STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0638	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments A state licensure complaint investigation survey was conducted from 05/28/2024 through 05/30/2024. The following intake was investigated NC00217294. One (1) of the 2 allegations resulted in a deficiency. The deficiency resulted in a Past Corrected Type A2 violation. The violation began on 03/19/24 and was found in compliance on 03/23/24. Event ID # 9MUL11.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, record review, review of manufacturer's instructions, and staff interview the facility's transportation driver failed to ensure the wheelchair was secured to the van by using all four of the transport van's wheelchair tiedown retractors and Resident #1 was secured to the van with a lap and shoulder belt during a transport for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1's wheelchair flipped backwards, and she struck her head on the wheelchair lift platform inside of the van. Resident #1 was transported to the hospital for an evaluation. Resident #1 was discharged from the hospital	D 270	Citation D270- Persdonal Care and Supervision 1. Corrective action for resident affected by the deficient practice: On March 19th, 2024, approximately 11:45 pm, facility Transport Driver #1 was preparing to transport Resident #1 back to facility from an appointment and failed to secure the resident's seatbelt and wheelchair properly due to resident distracting transporter by repeated asking transporter to fix her hair and her phone. While in route to facility, Transport Driver	5/31/24

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

Electronically Signed | 06/20/24

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D 270	Continued From page 1 and was re-admitted to the facility on the same day with no injuries noted. Failure to secure a resident and the wheelchair to the vehicle during transport resulted in a past corrected Type A2 violation meaning there was substantial risk that death or serious physical harm could occur. Findings included: Review of the manufacturer's instructions for the securement system used by the facility's transport van to secure residents who are seated in wheelchairs during transport read in part, "the following parts make a complete wheelchair/passenger securement system: 4 wheelchair tiedown retractors, 1 occupant lap belt, and 1 occupant shoulder belt and mounting hardware." Resident #1 was admitted to the facility 09/01/23 with diagnoses including osteoporosis. The quarterly nursing home comprehensive assessment dated 02/10/24 revealed Resident #1 was cognitively intact and was independent for transfers. On 05/28/24 at 11:45 AM an interview was conducted with Resident #1. During the interview she stated on 03/19/24 she was transported to a dental appointment. She stated Transport Driver #1 secured the wheelchair on all four sides using wheelchair tiedowns going to the appointment. She stated once the appointment had ended, Transport Driver #1 assisted her back into the van. She placed her onto the back lift of the van and lifted her up. She stated she then rolled her wheelchair forward and pushed the wheelchair brakes on. Resident #1 stated Transport Driver #1 did not secure all four wheelchair tiedowns as	D 270	#1 noted from her rearview mirror, resident in her wheelchair which had flipped backwards and pulled van over to safe location to check on resident. Transport Driver #1 checked resident for injuries at which time resident verbalized her head hurting. Transport Driver #1 immediately notified her supervisor and called Emergency Medical Services. At approximately 12:05pm Emergency Medical Services arrived and transported resident to hospital for evaluation and treatment. On 3/19/2024, the Administrator obtained a statement and instructed Transport Driver #1 to complete reenactment of incident. The reenactment revealed Transport Driver #1 failed to secure the wheelchair to the floor of the transportation van and secure seatbelt harness per manufacturer's recommendations. Transport Driver #1 stated the incident was due to distractions from Resident #1 distracting Transport Driver #1 with repeated requests to fix her hair and her phone. On 3/19/2024, Transport Driver # 1 was re-educated on van safety protocols with skills checkoff and the need to make sure she was not distracted. Transport Driver #1 was educated to pull over and call facility if a resident was requesting assistance or was having issues as well as need to go to hospital for evaluation if applicable. Following reeducation, Transport Driver #1 was immediately suspended pending investigation.	

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D 270	Continued From page 2 she normally did, and she did not remember having a seatbelt around her waist or shoulder. Resident #1 stated she did not think quickly enough to let Transport Driver #1 know. She stated Transport Driver #1 then pulled out of the parking lot onto the main road and began to do a U-turn in the road when the wheelchair flipped backwards. She stated she was looking up at the ceiling of the van with the back of her head onto the van floor. Transport Driver #1 immediately pulled over into a parking lot on the side of the road and called the facility. She stated when she felt the back of her head, she felt a raised area where she had hit her head on the floor of the van. Resident #1 stated the facility told Transport Driver #1 to call Emergency Medical Services (EMS) and stay with the resident until EMS arrived. Resident #1 stated she was evaluated at the hospital and returned to the facility on the same day. A telephone interview conducted with Transport Driver #1 on 05/28/24 at 10:44 AM confirmed she was driving the transport van on 03/19/24 when Resident #1 fell backward in the wheelchair during transport. She stated she had taken Resident #1 to a dental appointment and once the dental appointment was completed the two 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 wheelchair onto the lift mechanism and lifted the resident up, she then pushed the resident's wheelchair forward into the van and placed the wheelchair brakes on. The interview revealed she did not attach the 4 wheelchair tiedown retractors to each side of the resident's wheelchair as she would normally do, nor did she place a seat belt around Resident #1's waist and shoulder. Transport Driver #1 stated she had	D 270	On 3/19/2024, transportation van #1 was parked and taken out of use pending investigation and inspection and facility scheduled all transports with transportation van #2 for future appointments. No other transports scheduled for 3/19/2024 following incident. Also, Resident #1's wheelchair was taken out of use and placed in the Administrator's office for inspection. On 3/19/2024, the Administrator notified Resident #1's responsible party and the Medical Director of the alleged van incident. On 3/19/2024 at 3:00pm, Resident #1 returned to the facility with no new orders. Resident #1 had CT of head which showed no intracranial findings and CT of the spine which showed no acute fractures. Resident was stable for discharge with no further screening, evaluation or treatment needed for any other medical condition or emergency medical condition. On 3/21/2024, transportation van #1 was taken in for inspection at contracted vehicle maintenance shop. No issues identified with safety belt securing system, four-point floor securing system or lift. On 3/22/2024, transportation van #1 and Resident #1's wheelchair were inspected by Liberty Healthcare Management Risk Management Insurance Manager. The inspection revealed no malfunctioning components of the van's wheelchair securing system or wheelchair.	

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D 270	Continued From page 3 several appointments scheduled for that day and wasn't thinking clearly due to being in a hurry. She stated as she pulled onto the main road, she went to complete a U-turn when she saw in the rear-view mirror Resident #1's wheelchair flip backwards. She stated she immediately pulled over into a parking lot on the side of the road and went to Resident #1. The interview revealed she sat with Resident #1 while calling the Social Worker of the facility. She stated the Social Worker told her not to touch the resident, and the facility would call Emergency Medical Services, which they did immediately. She stated within 10 minutes or less EMS was on site and assisted Resident #1 to the hospital. Once EMS left the scene with Resident #1, she then returned to the facility where she discussed what had happened with the Social Worker and Administrator. She was then sent home for the day. The interview revealed Transport Driver #1 was not allowed to work as a driver following the incident and was terminated from the facility. The facility transport log dated 03/19/24 revealed there were no other residents on the van at the time of Resident #1's fall. An interview conducted with the Social Worker on 05/28/24 at 9:43 AM revealed she was responsible for the Transport Drivers in the facility. She stated on 03/19/24 around 11:00 AM she received a phone call from Transport Driver #1 stating she had not secured the 4 tiedown wheel retractors in the van for Resident #1's wheelchair and while rounding a curve the residents wheelchair had flipped backwards. She stated Transport Driver #1 had immediately pulled over onto the side of the road when she made the call. The Social Worker stated she was on the phone with Transport Driver #1 and walked into	D 270	On 3/22/2024, Administrator concluded alleged van incident investigation and based on investigation findings, the root cause of incident was due to Transport Driver #1 being distracted by resident's repeated request for Transport Driver to fix her hair and her phone, Transport Driver #1 failing to follow facility policy and manufacturer's recommendations related to securing wheelchairs and safety harness prior to transport and lack of knowledge/skills of Transport Driver related to dealing with distractions from residents during transport. On 3/22/2024, Transport Driver #1 was terminated for failure to follow facility policy and manufacturer's recommendations related to securing wheelchair and safety harnesses. On 3/22/2024, after concluding investigation, a Quality Assurance and Performance Improvement (QAPI) meeting was held with the Interdisciplinary Team to review findings of investigation. Investigation revealed Transport Driver #1 failed to properly secure Resident #1 prior to transport and no other resident affected by deficient practice. QAPI team reviewed incident findings and discussed corrective actions, plan to monitor to ensure Transport Drivers are following facility policy and manufacturer's recommendation related to securing resident's prior to transport, and plan to review and modify plan if needed in weekly QAPI meeting. 2. Identify other residents with the potential to be affected by the deficient	

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D 270	Continued From page 4 the Administrators office to notify her of what had occurred. She stated they dialed Emergency Medical Services and sent the resident to the hospital for an evaluation. The interview revealed Transport Driver #1 was instructed not to touch the resident and to wait on EMS to arrive. She stated after EMS transported Resident #1, Transport Driver #1 returned with an empty van to the facility and parked it. The interview revealed Transport Driver #1 went into the Administrator's office to explain what had happened and she was not allowed to work as a driver in the facility pending an investigation. 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 #1 had admitted to not securing the tiedown wheelchair retractors in the van for Resident #1 during a transport from a dental appointment which resulted in Resident #1's wheelchair flipping backwards. She stated Transport Driver #1 was instructed to remain with the resident until EMS arrived on scene and she had called 911. She stated Transport Driver #1 then returned to the facility with no other residents in the van and parked it. The interview revealed the Administrator spoke with Transport Driver #1 regarding the incident after she returned to the facility and notified her, she would be suspended from driving a facility van pending an investigation. She stated Resident #1 returned from the hospital on the same day with no injuries except for a hematoma to the back of her head. She stated the facility immediately placed Resident #1 on neurological monitoring completed by the Director of Nursing (DON) and they began to in-service all other Transport	D 270	practice: Beginning 3/19/2024, the Administrator and Director of Nursing identified residents that would be potentially impacted by the alleged deficient practice by completing facility transportation audits for all current resident that had appointments in the past three months that had been transported by the facility van and asked if they had any issues or concerns when the Transport Driver transported them to or from an appointment. The results of the audit revealed no other residents identified with any issues or concerns with transports to or from appointments. This was completed on 3/21/2024. 3. Systemic Changes 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 dealing with challenging behaviors. The education included van safety, securing residents per manufacturer's recommendation prior to transportation and to pull over and call facility if a resident was requesting assistance or was having issues as well as need to go to hospital for evaluation if applicable and van safety skills checklist were completed. This was completed on 3/19/2024. Facility transports resumed on 3/20/2024 following reeducation of backup facility Transport Drivers. On 3/22/2024, additional education was	

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D 270	Continued From page 5 Drivers for the facility. The Administrator provided a summary of the investigation and Quality Assurance/Process Improvement (QAPI) that was put into place following the incident on 03/19/24. The facility's incident/accident report dated 03/19/24 written by the Social Worker indicated Resident #1 fell backwards in her wheelchair while being transported in the facility van. Resident #1 had a hematoma to the back of her head and was sent to the hospital. Resident #1 denied pain. The hospital discharge summary dated 03/19/24 revealed Resident #1 was examined in the Emergency Department (ED) after a fall. The report revealed Resident #1 was in her wheelchair that was not locked in place in the back of a transport van. When the van began to move forward, she rolled backwards hitting the back of her head. Resident #1 presented to the ED with a hematoma to the back lower portion of her head, with no open wounds. Resident #1 denied neck or back pain and no other injuries were noted. The resident was noted to be alert and oriented at the time of the assessment. Resident #1 received a Computerized Tomography (CT) scan (computer generated images of the bones, blood vessels, and soft tissues inside the body) of the head which resulted in no abnormal findings. Resident #1 was returned to the facility on the same day. The Administrator was notified of the Past Corrected Type A2 violation on 05/28/24. The facility provided the following QAPI with the plan of correction date of 03/23/24.	D 270	provided for all three backup Facility Transport Drivers by the Liberty Healthcare Management Risk Management Insurance Manager using the four-point securement system training material provided by the manufacturer. The training consisted of review with handouts and pictures and demonstrations. This was completed on 3/22/2024. On 3/22/2024, skills checkoff was completed with all three facility Transport Drivers by Liberty Healthcare Management Risk Management 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	

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D 270	Continued From page 6 1. Corrective action for resident affected by the deficient practice: On March 19th, 2024, approximately 11:45 pm, facility Transport Driver #1 was preparing to transport Resident #1 back to facility from an appointment and failed to secure the resident's seatbelt and wheelchair properly due to resident distracting transporter by repeated asking transporter to fix her hair and her phone. While in route to facility, Transport Driver #1 noted from her rearview mirror, resident in her wheelchair which had flipped backwards and pulled van over to safe location to check on resident. Transport Driver #1 checked resident for injuries at which time resident verbalized her head hurting. Transport Driver #1 immediately notified her supervisor and called Emergency Medical Services. At approximately 12:05pm Emergency Medical Services arrived and transported resident to hospital for evaluation and treatment. On 3/19/2024, the Administrator obtained a statement and instructed Transport Driver #1 to complete reenactment of incident. The reenactment revealed Transport Driver #1 failed to secure the wheelchair to the floor of the transportation van and secure seatbelt harness per manufacturer's recommendations. Transport Driver #1 stated the incident was due to distractions from Resident #1 distracting Transport Driver #1 with repeated requests to fix her hair and her phone. On 3/19/2024, Transport Driver # 1 was re-educated on van safety protocols with skills checkoff and the need to make sure she was not distracted. Transport Driver #1 was educated to pull over and call facility if a resident was requesting assistance or was having issues as	D 270	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 is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, Rehabilitation Director, Health Information Manager, Maintenance Director and the Dietary Manager. Date of Compliance: 3/23/2024	

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well as need to go to hospital for evaluation if applicable. Following reeducation, Transport Driver #1 was immediately suspended pending investigation.

On 3/19/2024, transportation van #1 was parked and taken out of use pending investigation and inspection and facility scheduled all transports with transportation van #2 for future appointments. No other transports scheduled for 3/19/2024 following incident. Also, Resident #1's wheelchair was taken out of use and placed in the Administrator's office for inspection.

On 3/19/2024, the Administrator notified Resident #1's responsible party and the Medical Director of the alleged van incident.

On 3/19/2024 at 3:00pm, Resident #1 returned to the facility with no new orders. Resident #1 had CT of head which showed no intracranial findings and CT of the spine which showed no acute fractures. Resident was stable for discharge with no further screening, evaluation or treatment needed for any other medical condition or emergency medical condition.

On 3/21/2024, transportation van #1 was taken in for inspection at contracted vehicle maintenance shop. No issues identified with safety belt securing system, four-point floor securing system or lift.
On 3/22/2024, transportation van #1 and Resident #1's wheelchair were inspected by Liberty Healthcare Management Risk Management Insurance Manager. The inspection revealed no malfunctioning components of the van's wheelchair securing system or wheelchair.

On 3/22/2024, Administrator concluded alleged

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D 270	Continued From page 8 van incident investigation and based on investigation findings, the root cause of incident was due to Transport Driver #1 being distracted by resident's repeated request for Transport Driver to fix her hair and her phone, Transport Driver #1 failing to follow facility policy and manufacturer's recommendations related to securing wheelchairs and safety harness prior to transport and lack of knowledge/skills of Transport Driver related to dealing with distractions from residents during transport. On 3/22/2024, Transport Driver #1 was terminated for failure to follow facility policy and manufacturer's recommendations related to securing wheelchair and safety harnesses. On 3/22/2024, after concluding investigation, a Quality Assurance and Performance Improvement (QAPI) meeting was held with the Interdisciplinary Team to review findings of investigation. Investigation revealed Transport Driver #1 failed to properly secure Resident #1 prior to transport and no other resident affected by deficient practice. QAPI team reviewed incident findings and discussed corrective actions, plan to monitor to ensure Transport Drivers are following facility policy and manufacturer's recommendation related to securing resident's prior to transport, and plan to review and modify plan if needed in weekly QAPI meeting. 2. Identify other residents with the potential to be affected by the deficient practice: Beginning 3/19/2024, the Administrator and Director of Nursing identified residents that would be potentially impacted by the alleged deficient practice by completing facility transportation audits for all current resident that had	D 270		

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D 270	Continued From page 9	D 270		

appointments in the past three months that had been transported by the facility van and asked if they had any issues or concerns when the Transport Driver transported them to or from an appointment. The results of the audit revealed no other residents identified with any issues or concerns with transports to or from appointments. This was completed on 3/21/2024.

3. Systemic Changes

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 dealing with challenging behaviors. The education included van safety, securing residents per manufacturer's recommendation prior to transportation and to pull over and call facility if a resident was requesting assistance or was having issues as well as need to go to hospital for evaluation if applicable and van safety skills checklist were completed. This was completed on 3/19/2024. Facility transports resumed on 3/20/2024 following reeducation of backup facility Transport Drivers.

On 3/22/2024, additional education was provided for all three backup Facility Transport Drivers by the Liberty Healthcare Management Risk Management Insurance Manager using the four-point securement system training material provided by the manufacturer. The training consisted of review with handouts and pictures and demonstrations. This was completed on 3/22/2024.

On 3/22/2024, skills checkoff was completed with all three facility Transport Drivers by Liberty Healthcare Management Risk Management

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D 270	Continued From page 10 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. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, Rehabilitation Director, Health Information Manager, Maintenance Director and the Dietary Manager.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0638	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

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D 270	Continued From page 11 Date of Compliance: 3/23/2024 The QAPI was validated 05/28/24 and concluded the facility implemented an acceptable corrective action plan on 03/23/24 once all authorized drivers were trained. The facility provided documentation that included Transport Drivers training and re-education records, Departmental Manager safety training records, and facility audits. Review of the in-service records revealed staff were trained in van safety, securing residents per manufacturer's recommendation prior to transportation and to pull over and call facility if a resident was requesting assistance or having issues. Residents who were transported to outside appointments were interviewed and reported no concerns. Facility staff were interviewed and confirmed they received training on transportation safety that included how to properly secure a resident in a wheelchair, and they were required to perform return demonstrations. On 05/28/24 at 9:20 AM an observation was conducted of Transport Driver #2 prepare a wheelchair for transport in the van. Transport Driver #2 lowered the lift mechanism located at the back of the van, rolled the wheelchair onto the lift, and lifted it up onto the van floor from the ground. She then pushed the wheelchair onto the van platform and pressed the wheelchair brakes on. Transport Driver #2 was then observed to obtain 4 wheelchair tiedown retractors, 1 occupant lap belt and 1 occupant shoulder belt. She began placing one tie down retractor on each four sides of the wheelchair and securing them onto the van floor. She then was observed placing the waist seat belt and should seat belt. Transport Driver #2 stated the process was	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 12 followed for all van transports of residents to and from appointments.	D 270		