STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING ______ B. WING ______	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 08/15/17 through 08/17/17. Immediate Jeopardy was indentifed at: CFR 483.24, 483.25 at tag F309 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.70 at a scope and severity (J). The tags F309 and F323 constituted Sub Standard Quality of Care. Immediate Jeopardy began on 08/10/17 and was removed on 08/17/17. An extended survey was conducted.	F 000		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		9/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/08/2017

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

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F 309	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews the facility failed to get professional staff to assess the resident for possible injury after a fall in the facility transport van and before moving and driving the resident to the facility for 1 of 1 sampled resident (Resident #4) with a van accident. Immediate Jeopardy began on 08/10/17 when Resident #4 was being transported to a medical appointment by a facility driver when Resident #4's wheelchair fell backwards resulting in his head hitting the floor of the facility van. Resident #4 reported a headache to the facility van driver who had assisted him into an upright position in his wheelchair in the facility van. The facility van driver reported he looked at the back of Resident #4's head to ensure there was no visible injury. The facility van driver assisted Resident #4 to his wound care appointment. After Resident #4's	F 309	On 8/16/17, a Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Regional Director of Clinical Services, Regional Vice President of Operations, Division Vice President of Clinical Services, Vice President of Safety, Division Director of Safety, Vice President of Clinical Education, and Chief Nursing Officer to determine the root cause analysis and develop corresponding action plan to ensure quality care is provided by qualified personnel to meet the needs of the resident. Through Root Cause Analysis and based on the findings for Resident #4, it was determined that the facility failed to properly train designated non-medically	

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Continued From page 2

wound care appointment, the resident was transported back to the facility by the facility van driver. The facility van driver reported the accident to the nurse for Resident #4 upon return to the facility. Immediate Jeopardy was removed on 08/17/17 when the facility proved and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to training of facility van drivers and how to respond in the event of an accident in the facility van.

The findings included:

Resident #4 was admitted to the facility 03/02/16. The significant change Minimum Data Set (MDS) dated 04/28/17 indicated Resident #4 was alert and oriented with no recent changes in condition or mental status. The MDS also indicated Resident #4 had a diagnosis of spina bifida and required extensive assistance with transfers along with the use of a wheelchair for mobility.

During an interview on 08/15/17 at 10:44 AM Resident #4 stated he had a wound care appointment on 08/10/17 that required the use of the transport van. Resident #4 stated as they were driving and went over a bump his wheelchair fell backward and he hit his head on the floor. Resident #4 stated the facility van driver assisted him back to an upright position in his wheelchair. Resident #4 stated he reported to the facility van driver that he had a headache and the driver checked the back of his head and saw

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licensed transport staff on proper procedure and response to resident incidents/accidents that may occur during transport.

On 8/16/17, the Regional Director of Clinical Services provided education to current facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central Supply Coordinator who was providing transport for Resident #4 on 8/10/17. The training included the process for responding to resident incidents/accidents during van transport by contacting 911 and the facility licensed nurse for medically related emergencies, and not moving or assessing the resident until licensed assistance arrives.

On 8/17/17 at 11:10 AM, the Regional Director of Clinical Services provided 1:1 reeducation to the licensed nurse caring for Resident #4 upon his return to the facility, on the importance of obtaining detailed information post incident/accident from the resident and/or witnesses to the event to ensure a comprehensive assessment can be completed including, but not limited to, neurological checks for residents who hit their head and an appropriate plan of care implemented.

Resident #4 will continue to be transported via the contracted transportation service related to non-traditional, specialized wheelchair needs. Care plan updated as indicated.

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no injury so Resident #4 went on to his wound care appointment. Resident #4 stated no one at his wound care appointment examined his head and after his appointment he was transported back to the facility. Resident #4 stated the nurse came to assess him for injuries at the facility and he reported to the nurse that he had a headache. Resident #4 stated the nurse gave him Tylenol for his headache. Resident #4 denies any further pain or discomfort related to the fall.

During an interview on 08/15/17 at 11:02 AM with the facility van driver he stated he was transporting Resident #4 to a medical appointment on 08/10/17 in the facility van. The facility van driver stated they were in the parking lot where Resident #4's appointment was and went over a speed bump and he heard a "thump" and looked back and saw Resident #4 had fallen backward in his wheelchair. The facility van driver stated the tie down straps had loosened which allowed the wheelchair to fall backwards but Resident #4 was still strapped securely in his wheelchair when he assisted him back into an upright position. The facility van driver stated Resident #4 told him he hit his head on the floor and the driver looked at the back of his head and did not see any redness, bruising or bleeding. The facility van driver stated he re-secured the wheelchair of Resident #4 until they were parked and then he assisted him out of the facility van for his medical appointment. After his medical appointment, Resident #4 was transported back to the facility and the facility van driver stated he told the nurse for Resident #4 about the accident and that Resident #4 had hit his head. The facility van driver stated he was not sure what happened after he told the nurse.

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The facility will ensure that professional licensed staff will assess residents for possible injury in the event of a fall or accident in the facility transport van prior to moving and driving the resident back to the facility.

On 8/16/17, the Regional Director of Clinical Services provided education to current facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central Supply Coordinator. The training included the process for responding to resident falls and incidents/accidents during van transport by contacting 911 and the facility licensed nurse, and not moving or assessing the resident until licensed assistance arrives. Newly hired facility designated drivers will be educated upon hire and bi-annually thereafter by the Maintenance Director.

On 8/16/17, the MDS registered nurse began reeducation to licensed nurses on the post incident/accident procedure including, but not limited to, the initial resident assessment, vital signs, pain assessment, fall assessment (if fall related accident), neurological assessment (if unwitnessed fall or head injury), notification to physician/responsible party and ongoing monitoring for changes in condition for 72 hours and conducting a thorough investigation to include witness statements as appropriate. Newly hired nurses will be educated upon hire by the Director of Clinical Services or registered

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F 309	Continued From page 4 During a phone interview on 08/15/17 at 1:10 PM with the nurse who assessed Resident #4 on the day of his accident, she stated she had been told by the facility van driver that Resident #4 had fallen out the wheelchair in the van. The nurse stated that she went to Resident #4 ' s room and assessed him and he had no injuries and no pain. The nurse also stated that she let the Family Nurse Practitioner know and completed an accident/incident report. The nurse stated that she did give Resident #4 Tylenol for a headache but it was unrelated to him having an injury from the accident as he already had this available for pain and headache and requested it regularly. During an interview on 08/15/17 at 1:47 PM with the Director of Nursing (DON), she stated she had been notified that Resident #4 had an accident on the van and went to his room on 08/10/17 to check on him. The DON stated Resident #4 stated that he was okay and that he was not hurt. The DON stated she told the facility van driver to write up his statement about what happened and submit it to her. The DON stated the facility van driver turned in his statement the next day and when she read it found out that Resident #4 had hit his head. The DON stated she went back down to see Resident #4 and he told her that he was fine, had no pain, and no injury from the accident. The DON stated her expectations were for the facility van driver to have called the facility when the accident occurred and let someone know what happened so it could be determined what medical treatment may be necessary. During an interview on 08/16/17 at 3:35 PM with the Family Nurse Practitioner (FNP), she stated she had been made aware of the incident on	F 309	nurse designee. The trained designated transportation staff will be equipped at all times with a cellular phone to contact licensed facility staff and emergency medical responders in the event of resident incident/accident during transport. The non-medically licensed transportation staff will not move or assess resident and will await professional staff assistance to arrive to complete a resident assessment and provide care as appropriate. The Executive Director and/or Maintenance Director will complete quality assurance monitoring of the facility transport van for presence of an operable cellular device to ensure that in the event of a van accident, a licensed professional will be contacted to complete a resident assessment for possible injury prior to being moved. Monitoring will be completed at a frequency of 5 days per week for a period of 12 weeks then, 3 times per week for 3 months, then weekly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee. The results of the quality assurance monitoring will be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and	

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F 309	Continued From page 5 08/10/17 but was not aware he had bumped his head at that time. The FNP further stated she had assessed him on 08/16/17 and Resident #4 stated he had bumped his head but had no injury from the incident that occurred on 08/10/17. On 08/16/17 at 8:44 AM the Administrator was informed of the Immediate Jeopardy. The facility proved a credible allegation of compliance on 08/17/17 at 11:55 AM. The allegation of compliance indicated the following: To remove the immediacy, the facility has initiated and/or completed the following: On August 10th, 2017, at approximately 8:30 AM, resident #4 was transported by facility staff to a physician appointment. Resident #4 does utilize a specialized modified wheelchair due to diagnosis of Spina Bifida. On 8/10/17 at 8:45 AM, during the transport of Resident #4, per the assigned the van driver, the van experienced a bump during locomotion into the parking lot of scheduled appointment. The van driver looked back and noted the resident's wheelchair had tipped backward with the resident remaining secured in the wheelchair. The van driver parked the van, tipped the resident, who was still seated in his wheelchair, into an upright position, and immediately responded to the resident by visually observing the back of the head for any bruising or cuts, and none were visualized. The resident stated to the van driver that he hit his head on the floor of the van when he fell. Resident did have initial complaint of headache which did self-resolve prior to returning to facility. The van driver did not contact the facility's licensed staff or call 911 to inform them	F 309	make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility Certified Nurse Aides and LPN/RN designees. The Executive Director will be responsible for the implementation of this Plan of Correction.	

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that the resident fell and hit his head. The van driver noticed the van's floor straps that were affixed to the front of the resident's wheelchair were now loose and he secured the straps to the wheel chair and transported the resident onto his appointment.

On 8/10/17 at 11:00 AM, resident returned to the facility and the van driver alerted the registered nurse assigned to Resident #4 of the occurrence in the van during transport, but did not inform her that the resident hit his head when he fell per the nurse. The nurse assessed the resident with no injuries noted, no complaints of pain or discomfort. Vital Signs were obtained by the registered nurse that were inclusive of blood pressure 124/55, Pulse 113, Respiration Rate of 18 per minute, and pulse oximetry of 99% and recorded utilizing documentation in the Situation Background Appearance and Review and Notify form, Fall Risk Evaluation, and Interdisciplinary Progress Note.

On 8/10/17 at 12:15 PM, the registered nurse assigned to resident #4 administered one 650mg tablet of Tylenol by mouth per physicians as needed orders for headache with positive results documented on the Medication Administration Record.

On 8/10/17 at 1:30 PM, the registered nurse assigned to Resident #4 notified the facility nurse practitioner with no new orders received for treatment. Resident #4 is his own responsible party. Resident continued to be monitored daily for changes in condition or complaints of headache and none were observed or reported. Neurological checks were not documented per policy and procedure for residents who hit their

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head due to nurse not being notified that the resident had struck his head during the incident.

The registered nurse assigned to Resident #4 will be provided one to one education by the Regional Director of Clinical Services prior to her next work shift on obtaining detailed information post incident/accident from the resident and/or witnesses to the event to perform a comprehensive assessment to determine appropriate plan of care. Education will include performing neurological observation for residents ' who have hit their head. Education occurred via telephone on August 17, 2017 at 11:10 AM.

On 8/16/17 at 10:15 AM, a Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Regional Director of Clinical Services, Regional Vice President of Operations, Division Vice President of Clinical Services, Vice President of Safety, Division Director of Safety, Vice President of Clinical Education, and Chief Nursing Officer to determine the root cause analysis and develop corresponding action plan to ensure quality care is provided by qualified personnel to meet the needs of the resident.

Through Root Cause Analysis completed on 8/16/17 at 11:15 AM, it was determined that the facility failed to properly train designated non-medically licensed transport staff on proper procedure and response to resident incident/accident that may occur during transport.

On 8/16/17 at 11:48 AM, the Nurse Practitioner evaluated Resident #4 who "denies any injury. He denies visual changes, headache, bump, loss of consciousness, nausea or pain from the fall.

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F 309	Continued From page 8 Denies abrasions, bruises, or injury. He is alert today, calm and pleasant and denies fever, cough, congestion, dyspnea, chest pain, or GI complaints." On 8/16/17 at 12:30 PM, the Regional Director of Clinical Services provided education to all facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central Supply Coordinator who was providing transport for Resident #4, who transport residents in the transport van. The training included the process for responding to resident incidents/accidents during van transport. The education included contacting 911 for medically related emergencies, contacting facility licensed nurse for non-emergent incidents/accidents, and not moving or assessing the resident until licensed assistance arrives. The trained transportation staff will be equipped with a cellular phone 8/17/17 to contact licensed facility staff or emergency medical responders in the event of resident incident/accident during transport. Facility designated drivers will receive reeducation on the process for responding to incidents/accidents during van transport bi-annually completed by the Maintenance Director. Newly hired transportation staff will receive education upon hire and bi-annually thereafter on facility process for responding to resident incident/accidents during van transport by the Maintenance Director. On 8/16/17 at 3:40 PM the MDS nurse reeducated licensed nurses on post incident/accident procedure, including but not limited to, initial resident assessment, vital signs, pain assessment, fall assessment (if fall related accident), neurological assessment (if	F 309		

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F 309	Continued From page 9 unwitnessed fall or head injury), notification to physician/responsible party and ongoing monitoring for changes in condition for 72 hours. Licensed nurses will not be permitted to work until education is completed. Newly hired nurses will be educated upon hire. The Executive Director will be responsible for implementing this credible allegation of compliance. The credible allegation was verified on 08/17/17 as evidenced by observations of each facility van driver securing a wheelchair in the facility van, verification of re-education for licensed nurses on post incident/accident procedure, education to all facility designated drivers of contacting 911 for medically related emergencies, contacting facility licensed nurse for non-emergent incidents/accidents, and not moving or assessing the resident until licensed assistance arrives, validating the nurse assigned to Resident #4 on the day of the accident was provided re-education regarding gathering post incident/accident information from the resident and/or witnesses to the event to perform a comprehensive assessment to determine appropriate plan of care and performing neurological observation for residents' who have hit their head.	F 309		
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	F 323		9/15/17

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F 323	Continued From page 10 (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, resident, and staff interviews the facility failed to secure a resident and his wheelchair during van transportation from the facility to a medical appointment. The driver hit a speed bump in the parking lot and the resident fell backward in his specialized wheelchair resulting in the resident hitting his head. This is evident in 1 of 3 sampled residents (Resident #4). Immediate Jeopardy began on 08/10/17 when Resident #4 was being transported to a wound care appointment by a facility driver when Resident #4's wheelchair fell backwards resulting in his head hitting the floor of the facility van. Resident #4 reported a headache to the facility van driver who had assisted him into an upright position in his wheelchair in the facility van. The	F 323	On 8/16/17, a Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Regional Director of Clinical Services, Regional Vice President of Operations, Division Vice President of Clinical Services, Vice President of Safety, Division Director of Safety, Vice President of Clinical Education, and Chief Nursing Officer to determine the root cause analysis and develop corresponding action plan to ensure residents are free from accidents during facility van transportation. Through Root Cause Analysis and based on the findings for Resident #4, it was determined that the facility failed to	

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facility van driver reported he looked at the back of Resident #4's head to ensure there was no visible injury. The facility van driver assisted Resident #4 to his wound care appointment and called back to the facility to speak with the Maintenance Assistant for further instructions on securing the wheelchair. After Resident #4's wound care appointment, the resident was transported back to the facility by the facility van driver. The facility van driver reported the accident to the nurse for Resident #4 upon return to the facility. Immediate Jeopardy was removed on 08/17/17 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to training of facility van drivers and how to respond in the event of an accident in the facility van.

The findings included:

Upon review of the manufacturer's instructions for inspection and maintenance for wheelchair securement and occupant restraint systems with a revision date of 02/11, it was noted there were no instructions listed for securing a specialized wheelchair.
Resident #4 was admitted to the facility 03/02/16. The significant change Minimum Data Set (MDS) dated 04/28/17 indicated Resident #4 was alert and oriented (BIMS of 15) with no short or long term memory problems. The MDS also indicated Resident #4 had diagnoses of chronic pain and malnutrition among others and required extensive

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1)identify non-traditional wheelchair equipment that may require additional or alternate transport mechanisms or considerations and 2) provide an individualized care plan to meet the safety needs of each resident.

Resident #4 will continue to be transported via the contracted transportation service related to non-traditional, specialized wheelchair needs. Care plan updated as indicated.

On 8/15/17-8/16/17, the Maintenance Director completed a review of current facility residents to identify any specialty or adaptive wheelchairs or durable medical equipment that may prevent them from transporting residents safely in a traditional wheelchair. Identified residents will be transported with a contracted transportation service that will ensure resident safety during medically related transports.

On 8/16/17, the MDS nurse updated the identified residents□ safety care plan to reflect the contracted transport needs related to the residents use of specialized and/or modified, non-traditional wheelchairs.

On 8/15/17, the Maintenance Director provided education to facility designated drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator on the facility procedure for Loading and Unloading a Resident with a Wheelchair Lift on a Transport Van. Procedure

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F 323	Continued From page 12 assistance with transfers along with the use of a wheelchair for mobility. During an interview on 08/15/17 at 10:44 AM Resident #4 stated he had a wound care appointment on 08/10/17 that required the use of the transport van. Resident #4 stated as they were driving and went over a bump his wheelchair fell backward and he hit his head on the floor. Resident #4 stated the facility van driver assisted him back to an upright position in his wheelchair. During an interview on 08/15/17 at 11:02 AM with the facility van driver he stated he was transporting Resident #4 to a medical appointment on 08/10/17 in the facility van. The facility van driver stated they were in the parking lot where Resident #4's appointment was and went over a speed bump. The facility van driver stated he heard a "thump" and looked back and saw Resident #4 had fallen backward in his wheelchair. The facility van driver stated the tie down straps had loosened which allowed the wheelchair to fall backwards but Resident #4 was still strapped securely in his wheelchair when he assisted him back into an upright position. The facility van driver stated Resident #4 told him he hit his head on the floor and had a headache. The facility van driver stated he looked at the back of his head and did not see any redness, bruising or bleeding. The facility van driver stated he re-secured the wheelchair of Resident #4 by tightening the tie down straps then he assisted him out of the facility van once they had parked for his medical appointment. While Resident #4 was at his medical appointment the facility van driver called the facility and spoke with the Maintenance Assistant for instructions to strap in	F 323	includes loading resident onto the lift, locking brakes while on the lift, transporting resident from lift into van, proper placement of resident within van, securing the resident on the van, unloading the resident onto the lift, and safely removing the resident from the van. Return demonstration was successfully completed by each designated driver. Newly hired designated transport staff will be educated upon hire and bi-annually thereafter with successful return demonstration. On 8/15/17, the Maintenance Director provided education to facility designated drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator on the facility policy and procedure S-390 the Fleet Safety Program Motor Vehicle Safety, which describes the expectations for transportation employees to operate company vehicles safely and prevent accidents, including but not limited to, training standards, accident reporting, vehicle inspections and maintenance and general safety regulations. A Safe Driving Quiz was completed by each designated drive with successful results. Newly hired transportation staff will be educated upon hire and bi-annually thereafter and complete a Safe Driving Quiz with successful results. Non traditional wheelchairs will be evaluated by the Maintenance Director prior to transport to validate if the chair can safely be secured within the company van or if alternate contracted	

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F 323	Continued From page 13 his wheelchair securely. After his medical appointment, Resident #4 was transported back to the facility and the facility van driver stated he told the nurse for Resident #4 about the accident and that Resident #4 had hit his head. The facility van driver stated he had completed training just over two years ago regarding driving the van and transporting residents but had no in-service or retraining since then. The facility van driver also stated this was the first time he had transported Resident #4 and had secured him the way he had been trained. The facility van driver further stated he had been unaware at the time of transport for Resident #4 that the rear axle on his wheelchair allowed the wheels to spin even when the chair was strapped down, so the straps loosened during transport and the wheelchair fell backward. The facility van driver denied having any accident where someone had flipped over in the wheelchair or been injured in any way during any time he had driven the facility van until this occurrence with Resident #4 in his wheelchair. During an interview on 08/15/17 at 11:45 AM with the Maintenance Assistant, he stated that the facility van driver had called him on 08/10/17 requesting assistance on how to safely strap Resident #4's wheelchair in the van. The Maintenance Assistant stated the facility van driver did not inform him at the time of the call that an incident with Resident #4 had taken place on the van. The Maintenance Assistant stated he told the facility van driver he needed to get to the highest point on the frame of his wheelchair to strap it down. The Maintenance Assistant also stated Resident #4 had something very different about his wheelchair and it looked to be designed like an Olympic racing wheelchair. The	F 323	transportation vendors may be necessary to maintain safety. On 8/17/17, the Executive Director completed education to the transportation staff (Maintenance Director, Maintenance Assistant, Central Supply Coordinator) and to the Scheduler on the use of the Non-Facility Transportation log, inclusive of the storage location and parameters for updating as necessary upon any changes or newly identified non-facility transport equipment. Newly hired transportation staff and schedulers will be educated upon hire. A master Non-Facility Transportation log will be maintained in the van and at the nurses□ station indicating the appropriate plan of care for safe transport. The master Non-Facility Transportation log will be updated by the Maintenance Director as needed for changes. Drivers will review the master Non-Facility Transportation log posted at the nurses□ station and within the van prior to transport. A Transport Van Securement Checklist and Daily Van Safety Checklist will be completed by the designated transport driver daily prior to van transports. Any safety concern identified will be reported to the Executive Director immediately and alternate contracted transportation utilized to ensure residents□ safety and to prevent accidents. The Executive Director and/or	

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F 323	Continued From page 14 Maintenance Assistant further stated he had transported Resident #4 several weeks ago and had no problems with his wheelchair. The Maintenance Assistant also stated he had not had an accident where someone had flipped over in the wheelchair or been injured in any way during any time he had driven the facility van. During an interview on 08/15/17 at 12:20 PM with the Maintenance Director, he stated the facility had a full time driver up until about 2 months ago. Since then the Maintenance Assistant and the Central Supply Clerk (facility van driver at the time of the accident) had been the 2 facility van drivers until someone could be hired for that position. The Maintenance Director also stated he believed that Resident #4's wheelchair was strapped in correctly but because of the bouncing around in the van and the tension it may have loosened the tie down straps. During the interview on 08/15/17 at 12:20 PM the Maintenance Director and the facility van driver during the incident demonstrated how Resident #4 had been secured in the facility van using Resident #4's wheelchair. The Maintenance Director stated the straps were to be ratcheted into place so there is very little, if any movement, from the wheelchair. During an interview on 08/17/17 at 4:37 PM, the Administrator acknowledged her expectations were for the wheelchair to have been evaluated prior to use in the van to transport the resident because of the wheelchair's modified nature. On 08/16/17 at 8:44 AM the Administrator was informed of the Immediate Jeopardy. The facility provided a credible allegation of compliance on	F 323	Maintenance Director will complete quality assurance monitoring of the Transport Van Securement Checklists, Daily Van Safety Checklists, and designated driver required training for completion to ensure resident safety during van transport. Monitoring will be completed at a frequency of 5 days per week for a period of 12 weeks then, 3 times per week for 3 months, then weekly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee. The results of the quality assurance monitoring will be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility Certified Nurse Aides and LPN/RN designees. The Executive Director will be responsible for the implementation of this Plan of Correction.	

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08/17/17 at 11:55 AM. The allegation of compliance indicated the following:

To remove the immediacy, the facility has initiated and/or completed the following:

On August 10th, 2017, at approximately 8:30 AM, Resident #4 was transported by facility staff to a physician appointment. Resident #4 does utilize a specialized modified wheelchair due to diagnosis of Spina Bifida. Resident #4, who was in a specialized/non-traditional wheelchair, was secured in the van per the facility procedure for Loading and Unloading a Resident with a (traditional) Wheelchair Lift on a Transport Van. Procedure includes loading resident onto the lift, locking brakes while on the lift, transporting resident from lift into van, proper placement of resident within van, securing the resident on the van, unloading the resident onto the lift, and safely removing the resident from the van. Non-traditional wheelchairs will be evaluated by the Maintenance Director prior to transport to validate if the chair can safely be secured within the company van or if alternate contracted transportation vendors may be necessary to maintain safety. A master Non-Facility Transportation log will be maintained in the van and at the nurses' station indicating the appropriate plan of care for safe transport. The master Non-Facility Transportation log will be updated by the Maintenance Director as needed for changes. Drivers will review the master Non-Facility Transportation log posted at the nurses' station and within the van prior to transport.

On 8/10/17 at 8:45 AM, during the transport of Resident #4, per the assigned van driver, the van

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experienced a bump during locomotion into the parking lot of scheduled appointment. The van driver looked back and noted the resident's wheelchair had tipped backward with the resident remaining secured in the wheelchair. The van driver parked the van, tipped the wheelchair into an upright position, and immediately responded to the resident by visually observing the back of the head for any bruising or cuts, and none were visualized. Resident did have initial complaint of headache which did self-resolve prior to returning to facility.

On 8/15/17 at 11:00 AM, the Maintenance Director completed education and observed reverse demonstration of the facility procedure for Loading and Unloading a Resident with a Wheelchair Lift on a Transport Van to facility designated drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator. The Maintenance Director administered a Safe Driving Quiz with successful results, and reviewed facility policy and procedure S-390 the Fleet Safety Program Motor Vehicle Safety. Facility policy S-390 describes the expectations for transportation employees to operate company vehicles safely and prevent accidents, including but not limited to, training standards, accident reporting, vehicle inspections and maintenance and general safety regulations.

On 8/15/17 at 12:00 PM, the Interdisciplinary Team consisting of the Executive Director, Regional Director of Clinical Services, Regional Vice Presidents of Operations, and the Maintenance Director elected to conduct all medically and non-medically related transportation via the contracted providers until completion of appropriate vehicle inspections,

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F 323	Continued From page 17 education, equipment validation, and appropriation of cellular phone for post incident/accident access to licensed facility staff and/or emergency responders. On 8/15/17 at 2:00 PM the Maintenance Director began reviewing current facility residents to identify any specialty or adaptive wheelchairs or durable medical equipment that may prevent them from transporting safely in a traditional wheelchair. Maintenance Director completed the audit 8/16/17 at 10 AM. Identified residents will be transported with a contracted transportation service that will ensure resident safety during future medically related transports. On 8/16/17 the MDS nurse updated the identified residents' safety care plan to reflect the contracted transport needs due to specialized and/or modified, non-traditional wheelchair transport needs. A master Non-Facility Transportation log will be maintained in the van and at the nurses' station indicating the appropriate plan of care for safe transport. The master Non-Facility Transportation log will be updated by the Maintenance Director as needed for changes. Drivers will review the master Non-Facility Transportation posted at the nurses station and within the van prior to transport. On August 16, 2017 the Executive Director provided education to the Maintenance Director on the Non-Facility Transportation log inclusive of the storage location and parameters for updating as necessary upon any changes or newly identified non-facility transport equipment. Education will be completed with the scheduler and other designated van drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator with education completion on August 17, 2017.	F 323		

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On 8/16/17 at 10:15 AM, a Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Regional Director of Clinical Services, Regional Vice President of Operations, Division Vice President of Clinical Services, Vice President of Safety, Division Director of Safety, Vice President of Clinical Education, and Chief Nursing Officer to determine the root cause analysis and develop corresponding action plan to ensure appropriate supervision is provided to prevent accidents and residents needs are being met.

Through Root Cause Analysis, it was determined that the facility failed to 1) properly train designated non-medically licensed transport staff on proper procedure for response to resident incident/accident that may occur during transport and licensed nurse post-incident/accident procedure 2) identify non- traditional wheelchair equipment that may require additional or alternate transport mechanisms or considerations and 3) provide an individualized care plan to meet the safety needs of each resident.

On 8/16/17 at 1:00 PM the Registered Nurse updated the Care Plan for Resident #4 to indicate that he will be transported via contracted transportation services that will ensure resident safety during future medically related transports due to the resident utilization of specialized modified wheelchair. Resident #4 will continue to be evaluated quarterly by a Registered Nurse and members of the Interdisciplinary team and as needed for any changes to the care plan. A master Non-Facility Transportation log will be maintained in the van, at the nurses' station, and provided to the scheduler indicating the

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appropriate plan of care for safe transport. The master Non-Facility Transportation log will be updated by the Maintenance Director as needed for changes. Drivers will review the master Non-Facility Transportation log posted at the nurses' station and within the van prior to transport.

Newly hired transportation staff will receive education from the Maintenance Director upon hire and bi-annually thereafter on procedure for safely loading and unloading a Resident, facility process for responding to resident incident/accidents during van transport, the Fleet Safety Program Motor Vehicle Safety.

The facility will provide supervision to prevent and properly respond to resident incidents /accidents by ensuring appropriate training to non- medically licensed and licensed nurses to maintain safety during medically related transport. In the event of a transport incident/accident, the non-medically licensed employee will contact emergency medical responders for life-threatening emergencies and will contact the facility for licensed nurse assistance. The licensed nurse will properly assess resident and complete the post incident/accident procedure as indicated.

The Executive Director will be responsible for implementing this credible allegation of compliance.

The credible allegation was verified on 08/17/17 as evidenced by observations of each facility van driver securing an occupied wheelchair in the facility van, verification of the Non-Facility Transportation Log which indicated the residents with specialty wheelchairs, and the updated care

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F 323	Continued From page 20 plan for Resident #4. Each driver was interviewed after a return demonstration of securing the wheelchairs in the facility van and verified they had all been retrained, had reviewed policies and procedures for securing residents in wheelchairs in the facility van and had reviewed and knew how to utilize the transport van securement checklist, and document in the transportation log and on the daily vehicle inspection report.	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 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 observations, record review, resident, staff and Family Nurse Practitioner (FNP) interviews, the administration failed to ensure a resident was afforded necessary care and services during facility van transport. This is evident in 1 of 1 sampled resident (Resident #4). Immediate Jeopardy began on 08/10/17 when Resident #4 was being transported to a medical appointment by a facility driver when Resident #4's specialized wheelchair fell backwards resulting in his head hitting the floor of the facility van. Immediate Jeopardy was removed on 08/17/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for	F 490	On 8/16/17, a Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Regional Director of Clinical Services, Regional Vice President of Operations, Division Vice President of Clinical Services, Vice President of Safety, Division Director of Safety, Vice President of Clinical Education, and Chief Nursing Officer to determine the root cause analysis and develop corresponding action plan to ensure residents are afforded necessary care and services during van transportation. Through Root Cause Analysis and based on the findings for Resident #4, it was determined that the facility failed to 1)	9/15/17

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more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for residents transportation to appointments and other activities and to complete education and ensure monitoring systems put into place are effective related to training of facility van drivers and how to respond in the event of an accident in the facility van and re-education of licensed nursing staff.

The findings included:

1. Cross refer to F309: Based on record reviews, resident, and staff interviews the facility failed to get professional staff to assess the resident for possible injury after a fall in the facility transport van and before moving and driving the resident to the facility for 1 of 1 sampled resident (Resident #4) with a van accident.

2. Cross refer to F323: Based on record reviews, resident, and staff interviews the facility failed to secure a resident and his wheelchair during van transportation from the facility to a medical appointment. The driver hit a speed bump in the parking lot and the resident fell backward in his specialized wheelchair resulting in the resident hitting his head. This is evident in 1 of 3 sampled residents (Resident #4).

The facility Administrator was informed of Immediate Jeopardy on 08/16/17 at 8:44 AM.

The facility provided a credible allegation of compliance on 08/17/17 as follows:

On August 10th, 2017, at approximately 8:30 AM, Resident #4 was transported by facility staff to a

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properly train designated non-medically licensed transport staff on proper procedure for response to resident incident/accident that may occur during transport and licensed nurse post-incident/accident procedure 2) identify non- traditional wheelchair equipment that may require additional or alternate transport mechanisms or considerations and 3) provide an individualized care plan to meet the safety needs of each resident.

On 8/16/17, the Regional Director of Clinical Services provided education to current facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central Supply Coordinator who was providing transport for Resident #4 on 8/10/17. The training included the process for responding to resident incidents/accidents during van transport by contacting 911 and the facility licensed nurse for medically related emergencies, and not moving or assessing the resident until licensed assistance arrives.

On 8/17/17 at 11:10 AM, the Regional Director of Clinical Services provided 1:1 reeducation to the licensed nurse caring for Resident #4 upon his return to the facility, on the importance of obtaining detailed information post incident/accident from the resident and/or witnesses to the event to ensure a comprehensive assessment can be completed including, but not limited to, neurological checks for residents who hit their head and an

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F 490	Continued From page 22 physician appointment. Resident #4 does utilize a specialized modified wheelchair due to diagnosis of Spina Bifida. Resident #4, who was in a specialized/non-traditional wheelchair, was secured in the van per the facility procedure for Loading and Unloading a Resident with a (traditional) Wheelchair Lift on a Transport Van. Procedure includes loading resident onto the lift, locking brakes while on the lift, transporting resident from lift into van, proper placement of resident within van, securing the resident on the van, unloading the resident onto the lift, and safely removing the resident from the van. Non-traditional wheelchairs will be evaluated by the Maintenance Director prior to transport to validate if the chair can safely be secured within the company van or if alternate contracted transportation vendors may be necessary to maintain safety. On 8/10/17 at 8:45 AM, during the transport of Resident #4, per the assigned the van driver, the van experienced a bump during locomotion into the parking lot of scheduled appointment. The van driver looked back and noted the resident wheelchair had tipped backward with the resident remaining secured in the wheelchair. The van driver parked the van, tipped the wheelchair into an upright position, and immediately responded to the resident by visually observing the back of the head for any bruising or cuts, and none were visualized. Resident did have initial complaint of headache which did self-resolve prior to returning to facility. On 8/10/17 at 11:00 AM, Resident #4 returned to the facility and the van driver alerted the registered nurse assigned to Resident #4 of the occurrence in the van during transport. The	F 490	appropriate plan of care implemented. Resident #4 will continue to be transported via the contracted transportation service related to non-traditional, specialized wheelchair needs. Care plan updated as indicated. The facility will ensure that professional licensed staff will assess residents for possible injury in the event of a fall or accident in the facility transport van prior to moving and driving the resident back to the facility. On 8/15/17-8/16/17, the Maintenance Director completed a review of current facility residents to identify any specialty or adaptive wheelchairs or durable medical equipment that may prevent them from transporting residents safely in a traditional wheelchair. Identified residents will be transported with a contracted transportation service that will ensure resident safety during medically related transports. On 8/16/17, the MDS nurse updated the identified residents□ safety care plan to reflect the contracted transport needs related to the residents use of specialized and/or modified, non-traditional wheelchairs. On 8/16/17, the Regional Director of Clinical Services provided education to current facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central	

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nurse assessed the resident with no injuries noted, no complaints of pain or discomfort. Vital Signs were obtained by the registered nurse that were inclusive of blood pressure 124/55, Pulse 113, Respiration Rate of 18 per minute, and pulse oximetry of 99% and recorded utilizing documentation in the Situation Background Appearance and Review, Fall Risk Evaluation, and Interdisciplinary Progress Note.

On 8/10/17 at 12:15 PM, the registered nurse assigned to Resident #4 administered one 650mg tablet of Tylenol by mouth per physicians as needed orders for headache with positive results documented on the Medication Administration Record.

On 8/10/17 at 1:30 PM, the registered nurse assigned to Resident #4 notified the facility nurse practitioner with no new orders received for treatment. Resident #4 is his own responsible party. Resident #4 continued to be monitored in excess of 72 hours for changes in condition. No new orders were received and resident did receive two doses of as needed 650 mg Tylenol that was previously ordered for generalized pain. Neurological checks were not documented per policy and procedure for residents who hit their head due to the nurse not being notified that the resident had struck his head during the incident.

On 8/15/17 at 11:00 AM, the Maintenance Director completed education and observed reverse demonstration of the facility procedure for Loading and Unloading a Resident with a Wheelchair Lift on a Transport Van to facility designated drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator. The Maintenance Director administered a Safe Driving

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Supply Coordinator. The training included the process for responding to resident falls and incidents/accidents during van transport by contacting 911 and the facility licensed nurse and not moving or assessing the resident until licensed assistance arrives. Newly hired facility designated drivers will be educated upon hire and bi-annually thereafter by the Maintenance Director.

On 8/16/17, the MDS registered nurse began reeducation to licensed nurses on the post incident/accident procedure including, but not limited to, the initial resident assessment, vital signs, pain assessment, fall assessment (if fall related accident), neurological assessment (if unwitnessed fall or head injury), notification to physician/responsible party and ongoing monitoring for changes in condition for 72 hours and conducting a thorough investigation to include witness statements as appropriate. Newly hired nurses will be educated upon hire by the Director of Clinical Services or registered nurse designee.

The trained designated transportation staff will be equipped at all times with a cellular phone to contact licensed facility staff and emergency medical responders in the event of resident incident/accident during transport. The non-medically licensed transportation staff will not move or assess resident and will await professional staff assistance to arrive to complete a resident assessment and

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F 490	Continued From page 24 Quiz with successful results, and reviewed facility policy and procedure S-390 the Fleet Safety Program Motor Vehicle Safety. Facility policy S-390 describes the expectations for transportation employees to operate company vehicles safely and prevent accidents, including but not limited to, training standards, accident reporting, vehicle inspections and maintenance and general safety regulations. On 8/15/17 at 12:00 PM, the Interdisciplinary Team consisting of the Executive Director, Regional Director of Clinical Services, Regional Vice Presidents of Operations, and the Maintenance Director elected to conduct all medically and non-medically related transportation via the contracted providers until completion of appropriate vehicle inspections, education, equipment validation, and appropriation of cellular phone for post incident/accident access to licensed facility staff and/or emergency responders. On 8/15/17 at 2:00 PM the Maintenance Director began reviewing current facility residents to identify any specialty or adaptive wheelchairs or durable medical equipment that may prevent them from transporting safely in a traditional wheelchair. Maintenance Director completed the audit 8/16/17 at 10 AM. Identified residents will be transported with a contracted transportation service that will ensure resident safety during future medically related transports. On 8/16/17 the MDS nurse updated the identified residents ' safety care plan to reflect the contracted transport needs due to specialized and/or modified, non-traditional wheelchair transport needs. A master Non-Facility Transportation log will be maintained in the van and at the nurses' station	F 490	provide care as appropriate. On 8/15/17, the Maintenance Director provided education to facility designated drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator on the facility procedure for Loading and Unloading a Resident with a Wheelchair Lift on a Transport Van. Procedure includes loading resident onto the lift, locking brakes while on the lift, transporting resident from lift into van, proper placement of resident within van, securing the resident on the van, unloading the resident onto the lift, and safely removing the resident from the van. Return demonstration was successfully completed by each designated driver. Newly hired designated transport staff will be educated upon hire and bi-annually thereafter with successful return demonstration. On 8/15/17, the Maintenance Director provided education to facility designated drivers, inclusive of the Maintenance Assistant and Central Supply Coordinator on the facility policy and procedure S-390 the Fleet Safety Program Motor Vehicle Safety, which describes the expectations for transportation employees to operate company vehicles safely and prevent accidents, including but not limited to, training standards, accident reporting, vehicle inspections and maintenance and general safety regulations. A Safe Driving Quiz was completed by each designated driver with successful results. Newly hired transportation staff will be educated upon	

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indicating the appropriate plan of care for safe transport. The master Non-Facility Transportation log will be updated by the Maintenance Director as needed for changes. Drivers will review the master Non-Facility Transportation posted at the nurses station and within the van prior to transport.

On 8/16/17 at 10:15 AM, a Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Regional Director of Clinical Services, Regional Vice President of Operations, Division Vice President of Clinical Services, Vice President of Safety, Division Director of Safety, Vice President of Clinical Education, and Chief Nursing Officer to determine the root cause analysis and develop corresponding action plan to ensure appropriate supervision is provided to prevent accidents during resident report and residents' needs are being met.

Through Root Cause Analysis, it was determined that the facility failed to 1) properly train designated non-medically licensed transport staff on proper procedure for response to resident incident/accident that may occur during transport and licensed nurse post-incident/accident procedure 2) identify non- traditional wheelchair equipment that may require additional or alternate transport mechanisms or considerations and 3) provide an individualized care plan to meet the safety needs of each resident.

On 8/16/17 at 11:48 AM, the Nurse Practitioner evaluated Resident #4 who "denies any injury. He denies visual changes, headache, bump, loss of consciousness, nausea or pain from the fall. Denies abrasions, bruises, or injury. He is alert

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hire and bi-annually thereafter and complete a Safe Driving Quiz with successful results.

Non traditional wheelchairs will be evaluated by the Maintenance Director prior to transport to validate if the chair can safely be secured within the company van or if alternate contracted transportation vendors may be necessary to maintain safety.

On 8/17/17, the Executive Director completed education to the transportation staff (Maintenance Director, Maintenance Assistant, Central Supply Coordinator) and to the Scheduler on the use of the Non-Facility Transportation log, inclusive of the storage location and parameters for updating as necessary upon any changes or newly identified non-facility transport equipment. Newly hired transportation staff and schedulers will be educated upon hire.

A master Non-Facility Transportation log will be maintained in the van and at the nurses station indicating the appropriate plan of care for safe transport. The master Non-Facility Transportation log will be updated by the Maintenance Director as needed for changes. Drivers will review the master Non-Facility Transportation log posted at the nurses station and within the van prior to transport.

A Transport Van Securement Checklist and Daily Van Safety Checklist will be

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today, calm and pleasant and denies fever, cough, congestion, dyspnea, chest pain, or GI complaints."

On 8/16/17 at 12:30 PM, the Regional Director of Clinical Services provided education to all facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central Supply Coordinator who was providing transport for Resident #4, who transport residents in the transport van. The training included the process for responding to resident incidents/accidents during van transport. The education included contacting 911 for medically related emergencies, contacting facility licensed nurse for non-emergent incidents/accidents, and not moving or assessing the resident until licensed assistance arrives. The trained transportation staff will be equipped with a cellular phone 8/17/17 to contact licensed facility staff or emergency medical responders in the event of resident incident/accident during transport. Facility designated drivers will receive reeducation on the process for responding to incidents/accidents during van transport bi-annually completed by the Maintenance Director. Newly hired transportation staff will receive education upon hire and bi-annually thereafter on facility process for responding to resident incident/accidents during van transport by the Maintenance Director.

On 8/16/17 at 1:00 PM the MDS nurse updated the Care Plan for Resident #4 to indicate that he will be transported via contracted transportation services that will ensure resident safety during future medically related transports due to the resident utilization of specialized modified wheelchair. Resident #4 will continue to be

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completed by the designated transport driver daily prior to van transports. Any safety concern identified will be reported to the Executive Director immediately and alternate contracted transportation utilized to ensure residents□ safety and to prevent accidents.

The Executive Director and/or Maintenance Director will complete quality assurance monitoring of the facility transport van for presence of an operable cellular device to ensure that in the event of a van accident, a licensed professional will be contacted to complete a resident assessment for possible injury prior to being moved, the Transport Van Securement Checklists, Daily Van Safety Checklists, and designated driver required training for completion to ensure resident safety during van transport.

Monitoring will be completed at a frequency of 5 days per week for a period of 12 weeks then, 3 times per week for 3 months, then weekly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee.

The results of the quality assurance monitoring will be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and

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F 490	Continued From page 27 evaluated quarterly by a MDS nurse and members of the Interdisciplinary team and as needed for any changes to the care plan. Newly hired transportation staff will receive education upon hire and bi-annually thereafter on procedure for safely loading and unloading a Resident, facility process for responding to resident incident/accidents during van transport, the Fleet Safety Program Motor Vehicle Safety completed by the Maintenance Director. On 8/16/17 at 3:40 PM the MDS nurse reeducated licensed nurses on post incident/accident procedure, including but not limited to, initial resident assessment, vital signs, pain assessment, fall assessment (if fall related accident), neurological assessment (if unwitnessed fall or head injury), notification to physician/responsible party and ongoing monitoring for changes in condition for 72 hours. Licensed nurses will not be permitted to work until education is completed. Newly hired nurses will be educated upon hire. On 8/16/17 at 4:30 PM the District Director of Safety completed education to the Maintenance Director on the utilization and completion of the Daily Vehicle Inspection Report and Transport Van Securement Checklist prior to initiating transport of residents in the facility van. Transportation staff will not be permitted to transport residents until completion of this education. Newly hired transportation staff will be educated upon hire and biannually thereafter. On 8/16/17 at 5:00 PM the District Director of Safety completed a visual van equipment inspection to identify any potential safety hazards.	F 490	make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility Certified Nurse Aides and LPN/RN designees. The Executive Director will be responsible for the implementation of this Plan of Correction.	

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F 490	Continued From page 28 No additional hazards were identified. The Director of Maintenance will ensure completion of bi-annual van inspections by a preferred service provider inclusive of the wheelchair securement system. The facility will provide supervision to prevent and properly respond to resident incidents /accidents by ensuring appropriate training to non- medically licensed and licensed nurses to maintain safety during medically related transport. The designated transporter will reference the Daily Vehicle Inspection Report and Transport Van Securement Checklist prior to initiating transport of residents in the facility van. The checklists, along with additional training and reference materials will be maintained and updated by the Maintenance Director and located in a Safety Reference Manual accessible to facility transport staff on van. In the event of a transport incident/accident, the non-medically licensed employee will contact emergency medical responders for life-threatening emergencies and will contact the facility for licensed nurse assistance. The licensed nurse will properly assess resident and complete the post incident/accident procedure as indicated above. The registered nurse assigned to Resident #4 will be provided one to one education by the Regional Director of Clinical Services on obtaining detailed information post incident/accident from the resident and/or witnesses to the event to perform a comprehensive assessment to determine appropriate plan of care. Education will include performing neurological observation for residents' who have hit their head. Education occurred via telephone on August 17, 2017 at 11:10 AM.	F 490		

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F 490	Continued From page 29 The Executive Director will be responsible for implementing this credible allegation of compliance. The facility administration will not tolerate failure to adhere to established policies, procedures, training, and other specified guidelines or indications for proper utilization of equipment, supplies, and resources in accordance with manufacturer guidelines to ensure care is provided per resident's individualized plan of care. Failure to adhere to aforementioned criteria can and will result in disciplinary action up to and including termination and reporting to governmental licensing boards and agencies. The credible allegation was verified on 08/17/17 as evidenced by the following: observations of each facility van driver securing a wheelchair in the facility van, verification of re-education for licensed nurses on post incident/accident procedure, education to all facility designated drivers of contacting 911 for medically related emergencies, contacting facility licensed nurse for non-emergent incidents/accidents, and not moving or assessing the resident until licensed assistance arrives, validating the nurse assigned to Resident #4 on the day of the accident was provided re-education regarding gathering post incident/accident information from the resident and/or witnesses to the event to perform a comprehensive assessment and neurological observations for residents' who have hit their head and updated care plans for residents with specialty wheelchairs. Also reviewed were the facility van driver's statement of the accident on 8/10/17, Transport Van Securement Checklist, Non-Facility Transportation Log, Transportation Log, Daily Vehicle Inspection Report, Policies and Procedures for Neurological Assessment and	F 490		

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F 490	Continued From page 30 Notification of Change in Condition, Neurological Assessment Flow Sheet, Fall Risk Evaluation, Fall Investigation and Documentation Checklist, SBAR (Situation, Background, Assessment, Review/Request), Fall Response Action Plan and the Root Cause Analysis Investigation.	F 490		