STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WHITE OAK MANOR - SHELBY	401 N MORGAN STREET SHELBY, NC 28150

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E 000	Initial Comments An unannounced Recertifiction survey was conducted on 08/26/19 through 08/29/19. The facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID# S4D411.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 08/26/19 through 08/29/19. There was one allegation investigated and it 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 04/05/19. The facility came back in compliance effective 04/11/19. An extended survey was conducted. The 2567 was to be posted on 9/13/19 but was delayed until 9/16/19 due to a review of a deficiency by management. The facility was notified of the delay on 9/13/19.	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 Minimum	F 641	White Oak-Shelby does complete assessments that accurately reflect the	9/23/19

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

Electronically Signed | 09/23/2019

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F 641	Continued From page 1 Data Set (MDS) assessment in the area of discharge for 1 of 1 closed record (Resident # 112) and in the area of hospice care for 1of 1 resident (Resident #67) reviewed for MDS accuracy. Findings included: 1. Resident #112 was admitted to the facility 09/10/18 with diagnoses including hypertension (high blood pressure), diabetes, and non-Alzheimer's dementia. Review of the care plan for discharge last updated 03/31/19 revealed Resident #112 was in the facility for short-term rehabilitation and planned on returning home after completion of therapies. A discharge Minimum Data Set (MDS) dated 05/31/19 revealed Resident #112 was discharged to an acute hospital. A review of the discharge summary dated 05/31/19 revealed Resident #112 was discharged to home. An interview with MDS Nurse #1 on 08/29/19 at 2:09 PM revealed Resident #112 was discharged home and not to a hospital. MDS Nurse #1 stated the MDS dated 05/31/19 should have been coded to reflect Resident #112 was discharged home. MDS Nurse #1 stated the information was coded in error and would require a correction to the MDS. An interview with the Director of Nursing (DON) on 08/29/19 at 2:31 PM revealed Resident #112 was discharged home. The DON stated the MDS	F 641	residents status. Resident #112 discharge Minimum Data Set (MDS) was corrected on 8-29-19 by the MDS Nurse to reflect that Resident #112 was discharge to home. Resident #67 Minimum Data Set (MDS) was corrected on 8-29-19 by the MDS Nurse to reflect that resident #67 was receiving hospice services. An initial Audit of Hospice Residents for coding accuracy on the last MDS was completed by the Director of Nursing on 9-16-19 with no issues noted. An initial Audit of Discharge Coding location for the last 30 days for accuracy of discharge was completed by the Director of Nursing on 9-16-19 with no issues noted. Social Services Director was re-educated by the Corporate Social Services Consultant on 8-29-19 on MDS Accuracy. The MDS nurses were re-educated by the Director of Nursing on 8-29-19 for MDS accuracy. Care Plan Team was re-educated by the Director of Nursing on 9-16-19 on MDS accuracy. Newly hired staff will be educated during orientation. Ongoing monitoring and compliance will be achieved by the completion of the MDS Coding of Discharge location audit and the MDS Hospice Coding Audit. MDS Coding Discharge audit will be completed by the DON/ADON or designee weekly x 4 weeks to include all discharged residents. Then monthly x 3	

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F 641	Continued From page 2 should have been coded to reflect Resident #112 was discharged home and not to a hospital. The DON also stated she expected the MDS to be coded correctly and she expected a correction to be done. An interview with the Administrator on 08/29/19 at 2:41 PM revealed she expected the MDS to be coded correctly. 2. Resident #67 was admitted to the facility 09/28/16 with diagnoses including heart failure and non-Alzheimer's dementia. Review of the medical record revealed Resident #67 was admitted to hospice on 04/23/19. Review of the care plan for significant weight loss last updated 06/14/19 revealed Resident #67 was under hospice care related to a diagnosis of terminal protein calorie malnutrition. A quarterly Minimum Data Set (MDS) dated 07/18/19 under Section O Special Treatments, Procedures, and Programs revealed Resident #67 was not coded as receiving hospice services. An interview with MDS Nurse #1 on 08/29/19 at 2:03 PM revealed Resident #67 had been receiving hospice services since 04/23/19 and should have been coded as receiving hospice services. MDS Nurse #1 stated the information was coded in error and would require a correction to the MDS. An interview with the Director of Nursing (DON) on 08/29/19 at 2:31 PM revealed she expected the MDS to be coded correctly.	F 641	months to include 10 discharged residents per month. The MDS Hospice Coding Audit will be completed by the DON/ADON or designee weekly x 4 weeks to include all hospice residents, then monthly x 3 months to include 5 hospice residents. The results from this monitoring tool will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Administrator for follow up re-education. The Director of Nursing is responsible for the ongoing compliance of F641.	

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F 641	Continued From page 3 An interview with the Administrator on 08/29/19 at 2:41 PM revealed she expected the MDS to be coded correctly.	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to apply a left elbow brace for 1 of 1 resident reviewed for positioning (Resident #77). Findings included: Resident #77 was admitted to the facility on 5/23/17 with diagnoses of spastic hemiplegia affecting the left non-dominant side and cerebrovascular accident (CVA).	F 688	The facility does ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the residents clinical condition demonstrates that a reduction in range of motion is unavoidable; and 483.25 (c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in	9/23/19

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F 688	Continued From page 4 A review of the Quarterly Minimum Data Set (MDS) Assessment dated 7/25/19 revealed Resident #77 was severely cognitively impaired and required extensive physical assistance with all Activities of Daily Living (ADL). The MDS further indicated Resident #77 had impairment to both left upper and lower extremity. A review of a Physician's Telephone Order Form dated 12/19/18 in Resident #77's medical record revealed the following: Restorative - Apply brace to left elbow 7 days a week, 4 hours daily r/t (related to) increased risk for contractions secondary to CVA. Place brace on left elbow at 8 AM and remove at 12 PM. A review of Resident #77's care plan which was last updated on 3/13/19 revealed the following goal: Resident #77 will not have signs or symptoms of decrease in ROM (range of motion). The following intervention was listed under Restorative Aide (RA) functions: Left elbow brace on at 8 AM, 7 days a week, 4 hours a day. Take left elbow brace off at 12 PM, 7 days a week. Based on Resident #77's care plan, the left elbow brace intervention was started on 12/19/18. On 8/26/19 at 10:30 AM, an observation of Resident #77 revealed she was sitting in her wheelchair and leaning towards her left side. Resident #77 did not have an elbow brace to her left arm. On 8/28/19 at 9:23 AM, an observation of Resident #77 revealed she was sitting up in bed and did not have an elbow brace to her left arm. On 8/29/19 at 9:10 AM, an observation of Resident #77 revealed she was sitting in her	F 688	range of motion. 483.25 (c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Resident #77 left elbow brace was applied by the Restorative NA on 8-29-19 and continues to have the brace on as ordered. An Audit of Restorative Orders was completed by the DON on 9-17-19 for Accuracy of the Orders no issues noted. An audit of Restorative orders was completed by the DON on 9/17/19, for accuracy of the orders with no issues noted. Re-education was completed on 9-16-19 by the Director of Nursing regarding following the Restorative plan for Brace/Splint Application with the Restorative RN and Restorative NA's, re-education was started on 9-16-19 by the DON/ADON for the following the Restorative Plan for Brace/Splint Application with Licensed Nurses and re-education was completed on 9-22-19. Newly hired staff will be educated during orientation. On going monitoring and compliance will be achieved by the completion of the	

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F 688	Continued From page 5 wheelchair in the dayroom and did not have an elbow brace to her left arm. On 8/29/19 at 9:30 AM, an interview was conducted with the RA. The RA stated that restorative services had been discontinued for Resident #77 a week ago and that the Nurse Aides (NA) were supposed to be applying her left elbow brace. The RA stated Nurse #1 told her that restorative services had been discontinued for Resident #77, but she was not given a paperwork about this. The RA further stated Nurse #1 has not yet switched over the documentation of Resident #77's left elbow brace to nursing instead of restorative so it still showed up under RA documentation. On 8/29/19 at 9:43 AM, an interview conducted with NA #1 revealed she thought Resident #77's left elbow brace was supposed to be applied at night. During this interview, the care guide in the hall computer monitor was reviewed with NA#1. The care guide indicated that Resident #77's left elbow brace was supposed to be taken off at 12 PM. NA #1 stated the direction to take off Resident #77's left elbow brace was under the RA documentation. NA #1 further stated that Resident #77 did not have her left elbow brace on at this time because the RA or therapy usually put it on. NA #1 stated she did not apply Resident #77's left elbow brace because she has not been shown how to do it. On 8/29/19 at 11:01 AM, an interview conducted with Nurse #2 revealed the RA was responsible for applying Resident #77's left elbow brace and she usually put it on in the mornings and took it off around lunch time. During this interview, an observation was made of Resident #77 wearing	F 688	Restorative Brace/Splint Audit. This audit will be completed weekly of 4 residents for Brace/Splints Application x 4 weeks by the DON/ADON or designee. Then monthly audit of 4 residents for Brace/Splint Application will be completed by DON/ADON or designee x 3 months. The results from this monitoring tool will be discussed during weekly Quality Assurance Meetings for effectiveness. Any identified issues will be corrected per Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Administrator for follow up re-education. The Director of Nursing is responsible for ongoing compliance of F688.	

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her left elbow brace. Nurse #2 stated the RA applied Resident #77's left elbow brace a few minutes prior to this interview.

On 8/29/19 at 10:13 AM, a follow-up interview conducted with the RA revealed she went ahead and applied Resident #77's left elbow brace because the NA on the hall did not do it. The RA was also observed tapping on the hall computer monitor and said she was going to document the application of the left elbow brace since it was still under the RA documentation but should have been switched over to nursing.

On 8/29/19 at 10:41 AM, an interview conducted with the Director of Nursing (DON) revealed she did not find a discontinue order for the left elbow brace on Resident #77's medical record so Resident #77's left elbow brace should have been applied this week. The DON stated either the RA or a licensed nurse could have applied Resident #77's left elbow brace and that the NA would need to be trained first before they were able to apply Resident #77's left elbow brace. The DON further stated Nurse #1 was over the restorative nursing services and must have planned to discontinue Resident #77's left elbow brace but only verbally notified the RA and that Nurse #1 must have forgotten to take it off the RA documentation.

On 8/29/19 at 1:20 PM, a phone interview was conducted with Nurse #1. Nurse #1 stated she was the restorative nurse coordinator and that she oversaw the facility's restorative nursing program. Nurse #1 stated Resident #77's order for left elbow brace was still active and should have been applied by the RA. Nurse #1 stated she worked day shift on 8/26/19 but she can't

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F 688	Continued From page 7 remember if she saw Resident #77 with her left elbow brace on. Nurse #1 stated the RA might have gotten pulled to work on the hall on 8/26/19 but if this happened, Nurse #1 told the NA assigned to Resident #77 to apply her left elbow brace. Nurse #1 further stated she did not work day shift on 8/28/19 and 8/29/19 so she did not see if Resident #77 had her left elbow brace on those dates. Nurse #1 stated NA #1 has not been trained to apply Resident #77's left elbow brace so she did not expect her to apply it, but the RA should have applied Resident #77's left elbow brace on 8/28/19 and 8/29/19. Nurse #1 stated she did not tell the RA that Resident #77's left elbow brace had been discontinued and was not sure why the RA said that it has been discontinued. On 8/29/19 at 2:45 PM, an interview conducted with the Administrator revealed she expected her staff to follow the restorative nursing program as individualized for Resident #77. The Administrator stated the RA should have applied the left elbow brace on Resident # 77 this week if there wasn't an order to discontinue it and it still showed up in the RA documentation.	F 688		
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	F 689		9/23/19

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F 689	Continued From page 8 by: Based on observations, record review, review of manufacturer's instructions, and staff and manufacturer representative interviews the facility failed to ensure all 4 of transport van's wheelchair tiedown retractors were 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 he struck his head on the wheelchair lift platform. Resident #1's head started bleeding. The Transport Aide (TA) assisted Resident #1 into an upright position in his wheelchair and placed gauze on the laceration to Resident #1's head prior to the resident being assessed by a nurse or emergency medical technician (EMT) and returned to the facility. Resident #1 was later transported to the hospital and was diagnosed with a head laceration (cut) and a fracture of the T1 spinous process (a bone in the upper part of the spinal column) and bilateral (both sides) T1 lamina (the back part of a vertebra that covers the spinal canal). Resident #1 was discharged from the hospital and was re-admitted to the facility. Findings included: Review of the manufacturer's instructions for the securement system used by the facility's transport van to secure residents who are seated in wheelchairs during transport read in part, "the following parts make a complete wheelchair/passenger securement system: 4 wheelchair tiedown retractors, 1 occupant lap belt, and 1 occupant shoulder belt and mounting hardware." Resident #1 was admitted to the facility 09/10/18	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 9	F 689		

with diagnoses including diabetes, non-Alzheimer's dementia, and kidney transplant status. The quarterly Minimum Data Set (MDS) dated 02/27/19 revealed Resident #1 was cognitively intact and required extensive assistance with transfers.

The facility's incident/accident report dated 04/05/19 indicated Resident #1 fell backwards in his wheelchair while being transported in the facility van. Resident #1 had a laceration to the top of his head and was sent to the hospital. Resident #1 denied pain.

Nurse #1's note dated 04/05/19 at 4:40 PM indicated the following: "At approximately 3:15 PM the TA and (Resident #1) entered the facility via wheelchair after returning from a dermatology appointment." Resident #1 had blood on his face, neck, and shirt. The Medication Nurse requested emergency assistance from the other nursing staff. Nurse #1 entered Resident #1's room noting blood on resident's face, neck, and shirt and the Medication Nurse was applying pressure to the top of resident's head. Resident #1 was alert and verbal. 911 was called. Nurse #1 assessed for head, neck, and spinal injury and denied pain to touch. Vital signs were obtained. Resident #1 was alert and oriented to person, place, time, and date. Neurological checks were within normal limits. Resident #1 denied losing consciousness. A laceration was noted to Resident #1's scalp and a discoloration was noted to his right knuckle. Nurse #1 asked Resident #1, "What happened?" Resident #1 replied, "I was on the van and my wheelchair flipped backwards. I hit my head on the back door." Resident #1 reported wearing his seatbelt. Resident #1 stated, "He (the TA) strapped me in,

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F 689	Continued From page 10	F 689		

he always does." Emergency Medical Services (EMS) arrived and checked for head, neck, and spinal injury. Resident #1 was able to stand and pivot from his wheelchair to the stretcher. The Physician was notified and approved an order to send Resident #1 to the hospital.

The Emergency Department (ED) report dated 04/05/19 revealed Resident #1 was examined after he fell out of a chair and struck his head. A laceration with bleeding was noted to the top of Resident #1's head. Resident #1 received a Computerized Tomography (CT) scan (computer generated images of the bones, blood vessels, and soft tissues inside the body) of the head. Resident #1 was diagnosed with a fracture of the T1 spinous process and bilateral T1 lamina (this was a single fracture through these components of T1), subluxation (partial dislocation) at C7-T1 (the lower cervical vertebra and upper thoracic vertebra) that was chronic and likely related to degenerative disk disease, and multilevel relatively severe degenerative disc changes of spondylosis (wear and tear of spinal discs) and facet arthropathy (degenerative arthritis which affects the facet joints of the spine). Resident #1 received laceration repair, was given a cervical collar (neck brace), and returned to the facility.

Resident #1 was unable to be interviewed because he was not in the facility at the time of the survey.

A telephone interview conducted with Transportation Aide #1 on 08/26/19 at 2:44 PM confirmed he was driving the transport van on 04/05/19 when Resident #1 fell backward in the wheelchair during transport and had not been back to work since the incident. TA #1 initially

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stated he picked Resident #1 up at the dermatologist's office after an appointment and strapped Resident #1's wheelchair in with the 2 rear securement straps and 1 front securement strap. TA #1 then stated he may have been distracted by talking with Resident #1 and only used 3 of the 4 securement straps or that Resident #1 could have messed with a securement strap and caused it not to be secure. TA #1 stated he drove out of the Physician's office parking lot and after a few minutes heard a noise from the back of the van. TA #1 stated he turned around and saw the wheelchair had fallen backwards and landed on the wheelchair lift platform. TA #1 stated he pulled off the road and got Resident #1 upright in his wheelchair. TA #1 stated he saw Resident #1's head was bleeding and he placed gauze over the cut and drove back to the facility. When the van returned to the facility TA #1 got Resident #1 out of the van, brought him inside the facility, and told the nurses Resident #1 needed assistance. TA #1 stated he used all 4 securement straps for transport back to the facility after Resident #1's fall. TA #1 stated he was trained to use 4 points of securement for all transports involving a wheelchair.

There were no other residents on the van at the time of Resident #1's fall.

An interview with Nurse #1 on 08/26/19 at 4:49 PM revealed she was the Staff Development Coordinator (SDC) at the time of Resident #1's van accident. Nurse #1 stated the day of the van accident an employee came running into her office and said she was needed in Resident #1's room. Nurse #1 stated when she entered Resident #1's room he was bleeding from his head. She stated a nurse was holding pressure

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to Resident #1's head and she asked another nurse to call 911. EMS came, placed a neck collar on Resident #1, and transported him to the hospital. Nurse #1 stated she interviewed Resident #1 before EMS arrived and he told her he was strapped into the van but he was uncertain how many straps were used.

An interview with the Maintenance Director on 08/26/19 at 3:39 PM revealed training for all staff driving the facility van involved watching a video made by the company which manufactured the securement straps, return demonstrations of wheelchair securement, a road test, and practice loading and unloading a resident. The Maintenance Director stated TA #1 did van transports and was a nurse aide (NA) before he became employed with the facility and TA #1's road test was done when he was originally signed off on driving the van. The Maintenance Director stated TA #1 was in-serviced on van operation and wheelchair transport on 12/09/16 and 05/22/17 for van safety. The Maintenance Director also stated he inspected the wheelchair securements used for transporting Resident #1 on 04/05/19 and found them to be in working order. The Maintenance Director stated 4 points of securement were to be used for all wheelchair transports and there was no situation when using 3 points of securement would be appropriate.

An interview with the Director of Nursing (DON) was conducted on 08/26/19 at 4:56 PM. The DON confirmed there was an incident on 04/05/19 where Resident #1 fell backwards in his wheelchair while being transported from an appointment in the facility van. She stated an investigation was begun and TA #1 was suspended following the incident. As part of the

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investigation the DON, Staff Development Coordinator, Administrator, Maintenance Director, and TA #1 re-enacted the entire occurrence with Resident #1's wheelchair. The Corporate Safety Manager inspected the wheelchair securements and other devices in the facility van and all the devices were functioning properly. The Corporate Safety Manager in-serviced the Maintenance Director regarding use of wheelchair securement devices. The DON stated during a re-enactment of the incident attempts were made to move the wheelchair with 3 straps and the wheelchair became unsecured with continuous movement of an individual's feet. Foot rests were not in place on the wheelchair at the time of the incident and by movement of Resident #1's feet it was possible he could have loosened the securement strap or tapped the red release button on the securement device. Another possible cause of the wheelchair turning over backwards was the van went over railroad tracks during the transport on 04/05/19 and the J-hook could have become loosened or become detached during transport.

A telephone interview with a representative from the manufacturer of the wheelchair securement device on 08/27/19 at 8:37 AM revealed all wheelchair securement devices were designed to be used with 4 points of securement. The representative stated if all 4 securement devices were used correctly it would be highly unlikely the wheelchair could tip backwards. The representative also stated it was highly unlikely the resident could have hit the red release button on the securement straps because it would require an extreme amount of force.

An interview with the Administrator on 08/27/19 at

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9:57 AM revealed the investigation was not able to determine the exact cause of the wheelchair falling backwards but contributing factors could have been driving over train tracks, stop and start traffic, or Resident #1 hitting the red release button on the wheelchair securement. The Administrator stated TA #1 should have pulled the van safely off the road, called 911, and not moved Resident #1. The Administrator provided a summary of the investigation and Quality Assurance/Process Improvement (QAPI) that was put into place following the incident on 04/05/19.

The facility provided the following QAPI with the plan of correction date of 04/11/19.

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

-The Quality Improvement Plan dated 04/05/19 had a problem statement that read 3 out of 4 safety belt straps were used to secure a resident in his wheelchair in the van resulting in the wheelchair turning over backwards. The root causes of the incident were determined to be 3 out 4 safety belt straps were applied to secure a

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wheelchair in the van, no foot rests were applied to the wheelchair, the positioning of the J-hook above the bracket of the foot rest, and the location of the incident including travel over railroad tracks. Barriers were education of staff and a busy transport schedule.

-The Maintenance Director was re-inserviced by the Corporate Safety Manager 04/05/19 on van safety and procedures with return demonstration and equipment check on the van. The Maintenance Director performed all safety procedures correctly on return demonstration. All equipment on the van was checked and was in working order.

-Facility van drivers were re-inserviced on van safety and procedures by the Maintenance Director with return demonstration and included watching a video of proper placement of securement straps by the manufacturer of the securement straps. Education began 04/08/19 was completed 04/10/19. Facility van drivers performed all safety procedures correctly on return demonstration.

-New retractable safety belts which secured the wheelchair to the floor of the van were ordered and replaced in the facility van by the Maintenance Director on 04/08/19.

-Facility van drivers were in-serviced on what to do in case of an emergency/accident in the van by the Maintenance Director and the Assistant Director of Nursing on 04/08/19. Training was completed 04/10/19. All van drivers were able to correctly state pull over and call 911.

-Facility van drivers were given road tests with

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return demonstration of safety procedures by the Maintenance Director on 04/11/19 and auditing is ongoing.

-An audit of all approved van drivers performing transportation was done Monday through Friday for 2 weeks by the Maintenance Director. The audit began 04/11/19 and is ongoing.

-An audit of 5 transports with demonstration was done weekly Monday through Friday for 4 weeks by the Maintenance Director beginning 05/20/19, then an audit of 2 transports with demonstration was done weekly Monday through Friday by the Maintenance Director beginning 06/24/19, then regular safety checks will be conducted monthly to all safety devices in the wheelchair van for 3 months by the Maintenance Director beginning 05/10/19, and van transports will be discussed daily Monday through Friday with morning QI meetings by the Maintenance Director and DON for issues and trends for 3 months beginning 04/11/19 and is ongoing.

The QAPI was validated 08/27/19 and concluded the facility implemented an acceptable corrective action plan on 04/11/19 once all authorized drivers were trained. The facility provided documentation that included transport drivers training and re-education records, Departmental Manager safety training records, and facility audits. Review of the in-service records revealed staff were trained if an accident occurred during a resident transport not to move the resident until the resident was assessed by a licensed professional.

Residents who were transported to outside appointments were interviewed and reported no

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F 689	Continued From page 17 concerns. Facility staff were interviewed and confirmed they received training on transportation safety that included how to properly secure a resident in a wheelchair and perform return demonstrations. Staff interviews also confirmed they were trained if an accident occurred during a resident transport to not move the resident until they have been assessed by a licensed professional.	F 689		