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	345457	A. BUILDING _____ B. WING _____	C 11/24/2020

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BELAIRE HEALTH CARE CENTER	2065 LYON STREET GASTONIA, NC 28052

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey and a complaint investigation was conducted on 11/02/20 with exit from the facility on 11/02/20. Additional information was obtained through 11/24/20. Therefore, the exit date was changed to 11/24/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 8HEI11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and a complaint investigation was conducted on 11/02/20 with exit from the facility on 11/02/20. Additional information was obtained through 11/24/20. Therefore, the exit date was changed to 11/24/20. There was one allegation which was substantiated and cited. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# 8HEI11. Past non-compliance was identified at: CFR.483.25 Tag F 689 constituted Substandard Quality of Care. An extended survey was conducted on 11/13/20.	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	F 689		12/2/20

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

Electronically Signed | 12/02/2020

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F 689	Continued From page 1 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, van driver and transportation owner interviews, the facility failed to secure a resident to ensure a safe van transport for a resident who had double above the knee amputations for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). During a van transport Resident #1 fell backwards in her wheelchair, hitting her head on the back door of the van but no injuries were identified. Resident #1 was taken to the hospital for evaluation and returned to the facility the same day. Findings included: The undated manufacturer's instructions, for the transport van's wheel chair securement system utilized by the facility, titled, "Vehicle Anchorages and Accessories for 4-Point Wheelchair Securement Systems," for the securement system used in the transport van to secure residents who were seated in wheelchairs during transports was made up of 4 wheelchair tie downs, 1 occupant lap belt, 1 occupant shoulder belt and floor anchorages. The instructions read in part, "Secure Passenger: 1. Attach Lap Belts-Use integrated stiffeners to feed belts through openings between seat backs and bottoms, and/or armrests to ensure proper belt fit around occupant. On the aisle side, attach belt with female buckle to rear tie-down in connector ensuring buckle rests on passenger's hip. On the	F 689	Past noncompliance: no plan of correction required.	

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window-side, attach belt with male tongue to rear tie-down pin connector and insert into female buckle. 2. Attach Shoulder Belt-Extend shoulder belt over passenger's shoulder and across upper torso and fasten pin connector onto la belt. 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort." The manufacturer's instructions provided no guidance regarding occupants sitting on pillows or having adequate back support while they were seated in their wheel chair during transport.

Resident #1 was admitted to the facility on 10/16/20 with diagnoses including end stage renal disease (ESRD) and hemiplegia. The most recent minimum data set dated 10/20/20, revealed Resident #1 was cognitively intact and was able to make decisions about her care. She had bilateral above the knee amputations and required assistance with activities of daily living and was totally dependent on 2 people and a mechanical lift for transfers.

Review of Resident #1's care plan, dated 10/16/20, revealed goals and interventions for assistance with transfers, fall prevention, resolve pressure ulcers, pain, and anticoagulant use.

Review of the facility's investigation, dated 10/21/20 and completed by the Director of Nursing (DON), revealed Resident #1 fell backward in her wheelchair while being transported in the transport van. She was alert and oriented and talking. The driver unhooked the belts holding the wheelchair in an upright position and the patient was laying on her back in the wheelchair and the driver had her head laying in his lap. The resident was noted to have a pillow and wheelchair cushion in her wheelchair.

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Nursing staff did not note any injuries however the resident was sent to the hospital for examination. The DON interviewed the resident. She stated she was not strapped in tight enough. The resident had bilateral above the knee amputations. Because of the amputations, the pillow and cushion in the wheelchair and the wheelchair not being tightly locked down, this made the resident top heavy causing the wheelchair to topple backward. The pillow was removed from Resident #1's wheelchair. The transport company supervisor was notified.

Review of the Emergency Department (ED) report revealed Resident #1 was evaluated on 10/21/20 at 12:55 PM for evaluation of headache, neck pain and left shoulder pain after a fall. A computerized tomography scan (CT) of the head and cervical spine were negative for any acute fractures, dislocations, hemorrhage or mass-effects. Resident's cervical spine was cleared. X-rays were negative for any acute fractures or dislocations. She was resting comfortably in bed and stable for discharge. The resident returned to the facility the same day.

An interview, conducted with Resident #1 on 11/2/20 at 10:45 AM, revealed on 10/21/20, she was sitting in her wheelchair, on top of a large pillow which was on top of the wheelchair cushion waiting to be transported in the van. She stated she needed the large pillow in the wheelchair because it was too uncomfortable sitting on the wheelchair cushion for the 45-minute transport to and from dialysis. While seated in her wheelchair the van driver put her in the van. The shoulder belt was placed across her left shoulder and hooked on the right side. The lap belt was placed across her abdomen. She stated there was a S

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hook and he hooked both to the wheel chair's front wheels. Resident #1 explained the van driver shut the door to the van and started to transport her to dialysis. She stated when the van driver accelerated the van and turned left out of the facility parking lot her wheelchair flipped backwards and the back of her head hit the back door of the van. She stated the wheelchair laid on her right stump and she had a knot on her left arm. She stated she never lost consciousness and did not think the back wheels to her wheel chair were locked down. The resident stated she was not injured in the incident.

Review of the statement by the van driver, signed and dated 10/21/20 at 12:20 PM, revealed the incident occurred on 10/21/20 at 11:20 AM. During transport the resident fell backwards from wheelchair. The resident had a seatbelt on and the wheelchair was fully restrained.

A telephone interview was conducted with the van driver (VD) on 11/2/20 at 12:45 PM. The VD stated he prior to transporting Resident #1 on 10/21/20 he assured all 4 of the van's wheel chair wheel chair securement straps, 2 in the front and 2 in the back, were tight and secured to the resident's wheel chair. He asked Resident #1 if the seatbelt was tight enough and she responded yes. The VD explained after he pulled out of the facility parking lot, he heard Resident #1 say I've fallen, help me. The driver stated he stopped the van and called the facility. After calling the facility, he went to the back door of the van and held the resident's head in his lap until the Director of Nursing (DON) arrived. The VD stated after the DON got to the van, he loosened the straps holding the front wheels of the resident's wheelchair at 2 points and disengaged the straps

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in the back at two points that were around the frame of the wheelchair. The van driver stated he always checked the van's wheel chair securement straps before he transported a resident in a wheel chair. He stated the resident had been sitting on a pillow in the wheelchair. She came out of the wheelchair and was laying in the floor of the van. The wheelchair was in an upright position. The DON had someone call EMS. EMS arrived and transported the resident to the emergency department. The VD stated the transportation company's owner came to the site of the incident and had him demonstrate how he had anchored the straps and reviewed the company's policies and procedures. The VD stated he return demonstrated to the owner how he hooked the straps when securing Resident #1.

A telephone interview with Nurse #1, conducted on 11/2/20 at 1:00 PM, revealed she was working inside the facility and heard a page for help needed outside. She went to the van. The wheelchair was laying down and the straps were connected at 4 points. The straps had to be unhooked at all 4 points to get the chair out. The front left strap was tight and difficult to unhook. Nurse #1 stated she crawled into the van, did an assessment then worked to get Resident #1 out of the wheelchair into a sitting position in the floor of the van. She used her knees to support the resident's back and neck until the ambulance arrived.

An interview, conducted with the Director of Nursing (DON) on 11/2/20 at 2:00 PM, revealed on 10/21/20, she was sitting in her office and heard an overhead page stat to the road. The transport van was stopped in the road in front of the facility. She approached the van. The DON

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explained the front wheels of the resident's wheelchair were suspended in the air and the resident's stumps were still in the chair. The chair was tilted all the way back touching the floor of the van and her head toward the back door. Resident #1 was alert and oriented and said her shoulder and her right leg were hurting. The DON stated she asked the discharge planner, who was at the scene, to call 911 and to call the resident's husband to let him know they were sending her to the emergency department (ED). Emergency medical services (EMS) arrived and transported her to the hospital. The DON called the nurse consultant and the corporate office and was instructed to get statements from staff and the driver. The owner of the transportation company came to the facility. The DON reported the incident during the facility's morning meeting on 10/22/20. Since the resident had bilateral above-the-knee amputations and was top heavy, the decision was made to transport her in a geri chair from that point on. The DON stated she confirmed that the transportation owner had trained the van drivers on safely transporting the residents before she allowed them to transport residents after the incident. She received a copy of the education document, dated 10/21/20 and provided by the owner, which included the following education: 1. Check the frame of wheelchair/geri-chair to ensure intact, no cracks or missing screws; 2. Safety belts are in good working order; 3. Ensure clients are secure in wheelchair and all straps are in place and working properly; 4. Review Safe Procedures for Transporting Clients using Wheelchair/Geri-chair. On 10/23/20, the first time the resident was transported in the geri chair following the incident, the DON stated she observed the resident being strapped into the van in the geri chair and it was

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secured at all 4 points, 2 points in the front and 2 points in the back to the floor anchors. The driver placed the seatbelt around the resident and secured it. The DON stated the seatbelt was in an appropriate position for a safe transport.

An interview, conducted with the owner of the transportation company on 11/2/20 at 12:00 PM, revealed he went to the van immediately after the incident occurred. He stated the van driver anchored all 4 wheels of the wheelchair, secured the lap belt and the shoulder harness. He stated the resident was sitting in the wheelchair on a large pillow, which had her sitting up high in the wheelchair. He stated he had trained the drivers in all safety aspects, including anchoring the straps, checking the resident and not moving the resident, what to do if something happened, make the resident safe and call 911. He stated that he and the driver thought during the transport Resident #1 had little back support because she was sitting up high on a pillow in the wheelchair. That was the first time the VD had transported Resident #1. Immediately after the incident, he had the VD return demonstrate how he strapped the wheelchair down and reviewed policies and procedures with him. The owner stated competencies for the drivers were completed at hire and when needed thereafter. The owner stated, since the incident, he instructed the drivers not to transport residents who are sitting on pillows when using a regular wheelchair. He stated he recommended to the facility that Resident #1 be transported using a geri-chair since geri-chairs are considered a type of wheelchair by the Americans with Disabilities Act of 1990. The owner specified his company transports residents in geri chairs a lot and thought that using a geri chair would be a safer

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option for Resident #1. The owner stated he provided education to the drivers on 10/21/20 before they transported any residents after the incident.

Review of the therapy notes revealed on 10/21/20, Physical Therapist (PT) #1 wrote a note that Resident #1 complained of soreness and discomfort on her bottom. She insisted on having a large pillow on top of the wheelchair cushion while in the wheelchair.

An interview, conducted with PT #1 on 11/2/20 at 1:35 PM, revealed PT #1 evaluated Resident #1 who had bilateral above-the-knee amputations and had left side hemiplegia. The resident was in the facility for rehabilitation related to the recent amputation of her right leg. She had no core stability and was dependent on a mechanical lift for transfers. She had a cushion in her wheelchair but complained about not being able to tolerate the cushion. She used a large pillow on top of the cushion when she was in her wheelchair. PT #1 had recommended to the resident that she not use the large pillow as it defeats the purpose of the wheelchair cushion. The resident insisted on using the large pillow, especially when she went to dialysis as it was a 45-minute ride one way. Prior to the incident, the PT stated they had recommended to the resident not to use the large pillow but she continued to use it.

An interview, conducted with the Rehab Manager (RM) on 11/2/20 at 1:55 PM, revealed on 10/21/20 at 2:33 PM, she observed the wheelchair that the resident had been sitting in at the time of the incident. The wheelchair was in the lowest position. There was a huge pillow in the chair, on top of the wheelchair cushion. The

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RM stated the resident had bilateral above the knee amputations with left side hemiplegia. She had poor sitting balance. They have since put anti-tippers on her wheelchair. Since the incident on 10/21/20, Resident #1 had been transported in the van using a geri-chair.

On 11/24/20 at 9:42 AM, a conference call with the Rehab Manager and the DON revealed the therapy department nor the nursing department evaluated Resident #1 for safe wheelchair transport prior to the incident on 10/21/20.

An on-site observation, conducted on 11/2/20 at 11:16 AM, revealed Resident #1 was sitting in a geri-chair with no pillow and was placed in the transport van. The driver placed the seatbelt around the resident's upper abdomen and secured the seatbelt to the floor anchors, one on the left side and one on the right side of the wheelchair. The geri chair was secured to floor anchors in 4 points, 2 in the front and 2 in the back. The driver checked all 4 anchor points for chair movement and checked to assure the seatbelt was tight and securely anchored.

Another observation conducted on 11/2/20 at 11:40 AM revealed the DON checked Resident #1's chair to assure no movement of the chair and that the seatbelt was securely placed around her and anchored to the floor anchors. The DON also completed audits on 2 additional residents, one audit completed before the resident left the facility and one audit completed when the resident returned to the facility. Before the residents left the facility, the DON checked the security of the wheelchairs anchored at the 4 points, 2 in the front and 2 in the back as well as the seatbelt. When the one resident returned to

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the facility, she checked the 4 anchor points and the seatbelt to assure all had been secured for the transport back to the facility.

A telephone interview, conducted with the Administrator on 11/3/20 at 11:30 AM, revealed he was not involved with investigating the incident. The DON conducted the investigation and reported the findings to him. He presented the incident, the findings of the investigation and the plan of correction to the QA committee on 11/2/20.

The facility's corrective actions implemented after the incident to prevent a reoccurrence included the following:
All items listed on this self-imposed action plan have been completed and implemented on 10/22/20 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citations associated with this action plan should be considered past noncompliance as of 10/22/20.

CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:
- 10/21/20 Resident #1 was assessed by the DON following the fall in the van.
- 10/21/20 Physician was notified and Resident #1 was transferred to the hospital for evaluation. Resident #1 returned to the facility on 10/21/20 with no injuries.
- 10/21/20 The van owner assessed the straps and the anchors inside the van. He conducted education for the van drivers which included checking the frame of the wheelchair/geri chair to ensure intact, no cracks and inspect all hardware, safety belts in good working order, ensure clients were secure in wheelchair and all straps in place

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and working properly and reviewed the safe procedures for transporting clients using wheelchairs/geri-chairs.

IDENTIFICATION OF OTHER RESIDENTS:
-All resident's wheelchairs were assessed to assure that no pillows were in the wheelchair in addition to a wheelchair cushion.
-The DON interviewed the other interviewable residents, who were being transported by the van company, to assure the straps and seatbelt were secure when they were transported. No concerns were voiced.
-The Rehab Department assessed Resident #1's wheelchair and the other 5 residents' wheelchairs, who were using the transportation van, to assure the residents were in the correct wheelchair and using the appropriate wheelchair cushion. Rehab staff added anti-tippers to Resident #1's wheelchair

MEASURES FOR SYSTEMIC CHANGE:
-10/21/20 The van owner assessed the straps and the anchors inside the van.
-10/21/20 The van owner conducted education for the van drivers which included checking the frame of the wheelchair/geri wheelchairs/geri-chairs. The van drivers return demonstrated the safety checks.
-10/21/21 The van drivers will complete the pre-trip checklist before each transport.
-10/22/20 An in-service was provided to all nursing staff to assure no residents are sitting on a pillow in their wheelchair.

HOW CORRECTIVE ACTION WILL BE MONITORED:
-On 10/21/20 all residents were assessed for use of pillows in wheelchairs. All pillows were

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removed from resident wheelchairs.
-On 10/21/20 the plan was made to randomly check at least 3 residents being transported to an appointment or to dialysis by the DON or designee, starting on 10/22/20, daily x 2 weeks, 3 x week x 2 weeks weekly x 4 weeks then monthly x 2 months.
-10/21/20 the DON and the Administrator will review the audits monthly to identify any patterns or trends and will adjust the plan to maintain compliance.
-10/21/20 The DON and the Administrator will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee.
-On 10/22/20 the DON or designee began audits of at least 3 residents being transported daily for 2 weeks, then 3 times a week for 2 weeks, then weekly for 4 weeks then monthly for 2 months.

The Administrator was responsible for compliance.

The date for the decision to QA and monitor was 10/21/20.

End of QAPI/POC November 12, 2020.

Resident #1 was discharged home with home health on 11/12/20.

The Performance Improvement Project (PIP) was a self-imposed action plan that was reviewed in the QAPI meeting on November 13, 2020.

On 11/13/20 at 10:15AM, during the Partial Extended Survey, an interview was conducted with Resident #2. She stated she was transported by the transport van three times a week for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345457	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELAIRE HEALTH CARE CENTER	2065 LYON STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

dialysis. She stated the van driver locked her wheelchair down in the front and in the back after he puts her in the van. He then put the seatbelt around her and locked it. He checked to make sure the wheelchair would not move and he made sure the seatbelt was on tight enough. She stated she does not sit on a pillow in her wheelchair and she has never felt unsafe when the van has taken her to dialysis and back.

On 11/13/20 at 10:45AM, an observation was made of the van driver preparing to transport Resident #2 in a wheelchair. He demonstrated how he connected the securement system to the wheelchair at 4 points, 2 in the front and 2 in the back and secured the seatbelt around Resident #2 then secured the seatbelt to the floor anchors. He checked to assure the resident was not sitting on a pillow. The DON was observed checking behind the van driver to assure all 4 anchor points were secure and the seatbelt was securely intact around the resident and secured to the floor anchors. She rocked the wheelchair back and forth and pulled on the seatbelt straps to confirm the wheelchair and the resident were secure for transport.

An interview, conducted 11/13/20 at 10:50 AM with the van driver, revealed he was re-educated on 10/21/20 by the van owner regarding securing all 4 anchor points to the wheelchair and to assure the seatbelt is securely fastened and secured to the floor anchor. He stated he was instructed not to transport a resident if they were sitting on top of a pillow in a wheelchair.

On 11/13/20 at 1:00 PM the facility's plan for past noncompliance was validated by the following: 1) Review of the in-service training records revealed

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F 689	Continued From page 14 all four van drivers had been in-serviced on the van's securement system including return demonstrations on 10/21/20. 2) Review of the in-service training record revealed all the nursing staff were in-serviced on 10/22/20 regarding no resident had a pillow in their wheelchair. 3) Interviews were completed with the driver of the incident and the van owner. 4) The interviews validated the van drivers had undergone training regarding the safe application of the securement system including lap belts and shoulder harness. 5) A review of the facility's audits verified they were completed as specified in their self-imposed action plan. 6) Compliance was achieved on 10/22/20 when all the nursing staff were educated regarding there should be no pillows in resident wheelchairs.	F 689		