PRINTED: 06/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245494	B. WING			С	
	ROVIDER OR SUPPLIER	345481 ABILITATION CENTER	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO 400 PELT DRIVE FAYETTEVILLE, NC 28301		05/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT: Immediate Jeopard the wheelchair of Re the transportation varied onto the floor. The revaluation and sustainmediate jeopardy at 1:50 PM when the acceptable credible. The facility will remascope and severity lepotential for more the immediate jeopardy monitor and fully improresident's transporter activities. 483.20(g)-(j) ASSES ACCURACY/COOR (g) Accuracy of Assemust accurately reflective in the control of the alternation of the alternation of the alternation of the alternation (1) A registered nurse the assessment is control of the alternation of the alternation (2) Each individual variety of the whole	y began on 03/01/2017 when esident #39 fell backwards in an and ejected the resident resident was sent out for ained no injury. The was removed on 05/20/2017 a facility provided an allegation of compliance. Ain out of compliance at a level D (no actual harm with an minimal harm that is not allow the facility time to blement the new procedure fortation to appointments and assertion to appoint a set as a series of the assertion to appoint a set as a series of the assertion to appointment and assertion to appoint a set as a series of the assertion to appoint a set as a series of the assertion to appoint a set as a series of the assertion to appoint a	F 0	DEFICIENCY 00		6/15/17	
ADOD - TOS: V				TITLE		(X6) DATE	

Electronically Signed 06/15/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345481	B. WING _			05/:	20/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		40	TREET ADDRESS, CITY, STATE, ZIP CODE 00 PELT DRIVE AYETTEVILLE, NC 28301	, 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	resident assessment penalty of not more to assessment; or (ii) Causes another in and false statement is subject to a civil mone \$5,000 for each asses (2) Clinical disagreer material and false states for 2 of (Resident #30 and R Minimum Data Set (Not code Section G for (Resident #30). Findings included: 1. Resident #30 was 01/25/2017. During this admission diagnor Chronic Ulcer of Right Disease, Type 2 Dial Chronic Kidney Disease, Type 2 Dial Chronic Kidney Disease, Type 2 Dial Chronic Kidney Disease Gastro-esophageal F Ventricular Tachycard The Admission MDS Resident #30 was concept to assistant was assistant was a second for the fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states and the second fall states are second fall states are second fall states and the second fall states are second fall states are second fall states are second fall states and the second fall states are s	I and false statement in a is subject to a civil money than \$1,000 for each andividual to certify a material in a resident assessment is ey penalty or not more than essment. In ent does not constitute a stement. I is not met as evidenced on, record review and staff failed to accurately code the 3 sampled residents esident #66) whose MDS) was reviewed and did or 1 of 3 residents reviewed and did or 1 of 3 residents reviewed when the facility on review of his medical record, uses included Non-pressure of Ankle, Peripheral Vascular petes Mellitus, Hypertension, ase, Heart Failure, Reflux Disease and	F2	278	The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or wil take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F278 Corrective Action for Resident Affected For resident #30, the resident's oral stawas assessed by the MDS Nurse and compared to the most recent annual M assessment section L. A significant correction MDS to the most recent comprehensive assessment was opened by the MDS Nurse with an ARD of 06/14/2017. This process will be	d. atus	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2017	
				400 PELT DRIVE		
WOODLAI	NDS NURSING & REHAE	BILITATION CENTER		FAYETTEVILLE, NC 28301		
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F 278	Continued From page 2 Resident #30 was interviewed on 5/15/17 at 5:58		F 27	completed by 06/15/2017.	tatua	
				For resident #66, the resident's oral s		
		aled he had not had teeth		was assessed by the MDS Nurse and		
		eat most things. One day I		compared to the most recent annual N	/IDS	
	may decide to get some more teeth, but I am			assessment section L. A significant		
		e other things that are more		correction MDS to the most recent		
	important to me." When asked if he had problems eating, he said no I am okay. I eat better with no teeth than some people eat with			comprehensive assessment was		
				completed by the MDS Nurse. This		
				process was completed by 06/15/201		
		know when I want more		For resident #30, the current diagnosi	s list	
		erview, he was observed as		was reviewed by the MDS Nurse and		
	not having any visible	e teetn.		active diagnosis were compared to	.	
	The Divertor of Numeric	or/MDC Coordinator was		section I of the most recent completed		
		ng/MDS Coordinator was		MDS assessment. A significant correct		
		7 at 4:35 pm. She revealed		MDS to the most recent comprehensing assessment was opened by the MDS	/e	
	_	n the MDS. When asked e stated she was not sure if		Nurse with an ARD of 06/14/2017. Th	ie	
		lous or just some teeth, but		process will be completed by 06/15/20		
		nission MDS was incorrectly		Corrective Action for Resident Potenti		
		nowledged in section I -		Affected	any	
	there were no diagnos	_		All current residents who have oral/de	ntal	
		file a correction for the error		problems have the potential to be affe		
	in coding.			by this alleged deficient practice. An		
	g.			assessment of all current resident's		
	2. Resident #66 wa	s admitted to the facility on		oral/dental status was conducted by the	ne l	
		ission diagnoses included		MDS Nurse and compared to the		
		nsion, Gastro-Esophageal		resident's most recent comprehensive		
	Reflux Disease, Rena	· · · · · · · · · · · · · · · · · · ·		MDS assessment for accuracy of sec		
	Non-Alzheimer 's De	mentia, Seizure Disorder,		L coding. If incorrect coding was noted		
	Psychotic Disorder, C	Chronic Pulmonary Edema,		significant correction assessment was		
	Pressure Ulcer of left	ankle, stage 3,		completed by 06/15/2017 and the plan	n of	
	Restlessness and agi	tation, and Wandering.		care updated if indicated by the MDS Nurse.		
	The Admission MDS	dated 03/07/2017 indicated		All current residents with coding errors	s in	
		verely cognitively impaired.		section I of the most recent MDS have		
		ve assistance with personal		potential to be affected by this alleged		
	hygiene. There were			deficient practice. The MDS nurse		
	identified on the MDS			reviewed all current resident's active		
				diagnosis and compared it to the mos	t	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NDS NURSING & REHAE	BILITATION CENTER		40	TREET ADDRESS, CITY, STATE, ZIP CODE O PELT DRIVE AYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE	
F 278	at 3:50 pm. During the 5/15/17, it was observed on the top and botton. The DON/MDS Coord 5/17/17 at 4:35 pm. So coding error in Reside She stated that Reside When she reviewed to not reveal the correct correction needed to On 5/20/17 during an Administrator it was resident to the correct of the correct correction of the	t interviewable on 5/15/2017 ne attempted interview on ved that teeth were missing n. dinator was interviewed on She stated there was a ent # 66 ' s admission MDS. dent #66 had no teeth. the Admission MDS, it did t coding. She revealed a be done.	F2	278	recent MDS assessment to identify any coding errors. Findings were: there wer no other residents affected by this practice. This audit was completed by 06/13/2017. Systemic changes: On 06/12/2017, the MDS Nurse was in-serviced by the MDS Consultant on accurate coding of MDS Sections I and Education topics included purpose, definitions, steps for assessment and coding instructions. This information habeen integrated into the standard orientation training for new MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The MDS Consultant or designee will complete QA tool MDS Accuracy and audit 5 residents for MDS accuracy of section I and L. This will be completed monthly for three months or until resolv by Quality Assurance Committee. Repowill be presented to the weekly QA committee by the Administrator or DON ensure corrective action initiated as appropriate. Compliance will be monito and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	re IL: as ne at red brits I to ared d at		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	03/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.	
F 323 F 323 SS=J	483.25(d)(1)(2)(n)(1) HAZARDS/SUPERV (d) Accidents. The facility must ensistence device of the following element of the following element of the facility of the facilit	and benefits of bed rails with ent representative and obtain ior to installation. and benefits of bed rails with ent representative and weight. IT is not met as evidenced wiews and resident and staff	F 323	3	6/15/17	
	resident's wheelcha resident from the dia 03/01/2017 (Reside #39 was ejected on the resident to hit he	uctions to safely secure a ir during transport of 1 of 1 alysis center to the facility on at #39). As a result, Resident to the floor of the van causing er head. The facility also failed bied wheel chairs in the van		The facility immediately began investigating the incident involving resident #39 occurring on 03/01/2017 which resident was being transported back to the facility after receiving her		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION GUILDING			(X3) DATE SURVEY COMPLETED	
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WOODLA	NDS NURSING & REHA	ABILITATION CENTER			LT DRIVE TEVILLE, NC 28301			
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F 323	Continued From pag	ge 5	F 3	23				
	wheelchairs to be the residents during the limmediate Jeopardy the wheelchair of Rethe transportation valonto the floor. The evaluation and sustimmediate jeopardy at 1:50 PM when the acceptable credible. The facility will remain scope and severity is potential for more the immediate jeopardy monitor and fully im	ysis appointment on aused one of the unoccupied frown onto the leg of 1 of 3 transport (Resident #39). y began on 03/01/2017 when esident #39 fell backwards in an and ejected the resident resident was sent out for ained no injury. The was removed on 05/20/2017 e facility provided an allegation of compliance. ain out of compliance at a level D (no actual harm with than minimal harm that is not) to allow the facility time to plement the new procedure ortation to appointments and		res cau hea fac roo fac thro cor rep Ou to s fac sus sub On inve	lysis treatment. In route to the facilident #39 wheelchair fell backward using her to fall on the floor hitting lad. The resident was assessed by ility LPN and sent to the emergency of the for evaluation. On 03/01/2017, tillity van was taken out of operation ough 03/06/2017. A 24 hour report impleted on 03/02/2017 and a 5 day out was completed on 03/09/2017. It is to transportation company was excheduled necessary transports for ility. The involved employee #1 was pended on 03/01/2017 and obsequently terminated on 03/09/20 03/02/2017, the corporate van traitestigated the incident and determinate root cause of this event was the insportation aide failed to secure the	ts ner the the the was the the as		
	facility for securing a during transport in the Instructions Manual A. Secure Wheelch 1. Place wheelchair area; apply wheel to 2. Attach tie-downs ensure they are lock 3. Attach the 4 tie-downs are fixed and are within angle 4. Ensure all tie-dowtensioned. If necessions in the Instruction of the I	facing forward in securement bocks or turn power off. into floor anchorages, and ked in. own hooks to solid frame ents near seat level. Ensure at approximately 45 degrees		who ma star also Em and was did #1 star roo did gui the cor On res	nt floor retractors to the resident's eelchair according to Q' Straint inufacturer guidelines. Resident #3 tes that "the lap and shoulder belt to not hooked during the transport". Inployee #1 stated "I hooked the froid back retractors". When employees informed that the resident stated not hook the front retractors employed stated "I thought I did but if the resided I didn't then I guess I didn't". The cause of the incident is employed not follow Q' Straint manufacturer delines and facility policy in security resident and wheelchair prior to empleting the transport. 04/12/2017 during transport of cident #39 to dialysis, one of two occupied wheelchairs shifted during and was leaning on the right sides.	was nt #11 she byee ident ne #11 ng		

OL. TILIT	O T OIT MEDIO TITLE OF	WEDIO/ ND CEITVICES				<u> </u>	2. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES		<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 323	Continued From page	e 6	F	323			
	take up additional we	bbing slack.			resident #39 footrest and knee. Upon		
	·				return to the facility, resident #39 was		
	B. Secure passenge				assessed for injury by the facility LPN.	No	
	1. Attach lap belts: L	Jse integrated stiffeners to			injuries were noted. On 04/12/2017, the	е	
		enings between seat backs			facility van was taken out of operation		
	and bottoms and/or armrests to ensure proper belt fit around occupant. a. On the aisle side, attach belt with female buckle to rear tie-down pin connector ensuring buckle rests on passenger's hips.				through 05/01/2017. Outside		
					transportation company was used to		
					scheduled necessary transports for the		
					facility. The involved employee #2 was	8	
		- ·			suspended on 04/12/2017 and	7 A	
		e, attach belt with male wn pin connector and insert			subsequently terminated on 04/18/201	7. A	
	into female buckle.			24 hour report was completed on 04/12/2017 and a 5 day report was			
	2. Attach shoulder be			completed on 04/17/2017. On 04/16/20	117		
		oulder and across upper			the corporate van trainer investigated t		
		connector onto lap belt.			incident and determined the root cause		
		djusted as firmly as possible			this event was that the transportation a		
	but consistent with us				did not secure the wheelchairs tight		
					enough to prevent them from moving.	The	
	Review of the medica	al record of Resident #39			facility van remained out of use through		
	indicated she was ad	mitted to the facility on			05/01/2017 due to vacation of the seni	or	
	04/18/2016. The resi	ident's cumulative diagnoses			transportation aide. It was then		
	included End Stage F	Renal Disease and			determined on 05/01/2017 to no longer	٢	
	Dependence on Dialy	/sis.			transport empty wheelchairs on the fac	ility	
					van.		
	_ ·	rly Minimum Data Set			A root cause analysis investigation was		
	· ·	017 indicated the resident			completed for both incidents by corpor		
		airment. The MDS also			van educator and the facility administra	ator.	
	indicated the resident	ons for transfers between			The root cause for both incidents was		
		wheelchair for mobility. The			determined to be transporter failed to follow facility policy and procedures an	Ч	
		ight leg above the knee			manufacturer guidelines.	u	
	amputee.	ight log above the knee			Corrective Action for Potentially Affecte	ed	
	ampatoo.				Residents	~~	
	Review of a nursing p	progress note dated			On 03/01/2017, the facility van was tak	en	
	03/01/2017 indicated, "Informed by transportation				out of operation through 03/06/2017. C		
		ad fell on the bus while it was			03/06/2017, the maintenance Director		
		ursing home. Writer and			completed the Vehicle Inspection: Safe	ety	
	-	and one other Nursing			Inspection check list for the one facility	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345481	B. WING			05/	20/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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WOODLAI	NDS NURSING & REHA	BILITATION CENTER		F.	AYETTEVILLE, NC 28301		
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F 323	Continued From page	e 7	F:	323			
F 323	Assistant (NA) went to parked and found parked and found parked bus, asked patient when bus started mo of her wheelchair and the bus. Head to toe no bump on back of hus using life pad and (Signed by Staff Nurs Nursing notes also in sent to the hospital of for complaints of head Review of a hospital dated 03/02/2017 indicated of the Computerized To x-rays of the head, no information indicated with strained muscles and was ordered as resident returned to to 1:35 AM with orders and make the computerized To the resident was interested to the the computerized To x-rays of the head, no information indicated with strained muscles and was ordered as resident returned to the thing to the resident was interested to the thing occurred on 03/01/20 March 1st, and we was appointment around a stoplight. When the li	tient lying on back on floor of that happened, stated that ving, she fell backward out to hit her head on the floor of done, no open areas noted, nead noted. Patient helped placed back in wheelchair." se #1) dicated the resident was no 03/01/2017 for evaluation dache at 8:15 PM. emergency department note licated the resident was seen owing the incident in the van. In of fractures were seen on mography (CT) scans and eck and back. Discharge the resident was diagnosed as and ligaments in the neck needed pain medication. The he facility on 03/02/2017 at	F	323	owned van. No concerns were identified On 03/14/2017, Van Products of Raleig completed an inspection and service of the one facility owned van. No concern were identified. On 03/07/2017 the administrator begar interviewing all alert and oriented residents that were transported on the facility owned van to ensure they were secured by the shoulder and lap seated and front and back floor retractors according to facility policy and Q' Strair manufacturer guidelines. This audit wa conducted daily for 2 weeks. No conce were identified. Employee #1 was terminated on 03/09/2017 and #2 was terminated on 04/18/2017. Current residents that were transported on the facility owned van fround of the potential to be affected by this alleged practice. An audit was completed on 05/20/2017 by the Senior Transportation Aide to determine which residents were transported by the facility van from 04/13/2017 to 05/19/2017. 13 Current residents were identified. On 05/20/2017 the Director of Nursing interviewed the identified 10 alert and oriented resident that were transported 04/13/2017 to 05/19/2017 for any safety concerns durtransports and to validate that the following technique was used to secure their wheelchair during transportations:	gh n s n elt ts rns e om	
	out of my wheelchair van floor. The wheeld The driver couldn't ge	ir jerked back and threw me I landed on my back on the chair was sitting straight up. et me up by herself, and it ninutes when other people			4 floor retractors are hooked to the wheelchair, the seat belt is attached across the residents lap and secured to floor restraints, and the shoulder strap positioned across the shoulder and		

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WOODLAI	NDS NURSING & REHAE	BILITATION CENTER		400 PELT DRIVE		
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F 323	Continued From page	e 8	F 32	3		
	from the facility came	to help. One of the people		secured to the lap belt. All 10 alert an	d	
		e said it was amazing how I		oriented residents stated the above	_	
	~	chair, but the chair stayed		procedures have been followed for th	eir	
	up. The same driver had taken me to			transports occurring from 04/13/2017		
	appointments before. She always put the lift			05/19/2017 and they did not have any		
	down, put the wheelchair on the lift and got me in			safety concerns.		
	the van. When I was in the van, she put the			,		
	brakes on the back to keep the chair from moving			Systemic Changes		
		er me to put the lock on the				
	front. On that day, I o	lon't remember her locking		On 03/06/2017, 8 facility staff designation	ated	
	the front of the chair.	Before that day, she always		to aide in facility transportations were		
	leaned around me to	put my seat belt on. I know		checked off by the corporate van trair	ner	
	she did not do it that of	day, but I don't know why.		utilizing the skills checklist and Q' Stra	aint	
	-	k were hurting when we got		manufacturer guidelines. The current		
	back to the facility, so	they called the doctor, and		or		
	they sent me to the ho			he		
		eck is sore, but the doctor		corporate van trainer has received tra	-	
		le relaxers, and they help a		directly from Q' Straint/Surelock Nation		
	lot."			Training Seminar products in Septem		
				2016. The corporate van trainer utiliz	es	
		riewed on 05/19/2017 at		the training he received, Q' Straint		
		at the time of the incident,		manufacturer guidelines, and a skills		
		scheduler and also one of		checklist to educate van transporters		
	-	s for the facility. She stated		skills validation is also completed who		
		on 03/01/2017 and stated		the staff member must demonstrate the		
	•	rked back in the van, and fithe chair. I went with the		skills appropriately. On 03/30/2017, a transportation aide was placed in the	I ICVV	
		e. The chair was sitting up		position as facility transportation aide		
		lent was on the van floor on		Training was completed by the corpor		
		wake and talking. The nurse		van trainer on 03/30/2017 prior to the		
		t, and three of us got her		transportation aide completing any va		
		we inspected the chair. I		transports.	"	
		e chair. When I saw the		As of 04/13/2017, unoccupied		
		ers were not secured to the		wheelchairs have not been transported	ed in	
		e front of the wheelchair was		the facility van.		
		d the seat belt was not				
		per out training instructions.		Quality Assurance		
		uld not have been applied				
		ent could not have been		A quality review will also be implemen	nted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345481	B. WING _			05	5/20/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODLA	NDS NUDSING & DE	HARII ITATION CENTER		4	00 PELT DRIVE			
WOODLA	NDS NURSING & RE	HABILITATION CENTER		F	AYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
						-		
F 323	Continued From p	page 9	F3	323				
	thrown out of the	-			when transports are started back on			
					05/22/2017. The review includes the			
	Staff Nurse #1 wa	s interviewed on 05/19/2017 at			administrator or maintenance director	in		
	2:00 PM and state	ed he was notified of the van			their absence will observe facility van			
	incident on 03/01/	2017 while he was on duty. He			transports daily for 2 weeks to ensure			
	stated he and the	transportation scheduler went			residents and the chair are secured to	the		
	_	scene where the van was			vehicle by visualizing that all 4 floor			
	'	g lot. He stated he observed			retractors are hooked to the wheel cha	•		
	, ,	on her back inside the van. He			that the seat belt is attached across the	Э		
		vake and alert. He stated she			residents lap and secured to floor			
		eadache. He also reported he			restraints, shoulder strap is positioned			
		n head to toe, and saw no ury. He said after the			across the shoulder and secured to the lap belt. This review will be documented			
		eduler checked out the			on the QA Checklist for Transportation			
		d the other 2 staff assisted the			Van. The administrator will be respons			
		ne wheelchair. He stated the			for ensuring safe transportation of	1010		
		eduler secured the wheelchair			residents. On 05/24/2017 the Corporat	te		
		eatbelt to the resident. He also			Van Educator checked off the senior			
		ne facility physician while still at			transportation aide utilizing the skills			
	the scene of the ir	ncident, and the physician said			checklist and Q' Straint manufacturer			
	observe her, and	if anything worsens, send her			guidelines. Facility transports resumed	on		
		rther stated the resident kept			05/25/2017. The transportation aide wa			
		neadache, so he sent her out to			observed by the Maintenance Director	on		
	the hospital to be	evaluated.			05/31/2017 and the Administrator on			
					06/05/2017 to ensure the residents and			
		the incident on 03/01/2017 was			the wheel chair were secured according	-		
		erview. The driver had been			manufacturer guidelines. On audit by t			
	were available.	facility and no phone numbers			Clinical Nurse Consultant on 06/08/20 was discovered that the senior	17 11		
	were available.				transportation aide was not observed of	lailv		
	The facility's plan	of correction for the incident on			from 05/25/2017 to 06/08/2017. The	lany		
		ewed for the Resident #39 and			senior transportation aide was complete	ting		
		te assessment by the facility			daily the TSP-101 DAILY VAN	3		
		of the facility physician and			CHECKLIST (which states that all			
		nospital emergency department.			residents will be properly secured with			
	The facility van wa	as immediately taken out of			appropriate strapping of wheelchairs			
	service, and the van driver was suspended				and/or seatbelt placement. Under no			
		a 24 hour report was done.			circumstances will the van be operated	t		
	Corrective action for potentially affected residents				without adequate seatbelts for every			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345481	B. WING _			05/2	20/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	00 PELT DRIVE		
WOODLA	NDS NURSING & REHAE	BILITATION CENTER		F	FAYETTEVILLE, NC 28301		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	*	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 10	F:	323			
	· -	nspection of the facility van	. ,		resident being transported. If there is a	an l	
		afe to use. While this was			issue identified on the daily checklist, it		
		nents were made for resident			must be reviewed and corrected prior to		
		nercial transport company.			the van being used if it is a patient safe		
		cluded the administrator			issue.) This check list was reviewed an		
	•	wly hired transportation staff			signed by the administrator daily from		
		he corporate educator prior			05/25/2017 to 06/08/2017. In response	e to	
	to him/her transportin	g any residents in the facility			this lapse in quality assurance monitori	ng,	
	van. The administrator was to also ensure any other facility staff that may transport residents in				the daily monitoring period has been		
					extended for 2 additional weeks beginn	-	
		ned and skills checklist			on 06/09/2017 and then will decrease t	.0	
		porate transport educator			weekly monitoring times 2 weeks then		
	prior to him/her trans	porting any residents.			monthly times 2 months. On 06/08/20		
	During an interview.	ith Decident #20 en			the Administrator, Maintenance Directo		
	During an interview w				and Transportation Aide were educated		
		AM, she reported a second ated "On 04/12/2017, the			on the requirements for quality assurar monitoring for F 323 and 490 as stated		
		was transporting 3 of us to			above by the Clinical Nurse Consultant		
		people sat in seats on the			addition to this, alert and oriented		
	_	r wheelchairs behind the			residents will be interviewed by the		
		was supposed to take this			administrator or designee using the QA	.	
		ound them to keep them			tool Resident Interview asking if their		
		didn't do it that day. When			wheel chairs were secured and seat be	elts	
		main road, one of the chairs			applied according to Q'Straint		
	flipped back and land	led against my stump on my			manufacturer instructions. This will be		
	right leg, and I yelled	for her to let her know the			completed weekly times 2 weeks then		
		and it was hurting. She			monthly times 3 months or until resolve		
	-	on me or take it off my leg			by Quality Assurance Committee. Repo	orts	
		llysis center. A different			will be presented to the weekly QA		
	· ·	ater that day after dialysis. I			committee by the Administrator or DON	l to	
		on my leg, and she said no			ensure corrective action initiated as		
	-	er. So when we got back to			appropriate. Compliance will be monito		
	_	me to the administrator,			and ongoing auditing program reviewed		
	and I reported to the				the weekly QA Meeting. The weekly QA		
		The nurse at the facility			Meeting is attended by the DON, MDS		
	over. I told her I was	t happened and checked me			Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the		
	OVEL. I LOIG HELL WAS	onay and not nuit.			Administrator. If errors are identified the	ے ا	
	Staff NA#1 was interv	viewed on 05/19/2017 at			employee will be suspended pending a		
		 	1		1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY MPLETED	
		345481	B. WING _			C 05/20/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 400 PELT DRIVE FAYETTEVILLE, NC 28301	•	7572072077
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	scheduler and also a transports. She state the resident up after stated when she arrithe resident asked if in the van earlier that on her right leg sturk knowledge of the incher. She further state what happened in the arrived at the facility administrator's office happened. She also secure any lose item "Those wheelchairs before the driver left had training and lear wheelchair, a reside van." The van driver for the unavailable for interverminated by the fact were available. The facility physician 05/19/2017 at 3:00 Fimmediately notified they occurred. He see the fall in the van on resident to be evaluated emergency department of lowed up with her as needed muscle recomplaint of neck particular of the popinion, the resident	I she was the transport a designated driver for ed was the driver who picked dialysis on 04/12/2017. She ved to pick up the resident, she heard about the incident at day the wheelchair landed up. She stated she had no eident until the resident told ted the resident described e van, and as soon as they, she took the resident to the expose she could report what to stated they used a strap to us in the van. She stated should have been secured the facility. All the drivers and any lose items in the resident on 4/12/2017 was view. The driver had been cility and no phone numbers of both van incidents when tated when he was advised of 03/01/2017, he ordered the	F 3	investigation of the allegati	ons.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345481	B. WING _	B. WING		C 05/20/2017		
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (400 PELT DRIVE FAYETTEVILLE, NC 28301	•	00/20/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 323	injuries sustained ar visit. The administrator wat 3:10 PM and state 03/01/2017 was investated the van driver revealed she was in the wheelchair as shadministrator stated demonstration of he wheelchair onto the correctly. The administrator stated investigation, the employment. The 2 were reviewed. The began a plan of correctly of the order of the 03/01/2017 incident. During a continued if 3:10 PM, the Administrator of the 04/12	da/12/2017 with the sident's knee, there were no and no cause for a hospital as interviewed on 05/19/2017 and the first van incident on estigated immediately. She was interviewed and a hurry and did not secure he should have. The the driver gave a re knowledge by loading a van, and she performed it instrator stated, as a result of a driver was terminated from 4 hour and 5 day reports administrator stated she ection immediately after the	F	323				
	following the investig admitted she left the the driver also stated dialysis center when until she got there to administrator further did not report the indibecause the resident. The facility's correct van incident on 04/1 immediate assessm	ive plan was reviewed for the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345481	B. WING			C 05/20/2047
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	l	05/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	affected residents, to the facility on 04/with the administrate staff and residents. van being placed bawas observed by the demonstrate correct transport. Systemic and any newly hired demonstrate correct to him/her providing the facility van. The were reviewed. At the time of the sucurrently in use by the transport residents. In an interview on 06 Corporate Transport both drivers in both how to secure a whe secure a resident or incidents. He also stimmediately after be the also stated neith happened, because but chose not to follow On 05/19/17 at 5:45 of IJ. The facility pro	tained. For potentially the corporate educator came 16/2017 to review the incident or, Director of Nursing (DON), On 05/01/2017 prior to the tack in use, the van transporter exadministrator to a securing of wheel chairs for changes included current transportation staff will a securing of wheelchairs prior transport of residents using 24 hour and 5 day reports Tree, there was no van the facility, and a private any was being used to any loose items prior to both the teation Educator, he stated incidents received training on the teation Educator, he stated incidents received training on the teation Educator, he stated incidents received training on the teation Educator, he stated incidents received training on the teation Educator, he stated incidents and did training. The training is the incidents and did training. The incidents should have both drivers knew what to do tow instructions. PM, the facility was notified by the facility at 1:50 PM:	F 33	23		

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345481	B. WING		C 05/20/2017
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	1 00/20/2017
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 323	Continued From pa	ge 14	F 323	3	
	incident involving R 03/01/2017 in which transported back to dialysis treatment. If #39 wheelchair fell on the floor hitting hassessed by the face emergency room for the facility van was 03/06/2017. A 24 h 03/02/2017 and a 5 03/09/2017. Outsid used to provide sort for the facility. The suspended on 03/00 terminated on 03/00	ately began investigating the desident #39 occurring on the resident was being the facility after receiving her an route to the facility Resident backwards causing her to fall the head. The resident was cility LPN and sent to the prevaluation. On 03/01/2017, taken out of operation through our report was completed on the transportation company was needled necessary transports involved employee #1 was 1/2017 and subsequently 1/2017. On 03/02/2017, the ter investigated the incident the root cause of this event was nide failed to secure the front the resident's wheelchair facturer guidelines. Resident alap and shoulder belt was ring the transport". Employee at the front and back retractors". was informed that the did not hook the front the #1 stated "I thought I did but at I didn't then I guess I didn't". The incident is employee #1 did turer guidelines and facility the resident and wheelchair the transport.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345481	B. WING		C 05/20/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	4	STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 323	return to the facility for injury by the facinoted. On 04/12/20 out of operation throt transportation compnecessary transpore employee #2 was subsequently terminour report was conditionally the facinoted for the incident and delevent was that the free secure the wheelch them from moving. Of use through 05/0 senior transportation on 05/01/2017 to now the incident and the facinose for both incident a	Resident #39 was assessed lity LPN. No injuries were 17, the facility van was taken ough 05/01/2017. Outside oany was used to schedule its for the facility. The involved uspended on 04/12/2017 and nated on 04/18/2017. A 24 inpleted on 04/12/2017 and a impleted on 04/12/2017. On porate van trainer investigated itermined the root cause of this transportation aide did not airs tight enough to prevent The facility van remained out 1/2017 due to vacation of the in aide. It was then determined to longer transport empty	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345481	B. WING		C 05/20/2017		
NAME OF PROVIDER OR SUPPLIER WOODLANDS NURSING & RE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	03/20/2017		
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
On 03/07/2017 the interviewing all all were transported ensure they were lap seatbelt and faccording to facility guidelines. This aweeks. No conce Employee #1 was #2 was terminate residents that were owned van from 0 the potential to be practice. An audity by the Senior Trawhich residents was van from 04/13/20 residents were idented of the potential to be practice of Nursing alert and oriented 04/13/2017 to 05/04/13/2017 to 05/	e administrator began ert and oriented residents that on the facility owned van to secured by the shoulder and ront and back floor retractors ity policy and manufacturer ludit was conducted daily for 2 rns were identified. Is terminated on 03/09/2017 and d on 04/18/2017. Current re transported on the facility 04/13/2017 to 05/19/2017 have e affected by this alleged it was completed on 05/20/2017 insportation Aide to determine were transported by the facility 017 to 05/19/2017. 13 Current evere transported by the facility 017 to 05/19/2017, the igniterviewed the identified 10 I residents that were transported (19/2017 for any safety concerns and to validate that the following is ded to secure their wheelchair tions: all 4 floor retractors are eelchair, the seat belt is the residents lap and secured to all the shoulder and secured to on the shoulder and secured to on all the shoulder and secured to on the shoulder and secured to on the shoulder and secured to on the shoulder and secured to	F 32	3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	345481 B. WING			C 05/20/2017		
	ROVIDER OR SUPPLIER NDS NURSING & REHA	BILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	•	0.20.20.1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	in facility transportate corporate van trainer and Q' Straint manus current administrato were included in the van trainer has recestraint National Traiseptember 2016. Tutilizes the training manufacturer guideleducate van transporalso completed wheedemonstrate the ski 03/30/2017, a new to in the position as factorial trainer on 03/30/201 aide completing any and the chair are starter review includes the director in their abset transports daily for 2 and the chair are sevisualizing that all 4 the wheelchair, that across the residents restraints, shoulder shoulder and secure administrator will be transportation of resalert and oriented reasking if their wheel belts applied according the composition of the salert and oriented reasking if their wheel belts applied according trainer trainer trainer wheel belts applied according trainer trainer trainer wheel belts applied according trainer	cility staff designated to aide ions were checked off by the r utilizing the skills checklist facturer guidelines. The r and maintenance director 8 staff trained. The corporate ived training directly from Q' ning Seminar products in he corporate van trainer ne received, Q' Straint ines, and a skills checklist to orters. A skills validation is re the staff member must ls appropriately. On ransportation aide was placed cility transportation aide. eted by the corporate van 7 prior to the transportation van transports. Inoccupied wheelchairs have d in the facility van. also be implemented when d back on 05/22/2017. The administrator or maintenance ence will observe facility van 8 weeks to ensure residents cured to the vehicle by floor retractors are hooked to the seat belt is attached alap and secured to floor estrap is positioned across the ed to the lap belt. The responsible for ensuring safe idents. In addition to this, sidents will be interviewed chairs were secured and seat	F3	323		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345481	B. WING		0.	C 05/20/2017	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301		5/20/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE	
F 323	3 Continued From page 18		F 32	23			
	will be suspended pe allegations.	nding an investigation of the					
	The validation of the completed on 05/20/1	credible allegation was 7 at 2:00 PM by:					
	with Resident #39 ve	ical record and interview rified she was assessed by g each van incident and sent valuation for the first					
	oriented residents be transported on the fact they were secured by seatbelt and front and according to facility p	d back floor retractors olicy and manufacturer was conducted daily for 2					
	administrator on 05/2 components of the critrainings, monitoring	conducted with the facility 0/2017 related to specific edible allegation related to tools and responsibility of safe transportation of					
F 490 SS=J	transportation (NA #1 related to trainings cooccurred. 483.70 EFFECTIVE	conducted with the sole) on 05/20/2017 at 2:00 PM empleted since incidents ESIDENT WELL-BEING	F 49	90		6/15/17	
	_	n. ninistered in a manner that esources effectively and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X	(X3) DATE SURVEY COMPLETED	
		345481	B. WING			C	
NAME OF D	DOVIDED OD SLIDDLIED	343401		STREET ADDRESS, CITY, STATE, ZIP CODE		05/20/2017	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,			
WOODLA	NDS NURSING & REHAE	BILITATION CENTER		400 PELT DRIVE			
				FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 490	Continued From page	e 19	F 4	90			
	well-being of each res	mental, and psychosocial					
	_ ·	iews and resident and staff		F 490			
	manufacturer's instruresident's wheelchair resident from the dial 03/01/2017 (Resident #39 was ejected onto the resident to hit her to secure 2 unoccupion the way to a dialys 04/12/2017 which cau wheelchairs to be through the wheelchairs to be through the wheelchair of Residents during the transportation varionto the floor. The reevaluation and sustait immediate jeopardy wat 1:50 PM when the	ctions to safely secure a during transport of 1 of 1 yysis center to the facility on t #39). As a result, Resident to the floor of the van causing thead. The facility also failed ed wheel chairs in the van sis appointment on used one of the unoccupied own onto the leg of 1 of 3 ransport (Resident #39). began on 03/01/2017 when sident #39 fell backwards in an and ejected the resident esident was sent out for ned no injury. The was removed on 05/20/2017		Corrective Action for Affected R The facility immediately began investigating the incident involvi resident #39 occurring on 03/01 which resident was being transpoach to the facility after receivin dialysis treatment. In route to the resident #39 wheelchair fell back causing her to fall on the floor head. The resident was assess facility LPN and sent to the emeroom for evaluation. On 03/01/2 facility van was taken out of ope through 03/06/2017. A 24 hour completed on 03/02/2017 and a report was completed on 03/09/Outside transportation company to scheduled necessary transportacility. The involved employee	ing 1/2017 in corted g her le facility lekwards litting her sed by the lergency 2017, the leration report was a 5 day ley/2017. If was used orts for the	s d	
	The facility will remain scope and severity le potential for more that immediate jeopardy) monitor and fully implifor transportation to a activities. Findings included: Cross referenced at F	n out of compliance at a vel D (no actual harm with in minimal harm that is not to allow the facility time to be seen the new procedure appointments and other. F323: Based on record and staff interviews, the		suspended on 03/01/2017 and subsequently terminated on 03/ On 03/02/2017, the corporate vinvestigated the incident and de root cause of this event was the transportation aide failed to sec front retractors on the resident's wheelchair. On 04/12/2017 during transport resident #39 to dialysis, one of unoccupied wheelchairs shifted turn and was leaning on the right	709/2017. an trainer etermined ecure the second two during a		

		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345481	B. WING			C		
NAME OF DE	ROVIDER OR SUPPLIER	0.0.0.		6.	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	20/2017	
NAME OF T	COVIDER OR SOLT EIER							
WOODLAI	NDS NURSING & REHA	ABILITATION CENTER			00 PELT DRIVE			
				F	AYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 490	Continued From page	ge 20	F4	490				
F 490	facility failed to follow to safely secure a retransport of 1 of 1 recenter to the facility #39). As a result, Rethe floor of the van chead. The facility also unoccupied wheel can dialysis appointment caused one of the unthrown onto the legatransport (Resident). The administrator was 3:10 PM and state 03/01/2017 was invested the van drive revealed she was in the wheelchair as standinistrator stated demonstration of he wheelchair onto the correctly. The administrator the investigation, the employment. The act a plan of correction 03/01/2017 incident stated as soon as stated the driver administrated follows the investigation, the employment of the was terminated follows the dialectic stated the driver administrator stated as soon as stated the was terminated follows the dialectic stated the driver administrator stated as soon as stated the was terminated follows the driver administrator stated the driver administrator stated as soon as stated the was terminated follows.	w manufacturer's instructions esident's wheelchair during esident from the dialysis on 03/01/2017 (Resident lesident #39 was ejected onto causing the resident to hit her so failed to secure 2 hairs in the van on the way to ent on 04/12/2017 which noccupied wheelchairs to be of 1 of 3 residents during the #39). The as interviewed on 05/19/2017 ed the first van incident on estigated immediately. She is was interviewed and if a hurry and did not secure the should have. The should have. The the driver gave a ser knowledge by loading a van, and she performed it inistrator stated, as a result of the driver was terminated from diministrator stated she began immediately after the should have. The Administrator also the learned of the 04/12/2017 of a statement from the driver. In the second incident owing the investigation. She mitted she left the 2 chairs a driver also stated she wasn't alysis center when it vaited until she got there to	F	490	resident #39 footrest and knee. Upon return to the facility, resident #39 was assessed for injury by the facility LPN and injury was noted. On 04/12/2017, the facility van was taking out of operation through 05/01/2017. Outside transportation company was used to scheduled necessary transports for the facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/20124 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/20126 the corporate van trainer investigated to incident and determined the root cause this event was that the transportation addit not secure the wheelchairs tight enough to prevent them from moving. facility van remained out of use through 05/01/2017 due to vacation of the seniotransportation aide. It was then determined on 05/01/2017 to no longer transport unoccupied wheelchairs on the facility van. Corrective Action for Potentially Affected Residents On 03/01/2017, the facility van was take out of operation through 03/06/2017. On 03/06/2017, the maintenance Director completed the Vehicle Inspection: Safe Inspection check list for the one facility owned van. No concerns were identified on 03/14/2017, Van Products of Raleig completed an inspection and service or completed an inspection	e 7. A 117, he of ide The n or he d en yh d, jh n		
	driver stated she did anyone at the facility	nt. She further stated the discount in the incident to because the resident was istrator stated a plan of			the one facility owned van. No concern were identified. On 05/20/2017 the Clinical RN consult met with the administrator to determine	ant		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		343461	B. WING_			0	05/20/2017
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F 490	Continued From p	page 21	F	490			
	· ·	plemented after the second van			who the facility utilized as facility van		
	incident.	piemented after the second van			drivers and that the designated drivers		
	incident.				met the following criteria: Resident	•	
	The administrator	was notified of the immediate			transportation should be completed by	,	
	jeopardy on 05/19				employees who have been trained to		
					so. Transportation aides must be curr		
	The administrator	provided the following credible			Nursing Assistants or Emergency		
		bliance was provided on			Medication Technicians. They must al	so	
	05/20/2017 at 1:5				have valid CPR training. All van drive	rs	
					must hold a valid North Carolina driver	s	
	Corrective Action	for Affected Residents			license, have had a drivers license DN	1V	
	The facility immed	liately began investigating the			check, and have had documented train	ning	
	_	resident #39 occurring on			on van usage prior to transportation of	:	
		ch resident was being			residents. In addition to this, the		
		to the facility after receiving her			administrator was educated on ensurir	-	
		. In route to the facility resident			that staff designated to transport resid	ents	
		Il backwards causing her to fall			on the facility van understand the		
	_	her head. The resident was			importance and expectation of the		
		acility LPN and sent to the			administrator for following Q' Straint		
		for evaluation. On 03/01/2017,			manufacturer guidelines when	_	
		s taken out of operation through hour report was completed on			transporting residents. There will be no tolerance of transportation staff not	,	
		5 day report was completed on			following the manufacturer guidelines	or	
		de transportation company was			having an attitude of non-compliance.	OI .	
		y transports for the facility. The			1 Employee was designated as facility	van	
		e #1 was suspended on			drivers meeting the above criteria. On		
		ubsequently terminated on			05/20/2017 the Clinical RN Consultant		
		3/02/2017, the corporate van			reviewed the skills check list for the		
	trainer investigate	d the incident and determined			designated van driver to ensure that th	ne	
		event was the transportation			skills check list were completed by the		
	aide failed to secu	ure the front retractors on the			corporate van trainer on 03/06/2017 o		
	resident's wheelch	nair.			sooner.		
		ring transport of resident #39 to			On 05/19/2017, the one facility owned		
		o unoccupied wheelchairs			was removed from operation and Outs	side	
	_	irn and was leaning on the right			transportation company was used to		
		\$39 footrest and knee. Upon			scheduled necessary transports for the	Э	
		ty, resident #39 was assessed			facility.		
		icility LPN and no injury was					
	noted. On 04/12/2	2017, the facility van was taking			Systemic Changes		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED	
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F 490	transportation compatransports for the facility was suspended or subsequently terminate hour report was composed for the incident and determined the incident and determined them from moving. The factor of the incident and determined them from moving. The factor of the incident and determined them from moving. The factor of the incident and determined them from moving. The factor of the incident and the factor of the wheelchairs on the factor of t	igh 05/01/2017. Outside any was used to necessary lity. The involved employee in 04/12/2017 and atted on 04/18/2017. A 24 coleted on 04/12/2017 and a inpleted on 04/17/2017. On corate van trainer investigated rmined the root cause of this cansportation aide did not its tight enough to prevent the facility van remained out aide. It was then determined longer transport unoccupied acility van. Potentially Affected acility van was taken out of 1/06/2017. On 03/06/2017, ector completed the Vehicle spection check list for the in. No concerns were	F	490	On 05/20/2017, the Clinical RN Nurse Consultant educated all current FT, PT and PRN employees who operate the of facility owned van were educated on the following Resident Transportation Policiand Procedure. Transportation Policy: 1. Resident transportation should be completed by employees who have beet trained to do so. Transportation aides must be current Nursing Assistants or Emergency Medication Technicians. To must also have valid CPR training. 2. PRIOR to operating a facility transportation vehicle, the TSP-101 DAVAN CHECKLIST will be completed. A residents will be properly secured with appropriate strapping of wheelchairs and/or seatbelt placement. Under no circumstances will the van be operated without adequate seatbelts for every resident being transported. If there is a issue identified on the daily checklist, it must be reviewed and corrected prior to the van being used if it is a patient safe issue. 3. The van will also be inspected by the maintenance director or designee on a weekly basis. Results of the inspection will be documented on form TSP-102 WEEKLY CHECKLIST. 4. All van drivers must hold a valid Not Carolina drivers license, have had a drivers license DMV check, and have he documented training on van usage prior transportation of residents. 5. In the event of an emergency, call 9	en hey AILY an ety e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 490	Continued From page	e 23	F	490				
		of residents. In addition to			it in indicated such as no heartbeat or			
	1 -	r was educated on ensuring			breathing. Do not move patient if injury	/ is		
		to transport residents on the			suspected or unless life is threatened.			
		d the importance and			All wheelchairs used for transportations	on		
	•	ministrator for following			of residents must be approved for			
		nes when transporting			transport use. If a personally-owned			
	residents. There will	. •			wheelchair (not a wheelchair provided	or		
	transportation staff no	ot following the manufacturer			arranged by the facility) is to be used for	or		
	guidelines or having	an attitude of			transportation, it must be approved by			
	non-compliance.				Liberty Risk Management to determine	if it		
	1 Employee was des	ignated as facility van drivers			is safe for transport use.			
	meeting the above cr	iteria. On 05/20/2017 the			7. Power wheelchairs must be fitted w	ith		
	Clinical RN Consulta	nt reviewed the skills check			transportation appropriate straps for			
		I van driver to ensure that			correct tie down procedures in order to			
	the skills check list w				ready for use in the transportation van.			
	T	on 03/06/2017 or sooner.			they do not have manufacturer installed			
		ne facility owned van was			safety strap attachment points or cannot			
	-	ion and, and an outside			be fitted with attachment devices from			
		ny was used to necessary			manufacturer, they cannot be consider	ed		
	transports for the faci	llity.			safe for transport.			
	Systematic Changes	NE LENA			8. All transportation Aids must have			
		Clinical RN Nurse Consultant			completed annual transportation safety			
		FT, PT and PRN employees			training.			
		facility owned van on the			Training must include the safe presedures for leading and unleading a	\f		
	~	ansportation Policy and			procedures for loading and unloading or residents, the safe and proper use of the			
	Procedure.							
	Transportation Policy	tation should be completed			approved safety restraint system provide by the manufacturer of the transportation			
		ave been trained to do so.			van and emergency measures to remo			
		must be current Nursing			residents from the safety restraint syste			
	•	ency Medication Technicians.			Immediately notify the Administrate			
	They must also have				when an incident occurs during a van			
	_	ng a facility transportation			transport regardless of how minor the			
	-	DAILY VAN CHECKLIST			incident is. This includes resident and			
	· ·	Il residents will be properly			non-resident incidents. Incidents include	e		
	•	iate strapping of wheelchairs			but are not limited to: fall from			
	and/or seatbelt place	· · · ·			wheelchair, equipment malfunction,			
	-	e van be operated without			refusal of resident to utilize safety belts	,		
		or every resident being			and injury of any nature. Administrator			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 490	Continued From page 24 transported. If there is an issue identified on the		F.	490	ahana awahar 70.4.240.0000		
	daily checklist, it mu prior to the van bein issue. 3. The van will also maintenance director basis. Results of the documented on form CHECKLIST. 4. All van drivers m	st be reviewed and corrected g used if it is a patient safety be inspected by the or or designee on a weekly e inspection will be a TSP-102 WEEKLY			phone number 704-340-8669. The following amendment to the policy to insure safety of residents during load and application of the safety restraint system; Item #1: All wheelchairs used in transportation must have foot rests in place (attached the chair) during loading, transport and unloading of residents. It has been determined that the resident's feet must	ding	
	Carolina driver's license, have had a driver's license DMV check, and have had documented training on van usage prior to transportation of residents. 5. In the event of an emergency, call 911. Provide basic first aid. Implement CPR if it in indicated such as no heartbeat or breathing. Do not move patient if injury is suspected or unless life is threatened. 6. All wheelchairs used for transportation of residents must be approved for transport use. If a personally-owned wheelchair (not a wheelchair provided or arranged by the facility) is to be used for transportation, it must be approved by Liberty Risk Management to determine if it is safe for transport use. 7. Power wheelchairs must be fitted with transportation appropriate straps for correct tie down procedures in order to be ready for use in the transportation van. If they do not have manufacturer installed safety strap attachment points or cannot be fitted with attachment devices from the manufacturer, they cannot be considered safe for transport. 8. All transportation staff must have completed annual transportation staff must have completed annual transportation staff must have completed annual transportation safety training. 9. Training must include the safe procedures for loading and unloading of residents, the safe and proper use of the approved safety restraint				be on the wheelchair foot rests to preve feet and toes being caught or pinched in the lift bridge plate during lift operations resulting in injury. Foot rests can help keep feet in a position that will not allow toes to slide under the bridge plate. If chair being used for transportation doe not have foot rests attached at the time transport, appropriate foot rests are to located and attached to the chair prope or another chair with foot rests is to be	ent in s, to v the s e of be	
					used. It is recommended the transportation aids set aside a wheelch for transportation use ahead of time to void the necessity of locating and fitting another wheelchair. Item #2: All wheelchairs used in transportation must be of the types that have removal arm rest. Access to the unrestricted be of the wheelchair seat is required to secure the lap safety belt in place over resident's lap. Placing the lap belt through the underside of the arm rest does not allow the belt to restrain the resident at the hip. The safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap to the safety the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the resident from slipping out of the safety lap belt must cross over the lap from hip to hip keep the safety lap be	ble ack the	

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F 490	Continued From page system provided by the	e 25 he manufacturer of the	F	190 seat.			
	transportation van an remove residents from system. 10. Immediately notification incident occurs during of how minor the incident and non-resident and non-resident and non-resident to utilize safe nature. Administrator 704-340-8669. The following amend insure safety of resident application of the safe left wheelchairs used foot rests in place (at loading, transport and has been determined be on the wheelchair and toes being caugh plate during lift opera Foot rests can help to will not allow toes to sift the chair being use	d emergency measures to measures to measures to measures to measure the safety restraint. fy the Administrator when an easy as a van transport regardless dent is. This includes dent incidents. Incidents inted to: fall from measurement measurement from the measurement of the policy of any phone number. ment to the policy is to ents during loading and		seat. Item #3: Wheelchair Floor restraints are never be attached to the cross (X) bars of the wheelchair. The cross bars are not puthe frame of the chair and will collapse the chair is forced on its side as in a hum. All floor straps are to be attached the frame at or above the point where welded joints connect the frame. This typically found where the wheels or we casters are attached. Item #4 Geriatric Chairs can never be used for transport. Gerri Chairs have no way lock the reclining feature of the chair may fall into a reclining position during transport. IN the event of a chair recliduring transport the safety harness system will not protect the resident armay result in a serious or fatal event. Item #5 Power Wheelchairs must be approve transportation before they can be used transport of a resident. If they are no considered safe for transport, the facing must provide a facility approved chair the resident transportation needs. Item #6 Unoccupied wheelchairs will no longer		t of if rd d to s eel o nd ing for for y or	
	appropriate foot rests attached to the chair with foot rests is to be the transportation aid	are to be located and properly or another chair e used. It is recommended as set aside a wheelchair for ead of time to void the		transported on the facility. This information has been the standard orientation transported in-service refresh all employees who operate and will be reviewed by the Assurance process to verichange has been sustained The administrator and mai director attended the van teen the standard or the standard	integrated in aining and in ler courses for the facility very Quality fy that the ed.	the or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 490	90 Continued From page 26		F 49				
F 490	All wheelchairs used the types that have re to the unrestricted bar required to secure the the resident's lap. Plathe underside of the abelt to restrain the resilap belt must cross owkeep the resident from least the reside	in transportation must be of emovable arm rest. Access ck of the wheelchair seat is a lap safety belt in place over acing the lap belt through arm rest does not allow the sident at the hip. The safety wer the lap from hip to hip to in slipping out of the seat. Traints are never to be (X) bars of the wheelchair. The part of the frame of the entitle that it is forced on its. All floor straps are to be at or above the point where the frame. This is typically tells or wheel casters are never be used for transport. In way to lock the reclining and may fall into a reclining front. IN the event of a chair port the safety harness the the resident and may fatal event. The part of the frame of the entitle that is typically the safety harness that the resident and may fatal event.	F	490	03/06/2017 provided by the corporate of trainer to ensure proper knowledge of the safety harness system in order to verify that it is completed correctly. As of 04/13/2017, unoccupied wheelchairs have not been transported the facility van. The van will not be use transport unoccupied wheelchairs. Quality Assurance A quality review will also be implemented when transports are started back on 05/22/2017. The review includes the administrator or maintenance director in their absence will observe facility van transports daily for 2 weeks to ensure residents and the chair are secured to vehicle by visualizing that all 4 floor retractors are hooked to the wheel chair that the seat belt is attached across the residents lap and secured to floor restraints, shoulder strap is positioned across the shoulder and secured to the lap belt. This review will be documented on the QA Checklist for Transportation Van. The administrator will be responsified for ensuring safe transportation of residents. On 05/24/2017 the Corporativan Educator checked off the senior transportation aide utilizing the skills checklist and Q' Straint manufacturer guidelines. Facility transports resumed	he / in d to ed ir, ed ble e	
	facility approved chair transportation needs.				05/25/2017. The transportation aide was observed by the Maintenance Director 05/31/2017 and the Administrator on	as on	
	Item #6				06/05/2017 to ensure the residents and		
	Unoccupied wheelchat transported on the factorial				the wheel chair were secured according manufacturer guidelines. On audit by the		

<u> </u>	OT OTT MEDIO THE C	MEDIO/ ND OLIVIOLO					7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 490	Continued From page	e 27	F	490			
	This information has	been integrated into the			Clinical Nurse Consultant on 06/08/20	17 it	
		training and in the required			was discovered that the senior		
		ourses for all employees			transportation aide was not observed of	laily	
		ity van and will be reviewed			from 05/25/2017 to 06/08/2017. The		
	by the Quality Assura	ince process to verify that			senior transportation aide was complet	ing	
	the change has been	sustained.			daily the TSP-101 DAILY VAN		
	A quality review will a	ilso be implemented when			CHECKLIST (which states that all		
	•	back on 05/22/2017. The			residents will be properly secured with		
		dministrator or maintenance			appropriate strapping of wheelchairs		
		nce will observe facility van			and/or seatbelt placement. Under no		
		weeks to ensure residents			circumstances will the van be operated	l	
		ured to the vehicle by			without adequate seatbelts for every		
	_	loor retractors are hooked to			resident being transported. If there is a		
	· ·	he seat belt is attached			issue identified on the daily checklist, if		
		lap and secured to floor			must be reviewed and corrected prior t		
	shoulder and secured	trap is positioned across the			the van being used if it is a patient safe issue.) This check list was reviewed ar	-	
		responsible for ensuring safe			signed by the administrator daily from	iu	
		dents. In addition to this,			05/25/2017 to 06/08/2017. In response	≏ to	
	•	sidents will be interviewed			this lapse in quality assurance monitor		
		ter secured both front and			the daily monitoring period has been	9,	
		es as well as the wheelchair			extended for 2 additional weeks beginn	nina	
	to the van floor. If en				on 06/09/2017 and then will decrease	-	
	employee will be sus	pended pending an			weekly monitoring times 2 weeks then		
	investigation of the al	llegations.			monthly times 2 months. In addition to		
	-				this, alert and oriented residents will be)	
	The administrator and	d maintenance director			interviewed by the administrator or		
	attended the van trair	ning on 03/06/2017 provided			designee using the QA tool Resident		
		trainer to ensure proper			Interview asking if their wheel chairs w		
		ety harness system in order			secured and seat belts applied accordi	ng	
	to verify that it is com	pleted correctly.			to Q'Straint manufacturer instructions.		
					This will be completed weekly times 2		
		occupied wheelchairs have			weeks then monthly times 3 months or		
		in the facility van. The van			until resolved by Quality Assurance		
	will not be used to tra	insport unoccupied			Committee. Reports will be presented	O	
	wheelchairs.				the weekly QA committee by the	4:	
	The validation of the	aradible allogation was			Administrator or DON to ensure correct	uve	
		credible allegation was			action initiated as appropriate.		
	completed on 05/20/1	i / aι ∠.∪∪ Γίνι υγ.			Compliance will be monitored and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345481	B. WING _				C / 20/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		40	REET ADDRESS, CITY, STATE, ZIP CODE O PELT DRIVE AYETTEVILLE, NC 28301	1 03/	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 490 F 520 SS=J	with Resident #39 ve medical staff following out to a hospital for e incident. 2. Reviewed audit too oriented residents be transported on the far they were secured by seatbelt and front and according to facility p guidelines. This audit weeks. No concerns 3. An interview was administrator on 05/2 components of the cr trainings, monitoring the facility to provide residents. 4. An interview was a transportation (NA #1 related to trainings cooccurred. 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS	ical record and interview rified she was assessed by greach van incident and sent valuation for the first. It of interviews with alert and gun on 03/07/2017 that were cility owned van to ensure of the shoulder and lap drough back floor retractors olicy and manufacturer was conducted daily for 2 were identified. Conducted with the facility 0/2017 related to specific edible allegation related to tools and responsibility of safe transportation of conducted with the sole on 05/20/2017 at 2:00 PM completed since incidents (i)(ii)(h)(i) QAA ERS/MEET Int and assurance. Intain a quality assessment sittee consisting at a		490 520	ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. If errors are identified th employee will be suspended pending a investigation of the allegations.	e	6/15/17

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345481	B. WING		C 05/20/2017		
	ROVIDER OR SUPPLIER	BILITATION CENTER	.	STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	1 03/20/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 520	Continued From page	e 29	F 520				
	(ii) The Medical Direc	ctor or his/her designee;					
	staff, at least one of v	a board member or other					
	(g)(2) The quality ass committee must :	sessment and assurance					
	coordinate and evalu	n respect to which quality					
		ement appropriate plans of tified quality deficiencies;					
	Secretary may not re records of such comr such disclosure is rel	rmation. A State or the quire disclosure of the mittee except in so far as ated to the compliance of the requirements of this					
	sanctions.						
	interviews, the facility	iews and resident and staff 's Quality Assurance and		F 520			
	failed to maintain imp	ement (QAPI) committee plemented procedures and cons put into place as a		Corrective Action for Affected Resident The facility administrator, Director of	s		
		ing 3 federal surveys. The		Nursing, and corporate van educator			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /) DATE SURVEY COMPLETED
		345481	B. WING _			C 05/20/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
WOODLA	NDS NURSING & REHA	BILITATION CENTER		400 PELT DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
F 520	during the recertifical survey of 11/16/16, a recertification survey area of administratic survey of 01/20/17 a recertification survey facility during three spattern of the facility effective Quality Assistance Immediate Jeopardy the facility's Quality Assistance Immediate Jeopardy the facility's Quality Assistance Immediate Jeopardy Improvement Common cause analysis after #39 fell backwards in ejected the resident was sent out for evaluation in the facility will remain acceptable credit. The facility will remain scope and severity Impotential for more the immediate jeopardy monitor and fully import resident's transport other activities. The administrator was jeopardy on 05/19/1	accidents (F 323) on 6/30/16 Ition survey, on a complaint and on the current In The facility was cited in the In (F 490) on a complaint Ind again on the current In The continued failure of the Isurveys within a year show a Is inability to sustain an In urance program. In began on 03/01/2017 when It is a survey and performance In the transportation van and It is onto the floor. The resident In the transportation van and In the transportation van and It is onto the floor and sustained no It is peopardy was removed on In When the facility provided It is a legation of compliance. In out of compliance at a It is not It is a legation to a level D (no actual harm with It is not of allow the facility time to It is allow the facility time to It is allow the new procedure In the immediate	F 5	· ·	occurring ident was acility after t. In route elchair fell on the floor was not sent to ation. On a taken out 7. A 24 03/02/2017 eted on ation ed cility. The pended on terminated the ted the ause of this de failed to be committee vestigation t of two d during a alt side of . Upon	
		f compliance was provided on		assessed for injury by the facili no injury was noted. On 04/12/ facility van was taking out of through 05/01/2017. Outside	2017, the peration	
	a) Cross referenced	at F323: Based on record		transportation company was us scheduled necessary transport		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345481	B. WING		C 05/20/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301	05/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 520	facility failed to follow to safely secure a retransport of 1 of 1 recenter to the facility of #39). As a result, Rethe floor of the van chead. The facility also unoccupied wheel chad a dialysis appointme caused one of the urthrown onto the legal transport (Resident #39). Cross referenced reviews and resident facility administration manufacturer's instructive in the dialog of the resident from the dialog of the resident from the dialog of the resident to hit he to secure 2 unoccup on the way to a dialy 04/12/2017 which can wheelchairs to be the residents during the the administrator was jeopardy on 05/19/13. During the QA interval M, the Administrator immediately the incidit was reported to he	and staff interviews, the wanufacturer's instructions sident's wheelchair during sident from the dialysis on 03/01/2017 (Resident esident #39 was ejected onto ausing the resident to hit her to failed to secure 2 mairs in the van on the way to not on 04/12/2017 which inoccupied wheelchairs to be of 1 of 3 residents during the eff39). The failed to follow failed to safely secure a reduring transport of 1 of 1 lysis center to the facility on the floor of the van causing read. The facility also failed the died wheel chairs in the van sis appointment on sused one of the unoccupied rown onto the leg of 1 of 3 transport (Resident #39). The facility also failed frown onto the leg of 1 of 3 transport (Resident #39).	F 520	facility. The involved employee #2 was suspended on 04/12/2017 and subsequently terminated on 04/18/20124 hour report was completed on 04/12/2017 and a 5 day report was completed on 04/12/2017 and a 5 day report was completed on 04/17/2017. On 04/16/2 the corporate van trainer investigated incident and determined the root cause this event was that the transportation adid not secure the wheelchairs tight enough to prevent them from moving. facility van remained out of use throug 05/01/2017 due to vacation of the sent transportation aide. It was then determined on 05/01/2017 to no longe transport empty wheelchairs on the fac van. The QA committee reviewed the findings of this investigation on 04/17/2017. Corrective Action for Potentially Affects Residents On 05/20/2017 the Clinical RN consult met with the administrator to determine who the facility utilized as facility van drivers and that the designated drivers met the following criteria: Resident transportation should be completed by employees who have been trained to consult to the completed by employees who have been trained to consult the following criteria: Resident transportation aides must be currour Nursing Assistants or Emergency Medication Technicians. They must all have valid CPR training. All van driver must hold a valid North Carolina driver license, have had a drivers license DN check, and have had documented train	7. A 017, the e of aide The h or right cility ed ant e do ent so rs so rs
	terminated. She also			on van usage prior to transportation of residents.	-

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345481	B. WING _				20/2017
NAME OF P	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				4	00 PELT DRIVE		
WOODLA	NDS NURSING & REHAI	BILITATION CENTER		F	AYETTEVILLE, NC 28301		
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F 520	20 Continued From page 32		F t	520			
	any residents. The administrator pro	necklist prior to transporting by ided the following credible nce on 05/20/2017 at 1:50			1 Employee was designated as facility driver meeting the above criteria. On 05/20/2017 the Clinical RN Consultant reviewed the skills check list for the designated van driver to ensure that th skills check list were completed by the		
	Credible Allegation for Corrective Action for The facility administration corporate van education investigating the incide which occurred on 03	Affected Residents ator, Director of Nursing, and tor immediately began dent involving Resident #39 8/01/2017 when the resident			corporate van trainer on 03/06/2017 or sooner. Systemic changes On 04/13/2017 the facility made the se transportation aide the primary employ	nior	
	receiving her dialysis facility resident #39 v causing her to fall on The resident was ass Licensed practical Nu emergency room for the facility van was ta	d back to the facility after treatment. In route to the wheelchair fell backwards the floor hitting her head. Sessed by the facility arse (LPN) and sent to the evaluation. On 03/01/2017, aken out of operation through ar report was completed on			for transporting the facility residents to their appointments. This aide has been completing facility transports for 6 year without incident. Effective 05/20/2017 the facility transportation aides will complete TSP-101 daily prior to transporting any residents in the facility owned van. On 05/20/2017, the Clinical RN	S	
	03/02/2017 and a 5 co 03/09/2017. Outside used to scheduled not facility. The involved suspended on 03/01/terminated on 03/09/corporate van trainer and determined root transportation aide faretractors on the resi committee reviewed investigation on 03/00 On 04/12/2017 during to dialysis, one of two shifted during a turn at	day report was completed on transportation company was ecessary transports for the employee #1 was '2017 and subsequently 2017. On 03/02/2017, the investigated the incident cause of this event was the liled to secure the front dent's wheelchair. The QA the findings of this			Consultant trained the 1 designated facility van driver on how to complete TSP-101 Daily Van Checklist. Training consisted of going through each item individually and emphasizing the importance for reviewing the check list ensure a safe transport. Daily when TSP-101 is completed, the transportati aide is to turn the check list into the administrator for signature and review. On 05/20/2017, the Regional Director of Operations educated the administrator the above Resident Transportation Poli and Procedure. In addition to this, education was provided on the importance of maintaining implemented	on of on icy	
		Resident #39 was assessed			procedures and monitoring intervention		

CENTERO CIR MEDIO/ IRE & MEDIO/ IID CERTIFICE					T T T T T T T T T T T T T T T T T T T			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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		345481	B. WING			05/	20/2017	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
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				F	AYETTEVILLE, NC 28301			
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IAG	NEODEATORT ORT	100 IDENTIF FING IN GRAMATION	IAG		DEFICIENCY)	W.E.		
F 520	Continued From page	e 33	F	520				
		y LPN and no injury was			identified in the facilities plan of correct	ion		
		7, the facility van was taken			for survey that began on 05/14/2017 ar			
		igh 05/01/2017. Outside			ended on 05/20/2017. The administrate			
	-	ny was used to scheduled			will be responsible for ensuring safe	71		
		for the facility. The involved			transportation of residents by ensuring	the		
	•	spended on 04/12/2017 and			transportation aide completes the			
		ited on 04/18/2017. A 24			TSP-101 Daily Van Checklist daily prio	r to		
		oleted on 04/12/2017 and a			transporting any residents.	10		
		pleted on 04/17/2017. On			This information has been integrated in	to		
		orate van trainer investigated			the standard orientation training and in			
	· ·	rmined the root cause of this			required in-service refresher courses for			
		Insportation aide did not			administrators and will be reviewed by			
		rs tight enough to prevent			Quality Assurance process to verify that			
		ne facility van remained out			the change has been sustained.			
	_	2017 due to vacation of the			the change has been sustained.			
	_	aide. It was then determined			Quality Assurance			
		onger transport empty			Quality / todarance			
	wheelchairs on the fa				A quality review will also be implement	ed.		
	committee reviewed t				when transports are started back on	5 G		
	investigation on 04/17				05/22/2017. The review includes the			
	Corrective Action for				Clinical RN Nurse Consultant will audit			
	Residents	otomium, rimotou			weekly times 4 weeks then monthly time			
		linical Registered Nurse			2 months using the QA tool QA review			
		with the administrator to			ensure the TSP-101 Daily Van Checkli			
		cility utilized as facility van			completed daily by the transportation a			
		esignated drivers met the			when facility transports are completed			
		ident transportation should			that the administrator is reviewing and			
	_	oloyees who have been			signing off on the completion of these			
		nsportation aides must be			safety audits daily. Investigations of al			
	current Nursing Assis				incidents involving transportation by the			
	_	ns. They must also have			facility van will be completed by the			
		ll van drivers must hold a			Administrator, Director of Nursing, Clin	cal		
		friver's license, have had a			RN Consultant and corporate van			
	driver's license DMV	•			educator as soon as the allegation or			
	documented training				issue is identified. The investigation wi	II		
	transportation of resid				include interviewing the resident involv			
		gnated as facility van driver			employee involved, other possible			
		iteria. On 05/20/2017 the			witnesses, and other potentially affecte	d		
		nt reviewed the skills check			patients to determine the root cause of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	I				AYETTEVILLE, NC 28301			
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F 520	Continued From page	age 34	F!	520				
	-	ted van driver to ensure that	' `	220	event. The results of the investigation	azill		
	_	were completed by the			be reviewed by the QA Team to ensure			
		ner on 03/06/2017 or sooner.			facility policy and manufacturer guideli			
	Systemic changes				were followed and will make any	1103		
	, ,	facility made the senior			recommendations for plan of correction	ne		
		the primary employee for			or interventions necessary to ensure the			
	1	cility residents to their			safety of the residents. The QA team is			
		s aide has been completing			attended by the Administrator, Director			
	''	or 6 years without incident.			Nursing, Unit Manager, and other nurs			
		17 the facility transportation			managers, Social Service, Therapy			
		e TSP-101 daily prior to			Department Manager Medical Director			
	1	esidents in the facility owned			and Dietary Manager. Reports will be			
	van.				presented to the weekly QA committee	by		
	On 05/20/2017, the	e Clinical RN Consultant			the Administrator or DON to ensure			
	trained the 1 desig	nated facility van driver on how			corrective action initiated as appropria	te.		
		01 Daily Van Checklist.			Compliance will be monitored and			
	_	of going through each item			ongoing auditing program reviewed at	the		
	· ·	nphasizing the importance for			weekly QA Meeting. The weekly QA			
	_	k list to ensure a safe			Meeting is attended by the DON, MDS	1		
	1 -	en TSP-101 is completed, the			Coordinator, Support Nurse, Therapy,			
		is to turn the check list into the			HIM, Dietary Manager and the			
		gnature and review.			Administrator.	ı		
		e Regional Director of			There were not any residents adverse	У		
	1 -	ed the administrator on the			affected by the lapse in the quality	^		
		ansportation Policy and			assurance process for F 323 and F 49 On 06/09/2017 the Clinical Nurse	0.		
		tion to this, education was portance of maintaining				rde		
	·	edures and monitoring			Consultant audited transportation reco for residents that were transported usi			
		ified in the facilities plan of			the facility van from 05/25/2017 when	•		
		ey that began on 05/14/2017			van was put back in use to 06/08/2017			
		20/2017. The administrator will			residents were identified. 2 of the 12			
		ensuring safe transportation of			residents have been discharged. The			
	· ·	ing the transportation aide			Clinical Nurse Consultant began			
		P-101 Daily Van Checklist daily			interviewing 9 of the identified resident	:S		
	prior to transportin	-			that were transported on the facility ow			
	1 -	as been integrated into the			van. The facility Maintenance Director			
		on training and in the required			interviewed 1 resident. Residents were			
		r courses for administrators			asked if they were secured by the			
	and will be reviewe	ad by the Quality Assurance			shoulder and lan seathelt and if the fro	nt		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345481	B. WING				20/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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WOODLA	NDS NURSING & REHAE	SILITATION CENTER		F	AYETTEVILLE, NC 28301		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 520	Continued From page	e 35	F	520			
	· -	the change has been		020	and back floor retractors were secured	to	
	sustained.	the change has been			their wheel chair (if transported in a wh		
		Iso be implemented when			chair) by the van driver prior to being	COI	
		back on 05/22/2017. The			transported on the van. Findings were:	AII	
	•	linical RN Nurse Consultant			10 residents indicated an understanding		
	will audit weekly that	the TSP-101 Daily Van			of the shoulder and lap belt restraint	5	
	_	d daily by the transportation			process and the 4 floor retractors in the)	
		sports are completed and			floor of the van needing to be hooked t	0	
	that the administrator	is reviewing and signing off			their wheel chair prior to being		
	on the completion of	these safety audits daily.			transported. All 10 residents confirmed		
	Investigations of all in	icidents involving			that they were secured correctly and fe	lt	
	transportation by the	facility van will be completed			safe traveling in the van. No concerns		
	by the Administrator,	Director of Nursing, Clinical			were offered.		
		orporate van educator as			The Clinical Nurse Consultant audited		
	_	n or issue is identified. The			facility incident reports from 05/01/2017	7 to	
		ide interviewing the resident			present to identify if any van related		
		volved, other possible			incidents had occurred. No incidents w	ere	
	· ·	potentially affected patients			identified.		
		cause of the event. The			On 06/08/2017, the Administrator,		
	_	ation will be reviewed by the			Maintenance Director, and Transportat		
	QA Team to ensure fa				Aide were educated on the requirement		
	make any recommen	nes were followed and will			for quality assurance monitoring for F3 The administrator or maintenance direct		
	-	ntions necessary to ensure			in their absence will observe facility val		
		lents. The QA team is			transports daily for 2 weeks beginning		
	attended by the Admi				06/09/2017 to ensure residents and the		
	Nursing, Unit Manage				chair are secured to the vehicle by	•	
		vice, Therapy Department			visualizing that all 4 floor retractors are		
		ector and Dietary Manager.			hooked to the wheelchair, that the seat		
	_	credible allegation was			belt is attached across the residents la		
	completed on 05/20/1	_			and secured to floor restraints, shoulde		
	•	-			strap is positioned across the shoulder		
	1. Review of the med	ical record and interview			and secured to the lap belt.		
	with Resident #39 ve	rified she was assessed by			In addition to this, the Administrator wil	I	
	medical staff following	g each van incident and sent			scan a copy of the completed monitor t	0	
	out to a hospital for e	valuation for the first			the Clinical Nurse Consultant daily		
	incident.				indicating that the quality assurance ch	eck	
					has been completed. This process will		
	2. Reviewed audit too	ol of interviews with alert and			continue from 06/09/2017 to 06/22/201	7.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C 05/20/2017	
		345481	B. WING _				
NAME OF PROVIDER OR SUPPLIER WOODLANDS NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 400 PELT DRIVE FAYETTEVILLE, NC 28301			
(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 APPROPRIA' DEFICIENCY)		3E	(X5) COMPLETION DATE
F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F5	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR		1 of lity 01, has ter of of ctor	