STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIAN CTR HLTH & REHABILITATION WALLACE	647 S RAILROAD STREET BOX 966 WALLACE, NC 28466

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, Nurse Practitioner interview, staff interviews and contracted van transportation staff interviews, the facility failed to ensure the lift platform of the contracted transportation company's van was in the elevated position before unloading a resident from the van for 1 of 3 sampled residents reviewed for accidents (Resident #2). When unloading Resident #2, who was seated in a wheelchair and on anticoagulant medication, from the transportation van the van driver failed to raise the van's lift platform to the level of the van floor which resulted in Resident #2 falling backwards from the van onto the ground. Resident #2 was transported to the hospital for evaluation and treatment and sustained a contusion to her scalp, abrasions to bilateral knees and skin tears on her bilateral upper extremities. The findings include: The manufacturer's operation notes and details for operation of the van's lift include, in part, it is the responsibility of the lift operator (attendant) to properly open, secure and close the vehicle lift door(s), to activate the vehicle interlock(s), to load and unload the wheelchair passenger on and off the lift platform, and to properly activate all lift functions. The operation notes indicated, the platform must be fully raised at floor level (the position (height) the platform assembly reaches for the wheelchair passenger to enter and exit the vehicle) and the bridge plate must be properly positioned when loading or unloading passengers in or out of the vehicle. It is the responsibility of the lift attendant to ensure the platform and the bridge plate are properly positioned at floor level with loading and unloading passengers. Resident #2 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the most recent quarterly Minimum Data Set ((MDS) dated [DATE], Resident #2's cognition was intact. The resident needed extensive assistance with transfers and required physical assistance of 2 persons. Resident #2 required the use of a wheelchair as a mobility device and received [MEDICAL TREATMENT] services and anticoagulant medication. Resident #2's Care Plan, reviewed by staff on 01/14/20, revealed the following: --Limited physical mobility related to deconditioning. Interventions included Resident #2 being totally dependent on 1 staff for locomotion using a wheelchair, initiated on 07/01/19. --High risk for falls related to previous falls. Interventions included staff to anticipate and meet Resident #2's needs, initiated on 11/04/19. --Anticoagulant therapy (blood thinning medication) related to [DIAGNOSES REDACTED]. An incident report completed by Nurse #1 on 01/15/20 at 3:45 p.m. revealed the nurse responded immediately to a report of Resident #2 having fallen outside of the facility, from a transportation van, upon returning from a doctor's appointment. The nurse documented the position of the resident on the ground and assessed her for injuries and range of motion. The incident report indicated the nurse provided treatment to the resident's bleeding abrasions and skin tears and applied an ice pack to the head injury. Nurse #1 explained the Nurse Practitioner (NP) was on scene and assessed the resident and ordered to send the resident to emergency room (ER) for further evaluation and treatment. The nurse documented notifications were made and 911 was called. Nurse #1 noted she and the NP stayed with resident until Emergency Medical Services (EMS) arrived. Nurse #1 documented the injuries observed at the time of incident and noted Resident #2 sustained a hematoma with open lesion to left temporal area, left cheek abrasion, left elbow skin tear, right hand and forearm skin tear, 2 abrasions on left knee and 1 abrasion on right knee. Nurse #1 also documented Resident #2 was alert and oriented, wheelchair-bound and rated her pain an 8 out of 10. During a telephone interview with Van Driver #1, on 03/12/20 at 9:41 a.m., she stated she worked for the facility's contracted transportation company and confirmed she was driver responsible for Resident #2's accident on 01/15/20. Van Driver #1 explained she arrived at the nursing home on 1/15/20 at around 3:25 p.m. and indicated she got out of the van, opened the van doors and opened the lift gait and then walked back into the van. Van Driver #1 explained when the liftgates are opened, they open to the floor level of the van and for the liftgate to be lowered to the ground a button would have to be pushed. She stated the only thing she remembered is opening the liftgate but for it to be in the down position she may have accidentally pushed the button to lower the liftgate. She further explained when she returned inside the van and while facing the resident in her wheelchair, she unhooked all the straps and belts from the resident's wheelchair and pushed the resident in her wheelchair backwards toward the van's liftgate, Van Driver #1 acknowledged by the time she realized what was happening, it was too late as the resident's wheelchair wheels had already started falling backwards off the van. She explained she grabbed the arm of the wheelchair in an attempt to stop it from falling but was unable to stop the resident from falling from the back of the van. She indicated she did not let go of the wheelchair and ended up being pulled out of the van as well by the weight of the resident and chair and landed another part of the lift gate. Van Driver #1 stated she did not know how the resident ended up falling on her face, but she assumed the wheelchair flipped during the fall. She confirmed she received retraining from her company after the accident which included safety, transporting and correctly loading and unloading passengers. During an interview with the facility's NP on 03/11/20 at 3:58 p.m., she explained she was informed by the Administrator Resident #2 had fallen off the transportation van on 01/15/20 and she and the treatment nurse went running outside to assess the resident. The NP stated upon arriving at the scene of the accident, Resident #2 had been lying face down on the ground and she immediately began assessing her and the resident was conscious with complaints of pain in her knees with noted bleeding on her arm and knees. She further explained Resident #2 had chronic ascites (the accumulation of fluid which causes abdominal swelling) which made it difficult for her to breathe and they needed to reposition the resident so further assessment could be performed. The NP acknowledged she assessed the resident's cervical spine to rule out any injury, stabilized her neck and rolled her onto her back to complete the assessment which revealed no areas of profuse bleeding. She indicated the resident had a goose egg on her head which appeared to be getting bigger and this concerned her because the resident was on anticoagulant therapy. She stated the resident was understandably anxious although spoke normally. The NP stated a call was placed to 911 for transport to the hospital ED and while awaiting the arrival of EMS, treatment was provided for the resident's bleeding areas, The NP confirmed she saw the resident a few times after her return from the hospital on the same date as the accident and the resident complained of continued pain in her knees. Knowing no x-rays had been taken of the resident's lower extremities while in the ED on 01/15/20, she said she ordered x-rays of both knees and hips on 01/22/20 and they were negative for fracture. During an interview with Nurse #1 on 03/11/20 at 4:25 p.m., Nurse #1 stated she was the treatment nurse for the facility and she and the NP were informed Resident #2 had fallen from the transport van on 01/15/20. The nurse explained she and the NP immediately ran outside to assess the resident and noted Resident #2 lying on her left side, face down with her right arm underneath her. Nurse #1 indicated they assessed her the best they could at that point. She documented the resident's injuries which included bilateral abrasions to her knees and arms and an abrasion to her right hand in addition to one small abrasion to the side of her head and thought a hematoma was starting. She indicated the resident's her head wound was not open or bleeding. Nurse #1 stated she continued to provide cervical spine support and applied an ice pack to the left side of the resident's face. She affirmed after the NP completed her assessment, 911 was called and stated they

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

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) both stayed with the resident until EMS arrived. Resident #2's hospital emergency department (ED) notes, dated 01/15/20, revealed Resident #2 presented to the ED with complaints associated with an accidental fall with contusion to the forehead and superficial abrasions to bilateral knees. Resident #2's physical exam in the ED indicated she had been alert and oriented with no cranial nerve deficit. A head computed tomography (CT) scan was performed with no acute intracranial abnormality noted. A medical doctor's clinical impression indicated Resident #2 had an accidental fall, contusion of scalp and acute pain in both knees. The doctor noted Resident #2 was stable and discharged her back to the facility with instructions to follow-up with her primary care provider in two to three days. During a telephone interview with the owner of the facility's contracted van transportation company on 03/12/20 at 8:45 a.m., the owner stated after Resident #2's accident, he immediately suspended Van Driver #1 pending a complete investigation of the incident. The owner stated they immediately retrained 100% of their van drivers and emergency medical technicians. The owner stated the retraining included safety videos and return demonstrations of loading and unloading a wheelchair passenger. The owner of the transportation company stated his conclusion for the accident was total operator error as no mechanical issues with the van were found during their investigation. When asked the height of the fall, the owner stated it was 24 inches from the van's lift to the ground plus the height of the wheelchair. During an interview with the District Director of Clinical Services (DDCS) on 03/12/20 at 3:00 p.m., the DDCS stated the therapy department measured the height of a wheelchair at 17 inches. During an observation on 03/12/20 at 10:28 a.m., Van Driver #2 assisted a wheelchair-bound resident onto the contracted transportation company's van to go to an appointment. Van Driver #2 placed the resident in position on the liftgate and raised the liftgate to floor level. Van Driver #2 went inside the van and secured the wheelchair front and back to the floor anchors and placed a shoulder harness and seatbelt securely on the resident. During an observation on 03/12/20 at 11:37 a.m., Van Driver #3 assisted a wheelchair-bound resident off the contracted transportation company's van. Van Driver #3 got off the van, opened the doors and liftgate. The liftgate opened at floor level of the van. Van Driver #3 went inside the van and released anchor straps and seatbelt from the wheelchair and positioned the resident onto the liftgate. Van Driver #3 got off the van and using the lift controls, lowered the resident safely to the ground. During an interview with the Administrator on 03/11/20 at 3:36 p.m., the Administrator stated she was walking towards the front office on 01/15/20 when she happened to look outside and saw Resident #2 had fallen from the transport van. She explained she immediately ran to the Physical Therapy Department and informed the NP and the treatment nurse of the accident and said they all immediately ran outside to care for Resident #2. On 03/12/20 at 12:19 p.m., the Administrator indicated she immediately began an investigation of the accident and had suspended all transportation with the contracted transportation company and after speaking with the owner of the contracted transportation company a plan of correction was put into place. The Administrator stated the facility's van driver was re-trained, out of an abundance of caution, in addition to the re-training of all the contracted transportation company's drivers and confirmed there were no transportations by van drivers who did not complete the re-training. The Administrator acknowledged Resident #2's fall from the van was because Van Driver #1 failed to realize the liftgate was not raised when she was assisting Resident #2 off the van. On 03/13/20, the facility provided an acceptable plan of correction with a correction date of 01/20/20. The plan of correction included: Resident #1 sustained a fall on 1/15/20 in the facility parking lot at approximately 3:30 pm. The resident was being unloaded from a van driven by the contracted transportation company. The resident received immediate assessment onsite by the Nurse Practitioner and she was transported by EMS for a complete exam at the hospital. The resident returned to the facility the same night without significant injury, but she did sustain some skin tears. The Responsible Party (RP) and the Medical Doctor were informed about the situation and the resident received monitoring. It was determined that the transportation company employee failed to raise the van lift to the height of the van before pushing the resident out of the van onto the lift. The facility Administrator notified the owner of the van transportation company on 1/15/20 that the facility will not use the transportation company until an acceptable plan of correction is provided by the transportation company. All residents that require transportation with the transportation company have the potential to be affected. The Administrator and Director of Nursing (DON) completed a review of the incidents since the facility reopened June 12, 2019 and there were no other residents identified with this deficient practice. This transportation company will ensure that all their personnel have received re-education and demonstrated understanding on the proper operation of the wheelchair unit prior to resuming transportation of the residents of the facility. Their retraining included safety videos and return demonstrations. 100% completion of his staff was achieved. This plan was presented and accepted on 1/20/2020 by the Administrator and Quality Assurance Performance Improvement (QAPI) committee. The facility will utilize a monitoring tool to observe safe practices are utilized by transport companies and facility transport at least four times monthly for the next two months. This was presented at an ad hoc QAPI on 01/20/20 and the results reviewed and revised if indicated at a QAPI meeting for the next two months. The facility alleges full compliance with this plan of correction effective 01/20/20. As part of the validation process on 03/13/20, the entire plan of correction was reviewed including the re-education of van drivers and observations and interventions put into place to ensure the correct loading and unloading of wheelchair passengers from the transportation vans. Interviews with transportation drivers revealed they were re-trained in safely loading and unloading wheelchair passengers from the transport van. A review of the contracted transportation company's plan of correction revealed 100% of staff were trained on safe wheelchair operations using a wheelchair lift and return demonstration which showed competency in the use of the wheelchair lift. The facility had initiated a QAPI meeting on 01/20/20 which included the medical director, Administrator, Director of Nursing, social services, treatment nurse and other administrative personnel. A review of the facility's monitoring tool for transportation revealed they completed the audits as planned. The facility's correction date of 01/20/20 was validated.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to provide management and oversight to ensure residents were provided incontinent supplies for 1 of 1 resident (Resident #1) reviewed for Administration. Findings included: Resident #1's Quarterly Minimum Data Set ((MDS) dated [DATE] revealed the Resident #1 was cognitively intact. Resident was always incontinent of urine and bowels and required use of briefs. Review of facility Grievances revealed a grievance filed on 10/1/19 by Resident #1's family regarding wipes not provided to the resident. A review of the Facility's Response to the Grievance dated 10/10/19, revealed that the Administrator spoke with the Central Supply Clerk, who stated when she went to pass out wipes, she noticed that the family had brought wipes in for the resident and assumed that the family was going to provide wipes for Resident #1. Resident #1 was given wipes upon request on the date the concern was voiced. During an interview with Resident #1, on 03/12/19 at 9:00 am, she stated that the facility seems to always runs out of wipes and briefs in all sizes but especially in her size of Large and Extra Large. They have to stop her care and go borrow them from another resident and that is not right During an interview with the Central Supply Manager (CSM) on 03/11/19 at 4:30 pm, she stated the supply delivery truck comes on Monday and Wednesday; if an item is ordered by 1pm, it would be available on the next truck delivery. Every Monday, Wednesday and Friday, the CSM looks in each resident's room to assess the needs of the resident then asks the resident/staff as well to see what supplies are needed. The CSM then goes to the shed to pull each item requested and delivers them to the appropriate room. The CSM stated that she also pulls extra supplies in the central supply room that is accessible to the Nursing Assistants (NA) by keypad; There was a shortage of wipes and XL and XXL briefs due to not ordering enough around the end of last year because it took a little time to coordinate the ordering of supplies with the needs of the facility. Since then this has not been a problem. On 3/12/2020 at 1545 During an interview with NA #1, a first shift NA, she stated there is always a shortage of briefs because the individual responsible for ordering supplies has too many responsibilities. The Central supply person, who is also over Transportation department, is the only person with a key to the shed where the supplies are kept. About 6 months ago, when she went on vacation, we had no one to order supplies or access the shed where the supplies were kept so we had to search the facility and borrow wipes and briefs from other residents. When we addressed this with Administration, we were told that they were going to hire someone to fill the Central supply position, but they have not hired anyone. During an observation of the facility's supply room on 03/13/19 at 3:55 pm, there were no briefs in small or medium sizes. There were 2 packages of large briefs, 1 package of extra-large and there were 2 packets of wipes. 03/13/19 at 5:32 pm, NA #2, a second shift NA, she stated the facility runs out of supplies often, mainly briefs. There is only one staff member, the central supply person, who has the

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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) key to the shed where the supplies are. When we run out of briefs, we have to search the facility to locate other residents who may have briefs in the same size and borrow and replace briefs and wipes as we use them. During an interview with the Director of Nursing (DON), she stated that around end of last year, we did have a problem with getting supplies timely, but since then we have been able to get the supplies ordered and to the residents without any problem. The DON further stated that it was her expectation that residents have the supplies that are needed.