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	345411	A. BUILDING _____ B. WING _____	C 07/30/2019

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HAYWOOD NURSING AND REHABILITATION CENTER	516 WALL STREET WAYNESVILLE, NC 28786

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 07/22/19 through 07/23/19. One of the seven allegations investigated was substantiated. Past non-compliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F 689 constitued substandard quality of care. Non-compliance began on 07/10/19. The facility came back in compliance effective 07/15/19. The survey team entered the facility on 07/22/19 to conduct a complaint investigation survey and exited on 07/23/19. The survey team returned to the facility on 07/25/19 to conduct an extended survey and exited on 07/25/19. Additional information was obtained on 07/30/19. Therefore, the exit date was changed to 07/30/19.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of manufacturer's instructions, and staff, resident, Physician, Emergency Medical Technician (EMT),	F 689	Past noncompliance: no plan of correction required.	8/13/19

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

Electronically Signed | 08/13/2019

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and manufacturer representative interviews, the facility failed to ensure the transport van's S-hooks were properly secured to a wheelchair during a van transport for 1 of 1 resident reviewed for supervision to prevent accidents. Resident #1's wheelchair flipped backwards and she struck her head and landed on the oxygen tank that was strapped to the back of her wheelchair. The Transportation Aide (TA) removed the oxygen tank and wheelchair prior to the resident being assessed by a Nurse or EMT. Resident #1 was transported to the hospital and diagnosed with a right-sided subdural hematoma (bleeding under the membrane covering the brain), a right-sided subarachnoid hemorrhage (bleeding in the area between the brain and tissues that cover the brain) and a T-11 burst fracture (type of traumatic spinal injury in which a vertebra breaks).

Findings included:

Review of the manufacturer's instructions for the "FF600 Retractor Systems Track Applications" which is the system used on the facility's transport van to secure residents who are seated in wheelchairs during transport specified, "place the S-hook securely around a structural member (non-detachable part of the frame) of the wheelchair. Pull on the S-hook to ensure full engagement around the structural member. Push the retractor release lever until loose webbing is retracted. Repeat procedure for other retractors."

Resident #1 was admitted to the facility on 03/09/18 with multiple diagnoses that included diabetes, muscle wasting and atrophy, and respiratory failure. The quarterly Minimum Data Set (MDS) dated 04/18/19 assessed Resident #1

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with intact cognition, used a wheelchair for mobility and required limited to extensive assistance with activities of daily living. Review of Resident #1's medical record revealed no diagnosis of seizure disorder.

The facility's incident/accident report dated 07/10/19 indicated the following:
*Location: "out of facility during transport."
*Description: "Resident #1 fell over in her wheelchair during transport. Nurse #1 received phone call and went to van to evaluate Resident #1. Appeared more confused than earlier in the AM. Complained of back pain from the neck down to her hips and in left arm. 911 called and Resident #1 sent to Emergency Department (ED) for evaluation and treatment."
*Immediate Action Taken: "Assessment was done and Resident #1 sent to the ED due to complaints of back pain from the hip to her neck and left arm." Reported level of pain 6 out of 10. It was noted Resident #1 was "lethargic (drowsy) and with tremor and frequent jerking motions."

Review of the facility's post fall review dated 07/10/19 read in part, "Witnessed fall with possible head injury, back pain, hit head. Resident #1 fell over in the wheelchair during transport. Physician and Responsible Party (RP) both notified."

The ED report dated 07/10/19 revealed Resident #1 arrived by ambulance for evaluation after a fall while being transported to an appointment. The report read in part, "She was being transported in a wheelchair van. She was not strapped into a wheelchair. When the van made a sharp curved the patient fell from the wheelchair. She hit her buttocks against the bottom of the van and had

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likely some degree of whiplash injury to her neck. She also may have hit her head. No loss of consciousness." Resident #1 received Computerized Tomography (CT) scans (computer generated images of the bones, blood vessels and soft tissues inside the body) of the head and lumbar spine that were positive for injury. Resident #1 was diagnosed with a nondisplaced T11 burst fracture (type of traumatic spinal injury in which a vertebra breaks), closed head injury, right cerebral hemorrhage, right-sided subdural hematoma (bleeding under the membrane covering the brain) and right-sided subarachnoid hemorrhage (bleeding in the area between the brain and tissues that cover the brain). Resident #1 was transferred to another hospital for a higher level of acute care on 07/10/19 and subsequently discharged to a hospice facility.

Resident #1 was unable to be interviewed.

A telephone interview was conducted with Transportation Aide (TA) #1 on 07/22/19 at 4:29 PM. TA #1 confirmed she was driving the transport van on 07/10/19 when Resident #1 fell over in the wheelchair during transport and has not been back to work since the incident. TA #1 explained prior to departure, she loaded Resident #1 into the facility van, secured the resident's wheelchair to the van using a 4-point S-hook floor straps and a 2-point lap/shoulder belt, ratcheted the floor straps down, and doubled-checked to make sure the safety straps were secure. TA #1 stated she then drove out of the facility's parking lot, stopped at a red light and as she veered the van toward the right, she felt "a couple of kicks on the back of her seat" and then heard Resident #7 state Resident #1 had fallen. She added she immediately pulled the van over into a parking lot

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and noticed Resident #1 had fallen backwards in the wheelchair landing on the floor of the van, looking upward toward the ceiling of the van and lying on top of the oxygen tank that was strapped to the back of the wheelchair. TA #1 verified the front 2 S-hook straps were no longer attached to the wheelchair. She added the Administrator and Nurse #1 were immediately notified and came to the scene of the incident. TA #1 stated Resident #1 was able to roll enough that allowed her to pull the oxygen tank and wheelchair out from underneath her. TA #1 stated she always made sure all safety measures were in place and secure prior to departure but was unable to explain how the front 2 S-hook floor straps had come loose.

An interview was conducted with Resident #7 on 07/22/19 at 5:41 PM, who was assessed with intact cognition on his comprehensive MDS dated 07/02/19. Resident #7 confirmed he was in the facility van with Resident #1 during transport on 07/10/19 and stated the incident occurred "just after we pulled out of the parking lot at the red light." Resident #7 added Resident #1 was positioned in her wheelchair, facing the front of the van, about a wheelchair's length in front of his wheelchair. Resident #7 recalled it was cold and he was looking down at the floor when the van was stopped at a red light and when the van started moving again Resident #1 fell backwards in the wheelchair, landing close to him, with her face looking up toward the ceiling of the van and her eyes appeared "to be bulging out of the sockets." Resident #7 stated he never noticed Resident #1 shaking prior to the fall or heard her saying anything as she fell backwards but did recall Resident #1 complaining of back pain and her left arm hurting while she was lying on the

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floor. He added Resident #1 seemed as if she couldn't catch her breath. Resident #7 stated TA #1 immediately pulled the van over, came to the back of the van and called the facility. He added 911 personnel and facility staff both came to the scene. Resident #7 confirmed TA #1 had transported him in the facility van on multiple occasions without incident and felt she was a safe driver.

A telephone interview was conducted with Nurse #1 on 07/22/19 at 9:11 PM. Nurse #1 confirmed she was contacted by the TA #1 on 07/10/19 after Resident #1 fell from her wheelchair during transport and immediately went to the scene of the incident. Nurse #1 recalled when she arrived, Resident #1 had already been removed from the wheelchair and was lying flat on her back on the floor of the van. Nurse #1 stated she was unsure who had removed the oxygen tank and wheelchair from underneath Resident #1 and recalled the oxygen tank was positioned next to the Resident #1's right side, her right arm was straight by her side and her left arm was up in the air next to the wall of the van. During assessment, Nurse #1 stated Resident #1 responded to questioning and complained of pain in her back. Nurse #1 added Resident #1 grimaced when her neck was "barely touched" and she instructed staff to call 911. She added she had stayed with Resident #1 until paramedics arrived to transport her to the hospital.

A telephone interview was conducted with the Emergency Medical Technician (EMT) on 07/24/19 at 3:30 PM. The EMT recalled when Emergency Medical Services (EMS) arrived at the scene of the incident, Resident #1 was lying on the floor of the van in a supine position and

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her oxygen tank and wheelchair had already been moved from underneath her. The EMT reported they were informed by facility staff that Resident #1 had slid out of her wheelchair during transport. He stated Resident #1 was alert and talking with some confusion and complained of back pain. He added she was assessed for injuries and there were several, questionable areas on her head that were raised but Resident #1 stated they were normal. The EMT stated Resident #1 was placed into the EMS vehicle and transported to the ED for evaluation, with no issues during transport.

An interview with the Administrator was conducted on 07/22/19 at 11:47 AM. The Administrator confirmed there was an incident on 07/10/19 where Resident #1 fell from her wheelchair while being transported to an appointment on the facility van. She added an investigation was initiated, TA #1 was suspended immediately following the incident and an outside company was utilized for transportation services. Immediately after the interview, the Administrator provided a summary of the investigation and Performance Improvement Plan (PIP) that was put into place following the incident on 07/10/19.

A follow-up, joint interview was conducted with the Administrator and Corporate Registered Nurse (CRN) on 07/22/19 at 4:46 PM. The Administrator confirmed she was notified by TA #1 that Resident #1 had fallen in her wheelchair during transport. The Administrator stated she instructed TA #1 to call the nurse on-call to come and assess the resident. She explained when she arrived at the scene of the incident, Resident #1 was lying on her back on the floor of the van with her wheelchair positioned toward the front of

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the bus. The Administrator recalled the 2 rear S-hook floor straps were removed from the track, so the wheelchair could be pulled from underneath Resident #1, and the front 2 S-hook floor straps were still in the track. She stated Resident #1 complained of back pain when assessed by Nurse #1 and a call was placed to 911 to transport her to the ED for evaluation. The Administrator stated an investigation was immediately initiated and she, along with the CRN and Maintenance Director, spent the day trying to reenact what could have possibly occurred to cause the front van's 2 floor S-hook straps to come loose from Resident #1's wheelchair. As part of the investigation, which included an interview with Resident #7 and TA #1's recollection of feeling kicks to the back of the driver's seat, the Administrator explained she had staff securely strap her into a wheelchair on the facility van and started making "jerking and kicking movements" which eventually caused the front 2 S-hook floor straps to come loose from the wheelchair. The Administrator stated based on their investigation and reenactments, they determined all straps were functioning properly and the S-hook floor straps had to have been secured prior to departure or Resident #1 would have fallen out of or slid in the wheelchair as soon as the van was leaving the facility parking lot. She added they concluded the only logical explanation to what possibly occurred was that Resident #1 had kicking and/or jerking movements in the wheelchair during transport which caused the front 2 S-hook floor straps to come loose.

A follow-up, joint interview was conducted with the Administrator and CRN on 07/22/19 at 4:46 PM. The CRN verified the Administrator's

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statement of events and added she also had staff securely strap her into a wheelchair while seated on the facility van. The CRN explained she started "rocking and kicking" while seated in the wheelchair, trying to mimic seizure-like activity, and stated the 2 front S-hook floor straps came loose which surprised her. The CRN then had the Maintenance Director drive the van, with her seated in the wheelchair with all safety straps securely in place except for the front 2 S-hook floor straps. She explained as soon as he started driving the van through the parking lot, she started sliding in the wheelchair and had to grab onto the left wall of the van to stabilize. The CRN stated when Resident #7 and the TA #1 were interviewed, neither recalled hearing anything prior to Resident #1's fall. She added Resident #1 had history of seizures but could not recall her having any type of seizure-like activity prior to this event. The CRN explained based on TA #1's recollection of feeling kicks to the back of the driver's seat along with the fact Resident #1 never made any sounds or yelled out prior to her fall, they felt it was possible she could have had a seizure just prior to the incident and her kicking movements somehow caused the front 2 S-hook floor straps to come loose from the wheelchair.

A joint interview was conducted with the Maintenance Director and Administrator on 07/23/19 at 8:25 AM. The Maintenance Director confirmed weekly maintenance was conducted on the facility van that included checking the shoulder and S-hook straps to ensure they were in good working order and not frayed. He added a safety inspection, as documented on the vehicle work history report, was conducted on 07/06/19 that identified no concerns. The Maintenance Director confirmed he also

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conducted annual training with authorized drivers, including TA #1, that consisted of reviewing the steps for transport safety, demonstration of how to properly secure someone in the wheelchair and had them provide return demonstration. He confirmed the S-hook straps and locks were checked after the incident involving Resident #1 and found to be in good working order. He added reenactments were conducted to try and determine what could have caused the S-hook floor straps to come loose from Resident #1's wheelchair and stated without knowing the exact position of her wheelchair or how the S-hook floor straps were placed they couldn't determine a definite cause. Both the Administrator and Maintenance Director agreed that in all likelihood, when the S-hook floor straps were securely placed they should not have come loose but added based on their reenactments, they determined the only logical explanation was Resident #1 somehow kicked or jerked the straps loose during transport.

An observation of the facility van was conducted with the Administrator, Maintenance Director and Director of Nursing on 07/23/19 at 8:25 AM. The Maintenance Director was placed in the exact wheelchair Resident #1 was seated in at the time of her fall on 07/10/19. The Administrator was observed following the manufacturer's instructions when placing the S-hook floor straps onto the wheelchair and once all straps were correctly placed, she double-checked to ensure the straps were all secure. The Maintenance Director rocked the wheelchair back and forth and all 4 of the van's floor S-hooks that were attached to the wheelchair remained secured.

A telephone interview was conducted with the

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Medical Director (MD) on 07/23/19 at 12:12 PM. The MD confirmed he was notified of the incident involving Resident #1 on 07/10/19. He added the Administrator discussed with him the investigation into the incident and subsequent PIP that was put into place by the facility. The MD stated while at the facility, he looked over the facility van and tried placing the S-hook floor straps on the wheelchair several different ways, but the straps seemed secure and never dislodged. The MD added he was not sure how the straps came loose while Resident #1 was being transported in the facility van and felt it was an "unfortunate accident."

A telephone interview was conducted with a representative of the manufacturer of the wheelchair safety lock system utilized by the facility on 07/23/19 at 3:24 PM. The representative confirmed if the van's floor S-hooks were secured correctly to the wheelchair as instructed in the training video, they should have not come loose from the wheelchair with any type of movement.

A follow-up telephone interview with TA #1 was conducted on 07/30/19 at 3:02 PM. TA #1 stated prior to Resident #7 telling her that Resident #1 had fallen, she did not hear any noises or Resident #1 say anything. She stated she only felt something kick the back of the driver's seat as the van moved and veered toward the right from the stop light. She explained it "all happened so quickly" and once the van was parked, she went to the back of the van where Resident #1 was lying on the floor. TA #1 recalled the back of Resident #1's wheelchair was lying directly on top of the oxygen tank and she had slid slightly up in the wheelchair with one

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leg up in the air and the other leg resting on the wheelchair. TA #1 could not recall if Resident #1 was having trouble breathing but did appear uncomfortable lying on top of the oxygen tank. TA #1 stated she was trained to never move a resident until they were assessed by a nurse and confirmed she did not move Resident #1 off the oxygen tank. She explained Resident #1 was moving on her own, independently lifted her head and arched her back slightly toward the left, so she could pull the resident's wheelchair and oxygen tank from underneath her.

A follow-up telephone interview was conducted with the EMT on 07/30/19 at 1:27 PM. The EMT stated in some life-threatening instances, it would be appropriate to move a resident after a fall to ensure their safety. The EMT added he was not sure how licensed or non-licensed facility staff were trained to respond when a resident fell but would not suggest moving someone without using manual stabilization (holding the head/neck in place) to prevent further injury.

A follow-up interview was conducted with the facility MD on 07/30/19 at 2:01 PM. The MD stated when Resident #1 was observed lying on the oxygen tank it would have been difficult to stabilize her neck without moving her and could understand why non-licensed staff would attempt to move the oxygen tank from underneath her to make her more comfortable. The MD added without knowing the extent of Resident #1's injuries at the time of her fall and because she complained of back pain, staff should have made sure Resident #1's head and neck were immobilized prior to her moving to avoid potential spinal cord injury.

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The facility provided the following Performance Improvement Plan with the plan of correction date of 07/15/19:

"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."

-The facility has self-identified an opportunity with transportation services related to the staffing and training of transportation attendants regarding safety precautions, utilization of required safety restraints and emergency management following an accident.

-On 07/10/19, Resident #1 received immediate assessment and medical attention as required. 911 was called at the time of the incident and Resident #1 was transported to the hospital via EMS. The Physician and Responsible Party were both notified. The Administrator or designee will complete a full investigation.

-On 7/10/19, the Administrator suspended the transportation attendant involved and suspended the usage of facility transportation until all transport staff are re-educated and return demonstration has been verified. The facility has made arrangements to meet residents transport needs in the interim. The facility has arranged outside transport to accommodate transport needs.

-The Administrator or designee will complete an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345411	A. BUILDING _____ B. WING _____	C 07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD NURSING AND REHABILITATION CENTER	516 WALL STREET WAYNESVILLE, NC 28786

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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audit of all employees currently designated as transportation attendants to verify the following and provide re-education as required. Transportation attendants will not provide transportation services prior to completing re-training as follows:
*Safe driving record verified
*Has received education on safety precautions related to operating a handicapped accessible vehicle
*Has received education and has return demonstrated usage of safety restraints and the completion of the Securement checklist prior to engaging the vehicle for transport
*Has received education and has return demonstrated appropriate usage of the mechanical lift associated with the vehicle
*Verbalizes understanding of emergency management following an accident.
*Verbalizes understanding not to move a resident involved in an accident situation until Medical personnel arrive.

Re-education of staff began on 07/12/19 and concluded on 07/15/19. The manufacturer guidelines and video were used for re-education and return demonstration.

-On 7/10/19, the Administrator or designee will observe residents being transported by facility staff daily for 14 days and then randomly each week for 10 weeks to ensure appropriate safety restraints are in use and the Securement Checklist is completed prior to engaging the vehicle for a transport. Opportunities identified through these audits will be corrected daily as identified. This was started on 07/12/19.

-The Performance Improvement Plan was

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F 689	Continued From page 14	F 689		

presented to and accepted by the facility Quality Assurance (QA) committee on 07/12/19.

-The results of the audits will be reported in the monthly Quality Assurance (QA) committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.

-The Administrator is responsible for compliance. The date of compliance is 07/15/19.

The Performance Improvement Plan was validated on 07/23/19 and concluded the facility implemented an acceptable corrective action plan on 07/15/19 once all authorized drivers were trained. The validation included observing the Administrator securing the Maintenance Director in the transportation van since the facility was using an outside company for transportation services. The facility provided documentation that included: Transport Drivers training, vehicle driver safety agreements and re-education records, Departmental Managers safety training records, in-service records provided to all staff on abuse and neglect, daily list of residents with outside appointments, and facility audits.

The daily monitoring of residents transported by the outside company's transportation driver were reviewed. There were no residents transported using the facility transport van since 07/10/19. The monitoring started on 07/12/19 with the outside transportation company's driver and was ongoing. Residents who were transported to outside appointments were interviewed and reported no concerns. Facility staff were interviewed and confirmed they received training

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F 689	Continued From page 15 on transportation safety that included how to properly secure a resident in the wheelchair and perform return demonstrations.	F 689		