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	345232	A. BUILDING _____ B. WING _____	06/21/2018

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F 000	INITIAL COMMENTS A recertification survey was conducted on 06/18/18 through 06/21/18. Past non-compliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F689 constituted substandard quality of care. 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 staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge status for 1 of 3 sampled residents (resident #116) reviewed for closed record. Findings included: Resident #116 was admitted to the facility on 05/08/18 with multiple diagnoses including hypertension, hyperlipidemia, hypothyroidism and presence of right artificial knee joint. A review of the Discharge Summary dated 05/22/18 revealed Resident #116 was admitted to the facility after hospitalization due to infected right knee arthroplasty. The physical exam indicated that Resident #116 was recovering well	F 641	F641- Accuracy of Assessments Criteria 1-The plan for correcting the deficiency: The facility will accurately code the discharge status and location of each resident that discharges or transfers from the facility. This process failure occurred because staff coded the wrong discharge location when completing the discharge assessment. Criteria 2- The procedure for implementing the plan of correction: • On 6/21/18 the MDS staff was in-serviced by the Director of Nursing on MDS accuracy related to discharge to the community. • On 6/21/18 The Resident Care Management Director completed a	7/28/18

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

Electronically Signed | 07/11/2018

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F 641	Continued From page 1 in the facility without any complications. She was discharged home on 05/22/18 in stable condition. A review of the physician order dated 05/22/18 indicated that the physician had ordered to discharge Resident #116 home on 05/22/18. A review of the nursing notes dated 05/22/18 revealed Resident #116 was discharged home with her son via private vehicle. A review of Resident #116's discharge MDS assessment dated 05/22/18 indicated that the Discharge Status under Section A had been coded as discharged to acute hospital. On 06/21/18 at 12:45 PM an interview was conducted with MDS Coordinator who acknowledged that she had incorrectly coded the Discharge Status under Section A for Resident #116's discharge MDS dated 05/22/18. The MDS Coordinator stated that she should have coded the discharge status as "Community" instead of "Acute Hospital". She stated that she was aware of Resident #116's discharge status and added the incorrect coding was due to human error. On 06/21/18 at 02:06 PM an interview was conducted with the Director of Nursing (DON) who stated that the incorrect MDS coding would be modified and resubmitted to accurately reflect Resident #116's actual discharge status. It was her expectation for all the MDS to be coded accurately and submitted in a timely manner. On 06/21/18 at 05:02 PM an interview was conducted with the Administrator who stated that the incorrect MDS coding for Resident #116's discharge status was a human error. It was her	F 641	modification to the discharge MDS for resident #116, correcting the discharge status to reflect discharge to home. • On 6/26/18 The Resident Care Management Director audited all discharge assessments for accuracy from the last 30 days with no errors noted. • A QA monitoring tool has been developed and a schedule for monitoring has been set to aide in monitoring for compliance of this regulation Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The Resident Care Management Director will audit all discharge MDS assessments, completed by the MDS nurse, daily for 2 weeks, then two times a week for 4 weeks, then weekly for 2 months to ensure all discharges have been entered correctly. • The MDS nurse coordinator will audit all discharge MDS assessments, completed by the Resident Care Management Director, daily for 2 weeks, then two times a week for 4 weeks, then weekly for 2 months to ensure all discharges have been entered correctly. • Any assessment found to be in error will be modified immediately to reflect accuracy. • Results will be reported to the QAPI committee monthly. • The QAPI committee will determine the need for further auditing after the initial 12 weeks.	

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F 641	Continued From page 2 expectation for all the MDS to be coded accurately and submitted in a timely manner.	F 641	Criteria 4- The person responsible for implementing the plan of correction; • Administrator is responsible for implementing the plan of correction. • Date of Compliance 7/28/18	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide the application of splints according to the restorative splint and positioning instructions for 1 of 3 residents sampled with limited range of motion (Resident #60). Findings included:	F 688	F688- Increase/Prevent Decrease in ROM/Mobility Criteria 1- The plan of correcting cited deficiency of F688 and the processes that lead to the citation; The facility will provide necessary services to provide ROM and splint appliances as needed to our residents. The process failure occurred because staff did not	7/28/18

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F 688	Continued From page 3 Resident #60 was admitted on 12/09/11 with diagnoses that included Alzheimer's, cerebrovascular accident affecting the left non-dominant side, left hemiplegia and hemiparesis, and contractures to left shoulder, left elbow, left hand, and left knee. A review of the quarterly Minimal Data Set (MDS) assessment dated 5/8/18 revealed Resident #60 was coded with impaired cognition and needing extensive assistance with activities of daily living. A review of the care plan revised on 6/21/18 revealed Resident #60 had limited physical mobility related to Alzheimer's and history of a stroke with left hemiparesis. Interventions included applying splints as tolerated. A review of the documentation by Restorative Nursing Assistant #2 (RNA) dated 5/1/18 regarding Resident #60 read, RNA to continue current plan of care as follows: passive range of motion to left upper and lower extremity (shoulder, elbow, wrist, hand). RNA to donn left upper and lower extremity splints to prevent contractures, check for pressure points and skin breakdown. A review of the documentation by RNA #2 dated 5/10/18 read, Resident #60 was discharged from restorative services. A splint and positioning protocol written on 5/10/18 by RNA #2 indicated Resident #60 was to have splints to the left upper extremity elbow and left lower extremity knee applied at the beginning of the first shift and wear up to 6 to 8 hours. Staff were instructed to check for pressure points during application and notify the nurse if a	F 688	ensure that a splint was applied as the plan of care indicated for a resident. Criteria 2- The procedure for implementing the plan of correction; • On 7/6/18 the Director of Nursing contacted the resident's physician and after assessment, the plan was revised and an order was given to discontinue the splint due to refusal by the resident; an order was received to refer the resident to therapy services. • On 7/6/18 The Director of Nursing audited all residents who had splints to ensure they were appropriately applied as the plan of care indicated and that the assignment sheets were updated for residents requiring splints to match the plan of care. • On 7/6/18 Nursing Staff were educated by the Director of Nursing, Assistant Director of Nursing and the Nurse Unit Managers to ensure splints were applied as ordered, document refusal and inform nurse of any signs and symptoms of skin breakdown. • On 7/6/18 License Nursing staff was educated by the DON, and RN Unit Managers when residents are discharged from therapy or from restorative nursing with a splint, the appropriate nursing staff will be educated on the application and removal of the splint as applicable. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The unit managers/ADON are	

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F 688	Continued From page 4 problem occurred. A review of the NA care guide dated 6/19/18 revealed Resident #60 was to wear a left knee splint and left hand splint daily as tolerated. An observation on 6/18/18 at 2:40pm revealed Resident #60 had contractures to the left elbow and left knee. No splint devices were in place. An elbow splint was noted on top of the resident's refrigerator beside his bed. Signage above Resident #60's bed read, Please be sure to remove all equipment from resident before evening meal. Thanks, Restorative. An observation on 6/19/18 at 10:00am revealed Resident #60 had no splint devices in place. An elbow splint was noted on the top of the resident's refrigerator beside his bed. An observation on 6/20/18 at 9:16am revealed Resident #60 had no splints in place. An elbow splint was noted on top of the resident's refrigerator beside his bed. During an interview on 6/20/18 at 10:55am, NA #2 indicated restorative applied all of the splints and positional devices for Resident #60. An interview on 6/20/18 at 11:00am with NA #2 revealed RNA #1 had just informed her that Resident #60 was off restorative and the NAs should be applying splints to the left elbow and left knee. During an observation on 6/20/18 at 11:10am the elbow splint was noted on top of the refrigerator beside Resident #60's bed while NA #2 and NA #3 gave him a bath. RNA #1 walked in the room	F 688	monitoring to ensure splints are applied as ordered three times a week for 4 weeks, then weekly for 8 weeks.. • Results will be reported to the QAPI committee monthly. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction; • The Director of Nursing is responsible for implementing the plan of correction. • Date of Compliance 7/28/18	

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F 688	Continued From page 5	F 688		

and stated restorative would pick Resident #60 back up on that day since his contractures had gotten worse.

An observation on 6/20/18 at 11:31am revealed RNA #1 giving NA #2 and NA #3 education as he assisted to apply the left knee splint and left elbow splint.

An interview on 6/20/18 at 11:43am with NA #2 revealed she had been working on 200 hall where Resident #60 resided and had not attempted to apply Resident #60's splints because she thought restorative had been involved.

An interview on 6/20/18 at 11:48am with NA #3 revealed she had worked different shifts on 200 hall and was assigned to care for Resident #60. She stated she had never applied his splints because she thought restorative put on the splints. NA #3 indicated she did not know she could apply splints and had not been trained.

An interview with RNA #2 on 6/20/18 at 11:57am revealed he had discharged Resident #60 on 5/10/18 and had in-serviced NAs on how the equipment should be placed, the duration, and how to remove the splints. RNA #2 indicated Resident #60 had different staff caring for him and the staff he had instructed no longer worked full time in the facility.

An interview on 6/20/18 at 12:01pm with Nurse #1 who was assigned to care for Resident #60 revealed she did not know he was not receiving restorative services.

An interview on 6/20/18 at 3:43pm with NA #4 and NA #6 revealed they had not been scheduled

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F 688	Continued From page 6 to work with Resident #60 on 6/18/18 or 6/19/18 but typically first shift would report to them if Resident #60 had refused his splints. NA #6 indicated the splints were usually on and he would remove the splints before dinner as he had been taught. An interview on 6/21/18 at 9:08am with the Rehab Director revealed she expected Resident #60 to receive passive range of motion prior to donning and doffing the splints according to his tolerance and skin integrity. The Rehab Director explained that when splints were not worn routinely the joints could stiffen and cause increased pain. An interview on 6/21/18 at 9:50am with the Director of Nursing (DON) revealed she expected the NAs to at least attempt to apply the splints and to communicate to the nurse and restorative if help was needed due to the resident refusing. The DON indicated all communication regarding splint devices had been verbal once a resident had been discharged from restorative and no physician order was written for positional devices. The NAs were to follow the resident's care guide for specific instructions. The DON stated NA #7 had cared for Resident #60 on 6/18/18 and 6/19/18 and had confirmed she had not attempted to place the splints because of his history of refusing and combative behavior at times. An interview on 6/21/18 at 4:00pm with the Administrator was conducted. She revealed she expected the nursing staff to follow the care guide and apply splints and positional devices as tolerated when recommended.	F 688		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		7/10/18

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F 689 SS=J	Continued From page 7 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 staff and resident interviews, record review and review of manufacturer's instructions, the facility failed to properly secure 1 of 2 residents who were transported on the facility's transport van. Resident #61 was seated in an unsecured wheelchair while being transported in the facility van and flipped backwards during transport. Resident #61 struck her head on the floor of the transportation van and diagnosed with a head contusion. The findings included: Review of the manufacturer's instructions for the L Track Applications and Retractors with S-hooks" which is the system used on the facility's transport van to secure residents who are seated in wheel chairs during transport specified, "Release the lever and place the S-hook securely around a structural member of the chair. Pull on the S-hook to ensure full engagement around the structural member. Repeat procedure with the other front retractor." Resident #61 was admitted to the facility on 08/01/14 with diagnoses that included	F 689	Past noncompliance: no plan of correction required.	

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osteopenia, chronic headaches, kyphosis, lumbar spinal stenosis and others. The most recent quarterly Minimum Data Set (MDS) dated 05/07/18 specified the resident's cognition was intact, she had no behaviors but required limited assistance with activities of daily living. The MDS also specified the resident used a wheelchair for locomotion.

Review of the medical record revealed a care plan for falls updated 05/15/18 to reflect an incident in which the "wheelchair tipped back in transport van, hematoma to back of head."

Further review of the medical record revealed a progress note dated 05/15/18 at 3:00 PM that read in part, "Resident out to DR (doctor) apt(appointment), arrived back around 3pm. Incident Report completed and neuro (neurological) checks initiated and are WNL (within normal limits). PA (Physician's Assistant) in to see resident and new orders received to send to ER (Emergency Room) for evaluation. Resident aware and is own RP (Responsible Party). EMS (Emergency Medical Services) notified and are in route to facility at this time."

A progress note dated 5/15/18 completed by the Physician's Assistant (PA) specified Resident #61 was complaining of a terrible headache and neck pain after her wheelchair fell backwards in van. "The resident tells me this happened about 45 minutes ago and that when the van took off her wheelchair went down backwards and landed on the ground and the back of her head hit the door. She complains of a terrible headache and points to the front of her head." The PA wrote an order to send the resident to the Emergency

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F 689	Continued From page 9	F 689		

Department for evaluation.

The Emergency Department (ED) report dated 05/15/18 was reviewed and revealed the resident presented to ED after she fell out of her wheelchair today. The report read in part, "patient states that her wheelchair was placed in a wheelchair van for transport. She states the wheelchair was not affixed to the floor of the van and then when the van drove off her wheelchair rolled backwards and tipped to the left. Patient struck the left side of her head on the door of the wheelchair van. She states she now has left-sided back pain." Resident #61 received a computerized tomography (CT) scan and x-rays that were negative for injury. Resident #61 was diagnosed with a head contusion and returned to the facility on 05/15/18.

On 06/19/18 at 10:02 AM Resident #61 was interviewed in her room and reported she had never had any issues with the facility ' s transportation van but "4 or 5 weeks ago" she was not properly strapped in. The Resident reported that the van driver secured her wheelchair as usual, closed the rear door to the van but when she looked down, the "S" hooks (metal hooks used to secure a tightened strap to the frame of the wheelchair) were not hooked. She added, "before I could say anything, he (van driver) jumped in the front seat, flew out of the parking lot and I went whirling backwards and hit my head on the door. If the door had been open I would have fallen out of the van." The resident described that she "hollered awful" and van driver stopped the van and went to the back of the van, opened the rear door to check on the resident. Resident #1 stated she hit her head from the fall and was assisted back up by the van driver. She

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also stated, the van driver re-secured the resident's wheelchair and drove her back to the facility. Resident #61 stated she told the Administrator after the incident the hooks had not been attached properly.

On 06/19/18 at 2:58 PM the Administrator was interviewed and stated the facility had a van incident. The Administrator reported she was not certain about what caused the incident but through an investigation concluded a problem occurred with the way Resident #61's wheelchair had been secured. The Administrator explained the van driver had been driving for the facility for 19 years and no previous incidents had been reported. She added the driver was trained yearly on a skills check list that was completed by herself or another corporate representative. The skills check list included online modules and demonstrations. The Administrator described that on 05/15/18 she was called by the Director of Nursing (DON) to come to the front entrance because there had been a van incident. She described seeing Resident #61 seated in a wheelchair and secured properly in the van using a 4-point security system and 2-point shoulder harness. The Administrator stated she was told by the van driver that Resident #61's wheelchair flipped backwards. She added there was a third person in the van when the incident occurred, nurse aide (NA) #1. The Administrator directed the DON to tend to Resident #61 to assess for injury while she separated the van driver and NA #1 and obtained statements. She stated the van driver and NA #1 stated the van driver had attached the front "S" hooks to the resident's wheelchair but when the wheelchair flipped backwards, the "S" hooks were no longer attached to the frame of the wheelchair. The

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Administrator reported that she also interviewed Resident #61 who reported to her the S-hooks were off the wheelchair causing her to flip backwards. During the interview, the Administrator provided the van driver's last annual skills check dated 07/25/17. Review of the skills check revealed the driver demonstrated he was aware of the manufacturer's instructions for securing a resident.

On 06/19/18 at 3:09 PM the van driver was interviewed and reported he was the only van driver for the facility. He stated he had been in his position for 19 years and only had one incident. The van driver added that on 05/15/18 he was picking Resident #61 up from a medical appointment when an "unfortunate incident" occurred. The van driver described it was a typical day and he performed his usual routine of rolling the resident in her wheelchair into the back of the van, proceeded to secure the resident using the van's 4-point S-hook system. The van driver reported Resident #61 "had a tendency of using her feet to press away from the front straps." The van driver added he secured the front S-hooks to the frame of the wheelchair in the front and back and tightened the straps. The van driver added he was not certain if the resident had her feet pressed in opposing force from the front straps or not and did not ask her to raise her feet to verify she was securely tightened. He then closed the back door, got in the front seat, drove out of the parking lot and when he accelerated out of the parking lot he heard a "thump." The van driver stated he stopped the van, ran to check on the resident and observed the resident had flipped backwards in the wheelchair and the front S-hooks were unhooked from the front of the wheelchair. He

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added he assessed the resident and saw no visible injury and the resident stated she was fine and wanted up. Nurse aide (NA) #1 was also witness.

During the same interview the van driver reported he called the DON to notify her of the situation and asked her to meet him outside of the facility because the incident happened less than a mile away from the facility. The van driver explained that once he was able to determine the resident was not seriously injured, he sat her up in the wheelchair and re-secured everything. Once he arrived at the facility, he was asked to reenact the incident and submit to a drug test. The van driver stated the only possible cause he could think of for why the front straps came off the wheelchair was that when the resident relaxed her legs, it allowed for slack in the straps and the S-hooks fell off.

On 06/19/18 at 3:35 PM nurse aide (NA) #1 was interviewed on the telephone and reported that part of her duties included assisting residents to medical appointments by riding along in the van. She stated she had not been trained on the van's securement system. The NA explained on 05/15/18 she was assisting Resident #61 to a medical appointment. When the van driver arrived at the medical office, she waited behind the van and watched as the van driver loaded Resident #61 into the back of the van and used a 4-point S-hook system to secure the resident into the van. The NA added that the resident was loaded first, then she got in the van, seated in front of the resident. NA #1 stated she observed the front S-hooks attached to the wheelchair prior to take off. The she described the van was

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leaving the parking lot and she heard Resident #61 holler and looked back and the resident had flipped backwards in the wheelchair.

On 06/21/18 at 8:40 AM the van driver was observed loading a resident into the van. The observations revealed he followed manufacturer's instructions, asked the resident to raise his legs to ensure the straps were secure.

The facility provided the following plan of correction with the correction date of 05/17/18:

F689-Free of Accidents Hazards/Supervision/Devices
Criteria 1- The plan of correcting cited deficiency of F689 and the processes that lead to the citation;
· On 5/15/18, Resident #61, who is alert and oriented with a BIMS of 13, was returning to the facility via facility transport van with the van driver and a transportation attendant. Approximately one mile away from the facility, Resident #61's wheelchair came loose from the 4-point security straps, causing her to tip backwards landing on the backs of the armrests, and hitting her head. The transportation attendant immediately notified the facility van driver, who immediately stopped the van. The resident denied pain or injury to the attendant and driver. The driver and attendant assisted Resident #61 into an upright position, secured her wheelchair into the security straps and proceeded to the facility. The Director of Nursing (DON) was notified immediately and met the driver and the attendant in the parking lot when they arrived. Resident #61 was assessed by the DON while in the van, no complaints of or obvious signs of pain

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or injury were noted. Resident #61 was taken to her room, placed in her bed, and further assessed by the DON, with still no complaints of pain or injury noted. The Nurse Practionier (NP) was available, and assessed the resident at the bedside, neuro checks completed and within normal limits. Per policy, the neuro checks continued through 5/18/18. As the day continued, Resident #61 began to complain of shoulder pain and a headache, she was sent to the Emergency Department for evaluation and all diagnostic testing came back negative.

·On 5/15/18, The van driver and transport attendant were interviewed separately by the Administrator (NHA) and DON regarding the incident; both interviews yielded the same details. Both indicated that the 4 "S" hooks were attached to the frame of the wheelchair at the start of the transport and could not explain how the incident occurred.

·On 5/15/18, Resident #61 was interviewed by the administrator and stated she was not sure how the straps came loose.

·On 05/15/18 van driver was not allowed to transport residents, transportation was stopped and outside transport was obtained for 5/15/18, and 5/16/18.

·On 5/15/18, after removing resident #61 from the van, the NHA removed the van from service until deemed safe and all upcoming transports were rescheduled with a contracted transportation service.

·On 5/15/18 at 4:30 pm the Staffing Coordinator conducted a drug screen for the van driver, per

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facility policy. The results were negative.

·On 5/15/18 The van driver performed a return demonstration to the NHA regarding proper procedures for securing a wheelchair prior to transport.

·On 5/15/18 The van driver completed a test drive with the NHA serving as the passenger, in the same wheelchair that involved in the incident. No issues were noted with the technique of the driver or mechanics of the van.

·On 5/15/18 the Sava Senior Care Manager of OSHA and Compliance (Compliance Manager) was notified by the NHA of the incident. The NHA, DON, Van Driver and Compliance Manager conducted a root cause analysis regarding this van incident. It was determined by the team that the strap securing the wheelchair to the van was likely not sufficiently tightened and the S hook became dislodged during travel allowing the wheelchair to tip backwards. The following plan of correction was implemented to ensure both human error or equipment failures were addressed.

Criteria 2- The procedure for implementing the plan of correction for F689;

·Per the Compliance Manager's phone recommendations on 5/15/18, the facility cleaned the van well and the securement straps were removed to another area on the security track by van driver and validated by the NHA.

·On 5/15/18 AD HOC QAPI meeting was held with the following members; Administrator, Van

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Driver, Director of Nursing, OSHA Compliance Manager.

·On 5/16/18 the Compliance Manager performed van inspection and van driver re-education provided following the manufacturer guidelines, along with participation in demonstration by the van driver in wheelchair security and driving technique, with no irregular findings.

·Any Van Drivers of this facility will be trained in safe operation of the transportation van before being allowed to transport residents. Training will be done by Administrator or the Compliance Manager.

·The facility Van Driver will complete a Safety Securement checklist with every resident transport and any negative finding will be immediately communicated to the facility administrator and addressed immediately.

·On 5/16/18 a new securement system was installed by the OSHA Compliance Manager who is certified by the manufacturer. A new securement system was installed to update the older system that was in place providing more safety and security.

·On 5/16/18 van driver was trained on the new manufacturer securement system by OSHA Compliance Manager by video, thru the manufacturer's "Safe and Secure" video "Doing It Right Training Program "and demonstration, and skill check company was completed.

·The van driver, who had been a paramedic, felt he was able to complete a minimal assessment to determine there were no visual injury or

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deformity. Resident #61 who is alert and orientated denied any pain or injury at the time of the observation. However, per the facility policy of "safety responsibility for authorized drivers", for incidents or accidents not involving vehicle accidents the driver is to report all incidents to the administrator and wait for instruction. The driver was re-educated n this policy on 5/16/18.

·On 5/17/18 A new system for loading residents, all residents will be loaded in the facility ' s main entrance for easy visibility

·On 5/17/18 the formal "S" hook securement hook was replaced with a Snap Hook and D-Ring with a Quick Strap by van driver who was trained by OSHA Compliance Manager who is Sure-Lok certified.

·On 5/17/18 Replaced 2-point seat belt harness with a three-point seat belt harness. This provides extra security and safety.

·On 5/15/18 Administrator reviewed daily transport log to determine and validate that driver had enough time scheduled between appointments to apply the securement system appropriately without the need to rush through the process.

·Starting 5/17/18 the van driver is required to give the administrator the daily securement checklist at the end of each day. This securement checklist is completed by the van driver before/ after each transportation with residents. This checklist was developed by the Manager of OSHA Compliance. The van driver was educated by the Manager of OSHA Compliance on completing this check list.

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·Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following;

The Administrator has completed visual audits of the securement of the resident and the safety securement checklist while residents are in the van and prior to being transported, 2x daily for 1 week then; 1x daily for 1 week then; 3x weekly for 6 weeks. At this time there has been no negative finding and audits will continue for up to 12 weeks.
Administrator has interviewed alert and oriented residents after their transportation for any adverse events. At this time, no further, adverse events have occurred and no residents have had any concerns regarding safety techniques or issues with wheelchair securement.

In addition administrator has reviewed weekly facility vehicle inspection checklist with van driver for the last 4 weeks. Administrator has verified the proper working condition of the securement and the operations of the van.
Any negative finding will be corrected immediately, if unable to correct immediately van will be place in out of service status until correction is made.

Results will be reported to the QAPI committee monthly.

The QAPI committee will determine the need for further auditing after the initial 12 weeks.

Criteria 4- The person responsible for

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F 689	Continued From page 19 implementing the plan of correction. The Administrator is responsible for implementing the corrective action. The date of compliance is 5/17/18. The plan of correction was validated on 06/21/18 and concluded the facility implemented an acceptable plan of correction on 05/17/18. The validation including observing the van driver loading and securing a resident in the transportation van. During the observation, the van driver asked the resident to lift his legs to ensure there was no slack in the straps. Observations were made of the new secure system installed in the transportation van. The facility provided documentation of the van driver s drug test, in-service records and monitoring. Documentation included facility audits and daily monitoring of the van driver. Resident #61 and other residents were interviewed and reported they had been secured properly in the van after the correction date of 05/17/18.	F 689		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service and failed to maintain control of flies during incontinence care for 1 of 3 sampled residents for limited range of motion (Resident #60).	F 925	F925- Maintains Effective Pest Control Program Criteria 1- The plan of correcting cited deficiency of F925 and the processes that lead to the citation; The plan to correct the sited deficiency of F925 the facility will maintain an effective	7/28/18

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F 925	Continued From page 20 Findings included: 1. On 06/20/18 at 11:15 AM the lunch meal service was observed and the Food Service Director/Dietary Manager and the District Manager were present in the kitchen. On 06/20/18 at 11:22 AM food was observed on the serving line in uncovered pans at the steam table and a fly was observed flying above the serving line. On 06/20/18 at 11:25 AM a fly was observed flying around the stove and at 11:29 AM Cook #1 started plating food for residents. On 06/20/18 at 11:32 AM a fly was observed flying above a food preparation table located next to the stove with open packages of sandwich bread and cheese slices lying on top of the food preparation table and the Food Service Director/Dietary Manager was making grilled cheese sandwiches. The observations also revealed there was a utensil rack above the food preparation table and a fly was observed on the handle of a large whisk hanging from a utensil rack. On 06/20/18 at 11:34 AM 2 flies were observed on the utensil rack above the food preparation table with slices of bread and cheese below the utensil rack that were open on top of the food preparation table. On 06/20/18 at 11:38 AM a fly was observed flying over clean plates stacked next to the tray line. On 06/20/18 at 11:41 AM a fly was observed flying over the food preparation table with slices of bread and cheese still open on the table. On 06/20/18 at 11:45 AM the door opened into the main dining room and a fly was observed flying inside the door from the dining room and flew to the utensil rack over the food preparation table and another fly was observed on the ceiling over the food preparation table. On 06/20/18 at 11:48 AM a fly was observed on the handle of a large whisk hanging from the utensil rack and multiple	F 925	pest control program so that the facility is free of pests and rodents. The facility will ensure that the pest control company replaces the fly paper in the lights monthly and add extra fly lights in the entrance of the building, front hallway and at the back of the kitchen. The process failure occurred because the pest control company was not changing out the fly paper every month in the lights and that staff were using unauthorized doors at back of dining rooms. Criteria 2- The procedure for implementing the plan of correction for F925; " On 6/25/18 staff was in-serviced not to use doors exiting dining rooms to the outside, or doors at the end of hallways to exit building, these doors are for emergency only. " On 6/20/18 update to the facility□s pest control contract to change fly light paper out monthly. New fly paper changed on 6/20/18 " Week of 7/9/18 pest control company will place 3 extra fly lights; 1 at front entrance, 1 at front hallway, 1 at back of kitchen. " On 7/7 new air fan blower curtain ordered for door to outside that staff use to enter break/smoking area. Delivery of this air fan blower curtain expected on 7/20 " The maintenance Director will tour the building monthly with the pest control company to ensure all fly lights paper is replaced. " During routine rounds, the Management team will report any flies and	

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F 925	Continued From page 21 flies were on the utensil rack above the food preparation table with open sandwich bread and cheese still below the utensil rack on the food preparation table. On 06/20/18 at 11:50 AM a fly was observed on a clean plate while the District Manager was standing beside the plates and as Cook #1 reached for the plate the District Manager was informed by the surveyor of the fly on the clean plate and he removed the plate and took it to the dishwashing area of the kitchen. The District Manager returned to the tray line and was informed by the surveyor that flies were on the utensil rack above the food preparation table and he removed the large whisk from the rack and directed staff to remove the bread and cheese from the food preparation table. Observations on 06/20/18 at 11:51 AM revealed a fly on a clean plate at the end of the serving line and as Cook #1 started to reach for the plate the District Manager was informed by the surveyor of the fly on a clean plate and he removed the plate and took it to the dishwashing area of the kitchen. During an interview on 06/20/18 at 11:55 AM, the Food Service Director/Dietary Manager stated she had not seen flies in the kitchen earlier today but pointed to the open door to the main dining room and stated she tried to keep the door closed because the flies came in when the door was open. She further stated it was difficult to keep the door closed because residents came to that door to request food and drinks. She verified there was 1 fly light in the kitchen across the room from the food prep area near the hand washing sink and there was a fly fan at the screen door at the back of the kitchen.	F 925	or rodents noted in resident□s rooms or around facility or any resident or family resident concerns identified during rounds.. The management team will report this in morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; " Maintenance will review fly lights and door blowers for proper function daily for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. " Results will be reported to monthly QAPI meeting. " The QAPI committee will evaluate and make further recommendations as indicated. Criteria 4- The person responsible for implementing the plan of correction; " Administrator is responsible for implementing the plan of correction. " Date of Compliance 7/28/18	

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During an interview on 06/21/18 at 9:05 AM, Cook #1 stated she had noticed flies in the kitchen yesterday on 06/20/18 but did not know what had happened to cause an increase of flies in the kitchen. She further stated it seemed as the doors to the kitchen were opened more the flies increased. She explained it was hard to manage resident requests and not open the doors but she expected for her co-workers to help keep flies away from food or drinks. She stated her main concern was flies or something else getting in a resident's food or drink but she could not watch everything all of the time. She verified food delivery was through the back screen door of the kitchen and there was a fly fan which automatically came on when the door was opened. She explained there was a fly light in the kitchen near the hand washing sink but it didn't work very well when the lights in the kitchen were on and the flies were more attracted to the food than the fly light.

During a follow up interview on 06/21/18 at 9:11 AM, the Food Service Director/Dietary Manager stated it was that time of year when flies came in and she was concerned about them getting on clean plates. She further stated it was her expectation that flies would not get on clean plates, utensils or food and she did not want to see flies near the food service or preparation areas.

During an interview on 06/21/18 at 11:15 AM, the District Manager stated he had been coming to the facility since November 2017 and there had not been a problem with flies until recently when it became more hot and humid. He explained he was not sure where the flies were coming in but that's what they had to figure out. He stated it

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was his expectation for the kitchen staff to manage flies as best as they could and to keep them out of the food preparation areas. He further stated it was difficult to keep all flies out of the kitchen but they needed to manage them when they were in the kitchen to keep them away from food and food preparation areas.

During an interview on 06/21/18 at 4:15 PM, the Assistant Maintenance Director explained the facility utilized a monthly pest control service. He stated there was a fly light in the kitchen but the fly trap inside the light had not been changed for a couple of months and the exterminator had checked it yesterday on 06/20/18 and changed the trap inside the light because it was getting full of flies.

During an interview on 06/21/18 at 4:46 PM, the Administrator stated it was her expectations for the staff to maintain control of flies.

2. Resident #60 in room 211 was admitted on 12/09/11 with diagnoses that included dementia, cerebrovascular accident, and left hemiparesis.

A review of the quarterly Minimal Data Set (MDS) assessment dated 5/8/18 revealed Resident #60 was coded with impaired cognition and needing extensive assistance with activities of daily living.

An observation on 6/20/18 at 9:16am revealed Resident #60 lying in his bed with a fly on his night gown.

During an interview on 6/20/18 at 9:16am, Resident #60's roommate stated the fly lived in room 211 and they could not get rid of it.

During an observation on 6/20/18 at 11:10am, NA

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	345232	A. BUILDING _____ B. WING _____	06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHABI HICK	3031 TATE BOULEVARD SE HICKORY, NC 28602

(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 925	Continued From page 24	F 925		

#2 and NA #3 gave Resident #60 a bath and performed incontinence care for a bowel movement. NA #3 was observed swatting a fly on the resident during the care.

An interview on 6/21/18 at 9:39am with NA #7 revealed she was responsible for Resident #60's care and had only seen 1 or 2 flies in room 211, where Resident #60 resided, once in a while.

An interview on 6/21/18 at 9:40am with Nurse #2 revealed occasionally flies would come in from the exit door outside of room 211 where Resident #60 resided and they would end up going away on their own.

An interview on 6/21/18 at 10:56am with NA #3 revealed she had not noticed any flies in room 211 where Resident #60 resided until 6/20/18 but had noticed increased fly activity in the building since the weather had gotten hot.

An interview on 6/21/18 at 4:13pm with the Maintenance Supervisor (MS) revealed the new pest control company had not changed out the fly light strips as part of the service and the strips had not been changed for approximately 2 months. The MS revealed the strips in the fly lights had started to get too full and had previously been changed out monthly by the original pest control company. The MS stated his expectation for fly control was to have zero flies in the building.

An interview on 6/21/18 at 4:26pn with the Director of Nursing (DON) revealed her expectation related to fly control during resident care was for the nursing staff to report to the Maintenance Department using the pest control

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F 925	Continued From page 25 book located at each nursing station. The DON indicated she did not expect to have flies or any other pest on residents at any time including during care and at meal time. An interview with the Administrator on 6/21/18 was conducted at 4:46pm. The Administrator indicated she expected the Maintenance Department to maintain the control of flies at all times.	F 925		