STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH CONTINUING CARE CENTER OFF COLLINS	201 14TH STREET NW MANDAN, ND 58554

(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) COMPLETION DATE
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedure, the facility failed to ensure reasonable accommodation of individual needs regarding positioning at the dining table for 1 of 12 sampled residents (Resident #10) observed seated at the dining table. Failure to provide appropriate seating at the dining table limited the quality of the dining experience, may cause discomfort, and unnecessary fatigue. Findings include: Review of the facility policy and procedure titled "Seating and Positioning Needs Assessment" occurred on on 10/25/12. This policy, dated 01/23/09, stated, " Policy: 1. PT [physical therapy] and/or OT [occupational therapy] assess a resident's seating and positioning needs upon admit to achieve proper body position, balance, alignment, and comfort. . . . 3. The Seating and Positioning Assessment includes dining needs and/or interventions. . . . Procedure: . . . 5. During the Seating and Positioning Needs Assessment the resident is observed while dining so that interventions can be initiated to promote dining	F 246	**F-246: Reasonable Accommodation of Needs/Preferences** It is the intent of the facility to remain in compliance with F-246 and provide services in the facility that meet the individual needs of all residents. This is evidenced by the following: The P & P "Seating and Positioning Needs Assessment" was reviewed and remains in place without changes. Emphasis is placed on adhering to this process so that all residents are screened on admission for seating and positioning needs. Education on this policy and procedure will be provided for nursing Team Leaders and therapy associates prior to 12-5-12 with an emphasis on the completion of the Seating and Positioning Plan of Care upon admission for all residents and adherence to the plan of care. A Seating & Positioning Plan of Care was completed for Resident #10 on 11-26-12. Adjustments were made in her chair height in the dining & activity room to allow her feet to reach the floor comfortably.	12/5/12 per Mindy Marcus 12/4/12 @ 3:50 p.m. (po)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindy Marcus	Administrator	11/29/12

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 246	Continued From page 1 independence, comfort and dignity. . . ." Observation in the dining room occurred on: * 10/22/12 at 5:50 p.m. * 10/23/12 at 9:50 a.m., and 11:50 a.m. * 10/24/12 at 4:45 p.m. * 10/25/12 at 8:25 a.m. Observation showed Resident #10 seated in a dining room chair with her feet dangling approximately 2 to 3 inches from the floor. Resident #10 occasionally crossed her legs at the ankles and her feet continued to dangle. One observation showed Resident #10 resting her left foot on the leg of the table and touching the right tip of her shoe on the floor. During an interview on 10/25/12 at 11:00 a.m., a physical therapy staff member (#3) reported no seating and positioning assessment had been completed for Resident #10.	F 246	Comfortable seating and positioning has the potential to affect all Off Collins residents. Seven residents have been identified that had not been screened for seating and positioning needs due to their independent status. Screenings will be completed on these residents on or before 11-30-12 to insure that needs are identified and interventions put into place. CQI Monitoring will be completed beginning the week of 12-3-12 by the CQI Coordinator and/or her designee X4 weeks and then monthly X2 on residents admitted during this time to insure that the Plan of Care is completed and interventions put in place where indicated. This CQI monitoring will include Resident #10 to ensure that interventions indicated are in place. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized by the CQI Coordinator at the Quarterly CQI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. P & P Seating and Positioning Needs Assessment	12/5/12 per Mindy Marcus on 12/4/12 @ 3:50 PM (poo)
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, resident and staff interview, the facility failed to assess, develop and implement specific individualized interventions, and monitor the effectiveness of the interventions used in response to specific behaviors for 1 of 4 sampled	F 250		

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F 250	Continued From page 2 residents (Resident #7) with behaviors and requiring the use of behavior altering medication. Failure to assess the contributing factors/causative reasons for Resident #7's behaviors toward other residents may result in unintended resident to resident retaliation, resulted in Resident #7 irritating/annoying other residents, intruding on their privacy, and frightening residents. Findings include: During group interview on the afternoon of October 22, 2012, three of nine residents (Resident #5, #18 and #19) reported concerns with a resident residing within the facility, due to behaviors directed at others. One resident identified Resident #7 as "going around and picking" on them, "hollers" at residents, "gets mad at every one," and sometimes scares them. The residents identified Resident #7 "hollers" at Resident #9. On the morning of 10/25/12, Resident #18 approached the survey team and reported Resident #7 was blocking the exit of the dining/activity room the evening before. During an interview on 10/22/12 at 4:45 p.m. Resident #5 stated Resident #7 makes faces and says mean things to her and other residents. Resident #5 also reported that she tries to ignore Resident #7, and a male resident commented he wanted to knock Resident #7 off her chair. Review of the facility's "Behavior Management Program" occurred on 10/25/12. The policy, revised 08/2000, stated, "Purpose: To provide guidelines and explanations to nursing, in dealing with residents	F 250	2. Completed Seating and Positioning Plan of Care for Resident #10 3. ADL care plan for Resident #10 4. CQI monitoring worksheet titled Seating and Positioning Plan of Care **F-250: Provision of Medically Related Social Services** It is the intent of the facility to remain in compliance with F-250 and provide medically related social services to attain or maintain resident well-being. This is evidenced by the following: The P & P titled Behavior Management Program was reviewed and revised. This P & P guides the care plan development specific to resident behaviors and implementation of interventions to address potential causes, patterns and/or trends. Noted behaviors will be documented in Point of Care. PRN documentation will be done using the Mood and Behavior Monitoring Form. The activity, behavior, dining, and ADL care plans for Resident #7 were revised to include individualized interventions to address specific behaviors affecting others. These care	

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F 250	Continued From page 3 with behavior problems. Behavior Committee: To provide an organized means of responding to disruptive behaviors through . . . care planning and follow-through by health care team members, as care is provided. Procedure: 1. Identify behaviors which alter or disturb overall safety, quality of life, and the ability of staff to care for the individual needs of residents. a. threatening behavior; verbal or physical . . . b. sexually/socially inappropriate behavior c. depressive type behaviors d. disruptive type behaviors 2. Identify behaviors on 'behavior monitoring form' using the behavioral symptom codes. (each behavior identified will be dealt with individually.) 3. Nursing shall then determine which interventions will be used and documented . . . This will provide consistency in how staff will deal with the behavior as it occurs. 4. This behavior needs to be then care planned, including specific intervention to protect staff, resident, and other residents from threatening behavior. . . . 8. If a resident is verbally or physically threatening the Administrator and D.O.N. [director of nursing] need to be notified immediately along with the attending physician for intervention. . . . Behavior committee reviews ongoing, residents with behavior issues. . . . Recommendations from the committee are make [sic] following review of Care Plan, behavior monitoring . . . and staff input as to behavior modification programs, care plan revisions, and specific action in response to resident behavior. Team Leaders will oversee implementation of behavior committee recommendations in a consistent manner through supervision of direct	F 250	plans were reviewed with Resident #7 and her husband at a care conference held on 11-26-12 with the understanding that resident behaviors impacting others must improve. The resident was informed that the speed of her electric wheelchair would be slowed as other residents expressed a fear of injury when she moves through out the facility. Weekly care conferences will continue with the resident in attendance. Family members are invited to each care conference so that behavioral issues continue to be addressed. Resident's #5, #9, #17, #18 & #19 expressed feelings of fear and apprehension to the survey team members due to the behaviors shown by Resident #7. The LSW will meet individually with these residents weekly X4 beginning the week of 1-3-12 and then monthly X2 so that the residents are able to discuss the situation confidentially without fear of reprisal. Because individual behaviors have the potential to affect all residents of the facility the general reporting process will be discussed at the Resident Council meeting scheduled for 12-4-12 so that residents are aware of how to report any type of concerns, including adverse behaviors that affect others.	

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F 250	Continued From page 4 care staff." - Review of Resident #7's medical record occurred on all days of survey. The record identified Resident #7's diagnoses included hemiplegia affecting the left extremities, anxiety state, depressive disorder and simple paranoid state. The record showed the resident on two antidepressant medications (Trazadone and Wellbutrin extended release, both started in June 2011); one antipsychotic medication once daily (Seroquel, started in February 2012); and one medication which may be utilized for behaviors (Depakote, started in October 2012). On 10/02/12, a physician ordered a consult with a mental health professional regarding Resident #7's increased behaviors and agitation. Review of the progress notes indicated a mental health professional evaluated Resident #7's medications on 10/16/12 for changes and stated it was "clinically contraindicated to change medications . . ." The record identified no other interventions or comments on the resident's increased behaviors. Review of Resident #7's Minimum Data Sets (MDSs), dated 08/12/12, 05/12/12 and 02/12/12 showed the resident cognitively intact, and no signs or symptoms of depression. The MDSs, dated 08/12/12 and 05/12/12 identified the resident with verbal behavioral symptoms directed toward others ("e.g., threatening others, screaming at others, cursing at others") and other behavioral symptoms not directed toward others "(e.g., physical symptoms such as hitting . . . or verbal/vocal symptoms like screaming, disruptive sounds"). Both MDSs identified this behavior occurring 1-3 times per week. The comprehensive MDS, completed on 05/12/12,	F 250	Reporting will be a monthly topic at the Resident Council meetings X3 months. Individual visits will be made by the LSW as needed. Education on the Behavior Management Program P & P, the care plan for Resident #7, and the reporting process will be provided for clinical team members prior to 12-5-12. Emphasis will be placed on identifying behaviors and consistently addressing the behavior according to an established care plan. CQI monitoring of Resident #7's behavior documentation will be done weekly X4 beginning 12-3-12 by the CQI Coordinator or her designee. Behaviors that occur will be discussed with Resident #7 and family at the weekly care conference. Behavior improvement and/or worsening will be used to determine future interventions necessary to protect Resident #7 and others in the facility. QI monitoring of individualized weekly visits X4 for Residents #5, #9, #17, #18 & #19 will be done weekly beginning 12-3-12 by the CQI Coordinator or her designee. QI Monitoring of monthly Resident Council meeting minutes will also be monitored monthly X3 beginning 12-4-	

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F 250	Continued From page 5 showed the behaviors did not impact others. The most current MDS (08/12/12) showed Resident #7 required supervision of one person for mobility on and off the unit. Observation on all days of survey showed Resident #7 in a motorized wheelchair which she was able to maneuver herself. The record included a physical therapist assessment, dated 08/15/12, to discuss safety issues using the motorized wheelchair and safety issues with other residents. Review of Behavior monitoring forms, completed by Certified Nursing Assistants (CNAs), showed the following behaviors: * August 2012: at least seven entries including rudeness, screaming, signs of paranoia, moodiness, name calling, displaying a poor me attitude, and inappropriate behavior. One entry identified behaviors occurring in the evening * September 2012: at least three entries identifying verbal behavior directed towards others, occurring in the evening hours * October 2012: an entry identifying the resident thought a CNA(s) was ganging up on her Progress notes regarding Resident #7's behaviors included the following : * 12/22/11: Staff met with Resident #7 regarding inappropriate comments made to other residents at the dining room table. Resident denied and started crying. * 04/12/12: An entry regarding the resident's rude behavior with nursing staff attempting to meet her needs. "She is screaming, yelling, swearing, crying, stamping her feel [feet] and slamming her hand down. Threatening to . . . report staff . . .	F 250	12 to identify resident concerns being voiced. Results of the CQI monitoring will be reviewed weekly by the clinical management team and at the monthly and Quarterly CQI meetings to determine if problem behaviors affecting others continue to occur or if concerns are being resolved. The need for further monitoring will be determined based upon these results. Attachments: 1. Behavior Management Program P & P 2. Mood and Behavior Monitoring Form 3. Revised Care Plans for Resident #7 (Activity, Behavior, Dining and ADL sections) 4. CQI Monitoring Worksheet titled Behavior Monitoring 5. CQI Monitoring Worksheet titled Resident Follow-up 6. CQI Monitoring Worksheet titled Resident Council Minutes/Behavior Concerns	

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F 250	Continued From page 6 continued to be out of control and yelling. . . . then she yell [yelled] 'don't you come back in my room again, I don't want to see your face' She has been very rude to the staff all night. Will be reported to the social worker and team leader." * 05/23/12: Stated she liked to initiate arguments with staff and other residents * 05/31/12: Stated a meeting occurred with the resident's husband and daughter to discuss Resident #7's behaviors towards staff and other residents in the activity and dining room * 06/07/12: ". . . met 6/6/12 to discuss [Resident #7's] recent behaviors toward other residents and staff. We first discussed her comments to residents, causing them to feel bad and not want to perhaps be in the activity room with her. [Resident #7] denied making any such comments, however, several staff, residents, and family members have reported the same information. . . . [told] you have to be respectful to them, and not display the type of behavior that she has. . . . discussed . . . that she will make statements to staff, in a threatening manner . . . not to take her frustrations out on the direct care staff. . . . care plan will be updated to alert staff on how to deal with her behaviors . . ." * 08/09/12: Stated she was chasing staff with her motorized wheelchair. This precipitated the wheel chair assessment completed on 08/15/12. * 08/12/12: Stated she was getting mean with two residents including taunting them and making faces at them * 08/16/12: "Met and reviewed care plan this AM with behavior team. Changes were made and a new care plan was placed in the binder for staff. . . . Met with resident's husband . . . [Resident] more short tempered and will cry more often. . . . "	F 250		

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F 250	Continued From page 7 * 08/27/12: "Resident was sitting at her table in the dining room during lunch. She had her right elbow resting on her armrest of the wheelchair. She was waving her fingers repeatedly. . . . It was causing disruptions with other residents but resident insisted she needed to do exercise." * 08/30/12: "Held Behavior team meeting . . . Resident has had increased behaviors . . . continual behaviors . . . Resident does deny some of the behaviors and will often look to blame others for the behavior. . . . family was very supportive of staff stating that it needs to stop . . . resident stated that she will work to decrease behaviors . . . continue to follow care plan. . . . We will monitor behaviors for a short time . . ." * 09/25/12: Resident #7 rude and "telling [CNA] she doesn't know anything. . . . started to curse at CNA about how she was walking and shaking her butt. . . ." * 09/28/12: ". . . met with Resident to discuss behavior in the dining room. [Administrative staff member] informed Resident that it has been reported to us that she continues making comments, faces and gestures in the dining room which are upsetting to other residents. It has escalated to the point of residents sitting near her table requesting to be moved. . . . [resident] needs to improve on behavior in the dining room. Resident initially denied behaviors and became emotional. . . . was told she would be moved to a different table located in the activity room area . . ." * 10/01/12: ". . . met with Resident to discuss behavior in the dining room . . . reported to us that she continues making comments, faces and gestures . . . which is upsetting to other residents. It has escalated to the point of residents sitting near her table requesting to be moved. . . ."	F 250		

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F 250	Continued From page 8 * 10/18/12: Stated Resident #7's behaviors included making fun of other residents and that when confronted she cries and denies the behavior Resident #7's current care plan, dated 07/12/12, addressing her behaviors, identified the problem of her history "of being verbally rude to staff. . . . impatient [sic] . . . She is also rude to certain residents . . . and makes comments regarding their looks, and has also been noted for wheeling by a female resident's room intimidating her. . . ." Approaches addressing her behaviors toward other residents included: * "Ask her to leave an area if she is being rude to other residents." (dated 06/10/11) * "Attempt to redirect her if being rude or making negative comments to other staff or residents." (dated 06/10/11) * "Staff are to re-direct [Resident #7] immediately when she makes any rude or unwanted comments to other resident's in the facility." (dated 05/31/12) The care plan lacked specific individualized interventions for Resident #7's behaviors. During interview on 10/25/12 at 9:10 a.m., Resident #17, identified as residing within the facility since January of 2012, and as cognitively intact on a recent MDS, expressed frustration with Resident #7's behavior. Resident #17 stated Resident #7 calls residents' names, will put her finger up her nose, gets into other residents rooms, will sit outside of her door to get her medications so she can listen to her conversations, calls residents a "cheat," and has "mean quirks." She stated Resident #7 will also sneak up behind her when she is eating. The	F 250		

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F 250	Continued From page 9 resident stated Resident #7 targets eight residents, rides her cart [motorized wheelchair] up and down the halls, and is vindictive. During interview on 10/25/12 at 9:20 a.m., Resident #18 stated Resident #7 blocked her from leaving the activity/dining room last evening. Resident #18 stated Resident #7 bothers residents in the activity room, can go "round and round" in her wheelchair, and when Resident #18 walks in the hallway (with her walker), Resident #18 voiced concern with Resident #7 approaching her with her motorized wheelchair while she ambulates down the hall. Record review and resident interviews identified Resident #7 continued to display similar and/or the same behaviors as identified nearly a year ago. The facility staff failed to identify potential causes, patterns, and/or trends of Resident #7's verbal and disruptive behaviors, and include specific interventions tailored to manage or reduce the incidents of verbal and disruptive behaviors towards residents and staff. During interview on 10/25/12, an administrative staff (#1) stated Resident #7's challenging behaviors has been a problem for residents as well as staff. The staff stated dealing with her behaviors has been difficult.	F 250		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F-323: Free of Accident Hazards/Supervisions/Devices** It is the intent of this facility to remain in compliance with F-323 and continue to ensure that the resident's environment remains as free of	12/5/12 per Mindy Marcus 12/4/12 at 3:50 pm (pco)

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturers recommendations, review of facility job descriptions, and staff interview, the facility failed to provide the necessary assistance to prevent a fall with injury for 1 of 1 closed record (Resident #15) who experienced a fall in the facility van. Failure of the facility to ensure staff transporting Resident #15 had the necessary training resulted in Resident #15 experiencing an unwitnessed fall resulting in a C6-C7 [neck] fracture. In addition the facility failed to ensure a medical assessment was completed by a qualified staff member prior to Resident #15 being moved/transferred to a stationary seat in the van resulting in possible further injury to Resident #15. Findings include: Review of the manufacturers recommendations titled "SURE-LOK Safe and Secure . . . Operation of Lap Belts" occurred on 10/24/12. These recommendations, dated 2005, stated, ". . . Sure-Lok Occupant Restraint Lap Belts are designed to bear upon the bony structure of the body and shall be worn low and snug across the front of the pelvis . . . The shoulder belt shall be properly extended over the shoulder and across the upper chest . . . when connecting it to the lap belt . . . Adjust occupant restraints as firmly as possible . . ."	F 323	accident hazards as possible as evidenced by the following: Immediately following the van incident involving Resident #15 the following action was taken: 1. Revision of the Van Driver Job Description a. The new job description was reviewed and signed by all associates assigned driving duties 2. The approved list of associates assigned driving duties was updated and continues to be updated with newly hired associates with driving/transportation duties. a. This approved list of drivers is posted at the nurses station b. Van keys are secured in a locked drawer at the nurses' station. Only an approved driver can access the van keys and transport a resident 3. Associates listed were trained on van safety which included watching the training video and successful completion of a	

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F 323	Continued From page 11 Review of the facility job description titled "Certified Nurse Aide" occurred on 10/24/12. This job description, updated by the facility on 08/19/10, stated, "Supervisor: Assistant Director of Nursing [ADON] . . . Essential Functions: . . . 2. Have knowledge, understanding, and use good judgement in the care and use of equipment . . . 6. Detect and correct situations that have a high probability of causing accidents or injuries to residents . . . 28. Assist with other related duties as requested by the . . . ADON . . ." Review of the facility job description titled "Assistant Director of Nursing" occurred on 10/24/12. This job description, updated by the facility on 08/17/09, stated, "Essential Functions: . . . 10. Supervise, train . . . CNAs . . . 15. Investigates accidents/incidents involving residents and provides immediate interventions . . ." Resident #15's medical record, reviewed October 23-24, 2012, identified diagnoses including depression, left above-knee amputation and chronic right leg weakness. The Minimum Data Set (MDS), dated 06/23/12, idenfied moderate cognitive impairment and extensive assist of one for transfers and locomotion on/off the unit. Resident #15's care plan, dated 06/26/12, stated, "Problem: ADL's: Resident unable to complete own cares due to altered mobility and unsteady gait related to left leg amputation . . . Approach: . . . Locomotion: Wheelchair used for locomotion . . . Assist of 1 to propel longer distances. . . ." The progress note, dated 07/24/12, stated, "Resident had fall in facility van during transfer	F 323	return demonstration on how to secure residents in the van. a. This competency is to be completed upon hire for a position requiring driving a Sanford owned vehicle & prior to providing transportation of a resident. 4. A check of an associates driving history is done prior to initial driving assignment, quarterly and PRN a. DMV summary requested if driving related citations noted Documentation of these actions were reviewed by the survey team at the time of the complaint and annual survey. All steps remain in place. There has been no further vehicle related falls since this incident occurred on 7-24-12. A P & P titled Moving Vehicle Accident Management was developed to address the concerns noted that this facility failed to ensure a medical assessment was completed prior to the resident being moved. Education on this P & P will be completed on or before 11-30-12 with clinical managers and associates assigned the duties of	

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F 323	Continued From page 12 from appointment to facility. Resident hit head on floor of facility van. Laceration and hematoma noted to back of head with bloody drainage present. Resident pale and unable to answer questions appropriately. [Physician] notified . . . Order received to transfer resident to ER [emergency room] via ambulance. Resident left via ambulance at 1650. . . ." The "Safety Events - Fall" report, dated 07/24/12, stated, ". . . Location of Fall Other - Facility Van . . . What was resident doing just prior to fall? sitting in facility van chair . . . Does resident . . . complain of pain related to the fall? Yes - head . . . On a scale of 0-10, how does the resident rate intensity of pain . . . 10 Excruciating Pain - Worst Possible . . . Location of Injury back of head Note any injury to the head . . . Bump, Laceration . . . Swelling . . . Level of Consciousness Lethargic/Drowsy - Does not perceive the environment fully; Responds to stimuli appropriately but slowly and with delay . . . Facial Muscle Movement . . . Upper Left Extremity Movement . . . Upper Right Extremity Movement . . . Lower Left Extremity Movement . . . Lower Right Extremity Movement Weak . . . Speech Unclear - Slurred, mumbled words . . . Does the resident exhibit or complain of any the following since the fall? Dizziness/Lightheadedness . . . Does the resident exhibit any of the following as a change in mental status of new onset? Confusion, Slurred Speech . . . Were restraints/adaptive equipment in use at the time of the fall? Yes, seat belt . . ." The "[Hospital] Clinical History and Physical" report, dated 07/24/12, stated, "HISTORY OF PRESENT ILLNESS: The patient is a 78-year-old	F 323	driving a Sanford-owned vehicle and/or providing transportation of a resident. CQI monitoring of the required training and driving record checks will be done monthly X3 months by the CQI Coordinator and/or her designee beginning 12-3-12. Any vehicle related falls will also be reviewed in depth according to the facility Accident/Incident Reporting Protocol. Results of the monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized by the CQI Coordinator at the Quarterly CQI meeting with the medical director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. P & P titled Moving Vehicle Accident Management 2. CQI monitoring worksheet titled Drivers and Resident Transporters	

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male who presents after had a fall in a wheelchair van. Apparenly he was on his way from [Radiology at hospital campus] where he was at an appointment. He was improperly loaded, therefore his wheelchair tipped over backwards and he struck his head. He is believed not to have any loss of consciousness. He complains of pain throughout his head, neck, back and shoulders . . . There was no true accident; his wheelchair was simply not appropriately secured and therefore tipped over backwards . . . HEENT: . . . He has several abrasions on his posterior occipital area . . . NECK: Supple, but diffusely tender going down throughout the cervical spine and into the shoulders . . . EMERGENCY ROOM (ER) COURSE: . . . He was tender in the cervical spine . . . A small subdural along the falx [a fold between the cerebral hemispheres] was noted, in addition there was a small amount of parenchymal blood in the right parietal region. CT [computed tomography] of the C-spine [cervical spine] showed a perched facet [a rounded smooth surface on a bone] at C6-C7 and a facet fracture on the right side of C6 . . . His pain was well controlled on fentanyl and Dilaudid [durogesic or pain medications]. An Aspen collar [a device used to restrict motion] was placed . . . ASSESSMENT: Fall from a wheelchair with small subdural hemorrhage and perched C6 facet and C7 facet fracture. . . ."

The "Discharge Summary," dated 08/24/12, stated, "Discharged to: Hospital . . . Cause of Death or Final Diagnosis: Multiple Medical Problems [and] fall . . ."

During an interview on 10/23/12 at 12:15 p.m., the certified nurse assistant (CNA)/Van Driver

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F 323	Continued From page 14 (#4) indicated he has transported residents in the facility van for approximately two years. He stated, "Residents should be secured in the van. There is a manual in the van showing how to strap people in. It's been there as long as I've been driving the van." Observation on 10/23/12 at 12:15 p.m. showed a bench placed in the raised position on the left side and near the back of the facility van. A copy of the "Sure Lok" instruction manual hung from the bench. Observation further showed two stationary chairs to the right of the bench. During two interviews on 10/24/12 at 10:15 a.m and 12:15 p.m., the administrative nursing staff member (#1) confirmed the certified nurse assistant failed to properly secure Resident #15 in the facility van prior to transport the morning of 07/24/12. She stated, "He [the CNA] tried to strap him [Resident #15] in, but couldn't get it [the strap] to stay. He propped him by the bench, secured him as best as possible. He put him by the side [of the van] and locked his [wheelchair] breaks. He [the CNA] was worried about side-to-side, not front-to-back [motion]. When he [the CNA] accelerated at the stop light, [Resident #15's] chair fell backwards." When asked if/how the driver returned the resident to the facility following the fall, she stated, "He had checked the resident and he seemed fine. He lifted the wheelchair and then pivoted him into a stationary chair. He did call the facility. They told him to bring him back [approximately 14 blocks to the facility]." She further stated upon returning to the facility, the ADON assessed the resident and felt he should be transported to the emergency room.	F 323		

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F 323	Continued From page 15 Also during the two interviews on 10/24/12 at 10:15 a.m and 12:15 p.m., when asked whose responsibility it was to assign staff to drive the facility van, the administrative nursing staff member (#1) explained the ADON "asked for volunteers" and then assigned the CNA to transport Resident #15 to his clinic appointment. She confirmed, "He [the CNA #5] had experience driving a van, but not necessarily this one [facility van]." The facility failed to locate documentation indicating the CNA had received training on the proper use of the van equipment prior to transporting Resident #15 to his appointment. The administrative nursing staff member (#1) confirmed the facility's expectation is that staff receive training on the use of the van equipment and that all residents be properly secured in the van prior to transport. The facility failed to ensure Resident #15 received the care and services necessary to attain the highest degree of safety possible while being transported via the facility van. They failed to ensure the CNA had been trained on the proper use of the lap/shoulder belts and was competent to drive the van prior to being assigned to transport residents. They also failed to properly secure the resident in the van prior to transport, and failed to ensure qualified staff assessed the resident prior to moving/repositioning him immediately after his unwitnessed fall.	F 323		