STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 02/14/2018

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LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 2/13/18 through 2/14/18. Past Non-Compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) An extended survey was conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		2/19/18

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

Electronically Signed | 02/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Responsible Party of a new wound for 1 of 3 residents (Resident #7) reviewed for notification of change in condition. The findings included: Resident # 7 was admitted to the facility on 11/3/17 with diagnoses including Dementia, Congestive Heart Failure, Gastroenteritis and Colitis, Diabetes Mellitus, chronic Pain, Altered Mental Status, Hypertension and Dysphagia. A review of the Admission Minimum Data Set (MDS) dated 11/17/17 revealed she was severely cognitively impaired. The resident required extensive two physical assistance with bed	F 580	Processes that lead to the deficiency: The facility failed to notify the Responsible Party of a new wound for Resident #7. Resident #7 was noted by the treatment nurse to have a new wound on 01/19/2018. The treatment nurse notified the physician on 01/19/2018, but failed to notify the Responsible Party (RP) at that time. The treatment nurse stated she had not called due to past difficulty in contacting the Responsible Party or inability to leave a voicemail to return call to the facility in the past due to a full voicemail box.	

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F 580	Continued From page 2 mobility and transfers. She was always incontinent of bowel and bladder. The MDS revealed she had no wounds present on admission. A review of the Wound Assessment Report dated 1/19/18 completed by the wound treatment nurse revealed Resident # 7 was assessed to have a new wound during nursing rounds and the in house physician was aware. The section Responsible Party (RP) notified on the wound report, documented "No" the RP had not been notified. In an interview with the wound treatment nurse on 2/13/18 at 2:59 PM she revealed it was difficult to get in contact with the resident ' s RP as her voice mail box was often full and she could not leave a message. The wound nurse revealed that she documented "No" she had not notified the resident ' s RP or left a message to call the facility. She stated that she should have documented that she was unable to contact the RP and left a message for the RP to call the facility. In an interview on 2/14/18 at 3:05 PM the Administrator revealed that staff are expected to notify the Responsible Party or leave a message to call the facility back and document any attempts to notify the RP or family.	F 580	Procedure for implementing the acceptable plan of correction: The treatment nurse was in-serviced on notification of the Responsible Party or to leave a message to call facility back and document any attempts to notify the RP or family of any change in resident condition on 02/15/2018 by the Quality Assurance (QA) Nurse. All other nurses have been in-serviced on notification of the Responsible Party or to leave a message to call facility back and document any attempts to notify the RP or family of any change in resident condition on 02/19/2018 by the QA Nurse. Any staff not available for the training will not be allowed to work until training is complete. Any newly hired nurses will receive in-service training on notification of the Responsible Party or to leave a message to call facility back and document any attempts to notify the RP or family of any change in resident condition. The monitoring procedure to ensure that the plan of correction is effective: The Director of Nursing (DON) or QA Nurse will complete a Clinical Review of Responsible Party Notification audit tool 5 times per week (Monday - Friday) during morning clinical meeting to assess for resident change in condition and nurse intervention to include notification of the RP and physician of any change in	

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F 580	Continued From page 3	F 580	resident condition. The results of the audit will be forwarded to the QA committee for review monthly for 3 months for review and further recommendations. The title of the person responsible for implementing the acceptable plan of correction. Director of Nursing	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, staff and nurse practitioner interviews, the facility failed to secure a resident in the van during transport according to manufacturer's recommendations causing the resident to fall for 1 of 3 sampled residents who were transported using a contracted van service and failed to notify a supervisor or call 911 for assistance when 1 of 1 fell to the van floor and remained on the van floor for the duration of her transport to a physician ' s visit (Resident #3). Resident #3 slid out of the wheelchair when the driver abruptly	F 689	Past noncompliance: no plan of correction required.	2/26/18

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F 689	Continued From page 4	F 689		

stopped and then swerved to avoid hitting the vehicle in front of him resulting in the resident landing on her buttocks and sliding forward on the van floor. The driver was unable to place her back in the wheelchair and she was left on the van floor for the remainder of the trip, which was approximately 7-9 minutes until she reached her appointment destination. There were no injuries sustained.

Findings included:

Resident #3 was admitted to the facility on 2/22/16 and re-admitted on 7/2/16 with diagnoses including Degenerative Joint Disease, End Stage Renal Disease and Diabetes Mellitus.

Review of the most recent quarterly Minimum Data Set (MDS) Assessment date 1/25/18 identified Resident #3 as cognitively intact with a Brief Interview for Mental Status score of 14.

Review of the medical record indicated Resident #3 had a physician ' s appointment on 2/1/18 at 7:15 AM.

The manufacturer's instructions for restraining the occupant in the van was reviewed. The instruction illustrated six (6) restraints to be used during wheelchair transportation including left rear wheel, right rear wheel, left front wheel, right front wheel, waist, and upper body. The instruction read, "BE CERTAIN THAT ALL PASSENGERS ARE PROPERLY SECURED BEFORE MOVING THE VEHICLE."

Review of the contracted van service policy read, in part, "if an incident results in injury or suspected injury, it is important that employees

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F 689	Continued From page 5	F 689		

report the incident immediately and secure the appropriate assistance. Of course, if the incident results in a serious trauma or emergency medical condition, call 911 immediately."

The record of the van driver was reviewed. The record indicated that the driver was trained on transportation safety using the manufacturer's instruction on how to secure the wheelchair and the resident in the van in April 2017 and the facility had a copy of his certificate for this training.

Review of the contract van company ' s supervisor ' s accident investigation report dated 2/1/18 indicated the driver was travelling too fast for the road conditions and too close to the vehicle in front of him. The report also indicated the seat belt was not checked properly when put on the resident and the driver failed to do his job as he was trained by not calling 911 to help place Resident #3 back into her wheelchair at the time of the incident.

Review of the nursing note dated 2/1/18 indicated Resident #3 had left for an appointment earlier in the day via a contract ambulance service. The facility staff received a phone call notifying them Resident #3 had been in an incident. When the resident arrived back to the facility she was assessed for injuries. Resident #3 had complaints of pain around her sacral area and was given a pain medication. The Nurse Practitioner was in the facility and assessed the resident and ordered x-rays. Resident #3 was sitting in a chair and talking at this time.

Review of the facility resident incident report dated 2/1/18 indicated Resident #3 was off facility

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F 689	Continued From page 6	F 689		

grounds in a private vehicle and involved in an automobile accident. Resident #3 had left the facility to go to an appointment. The facility was notified later that the resident had been in an incident and had fallen on the floor of the transport van. The resident return to the facility after the appointment and was assessed for injuries and x-rays were performed. The resident was given PRN (as needed) pain medication for complaints of pain.

Review of the Nurse Practitioner ' s note dated 2/1/18 indicated Resident #3 was seen following a motor vehicle accident and complaints of back pain. Resident #3 was noted to be alert and verbal and in no acute distress with mild anxiety. Her vital signs were stable and her pain was controlled. The note indicated x-rays of the lumbar and sacral regions would be ordered. Review of the Thoracic Spine x-ray results, dated 2/1/18, revealed mild degenerative disc disease of the thoracic spine. Review of the Sacrum/Coccyx x-ray results, dated 2/1/18 revealed no fracture or significant destructive osseous lesion seen. Review of the Pelvis x-ray dated 2/1/18 revealed modest Osteoarthritis, but no pelvic or hip fracture. Review of the Lumbar Spine x-ray dated 2/1/18 revealed No compression fracture or bone lesion was noted. Review of the Ankle x-ray dated 2/1/18 revealed no acute fracture, dislocation or destructive osseous lesion.

Review of the written statement from the driver dated 2/1/18 was reviewed. The report indicated he approached a merge in the road and realized the traffic was stopping so he braked hard and swerved to avoid hitting the car in front of him and heard a "clunk" which he realized was the seat

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F 689	Continued From page 7	F 689		

belt buckle of the van hitting the floor. The report further indicated the gel pad on which the resident was sitting on slid from the wheelchair. The driver stopped the van in the median to check on Resident #3. She voiced no complaints. The driver attempted to place Resident #3 back in the wheelchair but was unable to do so. The report indicated he "made her as comfortable as I could and proceeded to the destination which was only 7-9 minutes away." When the driver arrived at the destination a family member came outside and assisted by telling the driver how to place Resident #3 into her wheelchair.

The written statement from Resident #3 was reviewed. The statement from Resident #3 was dated 2/5/18 and read Resident #3 was "put on the bus and her wheelchair was fastened but not her." The driver was driving and to keep from hitting a car he slammed on the brakes. When he hit the brakes Resident #3 slid out of her wheelchair landing on her back feeling like she bruised her ankle as well as hurting her backside. She stated she slid all the way from the back of the bus to the front of the bus while on the floor. The driver then stopped and pulled the bus over and attempted to pick the resident up off the floor but was unable to do so. The "driver told her that he could not get her up, so he got back into the bus and drove while she was on the floor". When arriving at her appointment the driver pulled her by her leg trying to get her out of the bus and off the floor. A family member met the resident at the appointment and was at the scene when the driver placed the resident into her wheelchair.

During an interview with the Administrator on 2/13/18 at 10:41 AM she stated the contracted van service took Resident #3 to an appointment

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F 689	Continued From page 8	F 689		

on 2/1/18 and apparently the driver had to slam on the brakes and Resident #3 fell from her wheelchair. She further stated Resident #3 had a seat belt on that had not been applied correctly and she was not wearing a harness seat belt. She stated the resident ' s family member met Resident #3 at her appointment, learned what had happened and called the facility. She stated when she found out she called the ambulance service and stated she did not want that driver returning the resident to the facility and was informed by the service that the driver was already back in route to the facility. The Administrator then stated the Nurse Practitioner was in the building when the resident arrived and the resident was assessed and x-rays were done with no injuries noted. She also stated the family member had followed the transport van back to the facility and he told the facility he watched the van driver load the resident into the van and ensured the seat belts were applied correctly. The Administrator stated when she interviewed the resident the resident stated the wheelchair was locked down but she had no shoulder harness seat belt on. She stated the van driver should have applied the seat belt correctly and he should have notified 911 when the incident occurred and the resident was on the van floor. She stated on the day of the incident the facility began re-training all the of contract drivers for the named transport company when they arrived to transport any resident. She stated the first training started on 2/1/18 when the named transport company came to the facility at 9:30 AM. The Facility Environmental Services Director checked that the wheelchair was secure and the seat belt and shoulder harness were in working condition and applied correctly. She stated on 2/5/18 the facility transport personnel were

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F 689	Continued From page 9	F 689		

in-serviced on transport van safety including proper lock down of the wheelchair and pulling over in case of emergencies and calling 911 and the facility. She stated the Environmental Services Director was keeping a log of all of the named transport appointments and in-servicing each driver and checking to ensure each resident was secured properly.

During an interview with Resident #3 on 2/13/18 at 11:25 AM she stated she had a doctor ' s appointment and the driver from the van company put her in the van. She stated she was sitting towards the back of the van and the driver locked in the wheelchair but did not put the seatbelt harness over her. She stated the van was traveling down the road and the driver slammed on the brakes to not hit the car in front of him. She stated she came out of the wheelchair and slid on her back to the front of the van. She stated she was quite shook up to be in your wheelchair one minute and on the floor the next and this was frightening. She stated the driver pulled over and tried to get her up but could not and said she would have to stay on the floor until they arrived at her appointment. She continued by stating when she arrived at the physician ' s office the driver opened the side door and her feet were towards the door. She stated her family member was there waiting and helped get me into my wheelchair. She stated that after her appointment her family member made sure she was locked in and the seatbelt on before the driver brought her back to the facility. She stated she was not really complaining of too much pain but her buttocks was hurting and she had x-rays which were all ok. She stated it was just scary.

During an interview with the supervisor of the

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F 689	Continued From page 10	F 689		

driver of the named ambulance service on 2/13/18 at 12:56 PM he stated as far as he knew the driver was going down the road and he heard the seat belt strap hit the floor and the Resident #3 slid out the chair with her gel cushion. The driver pulled over and tried to pick Resident #3 up and could not so he then drove another 7 to 8 minutes to the physician ' s office to get help. He stated on this particular transport van the patient enters from the rear of the van. There are four wheelchair locks to secure the base of the wheelchair, two in the front of the chair and two in the rear. He stated there was a harness seatbelt that crosses over the patient and a lap seat belt. He stated he could only figure that the seat belt was not "snapped" in all the way. He stated all drivers take an online course in van safety and they receive a certificate stating they understand how to secure a wheelchair in the van. He stated he checked the van when the driver returned to the company and both the waist seat belt and harness were in working condition. He stated his expectation would have been for the driver to properly secure the patient in the van and to call 911 to get help when he could not place the patient back into the wheelchair in route to the appointment. He stated their policy read that the driver should have notified his supervisor and 911.

During an interview with transport driver on 2/13/18 at 1:00 PM, who transported Resident #3 on 2/01/18, he stated Resident #3 was sitting next to the nursing station at the time of the pickup. Resident #3 was going to an appointment in Raleigh near the hospital. He stated he put her in the van from the back while she was seated in her wheel chair. He stated he rode up on the lift with the wheelchair after wheels were locked on

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F 689	Continued From page 11	F 689		

the platform and once the wheelchair was up he unlocked the wheels and pushed the wheelchair into the van. At this time he aligned the wheelchair wheels to the straps mounted on the floor and secured the wheels. He stated there are four (4) hooks used to secure the wheelchair frame in four (4) areas. He then stated there was a lap seat belt that was connected from the bottom of the van and that was placed around Resident #3 ' s waist and attached to the other side of the floor. He stated he did not use a harness seatbelt because he had never been able to find the attachment that made this part of the seat belt work. He stated he was told that the lap seatbelt was sufficient sometime during his training in April 2017. He then stated while driving and merging near Capital Boulevard in Raleigh he noticed traffic "breaking hard." He stated he applied the brakes hard and realized he could not bring the van to a stop before hitting the car in front of him. He noticed the median and made a decision to turn the van right to miss the car in front and swerved over. At this time he heard a "clunk" sound and heard Resident #3 say, "whoa, whoa, whoa." He stated he knew the "clunk" sound was the seatbelt hitting the floor because he hears that sound multiple times a day when he unlatches the belt and drops it to the floor. He stated he looked in his mirror and saw Resident #3s head drop down slowly and he glanced back to see that she had slipped out of her seat. He stated he brought the van to a stop, put it in park, put the hazard lights on and jumped out and came around the van. When opening the van door the resident stated she was ok. He stated he tried to get her up but could not. He stated she had been sitting on a gel pad that slid out of the wheelchair onto the van floor. He stated he really did not remember what he was thinking at the

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	345358	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12	F 689		

time but decided the best thing was to continue on to her appointment where he could get help. When they arrived at the appointment he stated someone came out from inside that knew the resident and the resident suggested opening the side door and sliding her to the side so she could put her legs down and then get into her wheelchair. He stated he lifted her and she pivoted to the chair. He stated he waited for her until the appointment was finished and then put her back into the van to return to the facility. He stated he really did not know if the strap was hooked correctly or what happened but that he did push the two pieces of the seatbelt together but could not say if he ever heard the belt click closed in retrospect.

During an interview with the Nurse Practitioner on 2/13/18 at 1:24 PM she stated she evaluated Resident #3 upon her return to the facility on 02/01/18. She stated the resident was alert and oriented. She stated Resident #3 complained of some back pain so she ordered multiple x-rays which were negative. She stated the resident did have a diagnosis of Anxiety and she believed a lot of what she was feeling was this anxiousness. She also stated she would expect that the residents are seat belted in properly when being transported.

During an interview with the nurse consultant on 2/14/18 at 12:16 PM she stated it was 30 minutes from the time of the incident until the driver was able to get the resident out of the van at the physician appointment based on her interview with the family member in which he stated Resident #3 was approximately 30 minutes late for her appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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F 689	Continued From page 13	F 689		

During an interview with Resident #3 ' s family member on 2/14/18 at 12:33 PM he stated the driver of the company didn ' t have Resident #3 "tied in" so when the driver had to make a quick stop Resident #3 came out of the chair and hit the floor. He stated apparently the driver could not get her back into the wheelchair so he drove her to the doctor ' s office on the floor. He stated when he saw the van pull up he went out to meet her and the driver told him what happened. The driver opened the side door and the resident was on the floor. He stated the driver and he put her feet on the ground and the driver went inside the van and unbuckled the wheelchair. The driver then got her up by placing his arms under her arms and lifted her a little just enough to turn so she could sit in the wheelchair. The resident was supposed to be at her appointment at 7:15 AM and she arrived around 7:30-7:35 AM and it took about 5 minutes to get her off the floor into her wheelchair. He stated she was quite shook up. He stated after the appointment he watched the driver buckle the resident in and then he followed the van back at the nursing home.

CORRECTIVE ACTION

The Administrator and Regional Nurse Consultant were interviewed on 2/13/18 at 10:41 AM. They stated they had done an investigation, initiated re-training, in-services and audits for transportation staff and put a Plan of Correction (POC) in place that began on 2/1/18. The Administrator added that she strongly suggested the named Ambulance transport service re-train their employees and that she would expect her residents to be safe during a transfers. She stated the driver of the van had been terminated by the named transport service.

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F 689	Continued From page 14 On 2/1/18 the Administrator, Quality Assurance Nurse, Regional Nurse Consultant and the Facility Environmental Services Director had an impromptu Quality Improvement Executive Committee Meeting to specifically review the facility plan related to the re-training, in-services and audit tool. On 2/1/18 the facility began requiring all drivers from the named Ambulance transport service to be checked off by the facility Environmental Services Director for properly securing the wheelchair and resident with four point floor straps, waist and chest harnesses before the transport occurs. This training had been recorded in the Transport Log Book. On 2/2/18 the facility received requested training/policies from the named Ambulance transport service. This training included certifications of all named Ambulance transport drivers according to their van manufacturer ' s specifications. On 2/5/18 100% of the facility employed van drivers were re-trained on the facility policy for van safety according the van manufacturers ' specification, proper lock down of wheelchairs and pulling over in case of an emergency or incident that may cause injury to the resident and calling 911 and the facility. The Administrator will forward the results of the Transport Log book audit to the Executive QI Committee for monthly review and recommendations times one month. Final date of compliance 2/6/2018.	F 689		

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F 689	Continued From page 15 The Administrator and Environmental Services Director will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the credible allegation of compliance for prevention of accidents. As part of the validation process on 2/14/18, the plan of correction was reviewed including the re-education of staff and observations of interventions put into place to ensure wheelchairs were properly secured in the transport van with four point floor straps, waist and chest harnesses intact. Observations were made of other residents who required the use of the transport van for correct application of the wheelchair straps and seatbelts according to manufacturer's instructions. Interviews with transport drivers revealed they were retrained to ensure the wheelchair was securely locked down using four straps and the waist and shoulder harness seatbelts were applied to the resident correctly. A review of the monitoring tool revealed that the facility completed the audits and re-training of van drivers. The facility alleges full compliance with this plan of correction effective 2/6/18.	F 689		