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	345095	A. BUILDING _____ B. WING _____	C 08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM NURSING & REHABILITATION	700 JOHNSTON RIDGE ROAD ELKIN, NC 28621

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 08/09/21 through 08/11/21. There was one allegation that was substantiated and cited. Please see CMS 2567 dated 08/11/21. Event ID #: T2QC11	F 000		
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 record reviews, observations, and staff and transport company interviews the facility failed to transfer a resident in a manner that prevented Resident #1 from toe fractures with lacerations on an outside van company for 1 of 3 residents reviewed for supervision to prevent accidents. The findings included: Resident #1 was readmitted to the facility on 03/16/21 with diagnoses of dysphagia, dementia, Alzheimer's Disease, history of falls and muscle weakness. The Minimum Data Set (MDS) assessment dated 04/14/21 assessed Resident #1 as being severely cognitively impaired and required extensive assistance of two staff for activities of daily living	F 689	Past noncompliance: no plan of correction required.	8/24/21

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

Electronically Signed | 08/24/2021

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(ADL).

A nurses note dated 04/07/21 revealed Resident #1 was found on the floor on the right side of the bed with her feet tangled in the sheets with the bed in the lowest position. The note further revealed a hematoma was on Resident #1's forehead, approximately 2 inches in diameter, a skin tear was on the right dorsal hand and left elbow. The nurses note stated all injuries were cleaned with sterile saline and Resident #1 was sent to the Emergency Department (ED). The nurse's note further stated Resident #1 was picked up by Emergency Medical Services (EMS) at 8:30 AM.

A nurses note dated 04/07/21 at 5:32 PM indicated Resident #1 was injured during the transport back to the facility from the ED. The note further indicated the nurse did not witness the incident nor the injury.

A nurses note dated 04/07/21 at 7:57 PM indicated the nurse received the report from the ED and Resident #1 had multiple fractures on all 5 toes on the right foot and was given intravenous antibiotics, a tetanus shot, and the foot was placed in a splint. The nurses note further indicated Resident #1 was being transferred back by EMS with pain medications and orders for circulation checks.

A nurses note dated 04/07/21 at 10:01 PM indicated Resident #1 returned to the facility at 9:35 PM with non-emergent EMS. The right foot was bandaged and splinted and sutures were present. There was bruising noted to Resident #1's forehead and left hand from the previous fall and steri-strips were present on the left hand.

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There was no distress noted at this time.

A physician progress note dated 04/09/21 stated it was for a follow-up from the van accident and laceration to the right foot. The note further stated to continue follow-up as directed with orthopedics.

An interview on 08/09/21 at 2:55 PM with the Director of Nursing (DON) and the Clinical Nurse Liaison revealed the van driver came into the facility the morning of the accident and told the Human Resources (HR) Director the resident had blood on her foot. The HR Director got the Clinical Nurse Liaison and went out to the van. The Clinical Nurse Liaison stated Resident #1 was sitting in the van with her arms crossed and looking around with no signs of distress noted. The Clinical Nurse Liaison stated she saw blood on Resident #1's foot and she rolled the Resident#1's thrombo-embolus deterrent stockings (ted hose) back and saw the laceration. She further stated the laceration was all the way across the foot and about 1 inch in width with some swelling and blueish tint to the toes. The Clinical Nurse Liaison indicated they got Resident #1 off the van, called EMS, and sent her back to the ED. The DON stated the Executive Director called the transport company immediately after Resident #1 was sent out to the ED and informed them of what happened. The DON further stated a full Quality Assurance and Performance Improvement (QAPI) plan was completed on this incident and the daily appointment lists were audited daily for compliance by the Executive Director for 8 weeks and then monthly thereafter.

An interview on 08/10/21 at 10:20 AM with the director of the transport company indicated the

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first thing the transport company does when an accident happened that could have been prevented was to immediately look at the video footage, have a 1 on 1 huddle with everyone to go over loading and unloading of all clients, re-educating the van drivers on the yellow boundaries marked on the lift and the use of seat belts on the van. The director further indicated the 1 on 1 huddle was done on 04/08/21, the next day after the accident and after the video footage was viewed and everyone signed off on it. The director stated on 04/15/21 an Urgent Training was completed with all lift van drivers on proper wheelchair procedures, and the driver's responsibility to keep the client inside of the yellow lift boundaries. The director further stated each van driver signed a document acknowledging and agreeing to comply with the established procedures. The director reported he had looked at the video of the accident and felt the contributing factors included: the wheelchair didn't have footrests on it, the client did not have shoes on, a blanket was wrapped around her legs obstructing the view the van driver had of the client's feet, the client was not completely within the yellow safety boundary lines and the wheelchair lift plate lowered onto and pinned the client's foot under the plate. The director further reported the van driver should have paid better attention to the client's feet before and during loading. The director explained the van driver involved in the accident was disciplined and was not allowed to drive until successfully completing remedial training which included reviewing the video hard drive of the incident and discussed proper loading and unloading procedures, driver responsibility, and an actual hands on demonstration of proper loading, tie down and unloading of clients. The director further

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explained nothing new was put into place after the accident because the transport company was doing it the right way but sometimes people strayed from doing what was right. He explained the company had cameras and the videos were watched periodically and we rode with the drivers to make sure they're doing what they're supposed to be doing. The director stated he received the van driver's story of the event right after it happened. The director further stated the van driver loaded the client onto the ramp and stood behind the client as the lift was going up and the lift stopped almost at the top. The van driver explained she tried to see why the lift had stopped and tried to get the lift to go back down but the lift wouldn't move. The van driver further explained she looked under the wheelchair and saw a stuffed animal which belonged to the client and the stuffed animal appeared to be stuck between the lift and the lift plate. The van driver said she removed the stuffed animal, put the blanket back around the client's legs and feet and raised the lift and put the seatbelt back on the client. The van driver further stated when she went to wheel the client back on the lift to bring her down to the ground at the facility, she saw blood on the client's sock and called for an employee at the facility to come and look at her foot. The van driver stated she did not know her foot was what stopped the lift as she thought it was the stuffed animal. The director indicated he was aware the facility had a person in place to watch each resident load and unload.

An interview on 08/10/21 at 11:20 AM with a receptionist/scheduler revealed she was the one who scheduled the appointments and completed the paperwork for transports. The receptionist/scheduler further revealed she

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received her training from the transport company, and she trained the other receptionist who takes her place when she's not at the facility. The receptionist/scheduler stated the HR director was also trained as there are times she's at the front desk. She further stated she checked each resident for appropriate clothing, appropriate footwear, and footrests on the wheelchair. The receptionist/scheduler explained she followed the resident to the lift and made sure the resident was between the yellow lines and the brakes were on in the wheelchair. She further explained she was with the resident until they left the facility and was there when they came back and was unloaded. The receptionist/scheduler explained the van company only transports Monday through Friday and on the weekends the facility uses EMS for transports.

An interview on 08/10/21 at 12:04 PM revealed Resident #2 had used the transport van several times and never had any issues with them. Resident #2 further revealed there was always someone from the facility who watched them get on and get off the van and Resident #2 stated she felt comfortable with the driver and never felt afraid. Resident #2 stated she had an appointment that day and would be using the van for transportation to her appointment.

An interview on 08/10/21 at 12:15 PM indicated Resident #3 had used the transport van several times for physician appointments and never felt afraid to use the service. He further indicated he never had any issues with them and felt comfortable on the van and had an appointment today and would be using the van.

An interview on 08/10/21 at 12:45 PM with the

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van driver involved in the accident stated she had picked up Resident #1 at the hospital to bring her back to the facility. She further stated she had a blanket over her legs and pushed her onto the lift and rode with her up the lift. The van driver revealed as she was raising the lift it stopped before the flap went down, and the van driver couldn't figure out why it had stopped. She further revealed she saw a pink bear down where the flap was and pulled it out and the lift went up. She stated she thought that was why the lift had stopped and when she got to the facility and went to take Resident #1 off she saw blood and went and got the nurse. The van driver reported she had training right after the incident and wasn't allowed to drive until she had a refresher training course. The van driver further reported she pushed the resident forward onto the lift of the van and in my training it showed I should have pushed the resident backwards. She indicated she thought it was the stuffed animal that stopped the lift not the client's foot and I should have checked it again.

An observation was made on 08/10/21 at 12:30 PM of a resident being loaded onto a van. The van driver had the van open, and the lift was sitting on the ground and the yellow stripes were marked where the resident was to be placed. The van driver stated the resident was to go in backwards unless the resident didn't feel safe. An observation was made of the receptionist/scheduler checking the footrests again and making sure the brakes were on and the wheelchair was in the middle of the yellow stripes. Once the resident was on the van, the van driver released the brakes on the wheelchair and moved the resident, so she was facing the front of the van. The van driver strapped the floor

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belts to the wheelchair and pulled them tight, put the seat belt around the resident and put the wheelchair brakes on and closed the van door. The van driver continued around to the back of the van, where the door was open and checked the floor belts again and made sure they were tight, and the wheelchair didn't move. The receptionist/scheduler also checked the belts and the wheelchair brakes.

An interview with the Medical Director on 08/11/21 at 12:25 PM revealed Resident #1 had followed up with the orthopedic department and the laceration was fixed and doing well. He further revealed the foot was healing well with no complications.

The facility's corrective actions implemented after the accident to prevent a reoccurrence included the following: the receptionist was immediately trained on the lift operation of the van and how the wheelchair and resident would be positioned on the lift prior to loading. Education was completed on 04/08/21 with all receptionists who escorted all residents out of the facility and monitored the loading of the residents and ensured proper positioning on the lift to ensure safety. Any observed would be corrected before the resident was loaded onto the van. Verifications would be documented on a daily appointment list and the list would be turned into the Executive Director at the end of each day. The Executive Director reviewed the daily appointment lists for compliance for 8 weeks and then monthly thereafter. Any issues would be addressed immediately with the transportation company director and additional training would be provided. The transportation company's education was done on 04/08/21 and follow-up

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training was conducted with all van drivers on 04/15/21. The facility QAPI committee would review the findings of the audits on a monthly basis x 6 months, then quarterly for 2 quarters. Any revision or reviews to the plan of action would be included in the meeting minutes with the appropriate staff being re-in serviced to the revised plan and monitoring would take place. The facility alleges the corrective action date of 04/15/21.

On 04/15/21 the facility's plan for past noncompliance was validated by the following: (1) Review of in-service training records revealed all drivers were in-serviced on proper wheelchair lift operation procedures which included: the lift must always be operated from the ground, drivers are not allowed to ride up the lift with the client, drivers may ride up the lift with an unsteady standee for stability, and the driver's responsibility is to keep the client inside of the yellow lift boundaries. (2) Review of the remedial/refresher training in-service training records for the van driver who drove the van at the time of the accident included: review of the hard drive of the incident and discussion on proper loading and unloading procedure, watching a DVD on the Sure-Lok Braun Lift Operation which detailed proper loading, discussion of the policy regarding driver responsibilities and an actual hands on demonstration of proper loading, tie down and unloading clients. (3) Review of the receptionist training on how the resident should be positioned prior to loading and lift operation with an actual observation of a resident. (4) An interview with the van driver involved in the accident who validated the remedial/refresher training was received. (5) A review of the daily appointment list sent to the Executive Director daily for monitoring.

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F 689	Continued From page 9 Compliance was achieved 04/15/21 when all van drivers had been educated and receptionists educated on loading and lift operation of the transport van.	F 689		