Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
NH0638			B. WING		05/30/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
THE FOLI	V CENTED AT CHECTN	621 CHE	STNUT RIDGE F	PARKWAY		
THE FOLI	EY CENTER AT CHESTN	BLOWIN	G ROCK, NC 28	3605		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 000	Initial Comments		D 000			
	A state licensure com was conducted from 0 05/30/2024.	plaint investigation survey 05/28/2024 through				
	a Past Corrected Typ	-				
	Event ID # 9MUL11.					
D 270	10A NCAC 13F .090 ² Supervision	(b) Personal Care and	D 270		5/31/24	
		e supervision of residents in n resident's assessed needs,				
	manufacturer's instru the facility's transport the wheelchair was s all four of the transpo retractors and Reside van with a lap and sh transport for 1 of 3 re supervision to preven Resident #1's wheeld she struck her head of platform inside of the transported to the hos	ns, record review, review of ctions, and staff interview ation driver failed to ensure ecured to the van by using rt van's wheelchair tiedown ent #1 was secured to the oulder belt during a sidents reviewed for t accidents (Resident #1). hair flipped backwards, and		Citation D270- Persdonal Care and Supervision 1. Corrective action for resident affect by the deficient practice: On March 19th, 2024, approximately pm, facility Transport Driver #1 was preparing to transport Resident #1 ba facility from an appointment and failed secure the resident's seatbelt and wheelchair properly due to resident distracting transporter by repeated as transporter to fix her hair and her phot While in route to facility, Transport Dri	11:45 ck to t to king ne.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 06/20/24

STATE FORM 6899 If continuation sheet 1 of 13 9MUL11

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
NH0638			B. WING		C 05/30/2024
NAME OF D	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	ATE ZIR CODE	
NAME OF FI	ROVIDER OR SUFFLIER		HESTNUT RIDGE	,	
THE FOLE	Y CENTER AT CHESTN	UT RIDGE	VING ROCK, NC 2		
0(0) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(4/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
D 270	Continued From page	e 1	D 270		
	and was re-admitted	to the facility on the same		#1 noted from her rearview mirror,	
	day with no injuries n	oted. Failure to secure a		resident in her wheelchair which had	
	resident and the whe	elchair to the vehicle during		flipped backwards and pulled van over	to
		a past corrected Type A2		safe location to check on resident.	
		ere was substantial risk that		Transport Driver #1 checked resident for	
	death or serious phys	sical harm could occur.		injuries at which time resident verbalize her head hurting. Transport Driver #1	ed
	Findings included:			immediately notified her supervisor and called Emergency Medical Services. A	
	Review of the manufa	acturer's instructions for the		approximately 12:05pm Emergency	
	securement system used by the facility's transport van to secure residents who are seated in			Medical Services arrived and transport	ed
				resident to hospital for evaluation and	
	wheelchairs during tra	ansport read in part, "the		treatment.	
	following parts make	a complete			
	wheelchair/passenge	er securement system: 4		On 3/19/2024, the Administrator obtain	ed
		etractors, 1 occupant lap		a statement and instructed Transport	
	-	shoulder belt and mounting		Driver #1 to complete reenactment of	
	hardware."			incident. The reenactment revealed	
	5			Transport Driver #1 failed to secure the	;
		nitted to the facility 09/01/23		wheelchair to the floor of the	
	with diagnoses includ	ding osteoporosis.		transportation van and secure seatbelt harness per manufacturer's	
	The quarterly nursing	home comprehensive		recommendations. Transport Driver #1	
		2/10/24 revealed Resident #1		stated the incident was due to distraction	ons
	was cognitively intact	t and was independent for		from Resident #1 distracting Transport	
	transfers.			Driver #1 with repeated requests to fix hair and her phone.	her
	On 05/28/24 at 11:45	AM an interview was			
		dent #1. During the interview		On 3/19/2024, Transport Driver # 1 wa	s
		24 she was transported to a		re-educated on van safety protocols wi	
		She stated Transport Driver		skills checkoff and the need to make su	
		lchair on all four sides using		she was not distracted. Transport Drive	er
		going to the appointment.		#1 was educated to pull over and call	
		appointment had ended,		facility if a resident was requesting	
	T	assisted her back into the		assistance or was having issues as we	
		onto the back lift of the van		as need to go to hospital for evaluation	if
	·	e stated she then rolled her		applicable. Following reeducation,	
		nd pushed the wheelchair		Transport Driver #1 was immediately	
		#1 stated Transport Driver		suspended pending investigation.	
	#1 did not secure all 1	four wheelchair tiedowns as	I		

Division of Health Service Regulation

STATE FORM 9MUL11 If continuation sheet 2 of 13

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		NH0638	B. WING		05/30/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
		621 CHES	TNUT RIDGE F	PARKWAY		
THE FOLE	Y CENTER AT CHESTN	UT RIDGE BLOWING	ROCK, NC 28	3605		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
D 270	Continued From page	e 2	D 270			
	she normally did, and	I she did not remember		On 3/19/2024, transportation van #1 v	vas	
		und her waist or shoulder.		parked and taken out of use pending		
	Resident #1 stated sh	ne did not think quickly		investigation and inspection and facili	ıy	
	enough to let Transpo	ort Driver #1 know. She		scheduled all transports with		
	stated Transport Driv	er #1 then pulled out of the		transportation van #2 for future		
		nain road and began to do a		appointments. No other transports		
		en the wheelchair flipped		scheduled for 3/19/2024 following inci		
		ed she was looking up at the		Also, Resident #1's wheelchair was ta	ken	
	_	the back of her head onto		out of use and placed in the		
	=	ort Driver #1 immediately		Administrator's office for inspection.		
		king lot on the side of the acility. She stated when she		On 2/10/2024, the Administrator notifi	ad	
		ead, she felt a raised area		On 3/19/2024, the Administrator notifi Resident #1's responsible party and the		
		r head on the floor of the		ie		
		ited the facility told Transport				
		rgency Medical Services		incident.		
		the resident until EMS		On 3/19/2024 at 3:00pm, Resident #1		
	` ,	stated she was evaluated at		returned to the facility with no new ord		
	the hospital and retur	ned to the facility on the		Resident #1 had CT of head which		
	same day.			showed no intracranial findings and C	T of	
				the spine which showed no acute		
	•	conducted with Transport		fractures. Resident was stable for		
		1 at 10:44 AM confirmed she		discharge with no further screening,		
	_	port van on 03/19/24 when		evaluation or treatment needed for an	-	
		ward in the wheelchair		other medical condition or emergency		
		e stated she had taken tal appointment and once		medical condition.		
		nt was completed the two		On 3/21/2024, transportation van #1 v	vae	
				taken in for inspection at contracted	vas	
went back to the van and she used the lift mechanism to get the resident's wheelchair inside of the van. She stated she placed Resident #1's				vehicle maintenance shop. No issues		
			identified with safety belt securing sys			
		ft mechanism and lifted the		four-point floor securing system or lift.		
	resident up, she then	pushed the resident's		On 3/22/2024, transportation van #1 a		
		ito the van and placed the		Resident #1's wheelchair were inspec		
		. The interview revealed		by Liberty Healthcare Management R		
	she did not attach the	e 4 wheelchair tiedown		Management Insurance Manager. The	e	
	retractors to each sid	e of the resident's		inspection revealed no malfunctioning		
		ould normally do, nor did she		components of the van's wheelchair		
		and Resident #1's waist and		securing system or wheelchair.		
	shoulder. Transport D	Oriver #1 stated she had				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		NH0638	B. WING		05/30/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
			TNUT RIDGE F			
THE FOLE	EY CENTER AT CHESTN	UT RIDGE	ROCK, NC 28			
040.15	CHMMADV CT		· ·		1 000	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
			1	DEFICIENCY)		
D 270	Continued From page	e 3	D 270			
	several annointments	s scheduled for that day and		On 3/22/2024, Administrator conclude	.d	
		y due to being in a hurry.		alleged van incident investigation and		
		illed onto the main road, she		based on investigation findings, the ro		
		-turn when she saw in the		cause of incident was due to Transpor		
	-	dent #1's wheelchair flip		Driver #1 being distracted by resident		
		ed she immediately pulled		repeated request for Transport Driver		
	over into a parking lo	t on the side of the road and		her hair and her phone, Transport Dri		
	went to Resident #1.	The interview revealed she		#1 failing to follow facility policy and		
		while calling the Social		manufacturer's recommendations rela	ted	
	Worker of the facility.	She stated the Social		to securing wheelchairs and safety		
		o touch the resident, and the		harness prior to transport and lack of		
		ergency Medical Services,		knowledge/skills of Transport Driver		
		diately. She stated within 10		related to dealing with distractions from		
		was on site and assisted		residents during transport. On 3/22/20		
		ospital. Once EMS left the		Transport Driver #1 was terminated for	r	
		#1, she then returned to the		failure to follow facility policy and	41	
		cussed what had happened		manufacturer's recommendations rela	led	
		er and Administrator. She for the day. The interview		to securing wheelchair and safety harnesses.		
		river #1 was not allowed to		Harriesses.		
		wing the incident and was		On 3/22/2024, after concluding		
	terminated from the fa	•		investigation, a Quality Assurance and	1	
				Performance Improvement (QAPI)		
	The facility transport	log dated 03/19/24 revealed		meeting was held with the Interdiscipl	nary	
		esidents on the van at the		Team to review findings of investigation		
	time of Resident #1's	fall.		Investigation revealed Transport Drive	r #1	
				failed to properly secure Resident #1	prior	
	An interview conduct	ed with the Social Worker on		to transport and no other resident affe	cted	
	05/28/24 at 9:43 AM			by deficient practice. QAPI team revie		
	· ·	ansport Drivers in the		incident findings and discussed correct	tive	
		n 03/19/24 around 11:00 AM		actions, plan to monitor to ensure		
		e call from Transport Driver		Transport Drivers are following facility		
	_	ot secured the 4 tiedown		policy and manufacturer's		
		e van for Resident #1's		recommendation related to securing	,_	
	wheelchair and while	_		resident's prior to transport, and plan	.Ο	
		had flipped backwards. She		review and modify plan if needed in		
	· ·	er #1 had immediately pulled the road when she made the		weekly QAPI meeting.		
		er stated she was on the		2. Identify other residents with the		
		: Driver #1 and walked into		potential to be affected by the deficier	ıt	

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMILETED
		NH0638	B. WING		C 05/30/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
		621 CHES	TNUT RIDGE F	PARKWAY	
THE FOLE	Y CENTER AT CHESTN	UT RIDGE	ROCK, NC 28		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 4	D 270		
		ice to notify her of what had they dialed Emergency		practice:	
	hospital for an evalua Transport Driver #1 w the resident and to w stated after EMS tran Transport Driver #1 r the facility and parked Transport Driver #1 w	eturned with an empty van to d it. The interview revealed vent into the Administrator's		Beginning 3/19/2024, the Administrate and Director of Nursing identified residents that would be potentially impacted by the alleged deficient pract by completing facility transportation at for all current resident that had appointments in the past three month that had been transported by the facil	etice udits s ty
		had happened and she was s a driver in the facility tion.		van and asked if they had any issues concerns when the Transport Driver transported them to or from an	or
	An interview conducted with the Administrator on 05/28/24 at 10:00 AM revealed the Social Worker had come into her office on 03/19/24 and notified her of an incident that had occurred with the transportation van. She stated Transport Driver			appointment. The results of the audit revealed no other residents identified any issues or concerns with transport or from appointments. This was completed on 3/21/2024.	
	#1 had admitted to no	ot securing the tiedown in the van for Resident #1		3. Systemic Changes	
	which resulted in Res flipping backwards. S #1 was instructed to r EMS arrived on scene She stated Transport the facility with no oth parked it. The intervie Administrator spoke of regarding the inciden facility and notified he from driving a facility investigation. She state from the hospital on the except for a hemator She stated the facility Resident #1 on neuro	the stated Transport Driver remain with the resident until e and she had called 911. Driver #1 then returned to her residents in the van and ew revealed the with Transport Driver #1 t after she returned to the er, she would be suspended van pending an atted Resident #1 returned he same day with no injuries had to the back of her head.		Beginning 3/19/2024 the Administrator in-serviced all three backup facility Transport Drivers on safety protocols pertaining to van safety and securing residents prior to transport and dealin with challenging behaviors. The educating included van safety, securing resident per manufacturer's recommendation per manufacturer's recommendation per to transportation and to pull over and facility if a resident was requesting assistance or was having issues as we as need to go to hospital for evaluation applicable and van safety skills check were completed. This was completed 3/19/2024. Facility transports resumed 3/20/2024 following reeducation of bat facility Transport Drivers.	g ation s orior call ell n if list on
		ector of Nursing (DON) and ice all other Transport		On 3/22/2024, additional education w	as

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING: COMPLETE		
			A. BOILBING.	A. BOILDING:	
		NH0638	B. WING		C 05/30/2024
NFI0036					05/30/2024
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	ATE, ZIP CODE	
THE FOLE	EY CENTER AT CHESTNU	JT RIDGE	HESTNUT RIDGE F		
		BLOV	VING ROCK, NC 28	3605	_
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	÷ 5	D 270		
D 270	Drivers for the facility, a summary of the invext Assurance/Process Ir was put into place follo 03/19/24. The facility's incident/ 03/19/24 written by the Resident #1 fell backwhile being transporter Resident #1 had a he head and was sent to denied pain. The hospital discharger revealed Resident #1 Emergency Departmer report revealed Resident wheelchair that was in back of a transport various forward, she roused to back of her head. Resident with no open denied neck or back provided in the second oriented at the tire Resident #1 received Tomography (CT) scalinges of the bones, tissues inside the body resulted in no abnorm was returned to the factories of the second or second	The Administrator provided estigation and Quality improvement (QAPI) that lowing the incident on accident report dated be Social Worker indicated wards in her wheelchair ed in the facility van. Imatoma to the back of her of the hospital. Resident #1 as examined in the ent (ED) after a fall. The lent #1 was in her not locked in place in the ent (ED) after a fall. The lent #1 was in her not locked in place in the ent when the van began to led backwards hitting the sident #1 presented to the to the back lower portion of en wounds. Resident #1 pain and no other injuries dent was noted to be alert the of the assessment. In a Computerized and (computer generated blood vessels, and soft lay) of the head which and findings. Resident #1 accility on the same day.		provided for all three backup Facility Transport Drivers by the Liberty Healthcare Management Risk Management Insurance Manager usin the four-point securement system train material provided by the manufacturer The training consisted of review with handouts and pictures and demonstrations. This was completed of 3/22/2024. On 3/22/2024, skills checkoff was completed with all three facility Transp Drivers by Liberty Healthcare Management Risk Management Insur Manager. The skills checkoff included safety checks to include equipment, securing system to include checks to ensure wheelchair secured per manufacturer's recommendations and return demonstration of securing a pe prior to transport and unsecuring follor transport. The Administrator will ensur any newly hired facility transportation will receive this training during orienta 4. Quality Assurance Monitoring has been ongoing since th week of 3/25/2024, The Administrator designee is monitoring the issue using QA Tool for Transportation Van Trainir Skills Checkoff for Wheelchair Transp to ensure transportation driver is oper facility van equipment according to fac policy and manufacturer's recommendations prior to transport ar	ning on on ort ance rson wing re staff tion. e or g the rg or g the rg ort ating cility
	plan of correction date	he following QAPI with the e of 03/23/24.		upon return. The monitoring will include observing six residents being secured transport van prior to transport and	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COWII ELTED	
		C 05/30/2024				
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
THE FOLE	EY CENTER AT CHESTN	JT RIDGE	TNUT RIDGE F			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page		D 270			
	deficient practice: On March 19th, 2024 facility Transport Drive transport Resident #1 appointment and faile seatbelt and wheelch distracting transporter to fix her I route to facility, Transher rearview mirror, rewhich had flipped bacto safe location to che Driver #1 checked restime resident verbaliz Transport Driver #1 ir supervisor and called Services. At approxim	nair and her phone. While in sport Driver #1 noted from esident in her wheelchair ckwards and pulled van over eck on resident. Transport sident for injuries at which ed her head hurting. Inmediately notified her Emergency Medical nately 12:05pm Emergency wed and transported resident		unsecuring resident upon return, and observing safety belt and wheelchair securement. The monitoring will be completed for 6 resident transports we for 4 weeks and then monthly for 2 months or until resolved. Reports will presented to the weekly Quality Assur Committee by the Administrator or Director of Nursing to ensure correctivaction initiated as appropriate. Compliwill be monitored and ongoing auditing program reviewed at the weekly Quali Assurance Meeting. The weekly Quali Assurance Meeting is attended by the Administrator, Director of Nursing, State Development Coordinator, Minimum Det Nurse, Rehabilitation Director, He Information Manager, Maintenance Director and the Dietary Manager.	be ance re ance ty ty ty aff Data	
	statement and instruct complete reenactment revealed to secure the wheelch transportation van an per manufacturer's re Driver #1 stated the indistractions from Res Transport Driver #1 wher hair and her phonon On 3/19/2024, Transpre-educated on van scheckoff and the need distracted. Transport pull over and call facilities.	d Transport Driver #1 failed hair to the floor of the d secure seatbelt harness commendations. Transport heident was due to ident #1 distracting vith repeated requests to fix he. Doort Driver # 1 was afety protocols with skills d to make sure she was not Driver #1 was educated to				

Division of Health Service Regulation

STATE FORM 9MUL11 If continuation sheet 7 of 13

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		NH0638	B. WING		0:	C 5/30/2024
	PROVIDER OR SUPPLIER EY CENTER AT CHESTN	UT RIDGE 621 CHI	ADDRESS, CITY, STATE ESTNUT RIDGE PAR NG ROCK, NC 2860	RKWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	well as need to go to applicable. Following Driver #1 was immed investigation. On 3/19/2024, transpand taken out of use inspection and facility with transportation varpointments. No oth 3/19/2024 following in wheelchair was taken the Administrator's of the Administrator's of the alleged van incident of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with the spine of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with transportation and the facility with transportation and the facility with transportation and the facility with the facility with no needed for any other facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for any other emergency medical of the facility with no needed for	hospital for evaluation if reeducation, Transport diately suspended pending portation van #1 was parked pending investigation and y scheduled all transports an #2 for future for transports scheduled for incident. Also, Resident #1's in out of use and placed in effice for inspection. Idministrator notified Resident y and the Medical Director of ent. Image: Application of the property of the pro	D 270			

Division of Health Service Regulation

STATE FORM 9MUL11 If continuation sheet 8 of 13

Division of Health Service Regulation

	TION NUMBER:	A. BUILDING: _		COMPLETED	
AULOGO			A. BUILDING:		
NH0638		B. WING		C 05/30/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE FOLEY CENTER AT CHESTNUT RIDGE		NUT RIDGE PAROCK, NC 28			
(X4) ID SUMMARY STATEMENT OF DEFI				1 000	
(X4) ID SUMMARY STATEMENT OF DEFINE PREFIX TAG (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270 Continued From page 8		D 270			
van incident investigation and based investigation findings, the root cause was due to Transport Driver #1 bein by resident's repeated request for T Driver to fix her hair and her phone, Driver #1 failing to follow facility poli manufacturer's recommendations resecuring wheelchairs and safety hat transport and lack of knowledge/skil Transport Driver related to dealing v distractions from residents during tra 3/22/2024, Transport Driver #1 was for failure to follow facility policy and manufacturer's recommendations resecuring wheelchair and safety harr. On 3/22/2024, after concluding inve Quality Assurance and Performance Improvement (QAPI) meeting was h Interdisciplinary Team to review find investigation. Investigation revealed Driver #1 failed to properly secure F prior to transport and no other reside by deficient practice. QAPI team revincident findings and discussed corractions, plan to monitor to ensure The Drivers are following facility policy a manufacturer's recommendation relesecuring resident's prior to transport review and modify plan if needed in meeting. 2. Identify other residents with the paffected by the deficient practice: Beginning 3/19/2024, the Administra Director of Nursing identified resided be potentially impacted by the alleggractice by completing facility transported.	e of incident g distracted ransport Transport cy and elated to rness prior to ls of with ansport. On terminated lelated to nesses. stigation, a eled with the ings of Transport desident #1 ent affected riewed rective ransport nd ated to t, and plan to weekly QAPI otential to be ator and nts that would ed deficient	D 270			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		C	
		NH0638	B. WING		05/30/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
THE FOLE	EY CENTER AT CHESTNU	JT RIDGE	TNUT RIDGE PA ROCK, NC 28		
	CLIMMA DV CT				NI
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	9	D 270		
	been transported by to they had any issues of Transport Driver transported priver transported the transport Driver transported to the transport Driver transported to the transported transported to the transported transported to the transport	sported them to or from an ults of the audit revealed no fied with any issues or orts to or from appointments. on 3/21/2024. the Administrator in-serviced by Transport Drivers on ining to van safety and or to transport and dealing exiors. The education recurring residents per simendation prior to pull over and call facility if a nig assistance or was having do to go to hospital for the and van safety skills reted. This was completed on insports resumed on reducation of backup facility anal education was provided			
	the Liberty Healthcare	acility Transport Drivers by e Management Risk ce Manager using the			
	provided by the manu consisted of review w	t system training material facturer. The training ith handouts and pictures This was completed on			
	all three facility Trans	checkoff was completed with port Drivers by Liberty ent Risk Management			

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NH6638 NH6638 STEET ADDRESS, CITY, STATE. ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUR COMPLETE		
THE FOLEY CENTER AT CHESTNUT RIDGE CALL CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC. 28605 CALL CHESTNUT RIDGE PARKWAY BLOWING ROCK	NH0638		B. WING		1	2024	
CALL DEPTICE YEAR AT CHESTNUT RIDGE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIAT	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
D 270 SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL TAG RECULATORY OR LSC IDENTIFYING INFORMATION D PREFIX TAG DEFICIENCY MIST BE PRECEDED BY FULL TAG DEFICIENCY MIST BE PRECEDED BY FULL TAG DEFICIENCY DEFICIENCY			621 CHES	TNUT RIDGE P	ARKWAY		
TAG Continued From page 10 Insurance Manager. The skills checkoff included safety checks to include ecomemous prior to transport and unsecuring following transport. The Administrator or designee is monitoring the issue using the QA Tool for Transportation Administrator or designee is monitoring the issue using the QA Tool for Transportation View requirement according to fersion prior to transport and unsecuring secured per manufacturer's recommendations and return demonstration staff will receive this training during orientation. 4. Quality Assurance Monitoring has been ongoing since the week of 3/25/2024, The Administrator or designee is monitoring the issue using the QA Tool for Transportation View requirement according to facility policy and manufacturer's recommendations prior to transport and unsecuring resident upon return. The monitoring will include observing six residents being secured into transport van prior to transport and unsecuring resident upon return, and observing safety belt and wheelchair securement. The monitoring will be completed for 6 resident transports weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the	THE FOLE	Y CENTER AT CHESTNU	JT RIDGE BLOWING	ROCK, NC 28	605		
Insurance Manager. The skills checkoff included safety checks to include equipment, securing system to include checks to ensure wheelchair secured per manufacturer's recommendations and return demonstration of securing a person prior to transport and unsecuring following transport. The Administrator will ensure any newly hired facility transportation staff will receive this training during orientation. 4. Quality Assurance Monitoring has been ongoing since the week of 3/25/2024, The Administrator or designee is monitoring the issue using the QA Tool for Transportation Van Training Skills Checkoff for Wheelchair Transport to ensure transportation driver is operating facility van equipment according to facility policy and manufacturer's recommendations prior to transport and upon return. The monitoring will include observing six residents being secured into transport van prior to transport and unsecuring resident upon return, and observing safety belt and wheelchair securement. The monitoring will be completed for 6 resident transports weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting is attended by the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, Rehabilitation Director, Health Information Manager, Maintenance Director and the Dietary	D 270	Insurance Manager. I safety checks to incluse safety checks to incluse system to include chesecured per manufact and return demonstration prior to transport and transport. The Administration or training during orientated. Quality Assurance Monitoring has been a 3/25/2024, The Administration of the issue of the transport of transport of the issue of the of	The skills checkoff included de equipment, securing toks to ensure wheelchair turer's recommendations tion of securing a person unsecuring following strator will ensure any newly ation staff will receive this tion. Ongoing since the week of nistrator or designee is using the QA Tool for to ensure transportation staining Skills Checkoff for to ensure transportation dility van equipment policy and manufacturer's for to transport and upon g will include observing six ted into transport van prior to ring resident upon return, belt and wheelchair ditoring will be completed for the weekly for 4 weeks and then for until resolved. Reports the weekly Quality Assurance ministrator or Director of the rective action initiated as the more will be monitored and the profoundation. The weekly Quality attended by the profoundation of the profoundation of the profoundation of the profoundation.	D 270			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
						C
		NH0638	B. WING		0.5	C 5/30/2024
						0/00/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT			
THE FOLE	EY CENTER AT CHESTN	UT RIDGE	ESTNUT RIDGE PA			
		BLOWIN	NG ROCK, NC 286	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 11	D 270			
	Date of Compliance:	3/23/2024				
	Date of Compilation.	0/20/2024				
	the facility implement action plan on 03/23/drivers were trained. documentation that ir training and re-educa Manager safety traini audits. Review of the staff were trained in vresidents per manufa prior to transportation facility if a resident with having issues. Residents who were appointments were in concerns. Facility state confirmed they receive safety that included here.	ncluded Transport Drivers ntion records, Departmental ng records, and facility e in-service records revealed van safety, securing noturer's recommendation and to pull over and call as requesting assistance or transported to outside nterviewed and reported no aff were interviewed and ved training on transportation now to properly secure a nair, and they were required				
	On 05/28/24 at 9:20 /	AM an observation was				
		ort Driver #2 prepare a				
	1	ort in the van. Transport				
		e lift mechanism located at				
		folled the wheelchair onto the				
	-	to the van floor from the				
		shed the wheelchair onto the				
		ssed the wheelchair brakes				
		#2 was then observed to				
	obtain 4 wheelchair ti					
		l 1 occupant shoulder belt.				
		ne tie down retractor on each				
		elchair and securing them				
		ne then was observed				
	placing the waist sea	t belt and should seat belt.				
	-	tated the process was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
						С	
		NH0638	B. WING			/30/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
THE FOLEY CENTER AT CHESTNUT RIDGE 621 CHESTNUT RIDGE PARKWAY FLOWING POCK NG 28665							
BLOWING ROCK, NC 28605 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)							
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S	(EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE CROSS-REFERENCED TO THE APPROPRIATE DATE		
D 270	Continued From page 12		D 270				
D 270		e 12 ensports of residents to and	D 270				
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