STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 05/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	**400 PELT DRIVE FAYETTEVILLE, NC 28301**

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F 000	INITIAL COMMENTS Immediate Jeopardy began on 03/01/2017 when the wheelchair of Resident #39 fell backwards in the transportation van and ejected the resident onto the floor. The resident was sent out for evaluation and sustained no injury. The immediate jeopardy was removed on 05/20/2017 at 1:50 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for resident's transportation to appointments and other activities.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual	F 278		6/15/17

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

Electronically Signed | 06/15/2017

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F 278	Continued From page 1 who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to accurately code the dental status for 2 of 3 sampled residents (Resident #30 and Resident #66) whose Minimum Data Set (MDS) was reviewed and did not code Section G for 1 of 3 residents reviewed (Resident #30). Findings included: 1. Resident #30 was admitted to the facility on 01/25/2017. During review of his medical record, his admission diagnoses included Non-pressure Chronic Ulcer of Right Ankle, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Hypertension, Chronic Kidney Disease, Heart Failure, Gastro-esophageal Reflux Disease and Ventricular Tachycardia. The Admission MDS dated 02/02/2017 indicated Resident #30 was cognitively intact. He required extensive assistant with personal hygiene. There were no oral/dental issues identified on the MDS. There was no diagnosis listed in Section I.	F 278	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F278 Corrective Action for Resident Affected For resident #30, the resident's oral status was assessed by the MDS Nurse and compared to the most recent annual MDS assessment section L. A significant correction MDS to the most recent comprehensive assessment was opened by the MDS Nurse with an ARD of 06/14/2017. This process will be	

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F 278	Continued From page 2 Resident #30 was interviewed on 5/15/17 at 5:58 pm, the resident revealed he had not had teeth for some time. "I can eat most things. One day I may decide to get some more teeth, but I am okay right now. I have other things that are more important to me." When asked if he had problems eating, he said no I am okay. I eat better with no teeth than some people eat with teeth. I will let them know when I want more teeth." During the interview, he was observed as not having any visible teeth. The Director of Nursing/MDS Coordinator was interviewed on 5/18/17 at 4:35 pm. She revealed it was a coding error in the MDS. When asked about the resident she stated she was not sure if he was totally edentulous or just some teeth, but she admitted the Admission MDS was incorrectly coded. She also acknowledged in section I - there were no diagnoses recorded. She explained, she would file a correction for the error in coding. 2. Resident #66 was admitted to the facility on 02/27/2017. Her admission diagnoses included Heart failure, Hypertension, Gastro-Esophageal Reflux Disease, Renal insufficiency, Non-Alzheimer ' s Dementia, Seizure Disorder, Psychotic Disorder, Chronic Pulmonary Edema, Pressure Ulcer of left ankle, stage 3, Restlessness and agitation, and Wandering. The Admission MDS dated 03/07/2017 indicated Resident #30 was severely cognitively impaired. She required extensive assistance with personal hygiene. There were no oral/dental issues identified on the MDS.	F 278	completed by 06/15/2017. For resident #66, the resident's oral status was assessed by the MDS Nurse and compared to the most recent annual MDS assessment section L. A significant correction MDS to the most recent comprehensive assessment was completed by the MDS Nurse. This process was completed by 06/15/2017. For resident #30, the current diagnosis list was reviewed by the MDS Nurse and active diagnosis were compared to section I of the most recent completed MDS assessment. A significant correction MDS to the most recent comprehensive assessment was opened by the MDS Nurse with an ARD of 06/14/2017. This process will be completed by 06/15/2017. Corrective Action for Resident Potentially Affected All current residents who have oral/dental problems have the potential to be affected by this alleged deficient practice. An assessment of all current resident's oral/dental status was conducted by the MDS Nurse and compared to the resident's most recent comprehensive MDS assessment for accuracy of section L coding. If incorrect coding was noted, a significant correction assessment was completed by 06/15/2017 and the plan of care updated if indicated by the MDS Nurse. All current residents with coding errors in section I of the most recent MDS have the potential to be affected by this alleged deficient practice. The MDS nurse reviewed all current resident's active diagnosis and compared it to the most	

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F 278	Continued From page 3 Resident #66 was not interviewable on 5/15/2017 at 3:50 pm. During the attempted interview on 5/15/17, it was observed that teeth were missing on the top and bottom. The DON/MDS Coordinator was interviewed on 5/17/17 at 4:35 pm. She stated there was a coding error in Resident # 66 ' s admission MDS. She stated that Resident #66 had no teeth. When she reviewed the Admission MDS, it did not reveal the correct coding. She revealed a correction needed to be done. On 5/20/17 during an interview with the Administrator it was revealed the expectation was to have the Minimum Data Set coded accurately for all residents.	F 278	recent MDS assessment to identify any coding errors. Findings were: there were no other residents affected by this practice. This audit was completed by 06/13/2017. Systemic changes: On 06/12/2017, the MDS Nurse was in-serviced by the MDS Consultant on accurate coding of MDS Sections I and L: Education topics included purpose, definitions, steps for assessment and coding instructions. This information has been integrated into the standard orientation training for new MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The MDS Consultant or designee will complete QA tool MDS Accuracy and audit 5 residents for MDS accuracy of section I and L. This will be completed monthly for three months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 323	Continued From page 4	F 323		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility failed to follow manufacturer's instructions to safely secure a resident's wheelchair during transport of 1 of 1 resident from the dialysis center to the facility on 03/01/2017 (Resident #39). As a result, Resident #39 was ejected onto the floor of the van causing the resident to hit her head. The facility also failed to secure 2 unoccupied wheel chairs in the van	F 323	F 323 Corrective Action for Affected Residents The facility immediately began investigating the incident involving resident #39 occurring on 03/01/2017 in which resident was being transported back to the facility after receiving her	6/15/17

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F 323	Continued From page 5 on the way to a dialysis appointment on 04/12/2017 which caused one of the unoccupied wheelchairs to be thrown onto the leg of 1 of 3 residents during the transport (Resident #39). Immediate Jeopardy began on 03/01/2017 when the wheelchair of Resident #39 fell backwards in the transportation van and ejected the resident onto the floor. The resident was sent out for evaluation and sustained no injury. The immediate jeopardy was removed on 05/20/2017 at 1:50 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for resident's transportation to appointments and other activities. Findings included: Review of the [Q'Straint] (system used by the facility for securing a wheelchair and a resident during transport in the facility van) User Instructions Manual indicated the following: A. Secure Wheelchair 1. Place wheelchair facing forward in securement area; apply wheel locks or turn power off. 2. Attach tie-downs into floor anchorages, and ensure they are locked in. 3. Attach the 4 tie-down hooks to solid frame members or weldments near seat level. Ensure tie-downs are fixed at approximately 45 degrees and are within angles. 4. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs to	F 323	dialysis treatment. In route to the facility resident #39 wheelchair fell backwards causing her to fall on the floor hitting her head. The resident was assessed by the facility LPN and sent to the emergency room for evaluation. On 03/01/2017, the facility van was taken out of operation through 03/06/2017. A 24 hour report was completed on 03/02/2017 and a 5 day report was completed on 03/09/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #1 was suspended on 03/01/2017 and subsequently terminated on 03/09/2017. On 03/02/2017, the corporate van trainer investigated the incident and determined the root cause of this event was the transportation aide failed to secure the front floor retractors to the resident's wheelchair according to Q' Straint manufacturer guidelines. Resident #39 states that "the lap and shoulder belt was also not hooked during the transport". Employee #1 stated "I hooked the front and back retractors". When employee #1 was informed that the resident stated she did not hook the front retractors employee #1 stated "I thought I did but if the resident stated I didn't then I guess I didn't". The root cause of the incident is employee #1 did not follow Q' Straint manufacturer guidelines and facility policy in securing the resident and wheelchair prior to completing the transport. On 04/12/2017 during transport of resident #39 to dialysis, one of two unoccupied wheelchairs shifted during a turn and was leaning on the right side of	

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F 323	Continued From page 6 take up additional webbing slack. B. Secure passenger 1. Attach lap belts: Use integrated stiffeners to feed belts through openings between seat backs and bottoms and/or armrests to ensure proper belt fit around occupant. a. On the aisle side, attach belt with female buckle to rear tie-down pin connector ensuring buckle rests on passenger's hips. b. On the window side, attach belt with male tongue to rear tie-down pin connector and insert into female buckle. 2. Attach shoulder belt: Extend shoulder belt over passenger's shoulder and across upper torso, and fasten pin connector onto lap belt. 3. Ensure belts are adjusted as firmly as possible but consistent with user comfort. Review of the medical record of Resident #39 indicated she was admitted to the facility on 04/18/2016. The resident's cumulative diagnoses included End Stage Renal Disease and Dependence on Dialysis. The resident's quarterly Minimum Data Set (MDS) dated 05/08/2017 indicated the resident had no cognitive impairment. The MDS also indicated the resident required extensive assistance of 2 persons for transfers between surfaces and used a wheelchair for mobility. The resident was also a right leg above the knee amputee. Review of a nursing progress note dated 03/01/2017 indicated, "Informed by transportation person that patient had fell on the bus while it was on the way back to nursing home. Writer and transportation person and one other Nursing	F 323	resident #39 footrest and knee. Upon return to the facility, resident #39 was assessed for injury by the facility LPN. No injuries were noted. On 04/12/2017, the facility van was taken out of operation through 05/01/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/2017. A 24 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2017, the corporate van trainer investigated the incident and determined the root cause of this event was that the transportation aide did not secure the wheelchairs tight enough to prevent them from moving. The facility van remained out of use through 05/01/2017 due to vacation of the senior transportation aide. It was then determined on 05/01/2017 to no longer transport empty wheelchairs on the facility van. A root cause analysis investigation was completed for both incidents by corporate van educator and the facility administrator. The root cause for both incidents was determined to be transporter failed to follow facility policy and procedures and manufacturer guidelines. Corrective Action for Potentially Affected Residents On 03/01/2017, the facility van was taken out of operation through 03/06/2017. On 03/06/2017, the maintenance Director completed the Vehicle Inspection: Safety Inspection check list for the one facility	

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F 323	Continued From page 7 Assistant (NA) went to area where bus was parked and found patient lying on back on floor of bus, asked patient what happened, stated that when bus started moving, she fell backward out of her wheelchair and hit her head on the floor of the bus. Head to toe done, no open areas noted, no bump on back of head noted. Patient helped us using life pad and placed back in wheelchair." (Signed by Staff Nurse #1) Nursing notes also indicated the resident was sent to the hospital on 03/01/2017 for evaluation for complaints of headache at 8:15 PM. Review of a hospital emergency department note dated 03/02/2017 indicated the resident was seen for an evaluation following the incident in the van. The report indicated no fractures were seen on the Computerized Tomography (CT) scans and x-rays of the head, neck and back. Discharge information indicated the resident was diagnosed with strained muscles and ligaments in the neck and was ordered as needed pain medication. The resident returned to the facility on 03/02/2017 at 1:35 AM with orders for as needed pain medication. The resident was interviewed on 05/19/2017 at 11:15 AM concerning the van incident which occurred on 03/01/2017 and stated "It was on March 1st, and we were coming from my dialysis appointment around 6:00 PM. We stopped at the stoplight. When the light turned green, she (the van driver) took off fast, and when she turned the corner, my wheelchair jerked back and threw me out of my wheelchair. I landed on my back on the van floor. The wheelchair was sitting straight up. The driver couldn't get me up by herself, and it was about 10 or 15 minutes when other people	F 323	owned van. No concerns were identified. On 03/14/2017, Van Products of Raleigh completed an inspection and service on the one facility owned van. No concerns were identified. On 03/07/2017 the administrator began interviewing all alert and oriented residents that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and Q' Straint manufacturer guidelines. This audit was conducted daily for 2 weeks. No concerns were identified. Employee #1 was terminated on 03/09/2017 and #2 was terminated on 04/18/2017. Current residents that were transported on the facility owned van from 04/13/2017 to 05/19/2017 have the potential to be affected by this alleged practice. An audit was completed on 05/20/2017 by the Senior Transportation Aide to determine which residents were transported by the facility van from 04/13/2017 to 05/19/2017. 13 Current residents were identified. On 05/20/2017, the Director of Nursing interviewed the identified 10 alert and oriented residents that were transported 04/13/2017 to 05/19/2017 for any safety concerns during transports and to validate that the following technique was used to secure their wheelchair during transportations: all 4 floor retractors are hooked to the wheelchair, the seat belt is attached across the residents lap and secured to floor restraints, and the shoulder strap is positioned across the shoulder and	

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from the facility came to help. One of the people from the nursing home said it was amazing how I got thrown out of the chair, but the chair stayed up. The same driver had taken me to appointments before. She always put the lift down, put the wheelchair on the lift and got me in the van. When I was in the van, she put the brakes on the back to keep the chair from moving and then reached over me to put the lock on the front. On that day, I don't remember her locking the front of the chair. Before that day, she always leaned around me to put my seat belt on. I know she did not do it that day, but I don't know why. My head and my neck were hurting when we got back to the facility, so they called the doctor, and they sent me to the hospital. I still have headaches and my neck is sore, but the doctor here put me on muscle relaxers, and they help a lot."

Staff NA#1 was interviewed on 05/19/2017 at 11:45 AM and stated at the time of the incident, she was the transport scheduler and also one of the designated drivers for the facility. She stated "The driver called me on 03/01/2017 and stated the resident's chair jerked back in the van, and the resident fell out of the chair. I went with the nurse to the van scene. The chair was sitting up straight, and the resident was on the van floor on her back. She was awake and talking. The nurse assessed the resident, and three of us got her back in the chair after we inspected the chair. I personally secured the chair. When I saw the chair, the front 2 casters were not secured to the chair which meant the front of the wheelchair was not secured down, and the seat belt was not secured as it should per out training instructions. Also, the seat belt could not have been applied correctly, or the resident could not have been secured to the lap belt. All 10 alert and oriented residents stated the above procedures have been followed for their transports occurring from 04/13/2017 to 05/19/2017 and they did not have any safety concerns.

Systemic Changes

On 03/06/2017, 8 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The current administrator and maintenance director were included in the 8 staff trained. The corporate van trainer has received training directly from Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. On 03/30/2017, a new transportation aide was placed in the position as facility transportation aide. Training was completed by the corporate van trainer on 03/30/2017 prior to the transportation aide completing any van transports.
As of 04/13/2017, unoccupied wheelchairs have not been transported in the facility van.

Quality Assurance

A quality review will also be implemented

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F 323	Continued From page 9 thrown out of the chair." Staff Nurse #1 was interviewed on 05/19/2017 at 2:00 PM and stated he was notified of the van incident on 03/01/2017 while he was on duty. He stated he and the transportation scheduler went immediately o the scene where the van was parked in a parking lot. He stated he observed the resident lying on her back inside the van. He stated she was awake and alert. He stated she complained of a headache. He also reported he assessed her from head to toe, and saw no visible signs of injury. He said after the transportation scheduler checked out the wheelchair, he and the other 2 staff assisted the resident back to the wheelchair. He stated the transportation scheduler secured the wheelchair and applied the seatbelt to the resident. He also stated he called the facility physician while still at the scene of the incident, and the physician said observe her, and if anything worsens, send her out. The nurse further stated the resident kept complaining of a headache, so he sent her out to the hospital to be evaluated. The van driver for the incident on 03/01/2017 was unavailable for interview. The driver had been terminated by the facility and no phone numbers were available. The facility's plan of correction for the incident on 03/01/17 was reviewed for the Resident #39 and included immediate assessment by the facility nurse, notification of the facility physician and evaluation at the hospital emergency department. The facility van was immediately taken out of service, and the van driver was suspended immediately, and a 24 hour report was done. Corrective action for potentially affected residents	F 323	when transports are started back on 05/22/2017. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheel chair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. This review will be documented on the QA Checklist for Transportation Van. The administrator will be responsible for ensuring safe transportation of residents. On 05/24/2017 the Corporate Van Educator checked off the senior transportation aide utilizing the skills checklist and Q' Straint manufacturer guidelines. Facility transports resumed on 05/25/2017. The transportation aide was observed by the Maintenance Director on 05/31/2017 and the Administrator on 06/05/2017 to ensure the residents and the wheel chair were secured according to manufacturer guidelines. On audit by the Clinical Nurse Consultant on 06/08/2017 it was discovered that the senior transportation aide was not observed daily from 05/25/2017 to 06/08/2017. The senior transportation aide was completing daily the TSP-101 DAILY VAN CHECKLIST (which states that all residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every	

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F 323	Continued From page 10 included immediate inspection of the facility van to make sure it was safe to use. While this was being done arrangements were made for resident transports by a commercial transport company. Systemic changes included the administrator would ensure any newly hired transportation staff would be trained by the corporate educator prior to him/her transporting any residents in the facility van. The administrator was to also ensure any other facility staff that may transport residents in the van would be trained and skills checklist completed by the corporate transport educator prior to him/her transporting any residents. During an interview with Resident #39 on 05/19/2017 at 11:15 AM, she reported a second van incident. She stated "On 04/12/2017, the new transport person was transporting 3 of us to dialysis. The other 2 people sat in seats on the van, and she put their wheelchairs behind the passenger seat. She was supposed to take this rope thing and put around them to keep them from moving, but she didn't do it that day. When we pulled out on the main road, one of the chairs flipped back and landed against my stump on my right leg, and I yelled for her to let her know the chair was on my leg, and it was hurting. She didn't stop and check on me or take it off my leg until we got to the dialysis center. A different driver picked me up later that day after dialysis. I told her the chair fell on my leg, and she said no one reported this to her. So when we got back to the building, she took me to the administrator, and I reported to the administrator what happened in the van. The nurse at the facility asked me about what happened and checked me over. I told her I was okay and not hurt." Staff NA#1 was interviewed on 05/19/2017 at	F 323	resident being transported. If there is an issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safety issue.) This check list was reviewed and signed by the administrator daily from 05/25/2017 to 06/08/2017. In response to this lapse in quality assurance monitoring, the daily monitoring period has been extended for 2 additional weeks beginning on 06/09/2017 and then will decrease to weekly monitoring times 2 weeks then monthly times 2 months. On 06/08/2017, the Administrator, Maintenance Director, and Transportation Aide were educated on the requirements for quality assurance monitoring for F 323 and 490 as stated above by the Clinical Nurse Consultant. In addition to this, alert and oriented residents will be interviewed by the administrator or designee using the QA tool Resident Interview asking if their wheel chairs were secured and seat belts applied according to Q'Straint manufacturer instructions. This will be completed weekly times 2 weeks then monthly times 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. If errors are identified the employee will be suspended pending an	

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11:45 AM and stated she was the transport scheduler and also a designated driver for transports. She stated was the driver who picked the resident up after dialysis on 04/12/2017. She stated when she arrived to pick up the resident, the resident asked if she heard about the incident in the van earlier that day the wheelchair landed on her right leg stump. She stated she had no knowledge of the incident until the resident told her. She further stated the resident described what happened in the van, and as soon as they arrived at the facility, she took the resident to the administrator's office, so she could report what happened. She also stated they used a strap to secure any lose items in the van. She stated "Those wheelchairs should have been secured before the driver left the facility. All the drivers had training and learned how to secure a wheelchair, a resident and any lose items in the van."

The van driver for the incident on 4/12/2017 was unavailable for interview. The driver had been terminated by the facility and no phone numbers were available.

The facility physician was interviewed on 05/19/2017 at 3:00 PM and stated he was immediately notified of both van incidents when they occurred. He stated when he was advised of the fall in the van on 03/01/2017, he ordered the resident to be evaluated in the hospital emergency department. He also stated the resident had no injuries from that incident, and he followed up with her in the facility and ordered an as needed muscle relaxer for the resident's complaint of neck pain. He also stated in his opinion, the resident had suffered no residual effects from the incident. He stated as far as the

investigation of the allegations.

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second incident on 04/12/2017 with the wheelchair on the resident's knee, there were no injuries sustained and no cause for a hospital visit.

The administrator was interviewed on 05/19/2017 at 3:10 PM and stated the first van incident on 03/01/2017 was investigated immediately. She stated the van driver was interviewed and revealed she was in a hurry and did not secure the wheelchair as she should have. The administrator stated the driver gave a demonstration of her knowledge by loading a wheelchair onto the van, and she performed it correctly. The administrator stated, as a result of the investigation, the driver was terminated from employment. The 24 hour and 5 day reports were reviewed. The administrator stated she began a plan of correction immediately after the 03/01/2017 incident.

During a continued interview on 05/19/2017 at 3:10 PM, the Administrator stated as soon as she learned of the 04/12/2017 van incident, she got a statement from the driver. She also stated the driver in the second incident was terminated following the investigation. She stated the driver admitted she left the 2 chairs a little slack, and the driver also stated she wasn't very far from the dialysis center when it happened, so she waited until she got there to check on the resident. The administrator further stated the driver stated she did not report the incident to anyone at the facility because the resident was not hurt.

The facility's corrective plan was reviewed for the van incident on 04/12/2017 and included immediate assessment of the resident by medical staff. The facility physician was notified. There

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were no injuries sustained. For potentially affected residents, the corporate educator came to the facility on 04/16/2017 to review the incident with the administrator, Director of Nursing (DON), staff and residents. On 05/01/2017 prior to the van being placed back in use, the van transporter was observed by the Administrator to demonstrate correct securing of wheel chairs for transport. Systemic changes included current and any newly hired transportation staff will demonstrate correct securing of wheelchairs prior to him/her providing transport of residents using the facility van. The 24 hour and 5 day reports were reviewed.

At the time of the survey, there was no van currently in use by the facility, and a private transportation company was being used to transport residents.

In an interview on 05/20/2017 at 1:45 PM with the Corporate Transportation Educator, he stated both drivers in both incidents received training on how to secure a wheelchair in a van and how to secure a resident or any loose items prior to both incidents. He also stated he came to the facility immediately after both incidents and did training. He also stated neither incident should have happened, because both drivers knew what to do but chose not to follow instructions.

On 05/19/17 at 5:45 PM, the facility was notified of IJ. The facility provided the following credible allegation of compliance on 05/20/17 at 1:50 PM:

Credible Allegation for 323

Corrective Action for Affected Residents

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The facility immediately began investigating the incident involving Resident #39 occurring on 03/01/2017 in which resident was being transported back to the facility after receiving her dialysis treatment. In route to the facility Resident #39 wheelchair fell backwards causing her to fall on the floor hitting her head. The resident was assessed by the facility LPN and sent to the emergency room for evaluation. On 03/01/2017, the facility van was taken out of operation through 03/06/2017. A 24 hour report was completed on 03/02/2017 and a 5 day report was completed on 03/09/2017. Outside transportation company was used to provide scheduled necessary transports for the facility. The involved employee #1 was suspended on 03/01/2017 and subsequently terminated on 03/09/2017. On 03/02/2017, the corporate van trainer investigated the incident and determined the root cause of this event was the transportation aide failed to secure the front floor retractors to the resident's wheelchair according to manufacturer guidelines. Resident #39 states that "the lap and shoulder belt was also not hooked during the transport". Employee #1 stated "I hooked the front and back retractors". When employee #1 was informed that the resident stated she did not hook the front retractors employee #1 stated "I thought I did but if the resident stated I didn't then I guess I didn't". The root cause of the incident is employee #1 did not follow manufacturer guidelines and facility policy in securing the resident and wheelchair prior to completing the transport.

On 04/12/2017 during transport of Resident #39 to dialysis, one of two unoccupied wheelchairs shifted during a turn and was leaning on the right side of Resident #39's footrest and knee. Upon

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return to the facility, Resident #39 was assessed for injury by the facility LPN. No injuries were noted. On 04/12/2017, the facility van was taken out of operation through 05/01/2017. Outside transportation company was used to schedule necessary transports for the facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/2017. A 24 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2017, the corporate van trainer investigated the incident and determined the root cause of this event was that the transportation aide did not secure the wheelchairs tight enough to prevent them from moving. The facility van remained out of use through 05/01/2017 due to vacation of the senior transportation aide. It was then determined on 05/01/2017 to no longer transport empty wheelchairs on the facility van.

A root cause analysis investigation was completed for both incidents by corporate van educator and the facility administrator. The root cause for both incidents was determined to be transporter failed to follow facility policy and procedures and manufacturer guidelines.

Corrective Action for Potentially Affected Residents

On 03/01/2017, the facility van was taken out of operation through 03/06/2017. On 03/06/2017, the maintenance director completed the Vehicle Inspection: Safety Inspection check list for the one facility owned van. No concerns were identified.

On 03/14/2017, a van products company completed an inspection and service on the one

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facility owned van. No concerns were identified.

On 03/07/2017 the administrator began interviewing all alert and oriented residents that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and manufacturer guidelines. This audit was conducted daily for 2 weeks. No concerns were identified.

Employee #1 was terminated on 03/09/2017 and #2 was terminated on 04/18/2017. Current residents that were transported on the facility owned van from 04/13/2017 to 05/19/2017 have the potential to be affected by this alleged practice. An audit was completed on 05/20/2017 by the Senior Transportation Aide to determine which residents were transported by the facility van from 04/13/2017 to 05/19/2017. 13 Current residents were identified. On 05/20/2017, the Director of Nursing interviewed the identified 10 alert and oriented residents that were transported 04/13/2017 to 05/19/2017 for any safety concerns during transports and to validate that the following technique was used to secure their wheelchair during transportations: all 4 floor retractors are hooked to the wheelchair, the seat belt is attached across the residents lap and secured to floor restraints, and the shoulder strap is positioned across the shoulder and secured to the lap belt. All 10 alert and oriented residents stated the above procedures have been followed for their transports occurring from 04/13/2017 to 05/19/2017 and they did not have any safety concerns.

Systematic Changes

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F 323	Continued From page 17 On 03/06/2017, 8 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The current administrator and maintenance director were included in the 8 staff trained. The corporate van trainer has received training directly from Q' Straint National Training Seminar products in September 2016. The corporate van trainer utilizes the training he received, Q' Straint manufacturer guidelines, and a skills checklist to educate van transporters. A skills validation is also completed where the staff member must demonstrate the skills appropriately. On 03/30/2017, a new transportation aide was placed in the position as facility transportation aide. Training was completed by the corporate van trainer on 03/30/2017 prior to the transportation aide completing any van transports. As of 04/13/2017, unoccupied wheelchairs have not been transported in the facility van. A quality review will also be implemented when transports are started back on 05/22/2017. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. The administrator will be responsible for ensuring safe transportation of residents. In addition to this, alert and oriented residents will be interviewed asking if their wheelchairs were secured and seat belts applied according to manufacturer instructions. If errors are identified the employee	F 323		

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F 323	Continued From page 18 will be suspended pending an investigation of the allegations. The validation of the credible allegation was completed on 05/20/17 at 2:00 PM by: 1. Review of the medical record and interview with Resident #39 verified she was assessed by medical staff following each van incident and sent out to a hospital for evaluation for the first incident. 2. Reviewed audit tool of interviews with alert and oriented residents begun on 03/07/2017 that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and manufacturer guidelines. This audit was conducted daily for 2 weeks. No concerns were identified. 3. An interview was conducted with the facility administrator on 05/20/2017 related to specific components of the credible allegation related to trainings, monitoring tools and responsibility of the facility to provide safe transportation of residents. 4. An interview was conducted with the sole transportation (NA #1) on 05/20/2017 at 2:00 PM related to trainings completed since incidents occurred.	F 323		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and	F 490		6/15/17

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F 490	Continued From page 19 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility failed to follow manufacturer's instructions to safely secure a resident's wheelchair during transport of 1 of 1 resident from the dialysis center to the facility on 03/01/2017 (Resident #39). As a result, Resident #39 was ejected onto the floor of the van causing the resident to hit her head. The facility also failed to secure 2 unoccupied wheel chairs in the van on the way to a dialysis appointment on 04/12/2017 which caused one of the unoccupied wheelchairs to be thrown onto the leg of 1 of 3 residents during the transport (Resident #39). Immediate Jeopardy began on 03/01/2017 when the wheelchair of Resident #39 fell backwards in the transportation van and ejected the resident onto the floor. The resident was sent out for evaluation and sustained no injury. The immediate jeopardy was removed on 05/20/2017 at 1:50 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for transportation to appointments and other activities. Findings included: Cross referenced at F323: Based on record reviews and resident and staff interviews, the	F 490	F 490 Corrective Action for Affected Residents The facility immediately began investigating the incident involving resident #39 occurring on 03/01/2017 in which resident was being transported back to the facility after receiving her dialysis treatment. In route to the facility resident #39 wheelchair fell backwards causing her to fall on the floor hitting her head. The resident was assessed by the facility LPN and sent to the emergency room for evaluation. On 03/01/2017, the facility van was taken out of operation through 03/06/2017. A 24 hour report was completed on 03/02/2017 and a 5 day report was completed on 03/09/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #1 was suspended on 03/01/2017 and subsequently terminated on 03/09/2017. On 03/02/2017, the corporate van trainer investigated the incident and determined root cause of this event was the transportation aide failed to secure the front retractors on the resident's wheelchair. On 04/12/2017 during transport of resident #39 to dialysis, one of two unoccupied wheelchairs shifted during a turn and was leaning on the right side of	

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F 490	Continued From page 20 facility failed to follow manufacturer's instructions to safely secure a resident's wheelchair during transport of 1 of 1 resident from the dialysis center to the facility on 03/01/2017 (Resident #39). As a result, Resident #39 was ejected onto the floor of the van causing the resident to hit her head. The facility also failed to secure 2 unoccupied wheel chairs in the van on the way to a dialysis appointment on 04/12/2017 which caused one of the unoccupied wheelchairs to be thrown onto the leg of 1 of 3 residents during the transport (Resident #39). The administrator was interviewed on 05/19/2017 at 3:10 PM and stated the first van incident on 03/01/2017 was investigated immediately. She stated the van driver was interviewed and revealed she was in a hurry and did not secure the wheelchair as she should have. The administrator stated the driver gave a demonstration of her knowledge by loading a wheelchair onto the van, and she performed it correctly. The administrator stated, as a result of the investigation, the driver was terminated from employment. The administrator stated she began a plan of correction immediately after the 03/01/2017 incident. The Administrator also stated as soon as she learned of the 04/12/2017 van incident, she got a statement from the driver. She also stated the driver in the second incident was terminated following the investigation. She stated the driver admitted she left the 2 chairs a little slack, and the driver also stated she wasn't very far from the dialysis center when it happened, so she waited until she got there to check on the resident. She further stated the driver stated she did not report the incident to anyone at the facility because the resident was not hurt. The Administrator stated a plan of	F 490	resident #39 footrest and knee. Upon return to the facility, resident #39 was assessed for injury by the facility LPN and no injury was noted. On 04/12/2017, the facility van was taking out of operation through 05/01/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/2017. A 24 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2017, the corporate van trainer investigated the incident and determined the root cause of this event was that the transportation aide did not secure the wheelchairs tight enough to prevent them from moving. The facility van remained out of use through 05/01/2017 due to vacation of the senior transportation aide. It was then determined on 05/01/2017 to no longer transport unoccupied wheelchairs on the facility van. Corrective Action for Potentially Affected Residents On 03/01/2017, the facility van was taken out of operation through 03/06/2017. On 03/06/2017, the maintenance Director completed the Vehicle Inspection: Safety Inspection check list for the one facility owned van. No concerns were identified. On 03/14/2017, Van Products of Raleigh completed an inspection and service on the one facility owned van. No concerns were identified. On 05/20/2017 the Clinical RN consultant met with the administrator to determine	

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WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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F 490	Continued From page 21 correction was implemented after the second van incident. The administrator was notified of the immediate jeopardy on 05/19/17 at 5:45 PM. The administrator provided the following credible allegation of compliance was provided on 05/20/2017 at 1:50 PM. Corrective Action for Affected Residents The facility immediately began investigating the incident involving resident #39 occurring on 03/01/2017 in which resident was being transported back to the facility after receiving her dialysis treatment. In route to the facility resident #39 wheelchair fell backwards causing her to fall on the floor hitting her head. The resident was assessed by the facility LPN and sent to the emergency room for evaluation. On 03/01/2017, the facility van was taken out of operation through 03/06/2017. A 24 hour report was completed on 03/02/2017 and a 5 day report was completed on 03/09/2017. Outside transportation company was used to necessary transports for the facility. The involved employee #1 was suspended on 03/01/2017 and subsequently terminated on 03/09/2017. On 03/02/2017, the corporate van trainer investigated the incident and determined root cause of this event was the transportation aide failed to secure the front retractors on the resident's wheelchair. On 04/12/2017 during transport of resident #39 to dialysis, one of two unoccupied wheelchairs shifted during a turn and was leaning on the right side of Resident #39 footrest and knee. Upon return to the facility, resident #39 was assessed for injury by the facility LPN and no injury was noted. On 04/12/2017, the facility van was taking	F 490	who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. All van drivers must hold a valid North Carolina drivers license, have had a drivers license DMV check, and have had documented training on van usage prior to transportation of residents. In addition to this, the administrator was educated on ensuring that staff designated to transport residents on the facility van understand the importance and expectation of the administrator for following Q' Straint manufacturer guidelines when transporting residents. There will be no tolerance of transportation staff not following the manufacturer guidelines or having an attitude of non-compliance. 1 Employee was designated as facility van drivers meeting the above criteria. On 05/20/2017 the Clinical RN Consultant reviewed the skills check list for the designated van driver to ensure that the skills check list were completed by the corporate van trainer on 03/06/2017 or sooner. On 05/19/2017, the one facility owned van was removed from operation and Outside transportation company was used to scheduled necessary transports for the facility. Systemic Changes	

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F 490	Continued From page 22 out of operation through 05/01/2017. Outside transportation company was used to necessary transports for the facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/2017. A 24 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2017, the corporate van trainer investigated the incident and determined the root cause of this event was that the transportation aide did not secure the wheelchairs tight enough to prevent them from moving. The facility van remained out of use through 05/01/2017 due to vacation of the senior transportation aide. It was then determined on 05/01/2017 to no longer transport unoccupied wheelchairs on the facility van. Corrective Action for Potentially Affected Residents On 03/01/2017, the facility van was taken out of operation through 03/06/2017. On 03/06/2017, the maintenance Director completed the Vehicle Inspection: Safety Inspection check list for the one facility owned van. No concerns were identified. On 03/14/2017, a van product company completed an inspection and service on the one facility owned van. No concerns were identified. On 05/20/2017 the Clinical RN consultant met with the administrator to determine who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. All van driver's must hold a valid North Carolina driver's license, have had a driver's license DMV check, and have had documented training on van usage	F 490	On 05/20/2017, the Clinical RN Nurse Consultant educated all current FT, PT and PRN employees who operate the one facility owned van were educated on the following Resident Transportation Policy and Procedure. Transportation Policy: 1. Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. 2. PRIOR to operating a facility transportation vehicle, the TSP-101 DAILY VAN CHECKLIST will be completed. All residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every resident being transported. If there is an issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safety issue. 3. The van will also be inspected by the maintenance director or designee on a weekly basis. Results of the inspection will be documented on form TSP-102 WEEKLY CHECKLIST. 4. All van drivers must hold a valid North Carolina drivers license, have had a drivers license DMV check, and have had documented training on van usage prior to transportation of residents. 5. In the event of an emergency, call 911. Provide basic first aid. Implement CPR if	

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F 490	Continued From page 23	F 490		

prior to transportation of residents. In addition to this, the administrator was educated on ensuring that staff designated to transport residents on the facility van understand the importance and expectation of the administrator for following manufacturer guidelines when transporting residents. There will be no tolerance of transportation staff not following the manufacturer guidelines or having an attitude of non-compliance.
1 Employee was designated as facility van drivers meeting the above criteria. On 05/20/2017 the Clinical RN Consultant reviewed the skills check list for the designated van driver to ensure that the skills check list were completed by the corporate van trainer on 03/06/2017 or sooner.
On 05/19/2017, the one facility owned van was removed from operation and, and an outside transportation company was used to necessary transports for the facility.
Systematic Changes
On 05/20/2017, the Clinical RN Nurse Consultant educated all current FT, PT and PRN employees who operate the one facility owned van on the following Resident Transportation Policy and Procedure.
Transportation Policy:
1. Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training.
2. PRIOR to operating a facility transportation vehicle, the TSP-101 DAILY VAN CHECKLIST will be completed. All residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every resident being

it in indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened.
6. All wheelchairs used for transportation of residents must be approved for transport use. If a personally-owned wheelchair (not a wheelchair provided or arranged by the facility) is to be used for transportation, it must be approved by Liberty Risk Management to determine if it is safe for transport use.
7. Power wheelchairs must be fitted with transportation appropriate straps for correct tie down procedures in order to be ready for use in the transportation van. If they do not have manufacturer installed safety strap attachment points or cannot be fitted with attachment devices from the manufacturer, they cannot be considered safe for transport.
8. All transportation Aids must have completed annual transportation safety training.
9. Training must include the safe procedures for loading and unloading of residents, the safe and proper use of the approved safety restraint system provided by the manufacturer of the transportation van and emergency measures to remove residents from the safety restraint system.
10. Immediately notify the Administrator when an incident occurs during a van transport regardless of how minor the incident is. This includes resident and non-resident incidents. Incidents include but are not limited to: fall from wheelchair, equipment malfunction, refusal of resident to utilize safety belts, and injury of any nature. Administrator

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F 490	Continued From page 24 transported. If there is an issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safety issue. 3. The van will also be inspected by the maintenance director or designee on a weekly basis. Results of the inspection will be documented on form TSP-102 WEEKLY CHECKLIST. 4. All van drivers must hold a valid North Carolina driver's license, have had a driver's license DMV check, and have had documented training on van usage prior to transportation of residents. 5. In the event of an emergency, call 911. Provide basic first aid. Implement CPR if it in indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened. 6. All wheelchairs used for transportation of residents must be approved for transport use. If a personally-owned wheelchair (not a wheelchair provided or arranged by the facility) is to be used for transportation, it must be approved by Liberty Risk Management to determine if it is safe for transport use. 7. Power wheelchairs must be fitted with transportation appropriate straps for correct tie down procedures in order to be ready for use in the transportation van. If they do not have manufacturer installed safety strap attachment points or cannot be fitted with attachment devices from the manufacturer, they cannot be considered safe for transport. 8. All transportation staff must have completed annual transportation safety training. 9. Training must include the safe procedures for loading and unloading of residents, the safe and proper use of the approved safety restraint	F 490	phone number 704-340-8669. The following amendment to the policy is to insure safety of residents during loading and application of the safety restraint system; Item #1: All wheelchairs used in transportation must have foot rests in place (attached to the chair) during loading, transport and unloading of residents. It has been determined that the resident's feet must be on the wheelchair foot rests to prevent feet and toes being caught or pinched in the lift bridge plate during lift operations, resulting in injury. Foot rests can help to keep feet in a position that will not allow toes to slide under the bridge plate. If the chair being used for transportation does not have foot rests attached at the time of transport, appropriate foot rests are to be located and attached to the chair properly or another chair with foot rests is to be used. It is recommended the transportation aids set aside a wheelchair for transportation use ahead of time to void the necessity of locating and fitting another wheelchair. Item #2: All wheelchairs used in transportation must be of the types that have removable arm rest. Access to the unrestricted back of the wheelchair seat is required to secure the lap safety belt in place over the resident's lap. Placing the lap belt through the underside of the arm rest does not allow the belt to restrain the resident at the hip. The safety lap belt must cross over the lap from hip to hip to keep the resident from slipping out of the	

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F 490	Continued From page 25 system provided by the manufacturer of the transportation van and emergency measures to remove residents from the safety restraint system. 10. Immediately notify the Administrator when an incident occurs during a van transport regardless of how minor the incident is. This includes resident and non-resident incidents. Incidents include but are not limited to: fall from wheelchair, equipment malfunction, refusal of resident to utilize safety belts, and injury of any nature. Administrator phone number 704-340-8669. The following amendment to the policy is to insure safety of residents during loading and application of the safety restraint system; Item #1: All wheelchairs used in transportation must have foot rests in place (attached to the chair) during loading, transport and unloading of residents. It has been determined that the resident's feet must be on the wheelchair foot rests to prevent feet and toes being caught or pinched in the lift bridge plate during lift operations, resulting in injury. Foot rests can help to keep feet in a position that will not allow toes to slide under the bridge plate. If the chair being used for transportation does not have foot rests attached at the time of transport, appropriate foot rests are to be located and attached to the chair properly or another chair with foot rests is to be used. It is recommended the transportation aids set aside a wheelchair for transportation use ahead of time to void the necessity of locating and fitting another wheelchair. Item #2:	F 490	seat. Item #3: Wheelchair Floor restraints are never to be attached to the cross (X) bars of the wheelchair. The cross bars are not part of the frame of the chair and will collapse if the chair is forced on its side as in a hard turn. All floor straps are to be attached to the frame at or above the point where welded joints connect the frame. This is typically found where the wheels or wheel casters are attached. Item #4 Geriatric Chairs can never be used for transport. Gerri Chairs have no way to lock the reclining feature of the chair and may fall into a reclining position during transport. IN the event of a chair reclining during transport the safety harness system will not protect the resident and may result in a serious or fatal event. Item #5 Power Wheelchairs must be approved for transportation before they can be used for transport of a resident. If they are not considered safe for transport, the facility must provide a facility approved chair for the resident transportation needs. Item #6 Unoccupied wheelchairs will no longer be transported on the facility van. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees who operate the facility van and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The administrator and maintenance director attended the van training on	

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F 490	Continued From page 26 All wheelchairs used in transportation must be of the types that have removable arm rest. Access to the unrestricted back of the wheelchair seat is required to secure the lap safety belt in place over the resident's lap. Placing the lap belt through the underside of the arm rest does not allow the belt to restrain the resident at the hip. The safety lap belt must cross over the lap from hip to hip to keep the resident from slipping out of the seat. Item #3: Wheelchair Floor restraints are never to be attached to the cross (X) bars of the wheelchair. The cross bars are not part of the frame of the chair and will collapse if the chair is forced on its side as in a hard turn. All floor straps are to be attached to the frame at or above the point where welded joints connect the frame. This is typically found where the wheels or wheel casters are attached. Item #4 Geriatric Chairs can never be used for transport. Gerri Chairs have no way to lock the reclining feature of the chair and may fall into a reclining position during transport. IN the event of a chair reclining during transport the safety harness system will not protect the resident and may result in a serious or fatal event. Item #5 Power Wheelchairs must be approved for transportation before they can be used for transport of a resident. If they are not considered safe for transport, the facility must provide a facility approved chair for the resident transportation needs. Item #6 Unoccupied wheelchairs will no longer be transported on the facility van.	F 490	03/06/2017 provided by the corporate van trainer to ensure proper knowledge of the safety harness system in order to verify that it is completed correctly. As of 04/13/2017, unoccupied wheelchairs have not been transported in the facility van. The van will not be used to transport unoccupied wheelchairs. Quality Assurance A quality review will also be implemented when transports are started back on 05/22/2017. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheel chair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. This review will be documented on the QA Checklist for Transportation Van. The administrator will be responsible for ensuring safe transportation of residents. On 05/24/2017 the Corporate Van Educator checked off the senior transportation aide utilizing the skills checklist and Q' Straint manufacturer guidelines. Facility transports resumed on 05/25/2017. The transportation aide was observed by the Maintenance Director on 05/31/2017 and the Administrator on 06/05/2017 to ensure the residents and the wheel chair were secured according to manufacturer guidelines. On audit by the	

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F 490	Continued From page 27 This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees who operate the facility van and will be reviewed by the Quality Assurance process to verify that the change has been sustained. A quality review will also be implemented when transports are started back on 05/22/2017. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. The administrator will be responsible for ensuring safe transportation of residents. In addition to this, alert and oriented residents will be interviewed asking if the transporter secured both front and back safety harnesses as well as the wheelchair to the van floor. If errors are identified the employee will be suspended pending an investigation of the allegations. The administrator and maintenance director attended the van training on 03/06/2017 provided by the corporate van trainer to ensure proper knowledge of the safety harness system in order to verify that it is completed correctly. As of 04/13/2017, unoccupied wheelchairs have not been transported in the facility van. The van will not be used to transport unoccupied wheelchairs. The validation of the credible allegation was completed on 05/20/17 at 2:00 PM by:	F 490	Clinical Nurse Consultant on 06/08/2017 it was discovered that the senior transportation aide was not observed daily from 05/25/2017 to 06/08/2017. The senior transportation aide was completing daily the TSP-101 DAILY VAN CHECKLIST (which states that all residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every resident being transported. If there is an issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safety issue.) This check list was reviewed and signed by the administrator daily from 05/25/2017 to 06/08/2017. In response to this lapse in quality assurance monitoring, the daily monitoring period has been extended for 2 additional weeks beginning on 06/09/2017 and then will decrease to weekly monitoring times 2 weeks then monthly times 2 months. In addition to this, alert and oriented residents will be interviewed by the administrator or designee using the QA tool Resident Interview asking if their wheel chairs were secured and seat belts applied according to Q'Straint manufacturer instructions. This will be completed weekly times 2 weeks then monthly times 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and	

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F 490	Continued From page 28 1. Review of the medical record and interview with Resident #39 verified she was assessed by medical staff following each van incident and sent out to a hospital for evaluation for the first incident. 2. Reviewed audit tool of interviews with alert and oriented residents begun on 03/07/2017 that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and manufacturer guidelines. This audit was conducted daily for 2 weeks. No concerns were identified. 3. An interview was conducted with the facility administrator on 05/20/2017 related to specific components of the credible allegation related to trainings, monitoring tools and responsibility of the facility to provide safe transportation of residents. 4. An interview was conducted with the sole transportation (NA #1) on 05/20/2017 at 2:00 PM related to trainings completed since incidents occurred.	F 490	ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. If errors are identified the employee will be suspended pending an investigation of the allegations.	
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		6/15/17

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F 520	Continued From page 29 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions put into place as a result of citations during 3 federal surveys. The	F 520	F 520 Corrective Action for Affected Residents The facility administrator, Director of Nursing, and corporate van educator	

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WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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F 520	Continued From page 30 facility was cited for accidents (F 323) on 6/30/16 during the recertification survey, on a complaint survey of 11/16/16, and on the current recertification survey. The facility was cited in the area of administration (F 490) on a complaint survey of 01/20/17 and again on the current recertification survey. The continued failure of the facility during three surveys within a year show a pattern of the facility's inability to sustain an effective Quality Assurance program. Immediate Jeopardy began on 03/01/2017 when the facility's Quality Assurance and Performance Improvement Committee failed complete a root cause analysis after the wheelchair of Resident #39 fell backwards in the transportation van and ejected the resident onto the floor. The resident was sent out for evaluation and sustained no injury. The immediate jeopardy was removed on 05/20/2017 at 1:50 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for resident's transportation to appointments and other activities. The administrator was notified of the immediate jeopardy on 05/19/17 at 5:45 PM. The administrator provided an acceptable credible allegation of compliance was provided on 05/20/2017 at 1:50 PM. Findings included: a) Cross referenced at F323: Based on record	F 520	immediately began investigating the incident involving resident #39 occurring on 03/01/2017 in which the resident was being transported back to the facility after receiving her dialysis treatment. In route to the facility resident #39 wheelchair fell backwards causing her to fall on the floor hitting her head. The resident was assessed by the facility LPN and sent to the emergency room for evaluation. On 03/01/2017, the facility van was taken out of operation through 03/06/2017. A 24 hour report was completed on 03/02/2017 and a 5 day report was completed on 03/09/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #1 was suspended on 03/01/2017 and subsequently terminated on 03/09/2017. On 03/02/2017, the corporate van trainer investigated the incident and determined root cause of this event was the transportation aide failed to secure the front retractors on the resident's wheelchair. The QA committee reviewed the findings of this investigation on 03/06/2017. On 04/12/2017 during transport of resident #39 to dialysis, one of two unoccupied wheelchairs shifted during a turn and was leaning on the right side of resident #39 footrest and knee. Upon return to the facility, resident #39 was assessed for injury by the facility LPN and no injury was noted. On 04/12/2017, the facility van was taking out of operation through 05/01/2017. Outside transportation company was used to scheduled necessary transports for the	

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F 520	Continued From page 31 reviews and resident and staff interviews, the facility failed to follow manufacturer's instructions to safely secure a resident's wheelchair during transport of 1 of 1 resident from the dialysis center to the facility on 03/01/2017 (Resident #39). As a result, Resident #39 was ejected onto the floor of the van causing the resident to hit her head. The facility also failed to secure 2 unoccupied wheel chairs in the van on the way to a dialysis appointment on 04/12/2017 which caused one of the unoccupied wheelchairs to be thrown onto the leg of 1 of 3 residents during the transport (Resident #39). b) Cross referenced at F490: Based on record reviews and resident and staff interviews, the facility administration failed to follow manufacturer's instructions to safely secure a resident's wheelchair during transport of 1 of 1 resident from the dialysis center to the facility on 03/01/2017 (Resident #39). As a result, Resident #39 was ejected onto the floor of the van causing the resident to hit her head. The facility also failed to secure 2 unoccupied wheel chairs in the van on the way to a dialysis appointment on 04/12/2017 which caused one of the unoccupied wheelchairs to be thrown onto the leg of 1 of 3 residents during the transport (Resident #39). The administrator was notified of the immediate jeopardy on 05/19/17 at 5:45 PM. During the QA interview on 5/20/2017 at 11:30 AM, the Administrator stated she investigated immediately the incident of the van accident when it was reported to her and the two employees who were involved in separate van incidents were terminated. She also added the current designated van driver had been trained on how to	F 520	facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/2017. A 24 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2017, the corporate van trainer investigated the incident and determined the root cause of this event was that the transportation aide did not secure the wheelchairs tight enough to prevent them from moving. The facility van remained out of use through 05/01/2017 due to vacation of the senior transportation aide. It was then determined on 05/01/2017 to no longer transport empty wheelchairs on the facility van. The QA committee reviewed the findings of this investigation on 04/17/2017. Corrective Action for Potentially Affected Residents On 05/20/2017 the Clinical RN consultant met with the administrator to determine who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. All van drivers must hold a valid North Carolina drivers license, have had a drivers license DMV check, and have had documented training on van usage prior to transportation of residents.	

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F 520	Continued From page 32 daily complete van checklist prior to transporting any residents. The administrator provided the following credible allegation of compliance on 05/20/2017 at 1:50 PM. Credible Allegation for 520 Corrective Action for Affected Residents The facility administrator, Director of Nursing, and corporate van educator immediately began investigating the incident involving Resident #39 which occurred on 03/01/2017 when the resident was being transported back to the facility after receiving her dialysis treatment. In route to the facility resident #39 wheelchair fell backwards causing her to fall on the floor hitting her head. The resident was assessed by the facility Licensed practical Nurse (LPN) and sent to the emergency room for evaluation. On 03/01/2017, the facility van was taken out of operation through 03/06/2017. A 24 hour report was completed on 03/02/2017 and a 5 day report was completed on 03/09/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #1 was suspended on 03/01/2017 and subsequently terminated on 03/09/2017. On 03/02/2017, the corporate van trainer investigated the incident and determined root cause of this event was the transportation aide failed to secure the front retractors on the resident's wheelchair. The QA committee reviewed the findings of this investigation on 03/06/2017. On 04/12/2017 during transport of Resident #39 to dialysis, one of two unoccupied wheelchairs shifted during a turn and was leaning on the right side of Resident #39's footrest and knee. Upon return to the facility, Resident #39 was assessed	F 520	1 Employee was designated as facility van driver meeting the above criteria. On 05/20/2017 the Clinical RN Consultant reviewed the skills check list for the designated van driver to ensure that the skills check list were completed by the corporate van trainer on 03/06/2017 or sooner. Systemic changes On 04/13/2017 the facility made the senior transportation aide the primary employee for transporting the facility residents to their appointments. This aide has been completing facility transports for 6 years without incident. Effective 05/20/2017 the facility transportation aides will complete TSP-101 daily prior to transporting any residents in the facility owned van. On 05/20/2017, the Clinical RN Consultant trained the 1 designated facility van driver on how to complete TSP-101 Daily Van Checklist. Training consisted of going through each item individually and emphasizing the importance for reviewing the check list to ensure a safe transport. Daily when TSP-101 is completed, the transportation aide is to turn the check list into the administrator for signature and review. On 05/20/2017, the Regional Director of Operations educated the administrator on the above Resident Transportation Policy and Procedure. In addition to this, education was provided on the importance of maintaining implemented procedures and monitoring interventions	

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F 520	Continued From page 33 for injury by the facility LPN and no injury was noted. On 04/12/2017, the facility van was taken out of operation through 05/01/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/2017. A 24 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2017, the corporate van trainer investigated the incident and determined the root cause of this event was that the transportation aide did not secure the wheelchairs tight enough to prevent them from moving. The facility van remained out of use through 05/01/2017 due to vacation of the senior transportation aide. It was then determined on 05/01/2017 to no longer transport empty wheelchairs on the facility van. The QA committee reviewed the findings of this investigation on 04/17/2017. Corrective Action for Potentially Affected Residents On 05/20/2017 the Clinical Registered Nurse (RN) consultant met with the administrator to determine who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. They must also have valid CPR training. All van drivers must hold a valid North Carolina driver's license, have had a driver's license DMV check, and have had documented training on van usage prior to transportation of residents. 1 employee was designated as facility van driver meeting the above criteria. On 05/20/2017 the Clinical RN Consultant reviewed the skills check	F 520	identified in the facilities plan of correction for survey that began on 05/14/2017 and ended on 05/20/2017. The administrator will be responsible for ensuring safe transportation of residents by ensuring the transportation aide completes the TSP-101 Daily Van Checklist daily prior to transporting any residents. This information has been integrated into the standard orientation training and in the required in-service refresher courses for administrators and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance A quality review will also be implemented when transports are started back on 05/22/2017. The review includes the Clinical RN Nurse Consultant will audit weekly times 4 weeks then monthly times 2 months using the QA tool QA review to ensure the TSP-101 Daily Van Checklist is completed daily by the transportation aide when facility transports are completed and that the administrator is reviewing and signing off on the completion of these safety audits daily. Investigations of all incidents involving transportation by the facility van will be completed by the Administrator, Director of Nursing, Clinical RN Consultant and corporate van educator as soon as the allegation or issue is identified. The investigation will include interviewing the resident involved, employee involved, other possible witnesses, and other potentially affected patients to determine the root cause of the	

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F 520	Continued From page 34 list for the designated van driver to ensure that the skills check list were completed by the corporate van trainer on 03/06/2017 or sooner. Systemic changes On 04/13/2017 the facility made the senior transportation aide the primary employee for transporting the facility residents to their appointments. This aide has been completing facility transports for 6 years without incident. Effective 05/20/2017 the facility transportation aides will complete TSP-101 daily prior to transporting any residents in the facility owned van. On 05/20/2017, the Clinical RN Consultant trained the 1 designated facility van driver on how to complete TSP-101 Daily Van Checklist. Training consisted of going through each item individually and emphasizing the importance for reviewing the check list to ensure a safe transport. Daily when TSP-101 is completed, the transportation aide is to turn the check list into the administrator for signature and review. On 05/20/2017, the Regional Director of Operations educated the administrator on the above Resident Transportation Policy and Procedure. In addition to this, education was provided on the importance of maintaining implemented procedures and monitoring interventions identified in the facilities plan of correction for survey that began on 05/14/2017 and ended on 05/20/2017. The administrator will be responsible for ensuring safe transportation of residents by ensuring the transportation aide completes the TSP-101 Daily Van Checklist daily prior to transporting any residents. This information has been integrated into the standard orientation training and in the required in-service refresher courses for administrators and will be reviewed by the Quality Assurance	F 520	event. The results of the investigation will be reviewed by the QA Team to ensure facility policy and manufacturer guidelines were followed and will make any recommendations for plan of corrections or interventions necessary to ensure the safety of the residents. The QA team is attended by the Administrator, Director of Nursing, Unit Manager, and other nurse managers, Social Service, Therapy Department Manager Medical Director and Dietary Manager. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. There were not any residents adversely affected by the lapse in the quality assurance process for F 323 and F 490. On 06/09/2017 the Clinical Nurse Consultant audited transportation records for residents that were transported using the facility van from 05/25/2017 when the van was put back in use to 06/08/2017. 12 residents were identified. 2 of the 12 residents have been discharged. The Clinical Nurse Consultant began interviewing 9 of the identified residents that were transported on the facility owned van. The facility Maintenance Director interviewed 1 resident. Residents were asked if they were secured by the shoulder and lap seatbelt and if the front	

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F 520	Continued From page 35 process to verify that the change has been sustained. A quality review will also be implemented when transports are started back on 05/22/2017. The review includes the Clinical RN Nurse Consultant will audit weekly that the TSP-101 Daily Van Checklist is completed daily by the transportation aide when facility transports are completed and that the administrator is reviewing and signing off on the completion of these safety audits daily. Investigations of all incidents involving transportation by the facility van will be completed by the Administrator, Director of Nursing, Clinical RN Consultant and corporate van educator as soon as the allegation or issue is identified. The investigation will include interviewing the resident involved, employee involved, other possible witnesses, and other potentially affected patients to determine the root cause of the event. The results of the investigation will be reviewed by the QA Team to ensure facility policy and manufacturer guidelines were followed and will make any recommendations for plan of corrections or interventions necessary to ensure the safety of the residents. The QA team is attended by the Administrator, Director of Nursing, Unit Manager, and other nurse managers, Social Service, Therapy Department Manager Medical Director and Dietary Manager. The validation of the credible allegation was completed on 05/20/17 at 2:00 PM by: 1. Review of the medical record and interview with Resident #39 verified she was assessed by medical staff following each van incident and sent out to a hospital for evaluation for the first incident. 2. Reviewed audit tool of interviews with alert and	F 520	and back floor retractors were secured to their wheel chair (if transported in a wheel chair) by the van driver prior to being transported on the van. Findings were: All 10 residents indicated an understanding of the shoulder and lap belt restraint process and the 4 floor retractors in the floor of the van needing to be hooked to their wheel chair prior to being transported. All 10 residents confirmed that they were secured correctly and felt safe traveling in the van. No concerns were offered. The Clinical Nurse Consultant audited facility incident reports from 05/01/2017 to present to identify if any van related incidents had occurred. No incidents were identified. On 06/08/2017, the Administrator, Maintenance Director, and Transportation Aide were educated on the requirements for quality assurance monitoring for F 323. The administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks beginning on 06/09/2017 to ensure residents and the chair are secured to the vehicle by visualizing that all 4 floor retractors are hooked to the wheelchair, that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. In addition to this, the Administrator will scan a copy of the completed monitor to the Clinical Nurse Consultant daily indicating that the quality assurance check has been completed. This process will continue from 06/09/2017 to 06/22/2017.	

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F 520	Continued From page 36 oriented residents begun on 03/07/2017 that were transported on the facility owned van to ensure they were secured by the shoulder and lap seatbelt and front and back floor retractors according to facility policy and manufacturer guidelines. This audit was conducted daily for 2 weeks. No concerns were identified. 3. An interview was conducted with the facility administrator on 05/20/2017 related to specific components of the credible allegation related to trainings, monitoring tools and responsibility of the facility to provide safe transportation of residents. 4. An interview was conducted with the sole transportation (NA #1) on 05/20/2017 at 2:00 PM related to trainings completed since incidents occurred.	F 520	Effective 06/09/2017 The Regional Director of Operations or Clinical Nurse Consultant will review any outstanding Quality Assurance plan of correction audits with new administrators on day 1 of hire to ensure there is no lapse in Quality Assurance efforts. The Clinical Nurse Consultant will complete Van Observations QA tool 001, daily times 2 weeks, weekly times 2 weeks then monthly times 2 months ensuring that the Administrator or Maintenance Director in their absence has observed daily the facility van transporter securing residents according to manufacturer guidelines. The Quality of Life committee consists of the Director of Nursing, Administrator, Assistant Director of Nursing, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Health Information Management and meets weekly.	