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|---|---|---|---|
| | 345506 | A. BUILDING _____ B. WING _____ | C 03/08/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY** | **700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407** |

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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>An unannounced complaint survey was conducted on 1/31/14 with a follow-up phone call on 2/4/14, after further review of the findings an unannounced onsite extended survey with further investigation of the complaint was conducted on 3/6/14 -3/8/14.<br><br>Immediate Jeopardy began on 1/27/14 and was identified on 3/6/14. Immediate jeopardy was removed on 3/8/14. The facility remains out of compliance at the D level (No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy), in order to continue implementation of the process and monitor systems.<br><br>On 4/28/14 IDR was conducted. The IDR panel deleted F 309 J. | F 000 | | |
| F 323 SS=J | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interviews, service representative interview, observation and document review the facility failed to prevent a resident fall, caused by a mechanical failure, by failing to have a automated mechanical ramp for | F 323 | These allegations of compliance and plan of correction are in response to deficiencies cited in the survey ending March 8, 2014. Preparation and submission of this plan of correction | 3/14/14 |

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

Electronically Signed | 04/04/2014

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|---|---|---|---|---|
| F 323 | Continued From page 1<br>a resident transportation van serviced when it had known incidents of working improperly for 1 of 1 residents (Resident #1) and failed to follow the manufacturer ' s schedule for maintenance of the automated mechanical ramp for 2 of 2 resident transportation vans, which resulted in a resident fall for 1 of 1 residents (Resident #1).<br><br>Immediate Jeopardy began on 1/27/14 and was identified on 3/6/14. Immediate jeopardy was removed on 3/8/14. The facility remains out of compliance at the D level (No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy), in order to continue implementation of the process and monitor systems.<br><br>The findings included:<br><br>According to the Operator's Manual (30117 Rev A) "Maintenance is necessary to ensure safe and trouble free (brand name of ramp) operation. General preventative maintenance consisting of inspecting your (brand name of ramp) systems along with cleaning and lubricating procedures should be part of your routine" (Page 47). "Regular preventative maintenance procedures will increase the service life of the (brand name of ramp), as well as enhancing safety" (Page 47). "Clean and lubricate the specified points approximately every 4 weeks or 100 cycles" (Page 47). "Preventative maintenance visual inspections and lubrication procedures do not take the place of the procedures specified in the Maintenance and Lubrication Schedule provided in the (brand name of ramp) Service Manual. The procedure section in the Maintenance and Lubrication Schedule must be performed at the recommended scheduled intervals by an | F 323 | does not constitute an admission or agreement by Masonic and Eastern Star Home ("WhiteStone") of the truth of facts alleged or of the correctness of conclusions set forth in the statement of deficiencies or in correspondence from or actions by the North Carolina Department of Health and Human Services, Division of Health Service Regulation, or CMS. This plan of correction and the attached documents are prepared, executed, and submitted solely to comply with the requirements of State and federal law.<br><br>The electronic signature of WhiteStone's representative signifies that WhiteStone received the CMS-2567 statement of deficiencies and that the plan of correction submitted herein is accurate. This signature does not indicate acceptance by WhiteStone of the allegations contained in the statement of deficiencies or the manner in which the alleged deficiencies were cited.<br><br>F323<br>483.25(h) Accidents.<br>The facility must ensure that □<br>(1) The resident environment remains as free from accident hazards as is possible; and<br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>A. How the deficient practice will be corrected for those residents identified;<br><br>The vehicle in question was immediately | |

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|---|---|---|---|---|
| F 323 | Continued From page 2<br>authorized (name of manufacturer) service representative" (Page 48). "If there is any sign of damage, wear, abnormal condition or improper operation, discontinue (brand name of ramp) use immediately" (page 48).<br><br>Resident #1 was admitted on 12/10/13 for aftercare following a hip replacement secondary to a hip fracture and was readmitted on 1/13/14. She also was on dialysis three days a week. Review of the Admission Minimum Data Set (MDS) revealed Resident #1 was cognitively intact and used a walker or wheelchair for mobility.<br><br>Review of the Event Report dated 1/27/14 at 5 PM revealed that Resident #1 had an attended fall while on the mechanical ramp in her wheelchair: "Van Driver/Nursing Assistant #1 (VD/NA #1) was in the process of getting (Resident #1) into a transportation van and the lift on the van started to go up without VD/NA #1 engaging any buttons causing (Resident #1) to fall backwards in her wc (wheelchair) " , "(Resident #1) sustained a bump on her head that did not bleed nor did she loose (sic) consciousness". The incident occurred at the dialysis clinic. Resident #1's condition prior to the incident was documented as alert, oriented and calm and after the incident it was alert, agitated and anxious. The report also indicated that the van was taken out of service immediately after the incident.<br><br>A written statement signed by VD/NA #1, dated 1/27/14 revealed "On Mon Jan 27 about 5 pm after picking up (Resident #2) from her doctors appointment I proceeded on New Garden Rd to pick up (Resident #1) from Dialysis. I had | F 323 | taken out of commission on January 27, 2014 until an authorized service technician could endorse the vehicle was in proper working condition.<br><br>B. How other residents will be identified who have the potential to be affected by this deficient practice;<br><br>1) The remaining transportation van and ramp in operation were checked on February 7, 2014 by WhiteStone Plant Operations staff and all active transportation vehicles and ramps will continue to be checked weekly by WhiteStone Plant Operations staff for proper operation.<br>2) The ramp was cleaned and lubricated per manufacturer□s recommendations on February 12, 2014 and will be cleaned and lubricated monthly by WhiteStone Plant Operation staff.<br>3) All ramps/lifts were serviced by the authorized service provider on or prior to February 24, 2014 and will be serviced every six months per manufacturer□s recommendations.<br><br>C. What changes/processes will be initiated to ensure the deficient practice will not recur;<br><br>1) All home Care transportation aides and any staff with the potential to transport residents received training on reporting vehicle problems via the work order system on February 28, 2014.<br>2) All maintenance staff received training on a) immediately taking transportation | |

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| F 323 | Continued From page 3<br>Resident #2 in a wheelchair, knowing that (Resident #1) could stand up from her wheelchair to be seated in the van seat. I pulled up in the front of the door. Lifted down the ramp of the Gray van. Proceeded into get (Resident #1) asking her if she felt comfortable standing up with my help to sit her in the chair of the van. She said yes. I proceeded up the ramp reaching over sideways positioning her to stand, the ramp came up throwing both of us her falling backward, the ramp was folding upward she fell backward in her wheelchair and myself twisting and jumped off the ramp, I got twisted myself, there was no open cuts on her, no blood. She was very shaken and very upset but she never lost consciousness " .<br><br>Telephone Interview with VD/NA#1 on 1/31/14 at 4 PM was consistent with the above written statement from VD/NA#1. She stated that on 1/27/14 the van was turned off and she had the keys on her wrist when the incident occurred. VD/NA#1 said she had already pushed the remote button at the side door of the van to automatically lower the ramp for use. She also stated that she pushed the resident in her wheelchair onto the middle of the ramp, and was at the side of the wheelchair getting ready to help Resident #1 transfer from her wheelchair, to a seat on the van, when the ramp started to fold up on its own (the van only had one spot that could accommodate a wheelchair which was already taken by Resident #2). VD/NA#1 said that when the ramp started to move she reached for the resident's wheelchair, but could not reach it in time, and Resident #1 fell backward in her wheelchair and hit her head. VD/NA#1 also clarified that the ramp was not meant to move with people on it and that it was only supposed to move when a remote button was pushed to | F 323 | vehicles out of service and procedures for documenting such, b) seeking authorized service technicians for mechanism issues and c) monitoring/maintaining routine service from authorized service technicians only, and d) maintaining appropriate documentation of services performed on March 3, 2014.<br>3) Mandatory staff education and training done by the Administrator and Director of Plant Operations with all Home Care transportation aides and any staff with the potential to transport residents on loading and unloading residents utilizing vehicle ramp on February 28, 2014.<br><br>D. How the community proposes to monitor its performance to make sure the aforementioned solutions are sustained;<br><br>The NHA and/or Director of Plant Operations will audit vehicle service records weekly for four (4)weeks, monthly for six (6) months then quarterly via QAPI. Since March 8, 2014, four weekly audits have been completed and documented.<br><br>Dates when the corrective action will be completed □ March 14, 2014 | |

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|---|---|---|---|---|
| F 323 | Continued From page 4 | F 323 | | |

deploy or store the ramp. She added that the ramp was used for pushing residents in their wheelchairs into and out of the van or for walking residents into and out of the van; the ramp was not a mechanical lift.

During the 1/31/14 telephone interview at 4 PM, VD/NA#1 said she knew she should not move the resident so she had a man who had seen the incident get help and 3 Nurses from the Dialysis clinic came out and got Resident #1 back in her wheelchair. VD/NA#1 did not know if these Nurses did an assessment before they got Resident #1 up. VD/NA#1 indicated that Resident #1 was very upset and while on the ground had been searching for her phone to call her family member. The resident did find her phone and notified her family member. VD/NA#1 said the Dialysis Nurses told the resident she should go to the Emergency Room (ER) but Resident #1 refused to go until her family member told her to get there. VD/NA#1 said the family member arrived about 10 minutes after the incident and wanted the resident assessed in the ER. Emergency Medical Services was called and took Resident #1 to the ER about 5 minutes later.

Also during the 1/31/14 telephone interview at 4 PM, VD/NA#1 said she called VD/NA#2 to come and transport Resident #2; VD/NA#2 then called their supervisor to report the incident. VD/NA#1 also stated that she called the Maint Dir and he came to get Van #1. She added that when VD/NA#2 arrived they both got Resident #2 off of Van #1 by pushing her in her wheelchair down the ramp that was back in its lowered position and not moving; the ramp did not move while they transferred Resident #2 off of Van #1.

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|---|---|---|---|---|
| F 323 | Continued From page 5 | F 323 | | |

Review of the Hospital Emergency Services Discharge Record dated 1/27/14 revealed Resident #1 was discharged with a diagnosis of mid/lower back pain. While in the hospital Resident #1 had a CT scan of her head and spine which revealed " no acute inter-cranial process " and stable atrophy of the resident ' s spine. In addition the report noted that the nature of the injury was " rolled backwards down ramp and w/c fell backwards " . Resident #1 was not admitted to the hospital and was discharged back to the facility.

Review of the electronic and hand written Nursing Notes for 1/27/14 revealed no Nursing Notes written that day.

A Post Fall Assessment/Summary of Fall dated 1/28/14 revealed "staff member was assisting resident into the van at the dialysis center when the ramp began to rise. Malfunction of the equipment". The Root Cause of Fall was listed as "ramp on van malfunctioned causing both resident and staff to fall from ramp".

A 1/28/14 update to the resident ' s care plan revealed "fall backward during load to van, do not transfer to seat, keep in w/c during transport/transfer".

Review of the electronic Nursing Notes revealed a 1/28/14 note at 11:10 AM "no pain no c/o discomfort from fall".

Review of the 72 Hour Event Follow-up in the hand written Medical Record chart revealed that on 1/28/14 at 5 PM Resident #1 ' s vital signs were within normal limits and she had "no c/o (complaints) event pain / achiness takes

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|---|---|---|---|---|
| F 323 | Continued From page 6<br>scheduled Norco (narcotic pain medication)". The sections for the remainder of the 72 hours post the fall event were blank.<br><br>Review of the electronic Nursing Notes revealed a 1/28/14 note at 9:39 PM "no c/o pain as result of fall yesterday".<br><br>After 1/28/14 through 1/31/14 there were no further post fall assessment notes in either the electronic or hand written medical record.<br><br>On 1/31/14 at 4:30 PM telephone interview with the Service Representative (SR #1) where Van #1 was taken to be serviced revealed the van arrived at the shop to be serviced on 1/31/14 at 3PM. She stated that there had not been an appointment made so the ramp of the van could not be looked at until 2/3/14. SR #1 said that the last time Van #1 had been in their shop for service was November 2013. She added that in November she told the staff member who brought the vehicle in, that the manufacturer recommended that the ramp should have routine maintenance every 6 months and that a one time, complimentary, routine maintenance service had been done on the ramp at that time. SR #1 stated that the routine maintenance service entailed a checklist of service items including, but not limited to, checking for abnormal noises, cleaning, checking all bolts, ramp pivots and switches and checking the operation of switches and remotes. She added that when Van #1 was brought in on 1/31/14 the staff member who dropped it off said the ramp opened up on its own one time and did it with a resident on it. She also said that the facility staff member stated that the ramp operating on its own had happened before. SR#1 was unsure if the ramp had a weight | F 323 | | |

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|---|---|---|---|---|
| F 323 | Continued From page 7 | F 323 | | |

capacity but provided the name of the manufacturer and brand name of the ramp. SR#1 added that the mechanics in her shop also indicated that if two people were on the ramp when it malfunctioned and tried to store itself, the motor would have burned itself from the weight of trying to store itself while two people were actually on it. She further indicated that the motor was not burned out.

Interview with the Maintenance Director (Maint Dir) on 1/31/14 at 5:18 PM revealed that he had taken Van #1 for service in November 2013 because he had been told there was a problem with the ramp. He stated that VD/NA #1 and VD/NA #2 complained to him that the ramp was going up (stowing) and down (deploying) by itself. He added that when he checked the ramp he couldn't find anything wrong with it but then he moved the van to park it and when he shut off the engine the side door opened on its own and the ramp deployed. The Maint Dir stated that he had not activated the ramp by pushing the remote control, it just operated on its own. He also said that he immediately took the van out of service and a few days later he took it into the shop where conversion vans like Van #1 were serviced. The Maint Dir said that the shop he took Van #1 to in November said they could not find anything wrong with the ramp, so they performed a complementary routine maintenance service on the ramp. After this, Van #1 was again used for resident transportation at the facility. The Maint Dir did not recall being told by SR#1 that the manufacturer recommended that the ramp should have routine maintenance every 6 months. He also revealed that the ramp for Van #1 had been serviced in February 2013 because it wasn't working and a new control panel was put in when

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|---|---|
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|---|---|---|---|---|
| F 323 | Continued From page 8 | F 323 | | |

he took it for service at that time. He stated that he had never taken Van #1 or Van #2 for routine maintenance of the ramp in the 5 years he worked at the facility and did not believe anyone else had either. He noted that Van #2 had the same type of ramp as Van #1. In addition, he said that after November 2013 he recalled getting called twice about the ramp of Van #1 not closing to store itself, when the remote to close it was pushed. On one occasion he went to assist the Van Driver (#1 or #1 not specified) but the ramp had already started operating and was able to be stowed before he got there. On the other occasion the ramp was still down when he got there and he had to stow it manually. The Maint Dir said that he did not take Van #1 for service to the automated mechanical ramp after either of the post November 2013 incidents when it would not stow mechanically. He added that he had not informed the Administrator of these post November 2013 incidents of the Van #1 ramp not stowing.

On 1/31/14 at 6:30 PM the Maint Dir indicated there were no service invoices for Van #2 but provided copy of the Invoices for the service to the ramp of Van #1. Review of the 3/11/13 invoice revealed: "customer states that lift inop (inoperable), installed new control board and kneel accuator completed ". The 11/21/13 invoice revealed: "customer states ramp won't go up at times, won ' t come down at times and door won't close at times. Could not duplicate this". "Performed complementary first service". There were no charges for the service on 11/21/13.

During an interview with Resident #1, on 1/31/14 at 6:30 PM, she said that VD/NA#1 was not present with her on the ramp when it started to

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|---|---|---|---|---|
| F 323 | Continued From page 9 | F 323 | | |

move and flipped her (Resident #1) backwards. Resident #1 said that VD/NA#1 wheeled her onto the front of the ramp but then stopped. Resident #1 said it looked like VD/NA#1 was going to have her (Resident #1) sit in a seat in the van because someone else (Resident #2) was already in the one wheelchair spot. When asked, Resident #1 stated that she did not recall VD/NA#1 asking her if she felt capable of transferring to a seat in the van. She said that VD/NA#1 entered the van and had her hands on the arms of the other resident's (Resident #2) wheelchair. Resident #1 said she presumed that VD/NA#1 had stepped into the van to move Resident #2 over so there would be room for her (Resident #1) to be assisted to sit in a seat in the rear of the van, but she did not know for sure as VD/NA#1 did not say anything about it. Resident #1 said that while VD/NA#1 was inside the van, and not standing on the ramp, the ramp started moving on its own and threw her (Resident #1) backwards with her legs over her head. She added that she hit her head and sustained a bump. Resident #1 said that VD/NA#1 reached out to try and stop the wheelchair from flipping but could not reach the wheelchair in time. According to Resident #1, VD/NA #1 repeatedly said "it's broken" after the incident. Resident #1 stated that staff from the Dialysis clinic got her back into her wheelchair and the nurse there said she needed to go to the Emergency Room (ER), but she (Resident #1) wanted to wait for her family member to arrive. Resident #1 had called her family member and after the family member arrived Resident #1 went to ER via Emergency Medical Services. Resident #1 said she sustained a large bump on the back of her head and had a headache from the incident but returned to the facility without being admitted to hospital.

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| F 323 | Continued From page 10<br><br>Resident #2 was not interviewable and was therefore not interviewed regarding the incident.<br><br>Telephone interview with the Administrator on 2/4/14 at 11:30 AM revealed that she had not been informed of the 2 incidents when the ramp for Van #1 would not close (stow itself) mechanically which occurred after the maintenance service in November. She also indicated that after finding this out on 1/31/14, she interviewed both VD/NA #1 and VD/NA#2 and that VD/NA#2 had said she recalled at least one incident when the ramp would not close mechanically which she had reported to maintenance (post November 2013) but she was uncertain if she had witnessed and reported a second incident. The Administrator said VD/NA#1 denied being aware of any incidents of the ramp for Van #1 not closing mechanically.<br><br>The Administrator was notified on 3/8/14 of the Immediate Jeopardy that began on 1/27/14.<br><br>The facility presented a credible allegation of compliance on 3/8/14 which included:<br><br>The van involved (#1) was immediately taken out of service on 1/27/14.<br>The van was taken for repair and service on 1/31/14; it was not used following this date. Two wiring problems were repaired and the remote was disabled, however, this did not fix the problem. The van is now being traded in towards a new van and continues to be out of service until sold. A new van is being purchased.<br>Both transportation aides have been educated by the Administrator to utilize our work order system for any vehicle problems and not to just call for | F 323 | | |

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| F 323 | Continued From page 11 | F 323 | | |

assistance. This gets the problem into our system and these work orders are reviewed every week day by the Director of Plant Operations.
They were also instructed to notify the Director of Home Care of any vehicle problems.
Both transportation aides were also educated and given authority to take a vehicle out of service. They are to pull all keys for the vehicle and give written notice and the keys to the Director of Plant Operations, or if he is not available, the Health Center Administrator.
All maintenance staff were educated by the Director of Plant Operations that any issues involving the mechanical ramps or mechanical lifts on the vehicles are to be taken to the authorized service provider for repair and the vehicle to remain out of service until repair completed. They were also educated on procedures for taking a vehicle out of service.
Additional training on transportation to include the ramp operation, securing wheelchairs, and loading and unloading residents will be done with the transportation aides as well as other staff identified to potentially assist with transportation on Friday, February 28, 2014 by the Administrator and Director of Plant Operations.
Weekly vehicle inspections have been implemented for both vehicles which include checking the operation of the mechanical ramps.
Monthly preventative maintenance has been done and been scheduled for all vehicle ramps and lifts to clean and lubricate the equipment per the manufacturer□s instructions.
Each vehicle has been serviced by the authorized service provider for the recommended six-month servicing. This is now scheduled in our preventative maintenance system as a recurring item to be done every six-months.

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| F 323 | Continued From page 12<br>Validation of the facility's credible allegation was conducted on 03/8/14. Review of the facility accident reports was conducted and there were none prior to the incident on 1/27/14. Additional, validation included observation of staff driver ' s license, facility provided cell phone, review of management agreement with Whitestone for transportation services, policy on transporting clients and emergency procedures, emergency protocol for transportation and reporting vehicle problem protocol, vehicle out of service forms, vehicle maintenance invoices, weekly maintenance checklist and staff education on reporting vehicle issues utilizing work order system for any vehicle problems. The observation included staff demonstrating the proper usage/operation of the van ramp and securing residents in the vehicle.<br><br>Residents on all halls (100, 200, 300, 400, 500 and 600 halls) in the facility records were reviewed and observations were conducted on residents who had changes in conditions. The observations included interventions associated with falls, skin conditions, staff reporting/communication process from shift to shift, staff documentation of observed changes in condition in accordance with the facility newly developed guidelines/tools (05/20/13). The SBAR(Situation, Background, Assessment and Recommendation/Request)/Change in Condition Review Audit form for all residents from 5/17/13-5/31/13 was reviewed.<br><br>Reviews of maintenance checklist and invoices were completed to verify the implementation of the assessment tools and the functional process of staff communicating problems with the condition of the van between drivers. | F 323 | | |

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| F 323 | Continued From page 13<br><br>Staff interviews were conducted with the Whitestone maintenance staff and drivers to verify the implementation of the newly developed weekly vehicle checklist, utilization of the work order system for vehicle problems, out of service notification forms, policy on transporting clients and emergency procedures. The completion date for all in-services for maintenance and van drivers became effective 3/7/14.<br><br>The Quality Assurance Audit reports dated 3/6/14 was reviewed along with all the supportive documentation of the Credible Allegation of Compliance, to verify the implementation of the facility's Credible Allegation of Compliance. | F 323 | | |
| F 456 SS=D | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, service representative interview and document review the facility failed to have routine maintenance service, as recommended by the manufacturer, for 2 of 2 automated mechanical ramps (Entervan ramps) in resident transportation vans (Van # 1 and Van #2) and failed to have an automated mechanical ramp (Entervan ramp) for a resident transportation van serviced when it had known incidents of working improperly. The findings included: | F 456 | These allegations of compliance and plan of correction are in response to deficiencies cited in the survey ending March 8, 2014. Preparation and submission of this plan of correction does not constitute an admission or agreement by Masonic and Eastern Star Home ("WhiteStone") of the truth of facts alleged or of the correctness of conclusions set forth in the statement of deficiencies or in correspondence from or actions by the North Carolina Department | 3/14/14 |

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| F 456 | Continued From page 14<br>According to the BraunAbility Operator ' s Manual (30117 Rev A) " Maintenance is necessary to ensure safe and trouble free Entervan operation. General preventative maintenance consisting of inspecting your Entervan systems along with cleaning and lubricating procedures should be part of your routine " (Page 47). " Regular preventative maintenance procedures will increase the service life of the Entervan, as well as enhancing safety " (Page 47). " Clean and lubricate the specified points approximately every 4 weeks or 100 cycles " (Page 47). " Preventative maintenance visual inspections and lubrication procedures do not take the place of the procedures specified in the Maintenance and Lubrication Schedule provided in the Entervan Service Manual. The procedures outlines in the Maintenance and Lubrication Schedule must be performed at the recommended scheduled intervals by an authorized Braun Corporation service representative " (Page 48). " If there is any sign of damage, wear, abnormal condition or improper operation, discontinue Entervan use immediately " (page 48).<br><br>On 1/31/14 at 4:30 PM telephone interview with the Service Representative (SR #1) where Van #1 was taken to be serviced revealed the van arrived at the shop to be serviced on 1/31/14 at 3PM. She stated that there had not been an appointment made so the ramp of the van could not be looked at until 2/3/14. SR #1 said that the last time Van #1 had been in their shop for service was November 2013. She added that in November she told the staff member who brought the vehicle in, that the manufacturer recommended that the ramp should have routine maintenance every 6 months and that a one time, complementary, routine maintenance service had | F 456 | of Health and Human Services, Division of Health Service Regulation, or CMS. This plan of correction and the attached documents are prepared, executed, and submitted solely to comply with the requirements of State and federal law.<br><br>The electronic signature of WhiteStone's representative signifies that WhiteStone received the CMS-2567 statement of deficiencies and that the plan of correction submitted herein is accurate. This signature does not indicate acceptance by WhiteStone of the allegations contained in the statement of deficiencies or the manner in which the alleged deficiencies were cited.<br><br>F456<br>483.70(c)(2) Essential equipment, safe operating condition.<br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>A. How the deficient practice will be corrected for those residents identified;<br><br>The vehicle in question was immediately taken out of commission on January 27, 2014 until an authorized service technician could endorse the vehicle was in proper working condition.<br><br>B. How other residents will be identified who have the potential to be affected by this deficient practice;<br><br>1) The remaining transportation van and | |

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| F 456 | Continued From page 15<br>been done on the ramp at that time. SR #1 stated that the routine maintenance service entailed a checklist of service items including, but not limited to, checking for abnormal noises, cleaning, checking all bolts, ramp pivots and switches and checking the operation of switches and remotes. SR #1 indicated that according to her records, the last time the ramp for Van #1 had maintenance prior to November 2013 was in February 2005. SR #1 also said that when Van #1 was brought in on 1/31/14 the staff member who dropped it off said the ramp opened up on its own one time and did it with a resident on it. She also said that the facility staff member stated that the ramp operating on its own had happened before. SR#1 was unsure if the ramp had a weight capacity but stated that the manufacturer was Braun and that the ramp was a Braunability Entervan. She went on to say that the mechanics in her shop said that the motor of the ramp did not have the power to lift much more than it ' s own weight and that if two people were on the lift it would have burned itself out trying to lift them both. SR #1 also said that she did not have any records indicating that the Entervan ramp for Van #2 had ever been serviced.<br><br>Interview with the Maintenance Director (Maint Dir) on 1/3/14 at 5:18 PM revealed that he had taken Van #1 for service in November 2013 because a week or so before he took it in, he had heard there was a problem with the ramp. He stated that VD/NA #1 and VD/NA #2 complained to him that the ramp was going up and down by itself. He added that when he checked the ramp he couldn ' t find anything wrong with it but then he moved the van to park it and when he shut off the engine the side door opened on its own and the ramp lowered itself. The Maint Dir stated that | F 456 | ramp in operation were checked on February 7, 2014 by WhiteStone Plant Operations staff and all active transportation vehicles and ramps will continue to be checked weekly by WhiteStone Plant Operations staff for proper operation.<br>2) The ramp was cleaned and lubricated per manufacturer□s recommendations on February 12, 2014 and will be cleaned and lubricated monthly by WhiteStone Plant Operation staff.<br>3) All ramps/lifts were serviced by the authorized service provider on or prior to February 24, 2014 and will be serviced every six months per manufacturer□s recommendations.<br><br>C) What changes/processes will be initiated to ensure the deficient practice will not recur;<br><br>1) All home Care transportation aides and any staff with the potential to transport residents received training on reporting vehicle problems via the work order system on February 28, 2014.<br>2) All maintenance staff received training on a) immediately taking transportation vehicles out of service and procedures for documenting such, b) seeking authorized service technicians for mechanism issues and c) monitoring/maintaining routine service from authorized service technicians only, and d) maintaining appropriate documentation of services performed on March 3, 2014.<br>3) Mandatory staff education and training done by the Administrator and | |

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| F 456 | Continued From page 16<br>he had not activated the ramp, it just operated on its own. He also said that he immediately took the van out of service and a few days later he took it into the shop where conversion vans like Van #1 were serviced. The Maint Dir said that the shop he took Van #1 to in November said they could not find anything wrong with the ramp, so they performed a complementary routine maintenance service on the ramp. After this, Van #1 was again used for resident transportation at the facility. The Maint Dir did not recall being told by SR#1 that the manufacturer recommended that the ramp should have routine maintenance every 6 months. He also revealed that the ramp for Van #1 had been serviced in February 2013 because it wasn ' t working and a new control panel was put in when he took it for service at that time. He stated that he had never taken Van #1 or Van #2 for routine maintenance of the ramp in the 5 years he worked at the facility and did not believe anyone else had either. In addition, he said that after November 2013 he recalled getting called twice about the ramp of Van #1 not working properly. On one occasion he went to assist the Van Driver (#1 or #1 not specified) but the ramp had already started operating and was able to be closed before he got there. On the other occasion the ramp was still down when he got there and he had to close it manually. The Maint Dir said that he did not take Van #1 for service to the automated mechanical ramp (Entervan) after either of these incidents. He added that he had not informed the Administrator of these post November 2013 incidents of the Van #1 ramp not working properly.<br><br>On 1/31/14 at 6:30 PM the Maint Dir indicated there were no service invoices for Van #2 but provided copy of the Invoices for the service to | F 456 | Director of Plant Operations with all Home Care transportation aides and any staff with the potential to transport residents on loading and unloading residents utilizing vehicle ramp on February 28, 2014.<br><br>1) How the community proposes to monitor its performance to make sure the aforementioned solutions are sustained;<br><br>The NHA and/or Director of Plant Operations will audit vehicle service records weekly for four (4)weeks, monthly for six (6) months then quarterly via QAPI. Since March 8, 2014, four weekly audits have been completed and documented.<br><br>Dates when the corrective action will be completed □ March 14, 2014 | |

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| F 456 | Continued From page 17<br>the ramp of Van #1. Review of the 3/11/13 invoice revealed: " customer states that lift inop (inoperable), installed new control board and kneel accuator completed " . The 11/21/13 invoice revealed: " customer states ramp won ' t go up at times, won ' t come down at times and door won ' t close at times. Could not duplicate this. " " Performed complementary first service. " There were no charges for the service on 11/21/13.<br><br>Telephone interview with the Administrator on 2/4/14 at 11:30 AM revealed that she had not been informed of the incidents of the Entervan ramp for Van #1 not working properly prior to the incident involving a resident, and post the maintenance service in November. She also indicated that after finding this out on 1/31/14, she interviewed both VD/NA #1 and VD/NA#2 and that VD/NA#2 had said she recalled at least one incident of the ramp not working properly which she had reported to maintenance (post November 2013) but she was uncertain if she had witnessed and reported a second incident. The Administrator said VD/NA#1 denied being aware of any incidents of the Entervan ramp for Van #1 working properly. | F 456 | | |