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	345510	A. BUILDING _____ B. WING _____	08/23/2019

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E 000	Initial Comments An unannounced Recertification survey was conducted on 8/20/19 through 8/23/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9LZY11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 8/20/19 through 8/23/19. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G).	F 000		
F 641 SS=E	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 observations, record review, and resident and staff interviews the facility failed to accurately code minimum data set (MDS) assessments for the use of a wander guard (Residents #29 and #33), impairment in upper and lower extremities to one side (Resident #59), dental status (Resident#29), and for gradual dose reduction and the physician's documentation of gradual dose reduction contraindication (Resident #81) for 4 of 23 residents reviewed for MDS assessment accuracy. Findings included: 1. Resident #29 was admitted to the facility on 7/25/17. His active diagnoses included	F 641	Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 641: Accuracy of Assessments 1. Residents # 29, # 33, # 59 and # 81 MDS assessments were reviewed and MDS coding was corrected on 08/22/19 by the MDS team.	8/23/19

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

Electronically Signed | 09/13/2019

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F 641	Continued From page 1 hypertension and hemiplegia. Resident #29's minimum data set assessment dated 12/6/18 revealed he was assessed in section L to have no natural teeth or tooth fragments. Resident #29's minimum data set assessment dated 6/30/19 revealed he was assessed to not have a wander guard in use. Resident #29's orders for June 2019 revealed he was ordered to have his wander guard checked for placement each shift. Resident #29's medication administration record for June 2019 revealed the wander guard was in place and checked by each shift as in place every day of June 2019. Resident #29's care plan dated 7/1/19 revealed he was care planned to have a wander guard related to exit seeking behavior. During observation on 8/20/19 at 1:10 PM Resident #29 was observed to have a wander guard on his left leg and teeth were observed in his bottom gum. During an interview on 8/21/19 at 3:30 PM Nurse #1 stated Resident #29 had a wander guard on all of June 2019 and the documentation in the medication administration record for June 2019 showed he had it on every day. During an interview on 8/22/19 at 8:18 AM MDS Nurse #1 stated Resident #29 did have a wander in June of 2019 and it should have been captured in the 6/30/19 minimum data set assessment and	F 641	2.The annual MDS for current residents for the past 60 days will be reviewed for accuracy of coding for: Wander Guards, dental status, impairment in upper and lower extremities and gradual dose reductions with the physician contraindication. Completed on 08/23/19. 3. MDS team was in-serviced on Assessment Accuracy of coding per RAI manual on 08/22/19 by the Director of Nursing. 10% of MDS for residents to be reviewed by DON, SDC, RN Supervisor or designee monthly x 3 months starting in September to ensure ongoing compliance. 4. Director of Nursing will incorporate the POC into the facility's monthly QAA meeting to evaluate the effectiveness and compliance of the The plan will be modified and staff re-educated as appropriate. To be completed by DON or designee. 5. Completion date: 08/23/19.	

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it was not. She further stated Resident #29 had tooth fragments and it was not coded correctly in his comprehensive minimum data set assessment dated 12/6/18.

During an interview on 8/22/19 at 8:37 AM the Administrator stated minimum data set assessments should be coded to reflect the status of the residents accurately. He further stated Resident #29 should have been coded as having a wander guard in place on his 6/30/19 assessment and should not have been coded as having no teeth or tooth fragments in his comprehensive assessment dated 12/6/18.

2. Resident #59 was admitted to the facility on 9/11/18. His active diagnoses included hemiplegia following a cerebral infarction affecting the left non-dominant side.

Resident #59's minimum data set assessment dated 6/24/19 revealed he was assessed as cognitively intact. He was also assessed in section G question G0400 as having no impairment in his upper and lower extremities.

During an interview on 8/20/19 at 9:28 AM Resident #59 stated he could not turn over to his right side without help because he was unable to use his left arm, had, and leg.

During observation on 8/20/19 at 9:30 AM Resident #59 was observed to be unable to move his left arm and leg.

During an interview on 8/21/19 at 9:57 AM Nurse #2 stated Resident #59 could not move his left arm or leg without assistance, and he required help with activities of daily living do to the

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F 641	Continued From page 3	F 641		

limitations.

During an interview on 8/22/19 at 8:18 AM MDS Nurse #1 stated Resident #59 did have impairment on his left side to his upper and lower extremities and the minimum data set assessment dated 6/24/19 was coded incorrectly. She further stated she would correct those immediately.

During an interview on 8/22/19 at 8:37 AM the Administrator stated minimum data set assessments should be coded to reflect the status of the residents accurately. He further stated Resident #59 should have been coded as having impairment on his left side of his upper and lower extremities in his assessment dated 6/24/19.

3. Resident #33 was admitted to the facility on 6/9/16 with diagnoses that included dementia and diabetes mellitus.

Resident #33's minimum data set assessment dated 7/1/19, a quarterly assessment, revealed she was assessed to not have a wander alarm in use.

Resident #33's orders for June 2019 and June 2019 revealed she was ordered to have her wander alarm checked for placement each shift.

Resident #33's medical administration record for June 2019 and July 2019 revealed the wander alarm was in place and checked by each shift as in place every day of June 2019 and July 2019.

During an observation on 8/20/19 at 12:39 Resident #33 was observed with a wander alarm on her left leg.

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F 641	Continued From page 4	F 641		

During an interview with MDS Nurse #1 on 8/22/19 at 12:23 PM she stated Resident #33 did have a wander alarm on all of June 2019 and July 2019. She reported the wander alarm should have been reflected on the 7/1/2019 minimum data set assessment and it was not.

During an interview with the Administrator on 8/22/19 at 12:28 PM he stated minimum data set assessments should be coded to reflect the status of residents accurately. He indicated Resident #33 should have been coded as having a wander alarm in place on her 7/1/19 assessment.

4. Resident #81 was admitted to the facility on 3/5/12 with diagnoses that included dementia and hypertension.

Resident #81's minimum data set assessment dated 7/26/19, a quarterly assessment revealed no gradual dose reduction in psychotropic medications or physician's documentation of contraindication of a reduction in psychotropic medication were reflected on the assessment in Section N. The assessment revealed Resident #81 received psychotropic medication 7 days of the lookback period on a routine basis.

A physician's note dated 2/25/19 revealed a gradual dose reduction in psychotropic medication was initiated for Resident #81.

A physician's note dated 3/4/19 revealed the gradual dose reduction in psychotropic medication was stopped due to an increase in Resident #81's behaviors. It further revealed physician's documentation of contraindication of a reduction in psychotropic medication for Resident

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F 641	Continued From page 5 #81. During an interview with MDS Nurse #1 on 8/22/19 at 12:23 PM she stated Resident #81's minimum data set assessment should have accurately reflected an attempt to reduce her psychotropic medication and physician's documentation of the contraindication of a dosage reduction in psychotropic medication. During an interview with the Administrator on 8/22/19 at 12:28 PM he stated minimum data set assessments should be coded to reflect the status of residents accurately. He indicated Resident #81's assessment should have accurately reflected an attempt to reduce her psychotropic medication and physician's documentation of the contraindication of a dosage reduction in psychotropic medication.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide toe and finger nail care for 2 of 2 dependent residents (Resident # 25 and Resident # 91) reviewed for nail care. Findings included: 1. Resident # 91 was admitted to the facility on 1/18/2019 with diagnoses which included acute kidney failure, cerebral infarction, and peripheral	F 677	F 677 ADL Care Provided for Dependent Residents 1. Resident # 91 was placed on the list to be seen by podiatry on next facility visit which was scheduled for Friday, 09/09/19. Resident was seen at that time. Residents # 25 had nail care completed	9/9/19

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F 677	Continued From page 6 vascular disease. A review of a most recent quarterly Minimum Data Set (MDS) dated 8/5/2019 revealed Resident # 91 was moderately cognitively impaired and required total assistance with personal hygiene and bathing. The MDS further indicated Resident # 91 had functional limitations of the upper and lower extremities. The care plan dated 1/18/2019 (reviewed and continued on 8/12/2019) had a plan which focused on impaired mobility with the intervention to assist with activities of daily living (ADL) to completion. An observation on 8/20/2019 at 10:00 am revealed Resident # 91 toe nails on his feet was long and thick. An observation on 8/21/2019 at 2:00 pm revealed Resident # 91 toe nails on his feet continued to be long, and thick with the second toe nail curving downward. During an observation on 8/22/2019 at 9:30 am of Resident #91's toe nails, the resident stated his toe nails needed to be trimmed because the nails were getting caught on the bed linens. A review of an ADL assistance and support flowsheet for the months of July 2019 and August 2019 indicated Resident # 91 received assistance with bathing and personal hygiene on a daily basis. An interview with Nursing Assistant (NA) # 2 on 8/22/2019 at 10:24 am revealed Resident # 91 required total assistance with all activities of daily	F 677	on 08/23/19. 2. a) 100% of nurse aides were in-serviced regarding nail care by 09/09/19. All employees that were not in-serviced will be removed from the schedule until education is received. b) A 100% audit of all residents' nails was completed by DON and SDC on 08/28/19. No additional residents needing nail care were found. 3. A nail care audit will be conducted on 20% of residents weekly x 4 and monthly x 3 by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Team Leader or designee to monitor appropriateness of nail care provided. 4. The Director of Nursing will incorporate the POC into the facility's monthly QAA meeting to evaluate the effectiveness and compliance of the The plan will be modified and staff re-educated as appropriate. To be completed by the DON or designee.	

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F 677	Continued From page 7 living except for eating. The NA also stated when the resident received a bath or shower, she would check his toe nails to see if trimming was needed. The NA further stated she had not informed the nurse that Resident # 91 toe nails were long and thick and needed to be trimmed. The interview with Nurse # 4 on 8/22/2019 at 10:40 am revealed she had not been informed that Resident # 91 toe nails needed to be trimmed. Nurse # 4 also stated the nursing assistants would inform the nurse when the resident was a diabetic or the toe nails was thick. The nurse then stated if the nurse was unable to trim the nails, the resident would be placed on the list to be seen by the podiatrist. On 8/23/2019 at 11:00 am during an interview with the Director of Nursing (DON), she indicated the NA should check the nails during baths and trim the nails when needed. The DON also stated when the resident was a diabetic or the nails were long and thick the nurse should be informed, so the resident's name could be added to the list to be seen by the podiatrist. 2. Resident # 25 was admitted to the facility on 3/8/2017 with diagnoses which included Alzheimer's disease, chronic kidney disease and type 2 diabetes. A care plan dated 3/15/2019 (reviewed on 6/17/2019) with a plan that focused on self-care deficit with the interventions to assist with activities of daily living (ADLs) to completion and give verbal cues during bathing. The review of a most recent Quarterly Minimum Data Set (MDS) dated 6/27/2019 revealed	F 677	5. Completion date: 09/09/19	

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Resident # 25 was severely cognitively impaired and required extensive assistance with all activities of daily living (ADL) and set up assistance with meals.

A review of an ADL assistance and support flowsheet for the months of July 2019 and August 2019 indicated Resident # 25 received assistance with bathing and personal hygiene on a daily basis.

An observation on 08/20/19 at 11:02 AM revealed Resident # 25 fingernails were dirty on both hands.

On 08/21/19 at 08:42 AM Resident #25 was observed feeding himself toast with jelly on it. The resident's fingernails remained dirty on both hands.

Resident #25 was observed on 8/22/2019 at 3:00 pm resting in bed with his hands outside of the covers, there was a black substance under the nails of the right hand.

During an interview with Nursing Assistant (NA) # 1, she indicated Resident #25 received assistance with all activities of daily living. NA# 1 also stated nail care was given during the morning bath and she had never known the resident to refuse nail care. NA# 1 further stated she can only clean under the nails because Resident #25 was a diabetic.

An interview with Nurse # 3 on 8/22/2019 at 2:42 pm, revealed nail care was supposed to be done with morning care and if the resident was a diabetic the nurse would cut the nails, but the NA was allowed to clean from under the nails.

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F 677	Continued From page 9 During an interview with the Director of Nursing (DON) on 8/23/2019 at 11:00 am, she indicated fingernail care was completed with the morning care and the nails should be cleaned by the staff throughout the day when needed.	F 677		
F 689 SS=G	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, facility staff and physician's clinic staff interviews and record review the facility failed to follow correct loading procedures by not securing a resident's wheelchair while loading the resident (Resident #96) into the transport van which resulted in the wheelchair rolling backwards off of the lift while the lift was in the raised position resulting in a subdural hematoma and multiple fractures for 1 of 6 residents reviewed for accidents. The findings included: Resident #96 was admitted to the facility 7/5/13. He had diagnoses which included Alzheimer's dementia, Diabetes, Hypertension and cardiomyopathy. A review the annual Minimum Data Set (MDS) for Resident #96 dated 7/16/18 revealed he was	F 689	Past noncompliance: no plan of correction required.	9/13/19

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F 689	Continued From page 10	F 689		

cognitively intact and had no behaviors. He required extensive assistance for most of his activities of daily living (ADLs) except he needed supervision for locomotion and eating and was total dependence for bathing. He had no range of motion limitation of his upper or lower extremities.

A review of the hospital history and physical dated 8/23/18 revealed "presenting with falls: Was being loaded onto a wheelchair van in his wheelchair when it tipped back and he fell to the ground (approximately 3 feet in the air)."

On 8/22/19 at 12:41 PM the Director of Nursing (DON) reported Resident #96 was transported to a local physician's clinic to have lab work completed. She stated when the contracted van company was loading Resident #96 back into the transport van, after the appointment, Resident #96 fell backwards off of the van lift gate. The DON stated the physician's clinic office staff responded immediately and assisted Resident #96 until the ambulance arrived to transport him to the local hospital. The DON stated she was notified of the fall and that he was going to the emergency room (ER).

A record review of the contracted transportation company Incident Report revealed Van Driver #1 was driving vehicle #15323 on 8/22/18. The report also stated the passenger was Resident #96. The description of the incident was written as; VD #1 was loading Resident #95 when VD #1 walked "down to the side door to pull passenger into the van and he flipped backwards off of the lift. Back flap on lift was not connecting to the lift a lot. It was closed but not locked and that was how (Resident #96) fell off." The report was completed and signed by VD #1.

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Attempts to contact the contracted transportation van driver #1 were unsuccessful.

On 8/22/19 at 3:00 PM the contracted van transportation company with van driver (VD) #2 provided a demonstration of the van lift using the same van as identified in the incident report. The observation revealed as the lift gate was electronically lowered a set of hand grab handles automatically lowered into place. As the lift gate touched the ground a 7.5 inch high kick plate automatically lowered to the ground which provided a ramp for the wheelchair to roll onto the lift. The wheelchair was pushed forward onto the lift gate. VD #2 instructed the wheelchair occupant, who was facing toward the van, to hold onto the grab handles located on each side of the lift. VD #2 then checked the wheelchair brakes to make sure they were locked. VD #2 then reached for the strap which was anchored to the grab handles. The strap was pulled and extended around the rear of the wheelchair just under the wheelchair hand grips. The strap was clipped onto the opposite side grab bar similar to a seat belt strap and attachment. Next the lift was raised and as it began to come off of the ground the rear kick plate automatically popped up perpendicular (at a right angle) to the lift gate floor. VD #2 was observed to check the kick plate to be sure it was locked into place. VD #2 continued to raise the lift until it stopped at the level of the van entrance. When the lift gate was at this upper stopped position it was measured at 2.5 feet off of the ground.

On 8/22/19 at 3:10 PM VD #2 stated the strap which went around the rear of the wheelchair was present on the van when it was purchased. He

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stated some of the older model vans did not have this strap. VD #2 also stated the wheelchair's wheels had to be in a locked position in addition to the strap being put into place.

On 8/22/19 at 4:22 PM clinic lab worker #1 stated the clinic had a rapid response team that responded to any emergencies on the clinic's property.

On 8/23/19 at 10:12 AM clinic nurse #1was interviewed. Clinic nurse #1 stated she was the first person from the rapid response team to arrive at the scene of the fall. The nurse stated Resident #96 was laying o his back on the concrete walkway. She stated he was responding but not completely coherent. She said the lift was still up in the air and it was about waist high on her. Clinic nurse #1 said there was a moderate amount of blood on the back of the resident ' s head. She added it was enough blood that it required a dressing.

On 8/223/19 at 10:23 AM clinic nurse #2 stated she saw Resident #96 when he fell off of the van lift because she was already at the main entrance area but did she did not remember why she was there. She said Resident #96 came partially out of the wheelchair while he was still in the air. She said he fell on his back and was bleeding from the back of his head. She added Resident #96's arms were scratched and bleeding. She initially said the little panel (kick plate) had not or did not securely engage but upon additional questioning she stated she did not see if the kick plate was up or if the grip handles or a safety belt were present. She stated she responded as a member of the rapid response team.

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On 8/23/19 AT 10:42 AM clinic nurse #3 reported she was part of the rapid response team. Resident #96 was outside the main clinic entrance. He was on his back. She stated his vital signs were obtained and he was conscious. He complained of back pain and head pain. He could not state what happened. Clinic nurse #3 said 911 was called immediately and the response team tried to keep Resident #96 as comfortable as possible. She added Resident #96 could tell us about the pain but he could not tell us his name. He was not in respiratory distress or any distress and he was a bit diaphoretic (increased sweating). We tried not to move him but needed to see the back of his head. She said the physician's assistant (PA) was doing the assessment.

On 8/23/19 at 10:57 AM clinic PA was interviewed. He stated the van driver and a staff member from the facility were present at the scene of the fall. He referred to a progress note he had written which stated Resident #96 had his eyes open but he not verbally responsive initially. His initial vital signs were stable including his blood sugar and pulse ox. The PA stated he put a cervical collar on him. Resident #96 wanted to sit up but he could not do so on his own. The PA added there was an occipital (back of the head) abrasion on his head and his C-spine felt normal. His pelvis was stable and his level of consciousness improved.

On 8/23/19 at 11:53 AM Clinic receptionist #1 stated she looked out the front window area and saw as Resident #96 was pushed onto the ramp. She said he was lifted up and she saw him fall backwards off of the ramp. She said she called the rapid response team. She stated Resident

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#96 fell backwards in his wheelchair and his head hit the cement first. She said the response team responded and 911 were called. She said she stayed inside the building. She stated she remembered the name of the van and identified it as the contracted transportation company van.

On 8/23/19 at 12:43 PM the facility scheduler stated she went to the appointment to escort Resident #96 on 8/22/18. She stated after his appointment she was walking back to her vehicle on the side of the physician's clinic with her back towards the van when she heard a scream. The scheduler said she turned around and saw the contracted transport van was still in the same place so she went back to the van to see a large number of people around Resident #96. She stated Resident #96 was on the ground. She said she remembered saying out loud that she needed to call the facility. The facility scheduler reported she talked to the DON.

A review of the rescue squad report revealed on 8/22/18 at 11:43 AM a call was received in reference to a fall. Upon arrival Resident #96 was laying on his back on the sidewalk in front of the entrance and was surrounded by staff members. The report stated Resident #96 fell backwards and landed on his back and hit his head on the cement sidewalk. Resident #96 was alert but confused. "There were no remarkable injuries upon assessment. He was complaining of neck and back pain. Staff had already placed a c-collar on patient." He was placed into the ambulance and he was stable.

Additional record review revealed a history and physical report from the trauma center dated 8/23/18 at 7:47 AM which revealed the local

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hospital completed a workup which showed bilateral frontal subarachnoid hemorrhages, closed burst fracture of thoracic vertebra, fractures of the right ribs 7, 8, 10, 11 and left rib fracture of 8. He also had a right transverse process fracture of the first lumbar vertebra.

Resident #96 remained hospitalized for 5 weeks from 8/22/18 until 9/26/18.

The discharge summary from the trauma center dated 9/26/18 revealed Resident #96 was non-ambulatory at baseline and fell on his back when being loaded on the van. Resident #96 did not remember the event due to a history of dementia. Additional problems listed as dysphagia, urinary tract infection, subarachnoid hemorrhage medial, bilateral frontal lobes, closed burst fracture of 8th thoracic vertebra and on 8/23/18 had a T6-T10 percutaneous fusion with no brace needed. He had closed fracture of right ribs 5-7, 10 & 11 and left 4-8. He also had closed fracture of the first lumbar vertebra a closed fracture of the proximal end of the right ulna which did not have surgery and a splint/sling was used for management. He had a right hemothorax (blood collected in the space between the chest wall and the lung) for which a chest tube was placed and was removed on 8/27/18.

Resident #96's facility medical doctor (MD) was interviewed on 8/23/19 at 9:30 AM. The MD stated he had known Resident #96 for many years. The MD said when Resident #96 was admitted to the facility years ago he had no motivation and just wanted to lie in bed. Resident #96 had early dementia and some confusion before the accident. After the accident he was

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less vocal when he first returned to the facility. He was initially more passive. The MD said Resident #96 does not remember and has short term memory deficit but that was present before the accident too. The MD stated he monitored Resident #96 while he was in the hospital and when he returned to the facility he was not different. The MD also discussed the brain bleed. He stated a brain bleed could be immediately catastrophic and cause death but without a lot of swelling the blood gets reabsorbed and there are no other problems. Resident #96 did not require any surgical treatment for the brain bleed. The MD added Resident #96 had a bleed and got through it with no additional problems.

On 8/22/19 at 2:20 PM the facility Administrator stated immediate action was taken by the facility with the contracted van company.

On 8/23/19 at 1:46 PM the Administrator provided the following Plan of Correction:
Allegation of Compliance for Van Incident F689
1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.
· On 8/22/18 Resident #96 was taken out for appointment at a local Physician's Clinic via Transport Company 1.
· At approximately 11 am, the resident was placed on the van lift by the Transport Driver to return to the facility. The driver did not lock the wheels allowing the wheelchair to roll backwards as the lift was raised. This caused it to tip off and the resident fell to the ground.
· Resident received treatment at the scene from the Physician's Clinic staff until EMS (Emergency Medical Services) arrived to transport him to the local hospital.

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· Admin/DON made aware at approximately 11:30 am.
· Medical Director notified on 8/22/18
· All transportation with Transport Company 1 was suspended immediately.
· At 11:47am DON notified resident's Responsible Party.
· Root Cause analysis on 8/22/18 revealed the cause of the accident to be the failure of the transportation company van driver to follow proper protocol for safe loading/unloading of patients on to transportation vehicles by not engaging the wheelchair brakes.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.
· 8/22/18 The administrator spoke with the owner of Transport Company 1 and suspended all further transports.
· The administrator also requested proof of an inspection by a third party stating the vans general condition and all safety measures are in good working order.
· The administrator also made the owner of the Transport Company 1 aware that they must provide proof of retraining of all employees on safe loading/unloading procedures, safety protocols, and secure positioning of residents in the van before services will resume.
· All further transports were moved to EMS.
· Interviews and due diligence began with other transport companies to replace Transport Company 1. Another local transport company was selected as facilities Transport Company.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific

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deficiency cited remains corrected and/or in compliance with the regulatory requirements.

· The administrator will observe the loading and unloading of a resident by the transport company weekly x 8, monthly x 2, and quarterly x 3.

· The administrator will interview a transport driver for their knowledge of retraining regarding safe loading/unloading procedures, safety protocols, and secure positioning of residents weekly x 8, monthly x 2, and quarterly x 3.

· The administrator will complete a van inspection checklist weekly x 8, monthly x 2 and quarterly x 3.

· The QAA Committee will discuss all results monthly.

This allegation of compliance was in place on 8/22/18 by the Administrator.

The Plan of Correction was verified through interviews with the facility staff, observations of Resident #96 and record review of the education and monitoring of the current contracted van company. Based on the interviews and record reviews the facility did not use the original contracted van company for any other transports since the fall on 8/22/18. The facility's compliance date of 8/22/18 was verified.