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AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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F 000	INITIAL COMMENTS Recertification survey was conducted from 02/26/2018 through 03/02/2018. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 01/15/2018 and was removed on 03/02/2018. An extended survey was conducted.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS to reflect a fall with injury for 1 of 3 residents (Resident # 69) reviewed for falls. Findings included: Resident #69 was admitted to the facility on 3/10/15 with diagnoses that included Dementia and Unspecified Abnormalities in Gait and Walking. Review of Resident #69's MDS (Minimum Data Set) dated 2/6/18, coded as a quarterly assessment, indicated that resident had experienced two or more falls with no injury.	F 641	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceeding. The Plan of Correcting the specific deficiency: For resident #69 MDS Coordinator completed modification of 02/06/2018 MDS Assessment on 03/01/2018 and electronically transmitted 03/05/2018	3/16/18

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

Electronically Signed | 03/16/2018

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F 641	Continued From page 1 Review of the resident's medical record revealed a progress note dated 1/14/18. The note documented that the resident had been observed on the floor beside her bed, laying on top of her right arm. Her arm was noted to be cool to the touch and purple. In addition, the note read in part: resident noted to have a hematoma above right eye and a 2cmX2cm discolored area on her right hip from previous fall that occurred 1/13/18. During an interview with the MDS Coordinator on 3/1/18 at 4:30 PM she stated that she utilized the incident report to complete the assessment, which did not indicate any injury. She stated had not seen the progress note that indicated the resident had a minor injury. The MDS Coordinator stated that had she seen the progress note she would have coded the assessment to reflect a fall with injury. When interviewed on 3/2/18 at 9:39 AM, the Director of Nursing stated that it is her expectation that the MDS Coordinator review the entire chart when completing assessments.	F 641	The process that lead to deficiency: MDS Coordinator completing the MDS Assessment on 02/06/2018 did not review the entire record when completing the MDS Assessment. The procedure for implementing the acceptable Plan of Correction Education provided on 03/13/2018 by Regional Clinical Director for MDS Coordinators and Interdisciplinary Team members to accurately code the MDS by ensuring the entire record is reviewed when completing the MDS Assessment. Monitoring Procedures: The Director of Nursing will review 5 MDS Assessments weekly for 4 weeks then monthly for 4 months to ensure accuracy of MDS. Monitoring and results will be discussed in monthly QAPI as information is available from analysis of audit tool. The Administrator and Director of Nursing will receive weekly reports regarding the accuracy and completeness of the MDS weekly for 4 weeks then monthly for 4 months to ensure accuracy of MDS. Responsibility for development of this Plan of Correction will be overseen by the Administrator and Director of Nursing. Completion Date: 03/16/2018	

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F 689	Continued From page 2	F 689		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and wheelchair manufacturer securement system review, staff interviews, van manufacturer representative interview and resident interviews, the facility failed to secure 2 of 2 sampled residents (Resident #38 and #84) in the facility van while being transported to medical appointments. Neither Resident #38's wheelchair nor Resident #84's wheelchairs were attached to the van floor securement system with a four point safety restraint applied to their wheelchairs as specified by the manufacturer, resulting in Resident #38 from his wheelchair during transport. Immediate Jeopardy began on 1/15/2018 for Resident #38 when the facility did not secure him before transporting him back to the facility from a medical appointment resulting in the resident falling and hitting his head. Immediate Jeopardy began on 2/28/2018 for Resident #84 when the facility did not secure her before transporting her back to the facility. Immediate Jeopardy was removed for both Resident's #38 and #84 on 3/2/2018 at 11:00AM when the facility implemented a credible allegation of compliance.	F 689	The Plan for Correcting the Specific Deficiency The facility corrected the impact of the deficient practice regarding safety measures associated with wheelchair restrain system via completion of the following actions. Correction occurred on 02/28/2018. The Director of Nursing immediately corrected this issue with immediate decommission of facility transport van. The reason for the removal from service for this vehicle was due to the need for education associated with proper wheelchair securement for the Q-Straint wheelchair restraint system, which had to be completed correctly with all transport staff, all department heads, and all other appropriate personnel as deemed so per the Director of Nursing. The process that lead to the deficiency: Transportation Aide failed to secure wheelchair per manufacturer's guidelines.	3/16/18

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F 689	Continued From page 3 The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. The findings included: The facility Director of Nursing provided a document outlining how to secure wheelchairs in the facility van wheelchair securement system. The document read in part: 1. "J Hooks must be attached to a solid wheelchair frame (no spokes or movable components) at an approximate 45 degree angle with floor" 2. "Do not allow webbing to get twisted inside the retractors" 3. "Attach 4 retractors into floor anchorage points and lock them in place, with an approximate distance of 48 inches to 54 inches between the front and rear retractors" 4. "Move wheelchair forward and back to remove webbing slack or manual tension webbing with retractor knobs" 1. Resident #38 was admitted to the facility on 2/20/2017 with diagnoses that included neurogenic bladder, diabetes mellitus, long term use of anticoagulant and muscle weakness. The most recent annual Minimum Data Set	F 689	The procedure for implementing the acceptable plan of correction for the specific deficiency cited: After fully removing van from service, in aims of providing continuity in the provision of care related to transport, the Director of Nursing contacted American Specialty Transport Services and successfully transitioned all future transports into their schedule. After appointing all further transports to American Specialty, the Director of Nursing began the task of identifying best practices for the "QStraint" wheelchair restraining system for immediate implementation into facility transport educational protocol. In an effort to provide the most accurate and up-to-date, best practice educational information, The Director of Nursing contacted the facility van's manufacturer. At the time of contact, the manufacturer provided online resources for education. In addition, Director of Nursing, Administrator, and Regional Director of Clinical Services received training via teleconference and the use of educational videos, where instruction was provided by the manufacturer representative. Post teleconference, Director of Nursing, Administrator, and Regional Director of Clinical provided education through the use of the pre-screened video, class discussion, and finalization of the education with a quiz provided for each person attending. In attendance was all heads of departments, all transport staff,	

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F 689	Continued From page 4 (MDS) assessment dated 1/10/2018 revealed Resident #38 required extensive physical assistance of one person for transfers and set up assistance for locomotion off the unit. The MDS further revealed Resident #38 was coded as being cognitively intact. Review of Resident #38's incident report dated 1/15/2018 revealed Resident #38 was being transported to an outside medical appointment by Transportation Aide/Nurse Aide #1 in the facility transportation van. The report further indicated that on the way back from the medical appointment Resident #38 fell out of his wheelchair when Transportation Aide/Nurse Aide #1 accelerated when the traffic light turned green. The report stated his chair slightly moved back and Resident #38 fell over the back of his wheelchair. The immediate action taken stated Transportation Aide/Nurse Aide #1 pulled over and contacted the Director of Nursing (DON) and Emergency Medical Services (EMS). An interview with Resident #38 on 2/27/2018 at 4:30 PM revealed that he fell from his wheelchair while being transported back from a medical appointment on the facility van on 1/15/2018. He stated Transportation Aide/Nurse Aide #1 was driving the van and accelerated once the traffic light turned green. He further stated that once she accelerated his wheelchair moved and he fell out of the chair and hit the right side of his head on the metal portion of the stationary van seat located directly behind him. He stated the DON came to the site of incident along with EMS and he refused to go to the hospital and was transported back to the facility.	F 689	and all others deemed prudent by the Director of Nursing. Demonstration and Return demonstration was conducted. All transport staff returned proper demonstration 3 times to Regional Director of Clinical Services, Director of Nursing, Therapy Director, and Maintenance Director. Due to the Maintenance Director's role in completing annual competencies, he also demonstrated proper procedure 3 times. All other attendees were required to observe once. This concluded all necessary requirements to be in full compliance with safety practices and accident prevention related to facility van transports. However, continued education to assist in retention of information is planned, with a live video demonstration for all required staff, being presented by the manufacturer's representative. These education sessions will be followed with a question and answer session. The monitoring procedure to ensure that the plan of correction is effective and specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The facility will assure appropriate monitoring of all transports daily on facility transport van, Monday thru Friday for a total of 4 weeks. Staff who will be monitoring the process will include Maintenance Director, Director of Nursing, and Assistant Director of Nursing. The Director of Nursing has developed a schedule for auditors to be present for	

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F 689	Continued From page 5 An additional interview was conducted with Resident #38 on 2/28/2018 at 9:30 AM regarding the van incident of 1/15/2018. During this interview, he stated the straps (of the retractors) on his wheelchair were loose the entire trip back to the facility from his medical appointment. He stated he heard some clicking noise coming from the belts of the retractors connected to his chair. The resident stated that he asked the staff to tighten them but stated she did not and continued with the drive back to the facility. Interview with Transportation/Nurse Aide #1 on 2/28/2018 at 10:04 AM revealed that she had been driving the facility's new van since it was delivered to the facility at the beginning of January 2018. She reported that this was a new van, delivered in January 2018, and 1/15/2018 was the first time she had transported Resident #38 in this vehicle. She reported that her training for securing a wheelchair during transportation consisted of performing a hands-on demonstration and a return demonstration by a representative from the company, who manufactured the van with the wheelchair securement system. She stated she had demonstrated proper securing of residents' wheelchairs using the wheelchair securement system. The Transportation/Nurse Aide #1 revealed that on 1/15/2018 she transported Resident #38 to a medical appointment. During the trip back from the appointment, she stated she heard "clicks" coming from the retractors connected to Resident #38's wheelchair. She further stated she pushed pressed on the van's gas pedal when a traffic light turned green and Resident #38 "came forward and backwards" in his chair and fell out of the chair onto the van floor, hitting his head on the stationary seat	F 689	transports. After completion of the four weeks of initial monitoring, facility will monitor transports once weekly for 4 weeks. Once completion of the secondary monitoring occurs, facility will complete one random review per month for the next 6 months. The expectation for annual training for all department heads and competencies of transportation staff will be completed by the Maintenance Director, who will report results annually in QAPI. In addition, training and competencies will be completed for any new hires related to transportation of facility van. Monitoring and results will be discussed in monthly QAPI as information is available from analysis of audit tool. Annually, the Administrator will be responsible for auditing of associated staff to ensure its completion. However, the Van is still not being used for transports and has remained out of service since 2/28/18. Facility provided transports will begin no later than 3/26/18 and daily audits to follow. Education completed for facility staff was provided on or before 3/13/2018 and additional training for facility staff will be performed on 3/22/18. Title of person responsible for implementing the acceptable Plan of Correction: Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing and Maintenance Director. Completion Date: 03/16/2018	

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located behind him. She stated the DON and Scheduler/NA#2 came to the site of the incident and encouraged Resident #38 to go to the hospital, but stated he refused and was transported back to the facility. Transportation Aide/Nurse Aide #1 stated after the fall "I showed them how I hooked him." She stated she connected 2 of the retractors to the front and connected 2 of the retractors on the side of the wheelchair to the wheels of Resident #38's chair during transportation. She further stated that she always connected the retractors to his wheels on his chair during transport.

An observation was conducted of Transportation/Nurse Aide#1 on 2/28/18 at 10:30 AM in which she demonstrated how she secured Resident #38's wheelchair during transportation on 1/15/18 (date of van incident). She used Resident #38's customized wheelchair for this demonstration. Transportation/Nurse Aide #1 was observed to place Resident #38's chair in the front wheelchair position of the van. She proceeded to attach 2 front retractors (one of the outside track and one on the inside track of the van securement system) to the outer rim of the wheel. She was further observed to place the 2 back retractors to the wheels of the resident's chair. After placing the 4-point locking system (retractors) to Resident #38's chair, the chair was observed to move greater than 3 inches to the front when manipulated. The belts of the retractors to the front left were noticeably twisted. The Transportation/Nurse Aide #1 seat belt was secured during demonstration. The wheelchair was noted to be secured in a side way position between the two tie down bars Transportation/Nurse Aide #1 indicated that after

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the incident she was told by the DON that it would be better to use the T-bar located in the back of the resident's chair instead of the wheels of the resident's chair. Transportation/Nurse Aide #1 was observed next to perform a demonstration of the 4-point locking system with a standard non-customized wheelchair. She placed the 2 front retractors to the front base of the chair, and she placed 2 retractors to the side of the wheelchair, secured to the base of the chair. There were no retractors securing the back of the wheelchair. The belts of the retractors to front left were noticeably twisted. The seat belt was secured during demonstration. Transportation Aide/Nurse Aide #1 stated that this was her complete procedure for securing the wheelchair for transportation. Once she secured the chair, with mild manipulation the chair moved greater than 3 inches and locked in an angled position.

2. Resident #84 was admitted to the facility 12/8/17 with diagnoses including end stage renal disease, diabetes, osteomyelitis and generalized muscle weakness.

The admission minimum data set (MDS) assessment dated 12/15/17 coded Resident #84 as being cognitively intact, and as having clear speech. She required Extensive Assistance with transfer and limited assistance with most other activities of ADLs. The MDS noted Resident #84 as having no memory impairments and having no difficulty with decision making also read that she required a wheelchair for mobility.

Resident #84 was observed on 2/28/18 at 2:40 PM on the facility's transportation van after returning from a medical appointment. Resident

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F 689	Continued From page 8 #84 was observed in her wheelchair in the front position on the van with two retractors in the front connected to the base of the wheelchair and two retractors on the sides of the chair connected to the base of the chair. The belts on the left side of the wheelchair were noted to be twisted both belts of the retractor. There were no retractors at the back of Resident #84's wheelchair, as specified in the manufacturer specifications. Interview with Resident #84 on 3/1/18 at 3:20 PM revealed that her wheelchair was "generally" secured when in the van. She also stated that her wheelchair "sometimes" moved forward or backwards when being transported on the van but "for the most part it is secure." Interview with Scheduler/NA#2 on 2/28/2018 at 3:57 PM revealed on 1/15/2018 she arrived at the incident location with the DON. She stated that due to entering the rear of the van she was only able to make an observation of the back wheelchair retractors. Scheduler/NA#2 stated the rear wheelchair retractors were attached to the rear wheels of Resident #38's wheelchair. She stated the chair was in an upright position. The Scheduler/NA#2 revealed she did not provide transportation for the facility but was previously trained that retractors were to only be attached to frame of a wheelchair and not the wheels. She further stated that she was trained to secure 2 retractors to the front of a wheelchair and 2 to the back of a wheelchair. She stated that placing 2 retractors on the side of a wheelchair would not be appropriate to secure a wheelchair for transportation, according to her training. An interview was conducted via telephone with the vendor that sold the van to the facility with the wheelchair securement system on 2/28/2018 at	F 689		

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4:10 PM. During this interview, he stated his driver who delivered the van in January 2018 reviewed the wheelchair lift, wheelchair securement system, to include the use of the retractors and placement of retractors and operation of the vehicle with facility staff.
He reported that wheelchairs should be secured with a 4-point retractor lock system. He stated 2 retractors should be in the front of the wheelchair chair connected to the base of the chair and 2 retractors should be located in the back of the chair connected to the base of the chair. He also stated that all slack should be taken out of the belts (by using the retractor knob or by moving the chair forward and backwards prior to transport) prior to transport. He further stated that the belts should be flat, with no twist in the belts. He stated that retractors should have never been secured on wheels or any part of the wheels.

An interview was conducted with the DON and Regional Nurse Consultant on 2/28/2018 at 2:58 PM. They both stated the van was a new van delivered to the facility in January 2018. They stated the driver who delivered the van demonstrated the appropriate use of the wheelchair securement system, and a returned demonstration was performed by facility transportation staff to include Transportation Aide/Nurse Aide #1.The DON reported on the date of 1/15/2018, she got a call from Transportation/Nurse Aide #1 stating that Resident #38 fell out of his wheelchair during transport. She stated she told Transportation Aide/Nurse Aide #1 to call 911. The DON stated she went to assess Resident #38 along with Scheduler/Nurse Aide #2. She further stated when she got to the location, Resident #38 was on the van floor. She stated Resident #38

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wanted to be put back in the chair, but she told him to wait until EMS arrived. The DON stated that after EMS arrived, and Resident #38 refused to go to the hospital, they put the resident back in the chair and transported him back to the facility. She stated she interviewed Resident #38, and he stated, "when they went to take off he went backwards and kept going backwards." The DON reported that she and the previous Administrator conducted the re-in-service after the incident on 1/15/2018 on how to secure a wheelchair during transportation. Additionally during this interview the DON was informed of the observation of Resident #84 on 2/28/2018 at 2:40PM, in which the resident was observed to be transported without the required specification of the wheelchair securement system. The DON and Regional Nurse Consultant suspended all van transport at that time.

The Administrator was informed of Immediate Jeopardy on 2/28/2018 at 5:30PM for Resident #38 and #84.

A Credible Allegation of Compliance was accepted on 3/1/2018 at 6:05PM as follows:

Credible Allegation of Compliance:

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:
On the day of January 15th, 2018 resident was in the facility transport van on way back from MD appointment. The van was at a stop light. When the driver pressed the gas to go forward as the light turned green the resident leaned back into the chair. The chair slightly moved back and the resident fell over the back of his wheelchair. A

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detailed analysis of the incident took place. This included the Director of Nursing going to site of incident. The chair remained strapped in the seatbelt. The resident is a paraplegic with bilateral above knee amputations. This resident has his own personal wheelchair which he chooses to use for comfort and mobility to ensure peak independence in mobility. The resident's wheelchair has a low back. Once incident occurred the transporter notified the Director of Nursing and EMS. The Director of Nursing immediately went to the scene. She arrived before Emergency Medical Services. At that time the chair was in the upright position and had to be moved in order to get to the resident. The resident was lying on the floor of van the transporter was next to him. The resident was alert and verbal. The nurse assisted the resident to an upright position after assessing him for range of motion and injury. Soon after Emergency Medical Services arrived and took over the evaluation of the resident. The resident refused to go to the hospital for evaluation. He was educated by the Director of Nursing at this time. She explained risks and benefits regarding going to the hospital and reminded the resident he was on an anticoagulant which increased his risk of bleeding. She informed him hitting his head put him at more risk for bleeding. The resident stated understanding and he did not want to go. The director of nursing inspected his chair for any obvious signs of damage. None noted. Upon arrival back to the facility the chair was again inspected along with the administrator. None noted. The chair was taken to the back of the van and reenactment created. Anti-tippers noted to be working properly. During observation by state surveyors of resident affected during return demonstration by the transportation aide of

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reenactment of method used to secure resident's wheelchair on January 15th, 2018 it was noted wheelchair was not properly secured using the wheelchair securement systems specifications. The two front anchor straps were connected to the outside anchors of the floor. However, the two back anchor straps were also anchored to the outside tracks in the floor. This does not follow manufacturer's instructions. The J hook attaching wheelchair securement system to the wheelchair was not connected to a stationary site of the chair. It was connected to the wheelchair wheel which is not following manufacturer's specifications. States surveyors also noted some twisting in one of the anchor straps which is contraindicated in manufacturer instructions. State surveyors also observed transportation aides method of wheelchair securement using another type of wheelchair where again the improper usage of the wheelchair securement system was observed. The misuse of the system was the same as listed above. Front two straps anchored to outside anchor strip, however back anchor straps were anchored to outside anchor strips as well as opposed to the manufacturer instructions for the straps to be anchored in the middle locking strip located in the van floor. During this demonstration the J hook was properly attached to a nonmoving part of the chair. However, the same twisting in one anchor strap remained present. In addition state surveyors observed another resident on February 28th, 2018 returning from appointment on facility van and was also noted wheelchair was not properly secured per manufacturer recommendations. At this observation the front straps were anchored to the outside anchoring strips in the van floor, however rear straps were located being anchored to the outside strip of van

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floor as opposed to middle strip which allows anchorage directly behind the chair as per manufacturer recommendations. Upon surveyors discussions related to proper methods of wheelchair securement with Administrator, Director of Nursing, and Regional Director of Clinical Services immediate action was taken to stop all further transportations on facility van until further notice.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited: The facility corrected the impact of the deficient practice regarding safety measures associated with wheelchair restraint system via completion of the following actions. Correction occurred on 2/28/2018. The Director of Nursing immediately corrected this issue with (#1) immediate decommissioning of facility transport van. The reason for the removal from service for this vehicle was due to the need for education associated with proper wheelchair restraint for the wheelchair restraint system, which had to be completed correctly with all transport staff, all department heads, and all other appropriate personnel as deemed so per the Director of Nursing. After fully removing van from service, (#2) in aims of providing continuity in the provision of care related to transport, the Director of Nursing contacted transport services and successfully transitioned all future transports into their schedule. After appointing all further transports, the Director of Nursing began the task of identifying best practices for the Wheelchair Restraining System for immediate implementation into facility transport educational protocol. In an effort to provide the most accurate and up-to-date, best practice educational information, the Director of Nursing contacted the facility van's manufacturer. At the time of contact,

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the manufacturer provided online resources for education. In addition, Director of Nursing, Administrator, and Regional Director of Clinical Services received training via teleconference and the use of educational videos, where instruction was provided by the manufacturer representative. Post teleconference, Director of Nursing, Administrator, and Regional Director of Clinical provided education through the use of the pre-screened video, class discussion, and finalization of the education with a quiz provided for each person attending. In attendance were all heads of departments, all transport staff, and all others deemed prudent by the Director of Nursing. Demonstration and Return demonstration were conducted. All transport staff returned proper demonstration three times to Regional Director of Clinical Services, Director of Nursing, Therapy Director, and Maintenance Director. Due to the Maintenance Director's role in completing annual competencies, he also demonstrated proper procedure three times. All other attendees were required to observe once. This concluded all necessary requirements to be in full compliance with safety practices and accident prevention related to facility van transports. However, continued education to assist in retention of information is planned, with a live video demonstration for all required staff, being presented by the manufacturer's representative. This education will be followed with a question and answer session. Additional education is planned for March 22, 2018. This education is webinar-based training covering best practices, securing equipment, operation, securing the ambulation wheelchair, securing the occupant, and pre-trip inspection, and basic maintenance. 100% of all staff with potential to drive transport vehicle, and all staff who would

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participate in training and/or auditing safety practices were trained and marked with successful completion of training on February 28, 2018.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

The facility will assure appropriate monitoring of all transports daily, Monday through Friday for a total of four weeks. Staff who will be monitoring the process will include Maintenance Director, Director of Nursing, and Assistant Director of Nursing. The Director of Nursing has developed a schedule for auditors to be present for transports. After completion of the four weeks of initial monitoring, facility will monitor transports once weekly for four weeks. Once completion of the secondary monitoring occurs, facility will complete one random review per month for the next 6 months. The expectation for annual training for all department heads and competencies of transportation staff will be completed by the maintenance director, who will report results annually in QAPI. AS well as new hire training or competencies as indicated. Monitoring and results will be discussed in monthly QAPI as information is available from analysis of audit tool. Annually, the administrator will be responsible to audit training of associated staff to ensure its completion.

For ongoing actions, the facility has placed visual reminders of proper procedure in the transport van. These visual reminders are training posters, one large and one small, with step-by-step instruction, as well as illustration of correct

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F 689	Continued From page 16 procedure, providing explicit detail if needed. These posters have been placed in the transport van and can be used as a quick reference or constant reminder of correct procedure. As referenced afore, additional education via web-based training and video conference will be completed within the next thirty days as scheduled. Monthly, information will discussed in QAPI and analysis of the results completed. The QAPI Committee will review the results from the analysis and audits in order to ascertain the effectiveness of current training and intervention and the need for amended training and/or further intervention. The first review by QAPI Committee will be March 13, 2018, at which time phase one monitoring results that are available will be presented and reviewed. The title of the person responsible for implementing the acceptable plan of correction. The facility administrator will be responsible for implementing the acceptable plan of correction. Immediate Jeopardy was lifted on 3/2/2018 at 11:00AM. The facility provided evidence of additional in-service training for all transportation staff. Interviews and observations of transportation staff securing wheelchair bound residents in the facility van were completed. Interviews of transportation staff revealed that they are now aware of the correct securement procedures for wheelchairs on the van during transportation.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		3/16/18

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F 867	Continued From page 17 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions the committee put in place in January 2017. This was for a deficiency originally cited 12/22/16 and was subsequently recited on the current recertification survey 3/3/18. The repeated deficiency was in the area of accuracy of assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings include: This tag is cross referenced to F641 Accuracy of Assessment Based on record review and staff interviews, the facility failed to accurately code the MDS to reflect a fall with injury for 1 of 3 residents (Resident # 69) reviewed for falls. During the recertification survey of 12/22/2016, the facility was cited for failure to accurately code the Minimum Data Set for 2 of 18 sampled residents (resident #35 and #121). During an interview with the Director of Nursing (DON) and the Minimum Data Set (MDS) Coordinator on 3/2/18 at 3:37 PM revealed the	F 867	The plan for correcting the specific deficiency: For resident #69 MDS Coordinator completed modification of 02/06/2018 MDS Assessment of 03/01/2018 and electronically transmitted 03/05/2018 The process that lead to the deficiency: MDS Coordinator completing the MDS Assessment on 02/06/2018 did not review the entire record when completing the MDS Assessment. In addition, no ongoing, monitoring for accuracy of MDS was reviewed in QAPI to ensure sustained compliance. The procedure for implementing the acceptable Plan of Correction Education provided on 03/13/2018 by Regional Clinical Director for MDS Coordinators and Interdisciplinary Team members to accurately code the MDS for all residents by ensuring the entire record is reviewed when completing the MDS Assessment. Monitoring Procedures The Director of Nursing will review 5 MDS	

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F 867	Continued From page 18 quality assessment and assurance (QAA) committee met monthly. The monthly meetings consisted of the Administrator, the DON, Social Worker (SW), MDS Coordinators and other interdisciplinary staff members. The DON identified additional areas of focus as repeat MDS falls, accuracy of assessments (diagnosis) and infection control. The DON stated the corporate office completed audits for MDS discrepancy.	F 867	Assessments weekly for 4 weeks then monthly for 4 months to ensure accuracy of MDS. Monitoring and results will be discussed in monthly QAPI as information is available from analysis of audit tool. The Administrator and Director of Nursing will received weekly reports regarding the accuracy and completeness of the MDS weekly for 4 weeks then monthly for 4 months to ensure accuracy of MDS. In addition, to ensure sustained compliance, ongoing audits will be completed quarterly by Director of Nursing. Director of Nursing will audit 5 MDS Assessments quarterly to ensure accuracy of MDS Assessments and audit results will be discussed in QAPI as information is available from analysis. Title of person responsible for implementing the acceptable Plan of Correction: Implementation of the plan will be overseen by the Administrator of the facility with assistance from the Director of Nursing and Maintenance Director. Completion Date: 03/16/2018	