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	345129	A. BUILDING _____ B. WING _____	04/20/2018

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AUTUMN CARE OF MOCKSVILLE	1007 HOWARD STREET MOCKSVILLE, NC 27028

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F 000	INITIAL COMMENTS A Recertification survey was conducted from 04/16/18 through 04/20/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F 689 at a scope and severity J. CFR 483.70 at tag F 835 at a scope and severity J. Tag F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/27/17 and was removed on 04/20/18. An extended survey was conducted. The Statement of Deficiencies was amended on 05/09/18 at tag F-689 and F-835.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the comprehensive minimum data set for a resident that received dialysis services for 1 of 2 residents sampled for dialysis (Resident #33). The findings included: Resident #33 was admitted to the facility on 12/20/17 and most recently readmitted to the	F 641	This plan of constitutes our written plan ofcompliance for deficiencies cited; however,submission of the plan of correction is notan admission that a deficiency exists orthat one was cited correctly. This plan ofcorrection is submitted to meet requirements established by state and federal law. The plan of correcting the specific	5/14/18

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

Electronically Signed | 05/14/2018

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F 641	Continued From page 1 facility on 01/06/18 with diagnoses that included: dependence on renal dialysis. Review of a cumulative physician order sheet dated 01/06/18 read in part, please take to dialysis 3 times a week. Review of the comprehensive minimum data set (MDS) dated 01/13/18 revealed dialysis was not checked on Resident #33's MDS. An interview was conducted with the MDS Coordinator on 04/20/18 at 10:05 AM. The MDS coordinator stated that she completed most of the sections of the MDS including the section that included dialysis. She indicated that she obtained her information to complete the MDS from various places that included Nursing Assistant (NA) documentation, nurse's notes, assessments, doctor's notes, and physician orders. The MDS coordinator stated that Resident #33 received dialysis 3 times a week and had since she came to the facility. The MDS coordinator confirmed that she had completed the comprehensive MDS on Resident #33 dated 01/13/18 and stated she had just missed it but had coded it correctly in the subsequent assessments. The MDS coordinator stated she would immediately modify and correct the MDS. An interview was conducted with the Director of Nursing (DON) on 04/20/18 at 3:45 PM. The DON stated that the MDSs were completed as accurately as possible and the MDS coordinator had already notified her of the error and told her she had completed the modification to correct the inaccuracy.	F 641	deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to accurately code dialysis on the MDS for resident #33. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Regional MDS nurse provided education for MDS care plan team on 5/14/2018 which includes Dietary Manager, Social Worker, Activities Director, and MDS nurse. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The DON will audit 2 MDS assessments for accuracy per week for 4 weeks and then 2 MDS assessments monthly thereafter for 12 months. The MDS assessment audits will be brought by the DON to the Quality Assurance Committee for review to ensure sustained compliance for 12 months. Any areas of concern will be corrected at the time it is identified. The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing	
F 689	Free of Accident Hazards/Supervision/Devices	F 689		5/14/18

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F 689 SS=J	Continued From page 2 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, resident, and Medical Director interviews the facility failed to ensure that a resident who was transported on external public transportation van was safely transferred from the dialysis center back to the facility. When the van returned to the facility the resident was on the floor and the facility failed to thoroughly investigate and determine root cause of the incident. This affected 1 of 2 residents who received dialysis services (Resident #33). Immediate jeopardy began on 12/27/17 when the external public transportation driver entered the facility and stated to the staff that he needed assistance in getting Resident #33 off the floor of the van. Following the incident, the facility staff failed to thoroughly investigate the incident and to determine the root cause of the incident on the van that involved Resident #33. Immediate jeopardy was removed on 04/20/18 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 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective for	F 689	The plan of correcting the specific deficiency addressing the process that lead to the deficiency cited: Facility did not thoroughly investigate occurrence related to resident #33 fall from wheelchair on external transportation van on 12/27/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: In the event of an accident related to external contracted transportation, facility administrator/DON will collaborate with external contracted transportation in order to investigate to determine root cause of event. In the event of an accident related to external contracted transportation, Administrator/DON will notify supervisor that their services will be suspended until investigation is completed and corrective action taken. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remain corrected and/or in compliance with the regulatory	

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F 689	Continued From page 3 thoroughly investigating incidents and determining root cause of the incident. The findings included: Review of a facility contract titled Public Transportation Agreement dated 07/12/17 read in part, the contractor (external public transportation company) will follow the approved safety plan. All drivers are drug tested and criminal background checks done prior to hiring. A copy of the external public transportation company's safety plan was obtained and outlined the hiring process and training process that included defensive driving (which included distracted driving education and no cell phone use policy), emergency procedures, and behind the wheel training. Resident #33 was initially admitted to the facility on 12/20/17 and readmitted to the facility on 01/13/18 with diagnoses that included seizures, acute respiratory failure, encephalopathy, bilateral above the knee amputations, and dependence on renal dialysis. Review of the comprehensive Minimum Data Set (MDS) dated 01/13/18 revealed that Resident #33 had long and short-term memory problems but was independent with daily decision-making skills. Resident #33 required total assistance of 2 people for transfers. Review of a nurses note dated 12/27/17 at 2:00 PM signed by the Director of Nursing (DON) read in part, the external public transportation van driver came to the nurse's station and stated that Resident #33 was on the floor of the van. He stated that she must have slid out of her wheel chair during transport. The DON and Environmental Services Director (ESD) went to the van to observe the resident and 911 was called for assessment and transport. Resident #33 was alert however lethargic. The external	F 689	requirements: To ensure safety of our residents during transports on facility transport van, Administrator will perform direct observation of transport aid and validate that the transport aid is competent by utilizing the Competency: Securing Wheelchair and Resident in Van form which includes Wheelchair Securement, Securing Passenger, Releasing Wheelchair, and Releasing Passenger on loading and unloading of residents weekly x 4, then monthly x 3, and will be completed annually on current transportation staff. In addition, for new transportation hires, initial competencies will be completed to ensure safety during transport and at least annually thereafter. The competencies for Securing Wheelchair and Residents in Van will be brought to the Quality Assurance Committee monthly for review by the Administrator for 12 months. The Administrator will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies by utilizing the Competency: Securing Wheelchair and Resident in Van form which includes Wheelchair Securement, Securing Passenger, Releasing Wheelchair, and Releasing Passenger on loading and unloading of residents for current drivers and any new hires prior to residents being transported. The competencies will be performed quarterly thereafter by the	

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F 689	Continued From page 4 public transportation van driver was unable to vocalize how long she had been in the floor of the van during the transport however stated that there were cameras in the van that would show that. The external public transportation van driver, DON and ESD stayed with Resident #33 until Emergency Medical Services (EMS) arrived to assist in transferring. EMS assisted resident to her wheelchair and then down the lift and to the EMS stretcher. EMS then transported Resident #33 to the hospital. Resident #33's family was notified of the transport and the external public transportation company's security officer called. He stated they would be completing the investigation on the end of external public transport company and monitoring the camera recordings. Nurse practitioner (NP) was notified. Resident #33 was unable to verbalize what happened or how long she had been in floor. An interview was conducted the external public transportation company's security officer on 04/18/18 at 11:20 AM. He stated that he could not comment on the incident that it was a personnel issue and the external public transportation company's director had the full details of the investigation. An interview was conducted with the Public Transportation Director (PTD) on 04/19/18 at 11:18 AM. The PTD stated that he returned to work on 01/02/18 and learned of the incident. He further stated that they immediately began to investigate the incident and watched the video footage and made the determination of what they believed happened. He stated that the investigation led us to believe that Resident #33 was picked up at dialysis an was enroute to the facility. Resident #33 appeared to have a medical issue which appeared to be a seizure. The driver continued to the facility. While traveling the	F 689	Administrator. To ensure safety of our residents during external contracted transportation, the Administrator will perform initial competencies for all drivers on proper on loading and securing of residents properly. Until the facility is able to secure a contract with a transportation company to provide wheelchair transports, the facility will provide the transportation services. In the event that a stretcher transport is required, the facility will utilize the services of a medical transport company that specializes in stretcher transports. The title of the person responsible for implementing the acceptable plan of correction: Administrator	

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contracture of Resident #33's muscles caused her head to go back and she pushed her hips forward and slid under the seat belt to the floor with her back against the wheelchair. The driver arrived at the facility and opened the door and discovered Resident #33 on the floor of the van and entered the facility to get some help. The facility staff contacted EMS and Resident #33 was transported to the hospital.
The PTD stated they interviewed the driver, however the video footage told us what we needed to know. The driver was terminated because he did not respond appropriately to a medical emergency. The PTD state that drivers received education on lift position procedure, defensive driving, blood and air borne pathogens, first aid, cardiopulmonary resuscitation, automatic external defibrillator use, special needs children, car seat booster seat security, emergency procedure and evacuation, customer sensitivity, call center issues, use of the push to talk phones, inclement weather, and vehicle fueling procedures. He added that after the 39-hour class room training the drivers were put with more seasoned drivers for however long it took them to get acclimated to the process which generally took 2-5 days depending on the experience level of the driver. The PTD stated that the driver never indicated why did not pull over, he stated he did not see her in his mirror that was located directly above his head. The PTD stated that when he reviewed the video footage he was able to ascertain why he did not see Resident #33 in his mirror.
An observation of the video footage from the external public transportation van was made on 04/19/18 at 4:06 PM. The video footage was splint 4 ways with each camera having a different angle. One camera was pointed directly to the

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front of the van, one on the rear of the van, one camera was directly on Resident #33 and one camera was directly on the driver. On 12/27/17 at 12:32 PM the driver was noted to push Resident #33 onto the van and secure her 4-point straps to the floor of the van and apply the seat belt which came over her left shoulder across her abdomen and fastened to the floor behind her right side. The driver began to drive towards the facility at 12:36 PM and at 12:37 PM Resident #33 was observed to begin to violently twitch, her hands appear to become rigid and she threw her head back and her hips slide forward. The driver was observed to pick up his cell phone and proceeded to make a personal call at 12:37 PM, never checking his mirror or speaking to Resident #33. As the van proceeded down the road with each bump, Resident #33 who was now unconscious with her head back, her hips inched closer to the front of the wheelchair seat and at 12:39 PM Resident #33 slipped from the wheelchair to the floor of the van. The seat belt still secured but was now resting across her chest. The driver remained on the phone with no knowledge of what was happening behind him, he again never checked his mirror or spoke to Resident #33.

At 12:41 PM Resident #33 regained consciousness and lifted her head, she appeared disoriented and tried to lift her arm. Resident #33 was heard coughing and appeared to be trying to pull her shirt down over her abdomen. The driver again never checked his mirror and remained on his cell phone. At 12:47 PM the driver returned to the facility parking lot backed the van into the space and placed the van in park. The driver remained in his seat continuing his conversation on the phone and had yet to observe Resident #33 on the floor of the van. He finally exited the van and proceeded to the rear door and opened

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the door. He rode the lift gait up to the van and reached for Resident #33's wheelchair, at which time he realized Resident #33 was not in the wheelchair, he then hung up his phone.
At 12:50 PM the driver loosened the seat belt and attempted to pick up Resident #33 and when he could not, he exited the van and proceed to enter the nursing facility. Resident #33 was still on the floor of the van and the seat belt was now resting against the right side of her neck and was looped under her left arm.
The driver returned at 12:56 PM and completely removed the seat belt from Resident #33. The facility staff arrived at the van at 12:58 PM, the DON was heard speaking to the driver. At 1:00 PM the ESD entered the van and got down on the floor with Resident #33 and states are you feeling ok and Resident #33 stated "NO". The DON then asked Resident #33 "are you a diabetic?" and bent down to Resident #33 and checked a pulse in her right wrist. The DON was then overheard stating "I can't touch her she is on your property", she then dialed a number on her cell phone and was heard asking when EMS would be there and stated, "this is an emergency" and indicated Resident #33 was pale.
At 13:06 EMS arrived on the scene and entered the van and began to assess Resident #33, she was then placed in her wheelchair and exited the van using the rear lift. Once outside the van the EMS workers placed Resident #33 on the stretcher and into the back of the ambulance. At 1:16 PM the driver entered the van and left the parking lot while the EMS van was still parked in the facility parking lot.
An follow up interview was conducted with the PTD on 04/18/18 at 5:00 PM. The PTD stated that driver was terminated for violating the cell phone policy and not pulling over and contacting

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emergency personnel when a medical emergency occurred. The PTD verified that the external public transportation driver had received the education on the lift position procedure, defensive driving, blood and air borne pathogens, first aid, cardiopulmonary resuscitation, automatic external defibrillator, special needs children, car seat booster seat security, emergency procedure and evacuation, customer sensitivity, call center issues, HR, use of the push to talk phones, inclement weather, and vehicle fueling procedures on 08/17/17.

An interview was conducted on 04/18/18 11:42 AM with the current external public transportation driver. The driver of the public transportation van stated that when she was hired she had to complete an online course that included emergency procedures and how to respond to them. The driver explained that they were trained that if there was an emergency or an accident they were to pull over to a safe place and call 911 and to notify our dispatch. The driver stated that it was never appropriate to drive around with a patient on the floor of the van. She also stated that she was not the driver involved in the incident with Resident #33 but she was aware of it. She added that she ensured Resident #33 was always visible in her mirror and she would often talk to her during the commute to make sure she was ok and certainly did not talk on her cell phone while driving the van.

An interview was conducted with Resident #33 on 04/18/18 at 5:50 PM. Resident #33 stated she did not recall the incident on the van at all, she had no idea she had fallen. Resident #33 recalled being in the hospital and stated she has not had any recent seizures. Resident #33 stated she really liked her van driver now and she felt very secure in the van.

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An interview with the ESD was conducted on 04/18/18 12:54 PM. The ESD stated that on 12/27/17 he was called to go outside to meet the DON at the public transportation van. He stated when he walked onto the van he found Resident #33 sitting on her butt in front of her wheel chair. Resident #33 was very sleepy and would not say much. The ESD stated he asked the driver what happed and he stated, "I am trying to get a hold of my supervisor." He added that the DON called EMS and they came and picked her up and put her back in the wheelchair and then transferred her to the stretcher and took her to the hospital. The ESD stated that it appeared that she had slid out from under the seat belt. The ESD stated that he did not have anything to do with the public transportation company, and stated "we believe they have the ability to do what they need to do." He added that he had never ridden with the drivers of the external public transportation company before and did not verify any training or safe driving practices. He stated that when Resident #33 returned from the hospital he added anti tippers to both the front and back of her wheelchair and tilted her seat back a bit to alter her center of gravity since she was a bilateral amputee.

An interview was conducted with the DON on 04/19/18 at 9:10 AM. The DON stated that on 12/27/17 the public transportation driver walked to the nursing station and stated that he needed someone to come and help because he had a resident on the floor of the van. She stated when she entered the van Resident #33 was sitting on her butt in front of her wheelchair and did not look like her usual self but had no obvious injury and was not complaining of any pain. She added she had already called EMS. She stated the driver indicated he did not know what happened when

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he pulled in the parking lot this was what he found. The driver kept insisting that we needed to get Resident #33 up and he was informed that EMS would be there shortly to get her up. The DON stated the driver refused to answer any questions or to provide a statement about the incident.
EMS arrived and placed Resident #33 back in her wheelchair and down the lift and then transferred her to the stretcher and they took her to the hospital. After the driver left the facility the DON stated she contacted the transportation company and left a message and the safety officer returned her call and was informed about the incident.
The following day the public safety officer called the facility and stated to the DON that the driver had not driven since the incident and he had reviewed the video and it appeared that Resident #33 had seizure activity and the fall occurred before pulling into the parking lot. She added that they were later informed that the driver had been terminated for his actions that day and when she requested a copy of the investigation the request was denied. The DON stated that the driver should have immediately pulled over and called 911. She added that she had not seen the video footage and was not aware of any modification that were made to the van or the manner in which Resident #33 was transported. She added that she had not witnessed any further transported with Resident #33 and stated, "she was not the expert on that." She added that Resident #33 had no injury from her fall but did return to the facility on seizure medication and has had no further seizure activity.
An follow up interview was conducted with the DON on 04/20/18 at 3:45 PM. The DON stated that she had been thinking a lot about what she could have done diffidently and stated she should

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have reported the driver for neglect and proceeded to determine the root cause of the incident which should have included being more persistent about obtaining the full details of the investigation from the external public transportation company and watching the video footage.
An interview was conducted with the Administrator on 04/19/18 08:57 AM. The Administrator stated that primarily the facility used the external public transportation van to bring Resident #33 from dialysis He stated that the facility van was tied up with other residents and for consistency the facility used the external public transportation company. The Administrator stated the contract company was responsible for training and safe driving. He added that he had never been out to dialysis to watch them load and unload Resident #33 but at times seen them here at the facility and never had concerns with the staff or the way they unload or load a resident.
The Administrator, DON, and Regional Director of Clinical Operations were notified of the immediate jeopardy on 04/19/18 at 2:58 PM.
The facility provided an acceptable credible allegation of compliance on 04/20/18.

F689 Accidents
Credible Allegation of Compliance

· The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:
o On 12-27-2017, upon return of Resident #33 from dialysis, the contract transportation driver notified facility staff that Resident #33 was on floor of their van and needed assistance at which time the Director of Nursing (DON) and

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Environmental Services Director immediately responded to the van and noted Resident #33 sitting on floor of van in front of wheelchair. The Environmental Service Director reports that at the time he entered the van, Resident #33's wheelchair was secure. The external contracted transportation company driver stated to facility staff that the he had already removed the seat belt from resident #33. At the time of the event, DON did not recall wheelchair securement and the external contracted transportation driver stated that resident #33 slid under the seatbelt onto the floor. No obvious injuries were noted. Emergency Medical Services (EMS) was contacted via 911. The DON repeatedly asked the contract transportation driver about the details of this occurrence, but he would only state that he did not hear anything. Once EMS arrived, they assisted Resident #33 to her wheel chair and exited the van via the lift. EMS then transferred resident to stretcher and resident was then placed into ambulance. The DON again asked the contract transportation driver for details of this occurrence, but he refused to provide any information. The driver also refused to contact his supervisor. The driver then left the facility parking lot in the external contracted transportation van. The facility staff did not inspect the public transportation van. The DON immediately contacted the driver's Supervisor to report occurrence. The public transportation supervisor then informed the DON that there were cameras on the van and that he would review the video. He also stated that this driver would not drive again until this investigation was complete. The DON followed up with the public transportation supervisor on 12-29-2017. He relayed the information regarding the review of the video. He stated that it appeared that the

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resident may have had a seizure. The facility requested to view the video and the request was denied; therefor, the facility staff has not viewed the video. As reported by the Supervisor, the actions of Resident #33 during her seizure could have contributed to the resident sliding from her wheel chair.

o On January 3, 2018, the DON placed a follow up call to the public transportation Supervisor and she was informed that the driver was no longer employed. At the time of the incident, the facility was made aware that the driver was terminated as a result of his actions on December 27, 2017. The facility was only informed that the employee's actions resulted in termination. Root cause analysis completed by facility on 1-3-2018, determined that this was caused by the external contracted transportation driver ' s failure to follow the external contracted transportation's policy on emergency procedures by not supervising or monitoring Resident #33 during transport to ensure the resident remained safe.

· The procedure for implementing the acceptable plan of correction for the specific deficiency
o Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant Director of Nursing. All incidents involving a resident, regardless if the incident occurs on or off of facility property, must be thoroughly investigated.
o All external transports are suspended as of 4-19-2018 for at least the next two (2) weeks until facility can determine safety of our residents during transports in which our facility will require

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documentation/evidence of training and competency. The facility will not utilize external contracted transportation company until contract is updated to include the thorough investigation including all facts of any accident involving a facility resident and the facility will have the right to see all evidence relating to the accident. The Administrator will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies for current drivers and any new hires prior to residents being transported. In the meantime, residents will be transported with the facility van other than emergency transports.

o For resident #33, resident's wheel chair was modified by facility's physical therapist and environmental services director on 1-11-2018. For those residents who have amputations and/or physical challenges, facility occupational/physical therapy will do an evaluation of their wheelchairs to determine if alterations/modifications need to be made in order to ensure safety during transport. Two other residents with amputations were evaluated by Physical Therapist on 4-20-2018 which required no modifications in order to ensure safe transports.

o In the event of an accident related to external contracted transportation, facility administrator/DON will collaborate with external contracted transportation in order to investigate to determine root cause of event. In the event of an accident related to external contracted transportation, Administrator/DON will notify supervisor that their services will be suspended until investigation is completed and corrective action taken.

o On 4-20-2018, Administrator re-educated the transportation staff on proper wheelchair

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securement, seatbelt application, reporting requirements, what to do if there is an accident or if a resident has a medical emergency during transport, loading, and unloading of residents into facility van. In the event of an accident in the facility transportation van, the administrator and DON will be notified immediately and all other transports by facility transportation van will be suspended. Staff will be suspended until an investigation is completed in order to determine root cause and the corrective action is put into place.

· The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the Regulatory requirements.
o To ensure safety of our residents during transports on facility transport van, Administrator will perform direct observation of transport aid and validate that the transport aid is competent by utilizing the Competency: Securing Wheelchair and Resident in Van form which includes Wheelchair Securement, Securing Passenger, Releasing Wheelchair, and Releasing Passenger onloading and unloading of residents weekly x 4, then monthly x 3, and will be completed annually on current transportation staff. In addition, for new transportation hires, initial competencies will be completed to ensure safety during transport and at least annually thereafter.

The Administrator will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies by utilizing the Competency: Securing Wheelchair and Resident in Van form which includes Wheelchair Securement, Securing Passenger, Releasing

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F 689	Continued From page 16 Wheelchair, and Releasing Passenger onloading and unloading of residents for current drivers and any new hires prior to residents being transported. The competencies will be performed quarterly thereafter by the Administrator. To ensure safety of our residents during external contracted transportation, the Administrator will perform initial competencies for all drivers on proper onloading and securing of residents properly. · The title of the person responsible for implementing the acceptable plan of correction. o The Administrator Immediate jeopardy was removed on 04/20/18 when interviews with administrative and transportation staff revealed that they had been educated on reporting and thoroughly investigating incidents and determining root cause for each incident that occurred.	F 689		
F 835 SS=J	Administration CFR(s): 483.70 §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, and staff interviews the facility's administration failed to identify the root cause of an incident that occurred on external public transportation van and then failed to make any process, systemic, or contractual changes with the company and	F 835	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility Administration did not identify the root cause of an incident that occurred on	5/14/18

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F 835	Continued From page 17 allowed the resident to continue to be transported by the company. This affected 1 of 2 residents that received dialysis services (Resident #33). Immediate jeopardy began on 12/27/17 after an incident occurred on the external public transportation van and the facility failed to discern the root cause of the incident, failed to make any process or contractual changes, failed to make any changes to the safety plan and continued to use the external public transportation company to transport Resident #33. Immediate jeopardy was removed on 04/20/18 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 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems put into place are effective for investigating incidents to determine root cause and making subsequent changes to ensure the incident does not happen again. The findings included: This tag is cross referred to F689: Based on observations, record review, staff, resident, and Medical Director interviews the facility failed to ensure that a resident who was transported on external public transportation van was safely transferred from the dialysis center back to the facility. When the van returned to the facility the resident was on the floor and the facility failed to thoroughly investigate and determine root cause of the incident. This affected 1 of 2 residents who received dialysis services (Resident #33).	F 835	external public transportation van and then did not make any process systemic or contractual changes with the company and allowed resident #33 to continue to be transported by the external transport company. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant Director of Nursing. All incidents involving a resident, regardless if the incident occurs on or off of facility property, must be thoroughly investigated. o All external transports are suspended as of 4-19-2018 for at least the next two (2) weeks until facility can determine safety of our residents during transports in which our facility will require documentation/evidence of training and competency. The facility will not utilize external contracted transportation company until contract is updated to include the thorough investigation including all facts of any accident involving a facility resident and the facility will have the right to see all evidence relating to the accident. The Administrator, with corporate oversight and direction, will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies for	

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F 835	Continued From page 18 An interview with the Environmental Service Director (ESD) was conducted on 04/18/18 12:54 PM. The ESD stated that to his knowledge following the incident the driver was terminated and the facility continued to use the external public transportation company to transport Resident #33 back from dialysis. He stated, "we believe they have the ability to do what they need to do." He stated that when Resident #33 returned from the hospital he tilted her seat back a bit to alter her center of gravity since she was a bilateral amputee but that was the extent of it. An interview was conducted with the Director of Nursing (DON) on 04/19/18 at 9:10 AM. The DON stated that following the incident the driver was terminated and she believed that was appropriate action and continued to use the external public transportation company. She added that to her knowledge no systemic or contractual changes had been made. The DON also stated that she was unable to discern the cause of the incident because her request for the full detail of the investigation was denied and she believed that once the driver was terminated that was sufficient action to continue the use of the services. An interview was conducted with the Administrator on 04/19/18 08:57 AM. The Administrator stated that primarily the facility used the external public transportation van to bring Resident #33 back from dialysis. The Administrator stated the contract company was responsible for training and safe driving and he had not provided any oversight to the external public transportation company. The Administrator went on to say that following the incident, the facility did not determine the root cause of the	F 835	current drivers and any new hires prior to residents being transported. In the meantime, residents will be transported with the facility van other than emergency transports. In the event that a stretcher transport is required, the facility will utilize the services of a medical transport company that specializes in stretcher transports. o In the event of an accident related to external contracted transportation, facility administrator/DON, with corporate oversight, will collaborate with external contracted transportation in order to investigate to determine root cause of event. In the event of an accident related to external contracted transportation, Administrator/DON will notify supervisor that their services will be suspended until investigation is completed and corrective action taken. o On 4-20-2018, Administrator re-educated the transportation staff on proper wheelchair securement, seatbelt application, reporting requirements, what to do if there is an accident or if a resident has a medical emergency during transport, loading, and unloading of residents into facility van. In the event of an accident in the facility transportation van, the administrator and DON will be notified immediately and all other transports by facility transportation van will be suspended. Staff will be suspended until an investigation is completed in order to determine root cause and the corrective action is put into place. The monitoring procedure to ensure that	

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F 835	Continued From page 19 incident and they had not made any contractual, systemic, or process changes. He stated they continued to use the external public transportation company to transport Resident #33 back from dialysis because the driver had been terminated and he felt like that was appropriate action and continued to use their services to transport Resident #33. The Administrator, DON, and Regional Director of Clinical Operations were notified of the immediate jeopardy on 04/19/18 at 2:58 PM. On 04/20/18 the facility provided an acceptable credible allegation of compliance. F835 ADMINISTRATION- Corrective Action Plan for Immediate Jeopardy Removal Submission of the corrective action plan for immediate jeopardy removal is not an admission that a deficiency exists or that one was cited correctly. This corrective action plan is submitted to meet requirements established by state and federal law. · The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: o On 12-27-2017, upon return of Resident #33 from dialysis, the contract transportation driver notified facility staff that Resident #33 was on floor of their van and needed assistance at which time the Director of Nursing (DON) and Environmental Services Director immediately responded to the van and noted Resident #33 sitting on floor of van in front of wheelchair. The Environmental Service Director reports that at the time he entered the van, Resident #33's wheelchair was secure. The external contracted	F 835	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the Regulatory requirements. o To ensure safety of our residents during transports on facility transport van, Administrator will perform direct observation of transport aid and validate that the transport aid is competent weekly x 4, then monthly x 3, and will be completed annually on current transportation staff. The Regional Director of Clinical Services will oversee at least one of these audits per period specified to ensure they are being performed correctly. In addition, for new transportation hires, initial competencies will be completed to ensure safety during transport and at least annually thereafter. The Administrator, with corporate oversight, will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies for current drivers and any new hires prior to residents being transported. The competencies will be performed quarterly thereafter by the Administrator. To ensure safety of our residents during external contracted transportation, the Administrator will perform initial competencies for all drivers on proper on loading and securing of residents properly. Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to	

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F 835	Continued From page 20 transportation company driver stated to facility staff that the he had already removed the seat belt from resident #33. At the time of the event, DON did not recall wheelchair securement and the external contracted transportation driver stated that resident #33 slid under the seatbelt onto the floor. No obvious injuries were noted. Emergency Medical Services (EMS) was contacted via 911. The DON repeatedly asked the contract transportation driver about the details of this occurrence, but he would only state that he did not hear anything. Once EMS arrived, they assisted Resident #33 to her wheel chair and exited the van via the lift. EMS then transferred resident to stretcher and resident was then placed into ambulance. The DON again asked the contract transportation driver for details of this occurrence, but he refused to provide any information. The driver also refused to contact his supervisor. The driver then left the facility parking lot in the external contracted transportation van. The facility staff did not inspect the public transportation van. The DON immediately contacted the driver's Supervisor to report occurrence. The public transportation supervisor then informed the DON that there were cameras on the van and that he would review the video. He also stated that this driver would not drive again until this investigation was complete. The DON followed up with the public transportation supervisor on 12-29-2017. He relayed the information regarding the review of the video. He stated that it appeared that the resident may have had a seizure. The facility requested to view the video and the request was denied; therefore, the facility staff has not viewed the video. As reported by the Supervisor, the actions of Resident #33 during her seizure could have contributed to the resident sliding from her	F 835	Administrator, DON, and Assistant Director of Nursing. Regional Director of Operations or Regional Director of Clinical Services will audit one investigation weekly x 4 and monthly x 3, if applicable, to ensure investigations are being conducted correctly. o Monitoring results will be discussed in monthly QAPI as information is available from results of audits of investigation root cause analysis of investigation of incidents/accidents. In addition to ensure sustained compliance, after completion of the four-month monitoring of the investigation of accidents, Regional Director of Clinical Services will complete one random review of accident investigations per month for the next six months. In addition, Regional Director of Operations or Regional Director of Clinical Services will audit training and competencies for completion on new hires related to internal and external transport van drivers. The title of the person responsible for implementing the acceptable plan of correction: Regional Director of Operation and Regional Director of Clinical Services.	

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F 835	Continued From page 21 wheel chair. o On January 3, 2018, the DON placed a follow up call to the public transportation Supervisor and she was informed that the driver was no longer employed. At the time of the incident, the facility was made aware that the driver was terminated as a result of his actions on December 27, 2017. The facility was only informed that the employee s actions resulted in termination. Despite requesting additional information about the cause of the incident, the facility was only informed that the employee's actions resulted in termination, thereby leading the facility to believe that the employee had some culpability for the episode. Thus, because the individual had been terminated, the facility elected to continue using this company to transport residents. The facility's administration did not make additional attempts to obtain more information about this incident and continued using this company to transport residents. So, administration failed to conduct a thorough investigation to determine how the incident occurred and how to possibly prevent a reoccurrence. Root cause analysis completed by facility on 1-3-2018, determined the facility's administration believed the facility did not need to complete a thorough investigation of this incident, which involved Resident #33, since the transport van involved was not the facility's property. · The procedure for implementing the acceptable plan of correction for the specific deficiency o Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to	F 835		

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F 835	Continued From page 22	F 835		

Administrator, DON, and Assistant Director of Nursing. All incidents involving a resident, regardless if the incident occurs on or off of facility property, must be thoroughly investigated.

o All external transports are suspended as of 4-19-2018 for at least the next two (2) weeks until facility can determine safety of our residents during transports in which our facility will require documentation/evidence of training and competency. The facility will not utilize external contracted transportation company until contract is updated to include the thorough investigation including all facts of any accident involving a facility resident and the facility will have the right to see all evidence relating to the accident. The Administrator, with corporate oversight and direction, will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies for current drivers and any new hires prior to residents being transported. In the meantime, residents will be transported with the facility van other than emergency transports.

o In the event of an accident related to external contracted transportation, facility administrator/DON, with corporate oversight, will collaborate with external contracted transportation in order to investigate to determine root cause of event. In the event of an accident related to external contracted transportation, Administrator/DON will notify supervisor that their services will be suspended until investigation is completed and corrective action taken.

o On 4-20-2018, Administrator re-educated the transportation staff on proper wheelchair securement, seatbelt application, reporting requirements, what to do if there is an accident or if a resident has a medical emergency during

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F 835	Continued From page 23	F 835		

transport, loading, and unloading of residents into facility van. In the event of an accident in the facility transportation van, the administrator and DON will be notified immediately and all other transports by facility transportation van will be suspended. Staff will be suspended until an investigation is completed in order to determine root cause and the corrective action is put into place.

· The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the Regulatory requirements.
o To ensure safety of our residents during transports on facility transport van, Administrator will perform direct observation of transport aid and validate that the transport aid is competent weekly x 4, then monthly x 3, and will be completed annually on current transportation staff. The Regional Director of Clinical Services will oversee at least one of these audits per period specified to ensure they are being performed correctly. In addition, for new transportation hires, initial competencies will be completed to ensure safety during transport and at least annually thereafter.
The Administrator, with corporate oversight, will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies for current drivers and any new hires prior to residents being transported. The competencies will be performed quarterly thereafter by the Administrator. To ensure safety of our residents during external contracted transportation, the Administrator will perform initial competencies for all drivers on proper onloading and securing of residents

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F 835	Continued From page 24 properly. Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant Director of Nursing. Regional Director of Operations or Regional Director of Clinical Services will audit one investigation weekly x 4 and monthly x 3, if applicable, to ensure investigations are being conducted correctly. o Monitoring results will be discussed in monthly QAPI as information is available from results of audits of investigation root cause analysis of investigation of incidents/accidents. In addition to ensure sustained compliance, after completion of the four-month monitoring of the investigation of accidents, Regional Director of Clinical Services will complete one random review of accident investigations per month for the next six months. In addition, Regional Director of Operations or Regional Director of Clinical Services will audit training and competencies for completion on new hires related to internal and external transport van drivers. · The title of the person responsible for implementing the acceptable plan of correction. o Regional Director of Operations and Regional Director of Clinical Services Immediate jeopardy was removed on 04/20/18 after interviews with the Regional Director of Clinical Services, Administrator, DON, and Assistant DON had been educated on the process of identifying the root cause of the incident and making appropriate changes to prevent reoccurrence.	F 835		

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F 865	Continued From page 25	F 865		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April 2017 following a recertification survey and subsequently recited in May of 2017 on the follow up and complaint survey and then subsequently recited in April 2018 on the current recertification survey. The repeat deficiencies are in the areas of accuracy of the assessment (F641), accidents (F689) and administration (F835). These deficiencies were recited during the facility's current recertification survey. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to	F 865	F641 - Accuracy of Assessments The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to accurately code dialysis on the MDS for resident #33. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Regional MDS nurse provided education for MDS care plan team on 5/14/2018 including Dietary Manager, Social Worker, Activities Director, and MDS Nurse.	5/14/18

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F 865	Continued From page 26 sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F641: Accuracy of the assessment: Based on record review and staff interviews the facility failed to accurately code the comprehensive minimum data set for a resident that received dialysis services for 1 of 2 residents sampled for dialysis (Resident #33). 438.20 (Resident Assessment): During the follow up and complaint survey in May 2017 accuracy of assessments was cited for failing accurately code the minimum data set to reflect a resident's height for 1 of 9 residents sampled. 1b. F689: Accidents: Based on observations, record review, staff, resident, and Medical Director interviews the facility failed to ensure that a resident who was transported on external public transportation van was safely transferred from the dialysis center back to the facility. When the external public transportation van returned to the facility the resident was on the floor of the external public transportation van. Once the external public transportation van returned to the facility the facility failed to thoroughly investigate and determine root cause of the incident. This affected 1 of 2 residents who received dialysis services (Resident #33). 483.25 Accidents: During the recertification survey in April 2017 accidents was cited for failing to have a side rail securely attached to the bed for 1 of 40 residents.	F 865	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The DON will audit 2 MDS assessments for accuracy per week for 4 weeks and then 2 MDS assessments monthly thereafter for 12 months. The MDS assessment audits will be brought by the DON to the Quality Assurance Committee for review to ensure sustained compliance for 12 months. Any areas of concern will be corrected at the time it is identified. Monitoring effectiveness of corrective action: Audits brought to QA Committee monthly for ongoing review to determine sustained compliance of MDS accuracy. The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing F689 - Accidents The plan of correcting the specific deficiency addressing the process that lead to the deficiency cited: Facility did not thoroughly investigate occurrence related to resident #33 fall from wheelchair on external transportation van on 12/27/2017. The procedure for implementing the	

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F 865	Continued From page 27 1c. F835 Administration: Based on observations, record review, and staff interviews the facility's administration failed to identify the root cause of an incident that occurred on external public transportation van and then failed to make any process, systemic, or contractual changes with the company and allowed the resident to continue to be transported by the company. This affected 1 of 2 residents that received dialysis services (Resident #33). 483.75 Administration: During the recertification survey of April 2017 administration was cited for failing utilize its resources effectively to implement and sustain plans of correction to ensure the facility did not have a medication error rate of 5 percent or greater and resulted in observations during medication pass of a medication error rate of 6.66 percent. The facility also failed to ensure communication occurred from staff to administration to ensure the call light system was functioning properly for 3 resident rooms (Rooms 204 D, Room 204 W, and 216 D) on 1 of 3 resident halls. 483.75 Administration: During the follow up and complaint survey of May 2017 administration was cited for failing maintain dignity and respect of 1 of 3 residents by allowing staff to talk about the resident's weight and lack of mobility while providing care to the resident (Resident #72), repair a fire door on the 200 hall with a broken corner at the bottom of the door on the hinge side to prevent smoke or fire penetration. The facility failed to repair 1 of 1 smoke prevention doors on the 200 hall and 1 of 1 on the 300 hall, failed to repair the double doors of the main dining room on the 200 hall on 1 of 3 residents' hallways, failed to repair 1 of 18 resident bathroom doors	F 865	acceptable plan of correction for the specific deficiency cited: In the event of an accident related to external contracted transportation, facility administrator/DON will collaborate with external contracted transportation in order to investigate to determine root cause of event. In the event of an accident related to external contracted transportation, Administrator/DON will notify supervisor that their services will be suspended until investigation is completed and corrective action taken. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remain corrected and/or in compliance with the regulatory requirements: To ensure safety of our residents during transports on facility transport van, Administrator will perform direct observation of transport aid and validate that the transport aid is competent by utilizing the Competency: Securing Wheelchair and Resident in Van form which includes Wheelchair Securement, Securing Passenger, Releasing Wheelchair, and Releasing Passenger on loading and unloading of residents weekly x 4, then monthly x 3, and will be completed annually on current transportation staff. In addition, for new transportation hires, initial competencies will be completed to ensure safety during transport and at least annually thereafter. The competencies for Securing Wheelchair and Residents in Van will be	

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F 865	Continued From page 28 on the 200 hall (Room #214) and failed to repair resident room doors in 1 of 18 resident rooms on the 200 hall (Room #217) and 1 of 13 resident room doors on the 300 hall (Room #302). The doors were observed with broken and splintered laminate and wood that were rough to touch. The facility also failed to implement care plan interventions by not having a resident's bed in low position as instructed by the care plan for 1 of 3 sampled residents during 2 federal surveys of record. An interview was conducted with the Director of Nursing (DON) and the Administrator on 04/20/18 at 5:08 PM. The Administrator stated that that the Quality Assurance (QA) committee met at least quarterly but they generally met monthly. The QA committee was made up of all the department heads, the consultant pharmacist, and the Medical Director. He stated that they go through the process of reviewing rehospitalization rates, infections, infection control, weight loss, and wounds. The Administrator stated that at the quarterly meetings they discussed medication and the use of antipsychotics in the facility. The DON stated that they continued to report on last year survey results and continue to monitor the effectiveness of the systemic changes they put into place on a as needed basis. The Administrator stated that he could put systems in place to monitor his facility employees but monitoring the external entities was going to be challenging. He added that they were going to have to review admissions more closely and what the residents daily schedule would look like to see if they could adequately take the residents and meet all their needs. The Administrator stated that he was going to try to limit the use of the external public transportation and other outside	F 865	brought to the Quality Assurance Committee monthly for review by the Administrator for 12 months. The Administrator will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies by utilizing the Competency: Securing Wheelchair and Resident in Van form which includes Wheelchair Securement, Securing Passenger, Releasing Wheelchair, and Releasing Passenger on loading and unloading of residents for current drivers and any new hires prior to residents being transported. The competencies will be performed quarterly thereafter by the Administrator. To ensure safety of our residents during external contracted transportation, the Administrator will perform initial competencies for all drivers on proper on loading and securing of residents properly. Until the facility is able to secure a contract with a transportation company to provide wheelchair transports, the facility will provide the transportation services. In the event that a stretcher transport is required, the facility will utilize the services of a medical transport company that specializes in stretcher transports. Monitoring effectiveness of corrective action: Root cause analysis will be reviewed in monthly QA to ensure a thorough investigation is completed related to accidents.	

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F 865	Continued From page 29 resources. The DON and the Administrator stated, that this has been eye opening and would change the admission process and how we view contract employees. The DON added that they will complete a full scope investigation and will conduct root cause analysis to determine how to correctly identify issues as they arise.	F 865	The title of the person responsible for implementing the acceptable plan of correction: Administrator F835 - Administration The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility Administration did not identify the root cause of an incident that occurred on external public transportation van and then did not make any process systemic or contractual changes with the company and allowed resident #33 to continue to be transported by the external transport company. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant Director of Nursing. All incidents involving a resident, regardless if the incident occurs on or off of facility property, must be thoroughly investigated. o All external transports are suspended as of 4-19-2018 for at least the next two (2)	

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F 865	Continued From page 30	F 865	weeks until facility can determine safety of our residents during transports in which our facility will require documentation/evidence of training and competency. The facility will not utilize external contracted transportation company until contract is updated to include the thorough investigation including all facts of any accident involving a facility resident and the facility will have the right to see all evidence relating to the accident. The Administrator, with corporate oversight and direction, will collaborate with contracted transportation company to obtain a list of drivers that will be providing services to our facility in order to perform initial competencies for current drivers and any new hires prior to residents being transported. In the meantime, residents will be transported with the facility van other than emergency transports. In the event that a stretcher transport is required, the facility will utilize the services of a medical transport company that specializes in stretcher transports. o In the event of an accident related to external contracted transportation, facility administrator/DON, with corporate oversight, will collaborate with external contracted transportation in order to investigate to determine root cause of event. In the event of an accident related to external contracted transportation, Administrator/DON will notify supervisor that their services will be suspended until investigation is completed and corrective action taken. o On 4-20-2018, Administrator	

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F 865	Continued From page 31	F 865	re-educated the transportation staff on proper wheelchair securement, seatbelt application, reporting requirements, what to do if there is an accident or if a resident has a medical emergency during transport, loading, and unloading of residents into facility van. In the event of an accident in the facility transportation van, the administrator and DON will be notified immediately and all other transports by facility transportation van will be suspended. Staff will be suspended until an investigation is completed in order to determine root cause and the corrective action is put into place. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the Regulatory requirements. o To ensure safety of our residents during transports on facility transport van, Administrator will perform direct observation of transport aid and validate that the transport aid is competent weekly x 4, then monthly x 3, and will be completed annually on current transportation staff. The Regional Director of Clinical Services will oversee at least one of these audits per period specified to ensure they are being performed correctly. In addition, for new transportation hires, initial competencies will be completed to ensure safety during transport and at least annually thereafter. The Administrator, with corporate oversight, will collaborate with contracted transportation company to obtain a list of	

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F 865	Continued From page 32	F 865	drivers that will be providing services to our facility in order to perform initial competencies for current drivers and any new hires prior to residents being transported. The competencies will be performed quarterly thereafter by the Administrator. To ensure safety of our residents during external contracted transportation, the Administrator will perform initial competencies for all drivers on proper on loading and securing of residents properly. Regional Director of Clinical Services provided education on root cause analysis and thorough investigation of incidents/accidents to prevent re-occurrences on 4-20-2018 to Administrator, DON, and Assistant Director of Nursing. Regional Director of Operations or Regional Director of Clinical Services will audit one investigation weekly x 4 and monthly x 3, if applicable, to ensure investigations are being conducted correctly. o Monitoring results will be discussed in monthly QAPI as information is available from results of audits of investigation root cause analysis of investigation of incidents/accidents. In addition to ensure sustained compliance, after completion of the four-month monitoring of the investigation of accidents, Regional Director of Clinical Services will complete one random review of accident investigations per month for the next six months. In addition, Regional Director of Operations or Regional Director of Clinical Services will audit training and	

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F 865	Continued From page 33	F 865	competencies for completion on new hires related to internal and external transport van drivers. Monitoring effectiveness of corrective action: RVPO and RDCS will review QA data monthly to ensure accuracy of MDS assessments, audits are completed, and the completion of a root cause analysis for accidents. The title of the person responsible for implementing the acceptable plan of correction: Regional Director of Operation and Regional Director of Clinical Services.	