam on the brakes, and she fell out of her wheelchair. Nurse #1 also stated she stayed with her until EMS arrived. During an interview with UM on 12/11/2020 at 4:33PM, the UM stated he arrived at the incident about 4:30 PM. He got a call in his office stating they needed some assistance up front and asking if he can come outside. The UM stated when he arrived at the transportation van, he found Resident #1 lying on her back and complaining of pain to her right side of her body. The DON had assessed her and asked if he would stay with her so she could call EMS and the family. The UM further stated EMS arrived shortly after and she was taken to the hospital. During an interview with the Administrator on 12/11/2020 at 3:28 PM, the Administrator stated she received a report on the phone from the Director of Nursing (DON) son 12/02/2020 approximately 4:30 PM, stating Resident #1 was in the van at the facility, had a fall and was calling 911. Resident #1 was transported to the emergency room. She did have some swelling in her face, she had pain in her right leg. The Van	F 689		

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F 689	Continued From page 12 driver #1 stated that one of the seat belts must have popped off because he had strapped the patient in, and he thought because of her weight, the seat belt popped. The Administrator also stated she scheduled a meeting the next day with Family member #2, the supervisor of the contract transportation company, and Van driver #1. The next day at 10:00 AM, they met outside, with the van that was used in the accident. Van driver #1 reenacted the incident and stated Resident #1 was in her wheelchair and she was wearing her safety belt. Van driver #1 also stated because of her weight, the belt popped. There were no issues found concerning the safety belts. They also, brought out the wheelchair that was being used for the transport and they had him show them how it should be done. Van driver #1 then said the seat belt didn't pop the patient slid under the seat belt. The Administrator told him the injuries are not consistent with the resident sliding out. The Administrator also stated she was trying to explain to the manager, her injuries were not consistent with the story because she had a contusion right under her cheek and the huge hematoma mean some blunt trauma occurred. The next day, the Administrator had a conversation with Family member #1. Family member #1 stated she was at the dialysis center with her mom and that she had actually saw him load her up into the van and that he could not get the seat belt buckled. Van driver #1 told her she was fine. Family member #1 also stated the ED had indicated it was a force trauma and there were questions as to how she ended on her back when she had front facing injuries and none to her back. The Administrator acknowledged Resident #1's fall in the contracted transportation van was because Van Driver #1 failed to secure Resident #1 in her wheelchair with the seatbelt	F 689		

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F 689	Continued From page 13 before transporting her back to the facility after her Dialysis appointment. During an interview with the Contract Transportation Supervisor (TS) on 12/11/2020 at 5:02 PM, the TS stated Van Driver #1 was on administrative suspension until the investigation was completed concerning the incident on 12/02/2020. They were gathering information about the incident. The TS stated Van Driver #1 stated he was avoiding an accident and as he hit the brakes, Resident #1 came out of the wheelchair. The TS also stated they are investigating because he had two different stories. The first was the seat belt popped open due to the client's weight and the second was Resident #1 slid out of the wheelchair. On 12/03/2020, the TS visited the facility with the van used in the incident with Van driver #1 for a meeting with the Administrator and Resident #1's family member. They discussed the incident from 12/02/2020. Van Driver#1 stated as he was at the stop light in front of the facility. He was preparing to make a right turn and was cut off by a car and had to hit the brakes to avoid a collision with the vehicle. While at the facility, the adjustable seatbelts, the adjustable shoulder strap and restraints were checked and there were not any problems noted. The seatbelts are adjustable, so the size of a client would not cause the seatbelt to pop open unless there was a malfunction. There were not any malfunctions found with the seatbelt. The TS also stated before any transport, the drivers must have their passengers safely buckled in their safety belt and are required to perform a safety check using their safety checklist before they begin their transport. The TS stated he has not been able to get in contact with Van driver #1 since the meeting. The TS	F 689		

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further stated Van driver#1 did not have a safety checklist completed for 12/02/2020.

Van Driver #1 was not available to be interviewed.

Family member #2 was not available to be interviewed.

During a telephone interview with the attending Physician at the hospital on 12/12/2020 at 12:43 PM, the Physician stated Resident #1 was still admitted in the hospital and had been Resident #1's attending Physician since 11/08/2020. Resident #1 was admitted on 12/03/2020 from the ED due to an accident on a transportation van on 12/02/2020. She had diagnoses of a fracture of the right inferior and superior pubic rami (pelvis bone), a nondisplaced fracture at the proximal shaft of the fourth metacarpal (ring finger), questionable Hematoma to right wrist, DVT in right leg and right facial contusions. The Physician stated he cannot say what the circumstances were that occurred before the fall to cause the injuries to Resident #1.

The ED notes read: 12/02/2020, Patient arriving via EMS. Patient was on her way back from dialysis, wasn't secured properly, fell out of her wheelchair onto her right side sustaining pain to the hip as well as swelling and bruising to the right side of the face, pain in her right face, right shoulder swollen and tender and right arm swollen and tender. Resident #1's diagnosis included fractures of the right inferior and superior pubic rami nondisplaced, possible nondisplaced fracture at the proximal shaft of the fourth metatarsal, Patient was given pain medications in the ED and was being admitted for further evaluation and treatment.

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Resident #1 remained in the hospital at the time of the survey.

The facility's investigation and root cause summary completed by the Administrator dated 12/02/2020 read: Resident #1 fell out of her wheelchair in the transport van. Resident was able to answer all questions appropriately, however, did not know what happened in the incident. Nursing staff did notice injury to the right side of her face of redness and swelling. She also complained of right leg pain. The patient was supported in the van by staff until EMS arrived then she was transferred to the hospital for further evaluation. Van driver #1 was interviewed. He stated he was making the turn at the stop light directly in front of the facility when a car pulled out in front of him and he had to brake suddenly at the top of the driveway. He stated that the resident was properly seat belted and locked in and that the seat belt must have popped off due to her weight because he had placed it on her. On 12/03/2020, the TS from the contract transportation company was Informed that until further investigation was completed, we did not want the driver of the accident conducting any transports. On 12/03/2020 the Administrator, DON and ADON met with the Family Member #2, the TS of the transportation company and Van Driver#1 outside with the van used during the transport. They also brought out the wheelchair used during the accident. Van Driver #1 and the TS demonstrated to everyone how the patient was secured in the van. During that time, the driver changed his story and stated the resident was properly secured in and that she slid out from under the seat belt. The DON spoke to Family Member #1 via telephone on 12/03/2020 who

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indicated she was at the dialysis center with Resident#1 when the driver was loading her in and he was having a difficult time trying to get her buckled in and that she communicated to him if everything would be okay for her transport. He told her everything was fine. She stated she left and did not see if he was able to get the seat belt working. During the investigation the DON obtained statements of what transpired. It was also noted, from the Admissions Coordinator whose office overlooks the facility' s driveway, that Van driver #1 turned in and parked at the top of the drive for a few minutes before pulling into the facility and notified staff of the accident.

The facility performed an investigation on 12/02/2020 and put a corrective action plan in place. On 12/12/20, the facility provided an acceptable Plan of Correction with a correction date of 12/07/2020.

The Plan of Correction included:

Resident #1 sustained a fall on the transportation van 12/02/2020 at the stop light in front of the facility at approximately 4:15 PM. Resident#1 was being transported in a van driven by the contracted transportation company and her seatbelt was not fastened. Van driver #1 stopped suddenly, and she fell from her wheelchair causing injuries and was sent to the hospital. She assessed onsite by the DON and she was transported by EMS to the ED. Upon discussing with family, the hospital' s evaluation of her injuries her facial injury was consistent with frontal injury and nothing was noted to the back of the head. This was not consistent with the van driver's new story that she slid off the chair because the resident was lying flat on her back

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and wouldn't have sustained facial hematoma as noted by hospital. The resident sustained no upper body contusions or seat belt burns consistent with slipping out from under the seat belt. It was also noted that resident is larger in body mass and that she would have been found entangled in seat belt not flat on her back on the floor. During the investigation the DON obtained statements of what transpired. It was noted from the admissions coordinator whose office overlooks the facility' s driveway, that the driver had turned in and parked at the top of the drive for a few minutes before pulling into the facility and notifying staff of the incident.
Statements for incident on 12/02/2020 involving Resident#1 read: Van driver #1 on 12/02/2020: He was turning into Carolina Rehab, a car came out of traffic and accelerated rapidly in front of him, almost hitting him which caused him to break. While breaking to avoid the accident. Resident#1 slid from under seatbelt restraint feet first on the floor of van. ADON: On 12/02/2020 she was called outside because Van driver #1 stated Resident #1 fell out of her wheelchair in the van. As she approached the van, Resident#1 was lying flat on her back with the wheelchair at her head. She stated her face hurt and her ankle hurt. The ADON continued to assess the resident. Resident #1 asked her to move her right leg. She informed her that she did not think that was a good idea, in case something was fractured. She informed Resident #1 that EMS was called. Her right hand was edematous. The ADON stayed with patient until Fayetteville fire dept arrived. The Admission Coordinator statement dated 12/04/2020 read: On December 2, 2020, she witnessed the contract transportation van parked towards the end of the driveway of the facility. The driver was parked for approximately 4

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F 689	Continued From page 18 minutes. He then proceeded to pull up to the front door. As he came to the front door to let the receptionist know that the resident had fallen out of her wheelchair in the back of van. All while he was on his cellphone, his sense of urgency was not there at all. The DON's statement dated 12/02/2020 read: On 12/02/2020, she was alerted that a resident fell out of her wheelchair in the contract company's van. She immediately went to assess the resident with Nurse#1. Resident #1 was lying flat on her back, front of the wheelchair. Upon physical assessment, resident stated her right leg was in pain. We did not move her at all. She was able to state her name, daughters' names and date of birth, the wheelchair was still restrained on the bottom left side of the wheelchair. Nurse#1 and the Van Driver #1 unbuckled the left restraint to remove the wheelchair. EMS was called to assist with transfer to the hospital. Nurse#1 and The Unit Manager stayed with resident to wait for EMS while she called to inform family. Family member #1 cell phone had a voicemail that was full. The statement from Nurse#1 dated 12/02/2020 read: At approximately 1615/1630 on 12/02/2020 she was asked by the front admissions department to go outside to assist with a patient who had a fall in the contract transportation van. She found the resident laying on her back, feet towards the front of the van and her head facing towards the back. There weren't any signs of respiratory distress. Resident was alert and oriented x4. She stated that her right leg was hurt, and it was noted that she had a contusion to her right cheek. No signs of bleeding. Resident was kept in Supine position. DON notified. EMS called. The statement from the Unit Manager on 2/02/2020 read: Writer was called to the front of the building, upon arrival found staff members inside of transport van with	F 689		

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resident also in laying in van supine on the center of the floor. When asked what happened resident stated," She didn't know, they stopped suddenly, and she fell out. Resident #1 was noted to have right side facial swelling and also swelling to her right upper extremity. Resident complained of right-side discomfort. Determination was made to call EMS for further evaluation and to transport to hospital.

On December 2, 2020, therapy did an evaluation on the wheelchair of Resident #1 was using and determined that the wheelchair was in working condition. However, it was not her usual wheelchair.
On December 2, 2020, the rehab department assessed the other resident's wheelchairs that are going to dialysis to ensure they are in the correct wheelchair with proper functioning parts. All Dialysis resident's wheelchairs have been assessed and no issues with the wheelchair, brakes, or cushion were noted. Residents being transferred by contract transportation company services had their wheelchairs assessed and are appropriate for each resident for transport.

On 12/03/2020, 100% audits were performed to validate that residents were properly secured before departing the facility.

On 12/4/2020 operations manager sent over in-services done on 12/4/2020 for all drivers. On December 4, 2020 during an interview with Family member #1 via telephone, she indicated that Resident #1 was now able to converse with them and did not recall specifics about the accident, however, did know she did not have a seat belt on during the transport. At that time the TS at contract transportation company of the new

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F 689	Continued From page 20 finding. At that time, it was also discussed that education would need to be provided to all drivers to safely pullover at the scene of an accident that results in a fall or injury, to immediately call for help and not move the resident and for seatbelt safety. The in-service of all staff was be completed on 12/07/2020. The QAPI committee met on 12/07/2020 to ensure compliance/changes were met. As part of the validation process on 12/14/2020, the entire plan of correction was reviewed including the re-education of van drivers for safe transport of clients. An observation of the wheelchair inspections on 12/12/2020, performed by Therapy Director. An observation of a transport van on 12/14/2020 found Resident #3 safely being loaded onto the contract transportation van by Van Driver #3 using 4 restraints for the wheels, an adjustable lap belt and an adjustable seatbelt. On 12/14/2020, Resident#3 was interviewed, he stated the contract transportation drivers safely transports him using his lap belt and seatbelt. On 12/14/2020, Van Driver #2 was interviewed, he stated he received re-education for seatbelt safety and always follows his checklist and uses the 4 restraints to the wheelchair chassis, the lap belt and the seatbelt which are adjusted to fit all of his clients and has transported Resident #1 and has never had trouble with her size or her seatbelts. A review of the contracted transportation company's plan of correction revealed 100% of staff were trained on safe transportation for clients in wheelchairs by 12/04/2020. A review of the facility's 12/02/2020 data collection audit tool for transportation safety revealed they completed the audits as indicated.	F 689		

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F 689	Continued From page 21 The facility wheelchair audit was reviewed and was completed on 12/07/2020. The facility had completed a QAPI meeting on 12/07/2020 which included the Interdisciplinary staff to ensure all safety measures were in place. The facility's correction date of 12/07/20 was validated.	F 689		