STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 2/9/23 through 2/10/23. The following intakes were investigated: NC00197985 and NC0000198142. 1 of the 4 complaint allegations resulted in deficiency. Intake NC00198142 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J The tags F684 and F689 constituted Substandard Quality of Care. Non-compliance began on 1/6/23. The facility came back in compliance effective 1/12/23. A partial extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on facility and emergency department record review, observation, and interviews with staff, residents, dialysis staff and contract transportation staff, the facility failed to ensure a	F 684	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

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F 684	Continued From page 1	F 684		

transportation driver followed emergency protocol after Resident #1's fall from his wheelchair during van transportation. The driver failed to request emergency aid and continued driving with Resident #1 on the floor of the van. The resident had bleeding from his below the knee amputation sites and pain on his right shoulder. This situation had the high likelihood to cause serious injury and harm. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1).

Findings included:

Resident #1 was admitted to the facility on 12/29/22 with diagnoses that included bilateral below the knee (BKA) amputations and kidney failure requiring dialysis.

Resident #1's admission Minimum Data Set (MDS) dated 1/5/23 indicated moderately impaired cognition. He required extensive assistance with transfers and locomotion. He had not had any falls in the past 6 months or since admission. He required pain medication as needed for frequent pain. He had surgical wounds at admission. He required dialysis.

A written statement dated 1/6/23 from Resident #1 indicated the transportation driver hit his brakes and the seatbelt hooked to the wall gave out and he fell to the floor. The driver tried to get him up, but Resident #1 asked him to leave him on the floor. Resident #1 was lying on his stomach on the floor of the van. Resident #1 reported pain to bilateral BKA stumps and his shoulder.

During an interview on 2/9/23 at 11:35 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 2	F 684		

Resident #1 revealed that on 1/6/23 he did not have his usual driver for dialysis. Resident #1 indicated the driver was speeding during the 8-minute drive to dialysis. A car turned out in front of the van and the driver hit his brakes causing Resident #1 to fall from the chair onto his face and amputation stumps on the floor of the van. Resident #1 indicated the driver continued driving 3-5 minutes to the dialysis clinic. The driver went into the dialysis clinic to ask for help and returned with the Dialysis Nurse Supervisor. Resident #1 indicated he and the Dialysis Nurse Supervisor recommended the driver call an ambulance and he was taken to the hospital via ambulance.

A written statement from the transportation driver dated 1/6/23 indicated he had been driving for the contract transportation company for nine months. The day of the accident, he secured Resident #1 and Resident #4 into the van before leaving the facility. During the drive, a car pulled out into the street and the driver slammed on his brakes causing Resident #1 to fall from his wheelchair. The transportation driver pulled over to the side of the road and turned on his hazard lights. Resident #1 indicated he was "fine" and wanted to get back into his wheelchair. The driver tried to pick Resident #1 up and get him into his wheelchair but was unsuccessful. Resident #1 requested the driver take him to the dialysis clinic for assistance getting up to the chair. The transportation driver drove to the dialysis clinic for assistance. The dialysis clinic suggested the transportation driver call an ambulance. Resident #1's wheelchair remained strapped into the van with a large cushion to the seat. The transportation driver believed Resident slipped through the seatbelt due to the large slippery cushion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 3	F 684		

A telephone interview was conducted on 2/9/23 at 2:10 PM with the Transportation Driver. He revealed that during a drive to dialysis, a car pulled out in front of him, and he had to hit the brakes to avoid hitting the car. He heard Resident #1 call out and turned around to him lying the floor of the van. The transportation driver revealed he pulled over and turned on the van's hazard lights. Resident #1 requested the driver continue to the dialysis clinic across the street. The transportation driver recalled Resident #1 said he was not hurt and wanted the dialysis staff to assist him back to his chair. The driver then drove the van across the street with Resident #1 lying on the floor of the van. The transportation driver went into the dialysis clinic to request assistance getting Resident back into his chair. The dialysis nurse supervisor instructed the transportation driver to call an ambulance. Resident #1 was taken to the hospital via ambulance. The driver indicated he was trained to pull the vehicle to a safe spot and call 911 in the event of an accident, but Resident #1 stated he was fine and did not need an ambulance.

The facility interviewed the other passenger of the van during the drive to dialysis about his account of Resident #1's fall. A written statement on behalf of Resident #4 (no date) indicated that on 1/6/23 the driver stopped suddenly and then he heard the driver say, "What are you doing on the floor?" He did not know what happened. The driver drove the van to dialysis to ask for help. During an interview on 2/9/23 at 1:10 PM, Resident #4 indicated he did not know how Resident #1 fell from his wheelchair during transportation to dialysis. He did not hear Resident #1 fall; he only heard the driver address the fall. Resident #4 indicated the driver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 4	F 684		

continued driving 1 minute to the dialysis clinic following the fall to ask for assistance. Resident #4 was admitted to the facility on 8/26/22 with diagnoses that included kidney failure requiring dialysis and blindness. His quarterly MDS dated 12/28/22 indicated he was cognitively intact.

A telephone interview was conducted on 2/9/23 at 1:55 PM, the Dialysis Nurse Supervisor indicated the transportation driver arrived at the clinic and came to her office asking for assistance getting Resident #1 off the floor of the van. When she arrived at the van, Resident #1 was face down on the floor of the van with the wheelchair and seatbelt next to him. She did not recall if the wheelchair was strapped into the van. Resident #1 was requesting a mechanical lift to get him back into his wheelchair. The Dialysis Nurse Supervisor indicated she instructed the van driver to call an ambulance. The emergency medical technicians got Resident #1 into a seated position and revealed bleeding to his amputation sites. Resident #1 was complaining of pain and was taken to the hospital.

An Emergency Department Provider note dated 1/6/23 indicated Resident #1 was thrown from his wheelchair onto his bilateral amputation stumps during transportation to dialysis from the facility. Resident #1 was bleeding from his amputation sites. He was not on blood thinners at that time. Resident #1 complained of pain at his amputation sites and his right shoulder. Resident #1's x-rays were negative for leg or arm fractures.

A Nursing Progress Note dated 1/6/23 at 9:40 AM indicated Resident #1 called the facility to inform his nurse he fell from his wheelchair in the contract transportation van on the way to dialysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(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 684	Continued From page 5	F 684		

Resident #1 indicated he fell from his wheelchair when the transportation driver hit his brakes and he was at the hospital.

An Investigation Guide to determine the cause of the accident completed by the Administrator dated 1/6/23 indicated Resident #1 fell in the contract transportation van while traveling to dialysis. The transportation driver proceeded to the dialysis clinic for assistance with getting Resident #1 off the floor of the van. The dialysis clinic staff advised the transportation driver to call an ambulance and Resident #1 was taken to the hospital. The investigation guide did not indicate if the driver stopped immediately following the fall. The root cause of the fall was determined to be operator error in securing the resident with safety restraints.

A written statement dated 1/6/23 from the Contract Transportation Company owner indicated the transportation driver had been terminated. During an interview on 2/9/23 at 2:35 PM, the Contract Transportation Company owner revealed each transportation van had posted written instructions on what to do in an emergency. The owner revealed the driver should have called an ambulance and not moved the vehicle with Resident #1 on the floor.

An observation was made on 2/9/23 at 2:40 PM of signage posted in the contract van "In the event of an accident" instructions included: pull the van over to a safe area, do not move the resident if they have fallen from the chair, call 911 first then call the facility Director of Nursing (DON). The contract transportation company owner indicated this was posted in the van during the accident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

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F 684	Continued From page 6	F 684		

A Google Maps search indicated the distance from the named intersection to the dialysis clinic was 0.2 miles and would take one minute by vehicle.

During an interview on 2/10/23 at 3:50 PM, the Director of Nursing (DON) indicated that following Resident #1's fall in the contract consultation van, he was transported to the hospital for evaluation. The DON revealed the driver should have stopped immediately and called an ambulance.

During an interview on 2/10/23 at 4:15 PM, the Administrator revealed the driver should have pulled the vehicle over and called an ambulance immediately following Resident #1's fall from his wheelchair. She indicated that services with the contract transportation company were suspended following the accident and had not been reinstated. The facility's transportation staff was educated on what to do in an emergency following the incident. The facility had no further van accidents following Resident #1's fall.

The Administrator and DON were notified of the immediate jeopardy on 2/9/23 at 6:15 PM.

The facility provided the following corrective action plan with a completion date of 1/12/23.

Problem identified: On 1/6/2023, Resident #1 was traveling to the dialysis center via wheelchair transported by the contract transport company. The van driver hit his brakes and Resident #1 was propelled from the wheelchair landing on the floor of the van on his stomach.

Immediate action identified: Resident #1 was sent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 7	F 684		

to the emergency room for evaluation on 1/6/2023. Upon completion of the evaluation, the resident was sent back to the facility with pain control medications and bowel protocol.

Systemic changes made: On 1/6/2023, the facility suspended all transports scheduled with the contract transportation company until an inspection of the safety mechanisms could be conducted and a review of van driver training was completed. On 1/10/2023, the Administrator began contacting all current van transport companies used to transport facility residents. The following was requested: Current van inspection and training material and documentation of training for all van drivers utilized for facility transports. On 1/11/2023, all nurses, nurse aides, Transportation Aides, Maintenance Staff, and Administration staff were in-serviced by the staff development coordinator on the following: in the event of an emergency, call 911.

Monitoring process: A quality assurance monitor "Van Transports Audits" will be completed by the Transportation Aide or Maintenance Director or designee weekly x 4 weeks then monthly x 3 months until resolved by the Quality Assurance (QA) Committee. The Van Transport QA Tool will monitor all resident transport checklists to ensure checks are being completed prior to each van transport and are compliant. Reports of the audit will be given to the Director of Nursing to report in the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality-of-Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 8 Nurse and Health Information Management and meets weekly Onsite validation was completed on 2/10/23 through staff interviews, observation, and record review. Staff were interviewed to validate in-service completion on van safety and what to do in a van emergency. Residents were interviewed and indicated they felt safe during van transportation. Documentation of van safety audits were reviewed. QA (Quality Assurance) meeting signatures were reviewed. The facility's corrective action plan was validated to be completed as of 1/12/23.	F 684		
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 facility and emergency department record review, observation, and interviews with staff, residents, dialysis staff and contract transportation staff, the facility failed to ensure positioning and securement was according to manufacturer's recommendations to provide a safe contract van transport. Resident #1 fell from his wheelchair when the transportation driver put on the brakes. The resident had bleeding from his below the knee amputation sites and pain on his right shoulder. This situation had the high	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 9	F 689		

likelihood to cause serious injury and harm. This deficient practice affected 1 of 3 residents (Resident #1).

Findings included:

According to the "Use and Care Manual" updated 2014 for the four-point wheelchair securement system used by the contract transportation company details the following instructions for securing a passenger:

1. Make sure chair's Pelvic Belt is buckled over occupant's hips.

2. Attach Shoulder Belt Pin Connector to Pin located on Shoulder Belt Height Adjuster

3. Pull Shoulder Belt over occupant's chest and attach Shoulder Belt Pelvic Connector to Pin on Compliant Pelvic Belt

4. Adjust Shoulder Belt Height so that Shoulder Belt rests on shoulder. After the occupant and vehicle are secured, the occupant is ready for transportation

5. Attach Shoulder Belt Pin Connector to Pin on Rear Retractor closest to wall.

6. Attach the Pelvic Belt Pin Connector to Pin on Rear Retractor closest to the aisle.

7. Pull the Shoulder Belt over occupant's chest and buckle Shoulder Belt Pelvic Connector to Removable Pelvic Belt.

8. Adjust Shoulder Belt Height so that Shoulder Belt rests on shoulder. After the occupant and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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F 689	Continued From page 10	F 689		

vehicle are secured, the occupant is ready for transportation.

Resident #1 was admitted to the facility on 12/29/22 with diagnoses that included left below the knee amputation (BKA) performed in December 2022 and a right BKA performed in November 2022 and kidney failure requiring dialysis.

Resident #1's admission Minimum Data Set dated 1/5/23 indicated moderately impaired cognition. He required extensive assistance with transfers and locomotion. He had not had any falls in the past 6 months or since admission. He required pain medication as needed for frequent pain. He had surgical wounds at admission. He required dialysis.

A Nursing Progress Note dated 1/6/23 at 9:40 AM indicated Resident #1 called the facility to inform his nurse that he fell from his wheelchair in the contract transportation van on the way to dialysis. Resident #1 indicated he fell from his wheelchair when the transportation driver hit his brakes and he was at the hospital.

An Emergency Department Provider note dated 1/6/23 indicated Resident #1 was thrown from his wheelchair onto his bilateral amputation stumps during transportation to dialysis from the facility. Resident #1 was bleeding from his amputation sites. He was not on blood thinners at that time and did not lose consciousness. Resident #1 complained of pain at his amputation sites and his right shoulder. Redness and bleeding were noted to the amputation sites. Staples were intact to his incisions. Resident #1's x-rays were negative for leg or arm fractures. The Emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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F 689	Continued From page 11	F 689		

Department "After Visit Summary" dated 1/6/23 included new orders for a pain medication. Diagnoses included fall and pain of amputation stump of both lower extremities.

An Investigation Guide to determine the cause of the accident completed by the Administrator dated 1/6/23 indicated Resident #1 fell in the contract transportation van while traveling to dialysis. The transportation driver proceeded to the dialysis clinic for assistance with getting Resident #1 off the floor of the van. The dialysis clinic staff advised the transportation driver to call an ambulance and Resident #1 was taken to the hospital. The root cause of the fall was determined to be operator error in securing the resident with safety restraints.

A written statement dated 1/6/23 from Resident #1 indicated the transportation driver hit his brakes and the seatbelt hooked to the wall gave out and he fell to the floor. The driver tried to get him up but Resident #1 asked him to leave him on the floor. Resident #1 was lying on his stomach on the floor of the van. Resident #1 reported pain to bilateral BKA stumps and his shoulder.

During an interview on 2/9/23 at 11:35 AM, Resident #1 revealed that on 1/6/23, he did not have his usual driver for dialysis. The transportation driver pushed Resident #1 in his wheelchair into the van, locked the wheels, and used four straps to secure the wheelchair to the floor of the van. Resident #1 indicated an additional lap belt came up from the floor across his lap and connected a shoulder belt to the wall. Resident #1 indicated the transportation driver was speeding during the 8-minute drive to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

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F 689	Continued From page 12	F 689		

dialysis. A car turned out in front of the van and the driver hit his brakes. Resident #1 indicated the shoulder belt attached to the wall tightened and then pulled out of the wall causing Resident #1 to fall forward with the wheelchair falling on top of him. Resident #1 indicated the buckle around his waist remained buckled through the fall. Resident#1 fell onto his hands and amputation stumps causing pain and bleeding to his amputation sites. Resident #1 indicated the driver continued driving 3-5 minutes to the dialysis clinic with him on the floor of the van. Resident #1 indicated that he was transported by ambulance to the hospital where he received x-rays of his arms and legs, wound cleaning and dressing changes, and pain medication. The staples to his amputation sites were intact and he did not require hospital admission or additional wound care. He returned to the facility that day. Resident #1 indicated he was seen by the facility's wound care team and the wounds looked "ok." Resident #1 revealed he had seen his vascular surgeon and would need further surgery to his amputation site. Resident #1 indicated the transportation company no longer took him to dialysis and that he took the facility's transportation van since the fall.

A written statement from the transportation driver dated 1/6/23 indicated he had been driving for the contract transportation company for nine months. He indicated he properly secured Resident #1 into the van prior to leaving the facility. A car pulled out into the street and the driver slammed on his brakes causing Resident #1 to fall from his wheelchair. The transportation driver pulled over to the side of the road and turned on his hazard lights. Resident #1 indicated he was "fine" and wanted to get back into his wheelchair. The driver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 13	F 689		

tried to pick Resident #1 up and get him into his wheelchair but was unsuccessful. Resident #1 requested the driver take him to the dialysis clinic for assistance getting up to the chair. The transportation driver drove to the dialysis clinic for assistance. The dialysis clinic suggested the transportation driver call an ambulance. Resident #1's wheelchair remained strapped into the van with a large cushion to the seat. The transportation driver believed Resident slipped through the seatbelt due to the large slippery cushion.

A telephone interview was conducted on 2/9/23 at 2:10 PM with the Transportation Driver. He revealed that prior to leaving the facility, he strapped Resident #1's wheelchair into the van using four floor straps for the wheels. A lap belt hooked into the floor, went across Resident #1's lap, and connected to a shoulder belt that hooked to the wall. He recalled checking each strap before leaving the facility and did not recall any issues. The Transportation Driver indicated that a car pulled out in front of him while driving and he had to hit the brakes to avoid hitting the car. He heard Resident #1 call out and turned around to find him lying the floor of the van. The transportation driver revealed he pulled over and turned on the van's hazard lights. The transportation driver recalled Resident #1's wheelchair, lap belt, and shoulder belt remained strapped into the van. The driver continued driving to the dialysis clinic to request assistance getting him off the floor. The clinical nurse supervisor assisted him in calling an ambulance. The transportation driver believed Resident #1 slipped under the lap belt or flipped over it. The transportation driver indicated he then noticed two cushions in the seat of Resident #1's wheelchair.

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	345481	A. BUILDING _____ B. WING _____	C 02/10/2023

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F 689	Continued From page 14	F 689		

He was not aware Resident #1 was sitting on these cushions prior to leaving the facility.

A written statement dated 1/6/23 from the Contract Transportation Company owner indicated the transportation driver had been terminated. During an interview on 2/9/23 at 2:35 PM, the Contract Transportation Company owner believed one of the straps must have disconnected for Resident #1 to fall. He indicated all employees were trained on proper strap and belt securement for wheelchair use in the transportation van. He revealed the driver no longer worked for the company.

A Wound Care Nurse Practitioner (NP) note dated 1/10/23 indicated Resident #1 was complaining of moderate to severe pain, worse on the left stump than right. The left amputation site appearance was improved with no evidence of dehiscence (separation of wound opening) or infection. Minimal yellow tissue was noted along the incision line. Redness was noted around the wound. The right stump incision was intact and well approximated. Staples were intact to both amputation sites.

A Google Maps search indicated the distance from the named intersection to the dialysis clinic was 0.2 miles and would take one minute by vehicle.

A telephone interview was conducted on 2/9/23 at 1:55 PM; the Dialysis Nurse Supervisor indicated the transportation driver arrived at the clinic and came to her office asking for assistance getting Resident #1 off the floor of the van. When she arrived at the van, Resident #1 was face down on the floor of the van with the wheelchair and

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F 689	Continued From page 15	F 689		

seatbelt next to him. She did not recall if the wheelchair was strapped into the van. The Dialysis Nurse Supervisor indicated she instructed the van driver to call an ambulance. The emergency medical technicians got Resident #1 into a seated position and revealed bleeding to his amputation sites. Resident #1 was complaining of pain.

During an interview on 2/9/23 at 5:05 PM, the Wound Care NP revealed that Resident #1's wounds remained intact while at the facility. She noted increased necrotic tissue to the wound site but revealed it could have been natural progression and not caused by the fall.

During an interview on 2/10/23 at 3:50 PM, the Director of Nursing (DON) indicated that following Resident #1's fall in the contract transportation van, he was transported to the hospital for evaluation. Upon his return to the facility, a skin assessment was completed, pain checks were initiated, and an investigation was started. Resident #1 did not sustain additional injury to his amputation sites. The DON indicated that the contract transportation company was suspended from transporting residents from the facility. The contract transportation owner brought the van to the facility for a fall reenactment and a safety audit with the regional safety officer. The facility determined the cause of the fall was operator error of van safety belts. Education on van safety, proper cushions and slings for van transport was provided to all staff. The DON indicated that she and the Administrator conducted van safety audits and the maintenance director completed vehicle inspections.

During an interview on 2/10/23 at 4:15 PM, the

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F 689	Continued From page 16	F 689		

Administrator revealed Resident #1 reported to her in his statement that the transportation driver hit his brakes, his shoulder belt disconnected from the wall, and he was thrown from his wheelchair to the floor of the van. The facility began an investigation on 1/6/23. The Contract Transportation Company owner provided the van for inspection and accident reenactment of the fall. The safety team determined the cause of the fall was operator error due to not properly securing the shoulder belt. The contract transportation company services were suspended pending the company provided education records for their employees. The Administrator indicated that the facility began educating staff on van safety, safe chair devices (pillows, cushions) for transportation use. The DON and administrator began van safety audits, the maintenance director began weekly van inspections, and the facility's transportation driver began filling out a checklist for each ride. The facility had had no further van accidents since Resident #1's fall.

The Administrator and DON were notified of the Immediate Jeopardy on 2/9/23 at 6:15 PM.

The facility provided the following corrective action plan with a completion date of 1/12/23.

Problem identified: On 1/6/2023, resident #1 was traveling to the dialysis center via wheelchair transported the contract transportation company. The van driver hit his brakes and Resident #1 was propelled from the wheelchair landing on the floor of the van on his stomach.

Immediate action identified: Resident #1 was sent to the emergency room for evaluation on 1/6/2023. Upon completion of the evaluation, the

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F 689	Continued From page 17	F 689		

resident was sent back to the facility with pain control medications and bowel protocol. On 1/9/2023, the administrator initiated a grip mat to his wheelchair while using the sling on dialysis days Monday, Wednesday, and Fridays. This task was initiated in PCC on 1/10/2023 by the nurse consultant. On 1/11/2023, the resident was issued a wheelchair cushion with straps to utilize while sitting up in his wheelchair.

On 1/6/2023, the facility suspended all transports scheduled with the contract transportation company until an inspection of the safety mechanisms could be conducted and review of van driver training was completed. On 1/10/2023, the Administrator began contacting all current van transport companies used to transport facility residents. The following was requested: Current van inspections and training material and documentation of training for all van drivers utilized for facility transports. On 1/10/2023, all dialysis residents were reviewed by the DON to identify which residents required the use of a sling for transfer to the dialysis treatment chair. Only one resident was identified and that was Resident #1. On 1/10/2023, the Nurse management team audited all current residents by inspecting each room and current seating device (wheelchair, geriatric recliner, or other chair) for the use of pillows or facility non-issued cushions or cushions of fabric nature. If any of the described cushions were noted, the nurse managers replaced the device with a facility issued cushion

Systemic changes made: On 1/11/2023, all nurses, nurse aides, Transportation Aides, Maintenance Staff, and Administration staff were in-serviced by the staff development coordinator on the following: appropriate slings to be used in

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F 689	Continued From page 18	F 689		

wheelchairs during transportation, appropriate chair cushions and pillows to be used during transportation.

Monitoring process: A quality assurance monitor Van Transports will be completed by the Transportation Aide or Maintenance Director or designee weekly x 4 weeks then monthly x 3 months until resolved by the Quality Assurance (QA) Committee. The Van Transport QA Tool will monitor all resident transport checklists to ensure checks are being completed prior to each van transport and are compliant. Reports of the audit will be given to the Director of Nursing to report in the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality-of-Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly.

Onsite validation was completed on 2/10/23 through staff interviews, observation, and record review. Staff were interviewed to validate in-service completion on van safety and what to do in a van emergency. An observation was made of Resident #1 loaded into the facility's transportation van. Resident #1 was up to his wheelchair with a blue mesh sling in place. Resident #1 and the facility transportation driver indicated this was the sling used at the dialysis clinic. The facility transportation used the chair lift, wheeled Resident #1 into place, and secured his chair using four floor straps with hooks, a lap belt, and a shoulder belt. She tested the straps by moving the wheelchair back and forth. She implemented the wheelchair's brakes. Resident

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F 689	Continued From page 19 #1 indicated he felt secure and safe. Residents were interviewed and indicated they felt safe during van transportation. Documentation of van safety audits were reviewed. QA (Quality Assurance) meeting signatures were reviewed. The facility's corrective action plan was validated to be completed as of 1/12/23.	F 689		