

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2018
NAME OF PROVIDER OR SUPPLIER HAYWOOD NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
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F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, resident and physician interviews, the facility failed to ensure 1 of 3 residents was properly positioned in a wheelchair to maintain a safe center of gravity while being transported in the facility's transport van (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility 03/22/18 with diagnoses which included end stage renal disease, mood disorder, diabetes mellitus, and polyneuropathy (damage to nerves in lower extremities causing weakness, numbness, and burning.)</p> <p>A care plan created 03/29/18 identified Resident #1 as noncompliant by placing multiple pillows in the wheelchair increasing fall risk. The resident had an actual fall with no injury. The care plan goal specified the resident would resume usual activities without further incident through the next review date. Interventions included education provided on not placing extra pillows in the wheelchair and wearing nonskid socks while out of bed, ensure no more than 2 pillows while in wheelchair, and physical therapy consult. A</p>	F 689	<p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it the required by the provisions of federal and state law."</p> <p>F689</p> <p>1.)The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: A.)Resident #1 was transported with pillows in her wheelchair. The process failure that led to this deficiency was that the transporter failed to remove pillows from resident #1's wheelchair causing her to slide off of the pillows when the van was stopping.</p> <p>2.)The procedure for implementing the acceptable plan of correction for the specific deficiency cited: A.)A list has been compiled of current residents who place pillows in their wheelchair. Therapy will evaluate each</p>	8/29/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2018

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 689	<p>Continued From page 1</p> <p>revision of this care plan dated 04/09/18 described an actual fall experienced during an unassisted transfer from Resident #1's wheelchair to the toilet. No injury was observed, and the resident had extra pillows in the wheelchair. The revision also included the resident had been educated on the risk of using multiple pillows for potential falls.</p> <p>A care area assessment (CAA) associated with an admission Minimum Data Set (MDS) dated 03/31/18 specified Resident #1 was admitted to the facility from another facility to receive long term care. The resident was described as alert and oriented and able to make her needs known. The resident had a diagnosis of end stage renal disease and required dialysis 3 times a week. Other diagnoses included mood disorder and chronic pain. The CAA identified Resident #1 at risk for falls related to immobility requiring extensive assist with bed mobility, transfers and toileting. The resident propels self in a wheelchair. Resident #1 has had 1 episode of a fall without injury since admission due to the resident had placed multiple pillows in her wheelchair causing a fall out of the wheelchair. The resident was educated about not placing multiple pillows in her wheelchair. Resident #1 had chronic pain especially in both knees and has osteoarthritis increasing her risk for falls. Physical therapy was treating the resident to improve strength.</p> <p>An additional care plan dated 04/09/18 identified the resident had demonstrated manipulative behaviors. The care plan goal specified Resident #1 would have fewer episodes of manipulative behaviors by the next review. Interventions included if the resident was reasonable, discuss</p>	F 689	<p>resident identified for proper positioning in wheelchair on or before 8/29/2018.</p> <p>B.)On 8/8/2018, all van drivers were educated by the Administrator on the expectation that no resident is to have pillows in their wheelchair during transport. Included in the education was that the administrator must be notified immediately of any van related incidents, if it is a vehicle accident, 911 was must called first then the administrator must be notified of the incident.</p> <p>C.)On or before 8/24/2018, facility staff were educated by the Administrator or designee on the expectation that no resident will be transported with pillows in their wheelchair. If the resident refuses to remove pillows, the staff must inform the charge nurse and the resident will not be allowed to be transported in the transport van.</p> <p>3.)The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:</p> <p>A.)Administrator or designee will randomly observe 3 residents going out for or returning from transport to ensure no pillows are in wheelchair per week for 4 weeks, then 3 residents per month for 3 months to ensure they were not transported with pillows in their wheelchair. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved.</p> <p>4.)The title of the person responsible for implementing the acceptable plan of</p>		

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F 689	<p>Continued From page 2</p> <p>the resident's behaviors and explain /reinforce why behavior was inappropriate and/or unacceptable.</p> <p>A review of a facility incident report dated 03/28/18 described a witnessed fall experienced by Resident #1 in her room. The fall occurred when the resident self-propelled her wheelchair up to her overbed table with the intent of eating breakfast. The incident described she scooted to the front edge of her wheelchair and slipped to the floor due to a regular bed pillow under her bottom. An additional incident report dated 04/09/18 described Resident #1 sitting on the floor in her bathroom with her back against the toilet. The resident stated she was getting on the toilet when she slid to floor. The resident had several items tucked in her wheelchair.</p> <p>A review of physical therapy notes revealed Resident #1 participated with physical therapy rehabilitation from 3/29/18 until 05/17/18. Therapy notes dated 04/17/18 discussed working on posture by pulling shoulders back and holding her head up with response to treatment noted as fair. Therapy notes regarding services provided 05/09/18 specified much education was provided to the resident about safety regarding her wheelchair safety and not pilling so many pillows/towels/blankets under and around her in her wheelchair which pushes her forward and increases her fall risk. The resident's response to treatment was noted as fair. Again, regarding services provided on 05/14/18 the Physical Therapist documented the resident requested a pillow be placed in her wheelchair on top of her cushion as well as two pillows behind her. The resident was educated as to why this was not safe to sit like this in her wheelchair due to it</p>	F 689	<p>correction; The Administrator is responsible for implementing the corrective actions.</p>		

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F 689	<p>Continued From page 3</p> <p>causing her to sit so far forward in her chair and away from the back of her wheelchair. The resident was shown that this takes away her back support in her wheelchair the higher she sits in her chair. The resident would not take this advice and put the pillows in anyway. Further documentation for therapy services provided 05/17/18 specified Resident #1 had poor safety awareness. She was noncompliant with safety recommendations concerning how many pillows she kept underneath her in her and wheelchair and behind her.</p> <p>A quarterly MDS dated 07/01/18 described Resident #1 with clear speech, understands others and understood by others and her cognition was intact. The MDS coded the resident required limited staff assistance with personal hygiene, toilet use, dressing, walking in room, transfers, and mobility. The resident required supervision with locomotion. The MDS further indicated the resident did receive dialysis.</p> <p>During an interview on 08/07/18 at 8:42 AM, Resident #1 explained an incident that happened "the Monday before last Monday" which was 07/23/18. She stated she was in the facility's transport van on her way back to the facility from dialysis. Another resident was secured in a wheelchair right in front of where her wheelchair was secured. The resident stated the van driver stopped suddenly and she did not know why. At that time, she explained she slid out of her wheelchair when the cushion under her slipped off the seat of her chair and the seat belt came up to her chest. She explained she landed on the floor of the van on her bottom and hurt her left leg. When asked again what part of her body hit the floor she stated her bottom and added her</p>	F 689			

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F 689	Continued From page 4 back had hurt since. An interview was conducted via phone with the Van Driver on 08/07/18 at 10:34 AM. The Van Driver described how he secured wheelchairs to the floor of the facility's transportation van. The Van Driver further described how the lap/shoulder seat belt was utilized to secure residents to their wheelchairs. The Van Driver stated about 2 weeks ago he transported Resident #1 and another resident to the dialysis center which was nearby. He added Resident #1 was carrying 2 pillows with her in her wheelchair on the way to the dialysis center. He added he had been instructed the resident could take 2 pillows with her to dialysis carrying them in her wheel chair. When he went to pick up the residents after dialysis, he observed Resident #1 in her wheelchair sitting on a pillow and had another pillow between her back and the back of the wheelchair. He stated as he was driving down a steep hill when leaving the dialysis center, he heard Resident #1 tell the resident secured in a wheelchair in front of her that she slid out of her chair. He immediately pulled off in road in a safe place. He found Resident #1 with the lap/shoulder belt up under her armpits. The resident's bottom had slid out of the wheelchair along with a pillow and another cushion that was placed under the wheelchair cushion. The resident's bottom was not touching the floor and the resident's wheelchair did not move. The wheelchair brakes were engaged, and the wheelchair remained secured to the van floor. The Van Driver explained he had to unfasten the seat belt and lower the resident to the floor to clean out her chair and put her back in the chair so the seat belt could be replaced. When he cleaned out Resident #1's chair after he had	F 689			

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F 689	<p>Continued From page 5</p> <p>lowered the resident to the floor, he found 2 cushions and a pillow in the seat of the wheelchair and 2 pillows positioned between the resident's back and the back of her wheelchair. The Van Driver added the resident must have had some of these items in a bag she took with her to dialysis and he was not aware of the multiple items in her wheelchair until he cleaned it out. The Van Driver stated the resident reported to him she was not hurt and she did not appear to be in pain. Since it was not an actual fall and the resident was not hurt, he did not report this incident to any nursing home staff including the Administrator.</p> <p>An interview was conducted on 08/07/18 at 11:35 AM with Certified Medication Aide (CMA) #1. The CMA stated she had worked with Resident #1 frequently since the resident's admission to the facility. CMA #1 stated on several occasions she had observed Resident #1 with a bunch of pillows in her wheelchair. The resident had been instructed by the Administrator and therapy staff not to have those pillows in her chair because it was not safe. CMA #1 explained the resident would get very upset when staff attempted to remove them. CMA #1 further stated Resident #1 had not reported to her about any incident that occurred in the transport van.</p> <p>An interview was conducted on 08/07/18 at 11:37 AM with Nurse #1. This nurse explained Resident #1's hall was where she was assigned each time she worked. Nurse #1 described an incident where she observed Resident #1 slide out of her wheelchair because she was sitting on a pillow positioned over the wheelchair seat cushion. Nurse #1 further explained the nursing staff tried to explain to Resident #1 that this was</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>not a safe practice, but the resident continued to place pillows in her wheelchair. Nurse #1 stated she had completed Resident #1's weekly skin assessment on this day. She found no bruises or open skin areas. Nurse #1 reported Resident #1 had complained of back pain since she entered the facility. Nurse #1 confirmed Resident #1 had not reported any incident of falling out of her wheelchair in the transport van.</p> <p>The nurse that was working on 07/23/18 was not available for interview.</p> <p>An interview was conducted with the Administrator on 08/07/18 at 11:54 AM. The Administrator explained Resident #1 reported she needed the pillows to keep comfortable while she was at dialysis and she used them in her wheelchair at the facility. The Administrator stated the resident would have pillows under her, beside her, and between her back and the wheelchair back. In order for the resident to remain comfortable at dialysis, the Administrator stated she asked the dialysis center staff if the facility could provide pillows to be kept at the dialysis center for Resident #1. The dialysis center denied this request. The Administrator stated Resident #1 took a large bag with her to dialysis. The resident filled the bag with multiple blankets and had no room for pillows. The Administrator added she bought the resident 1 large, soft, warm blanket to give her more room in her bag for pillows and not carry them in her wheelchair. The Administrator stated Resident #1 remained adamant about taking pillows to dialysis. Therefore, the Administrator negotiated with the resident to only take 2 pillows outside the bag when she went to dialysis. The Administrator further explained the facility had mechanical</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>problems with the transport van. As of this week, the facility's transport van was out of commission and the facility was utilizing a transport company to transport residents to dialysis and appointments.</p> <p>An observation on 08/08/18 at 5:43 AM revealed Resident #1 sitting in her wheelchair in the hallway outside of her room. She had a pillow between her back and the back of the wheelchair and a pillow on each side of her between her side and the wheelchair armrests. Also, a large bag was strapped like a backpack to the back of her wheelchair. At 5:49 AM Nursing Assistant (NA) #1 was observed taking the resident back into her room stating to the resident they had to do something about all the pillows in her wheelchair. The NA came out of Resident #1's room and reported to Nurse #2 she could not get the resident to allow the pillows be removed. Both the nurse and the NA attempted once more to get the pillows out of Resident #1's wheelchair. They decided to wait until the van driver came to get the resident to discuss the pillows.</p> <p>At 6:16 AM on 08/08/18, the Administrator was observed going into Resident #1's room.</p> <p>At 6:37 AM on 08/08/18 the resident was observed being pushed down the hall by the transport agency driver in her wheelchair without pillows. The Administrator was also with the resident. At this time the Administrator stated she talked the resident into placing the pillows in her bag. The Administrator confirmed Resident #1 had a pillow on top of the cushion in the seat of her wheelchair.</p> <p>An interview was conducted via phone on</p>	F 689			

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F 689	<p>Continued From page 8</p> <p>08/08/18 at 3:32 PM with the facility Medical Director (MD). The MD confirmed Resident #1 was going to do things her way concerning wheelchair safety in spite of the facility's encouraging the resident to be compliant with safety issues.</p> <p>During an interview on 08/08/18 at 5:11 PM, the Administrator stated she expected to be notified immediately of any incident or accident which occurred in the transport van or while getting residents in and out of the van. If a resident was injured she expected 911 to be called before she was notified. The Administrator added she expected no pillows would be allowed in resident wheelchairs during transport. If the resident insisted on pillows or extra cushions in wheelchairs she expected van drivers to politely let the resident know this was not allowed and to call her if the resident insisted.</p>	F 689			