STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §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 resident, staff and physician interviews and record reviews the facility transferred a resident from the bed to the wheelchair in a lift. During this transfer the resident received a laceration on her leg that required stitches for 1 of 3 sampled residents. (Resident #1) The findings included: Resident #1 was originally admitted to the facility on 4/10/18 with diagnoses including Sarcoidosis (an inflammatory disease that affects multiple organs in the body), Diabetes and Obesity. The quarterly Minimum Data Set (MDS) assessment dated 1/8/19 revealed Resident #1 was cognitively intact and required extensive assistance of two staff for transfers. Review of the Incident/Accident report, dated 1/25/19 and completed by LPN #1 at 2:00 pm revealed Resident #1 was transferred to a wheelchair by 2 (two) staff members using a mechanical lift when the resident's right leg bumped the foot pedal and sustained a laceration to right lower extremity (leg). Resident #1 was assessed by the facility physician then	F 689	Corrective action for the resident 1. On January 25th 2019, the interdisciplinary team investigated the potential contributing factors that may have caused resident #1 to obtain a laceration during a transfer from bed to wheelchair. 2.Resident #1 assessed by in house physician on 1/25/19 after incident 3.Resident #1 sent to Emergency room 1/25/19 and received sutures 4.Wheel chair and mechanical lift was checked by maintenance on 1-25-2019 with no defects noted. Corrective action taken for those residents having the potential to be affected 5.Residents that require a mechanical lift for transfers were visually audited by the Director of nursing on 1-25-2019 to ensure the care plan is being followed. No issues were noted during observations.	2/15/19

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

Electronically Signed | 03/08/2019

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F 689	Continued From page 1 transported by Emergency Medical Services (EMS) to the hospital. Review of the care plan dated 2/27/18 and the Bedside Kardex for Resident #1 revealed the resident required a mechanical lift with 2 staff to move between surfaces and used a wheelchair for mobility. Review of the hospital emergency room record dated 1/25/19 revealed Resident #1 presented to the hospital emergency room with a semicircular shaped laceration inside the right lower leg, 18 centimeters long, which was closed with 19 sutures. Photos of the laceration before sutures were placed were included. An interview with Resident #1 was conducted on 2/13/19 at 11:00 am and 2/14/19 at 8:40 am. She stated she was transferred from her bed to the wheelchair by two nurse aides (NA) and a mechanical lift on 1/25/19. One NA was in front operating the lift and NA #1 was on the resident's right side. Resident #1 stated she was assisted into the lift from the bed and as she was being lowered into the wheelchair, she was slightly swaying back and forth. She then felt pressure and yelled out. During the transfer, her right leg hit something which resulted in a cut to her right lower leg. Resident #1 stated she did not see what caused the cut to her leg. She stated the doctor was in the building and he came to look at her leg. She was transported to the hospital emergency room (ER) where her leg was sewed up. Resident #1 stated the pedals on the W/C were out to the side and the metal part of the foot rest hit her leg. She shared photos of the C-shaped laceration with sutures noted.	F 689	Measures put into place or systemic changes 6.Current nursing staff including licensed nurses and certified nursing assistants will be re-educated by the licensed nursing home administrator and Director of Nursing on the use of mechanical lifts and how to transfer residents that require the use of a mechanical lift. 7.The director of nursing will visually audit 5 residents a week for 4 weeks then monthly transfers of residents requiring the use of a mechanical lift to ensure the care plan is followed. Monitor 8.residents requiring a mechanical lift will be evaluated by Director of Nursing/Designee to observe and evaluate resident□s correct positioning in the lift and To ensure all areas around the resident are clear prior to lift transport. Residents identified as a mechanical lift transfer will be accompanied by 2 staff members to monitor positioning during lift. Evaluations by Director of nursing and or designee to observe residents and to maintain safety for transfers from lift to bed or chair, and then to return back to bed transfer. The director of nursing will visually audit 5 residents a week for a period of 4 weeks, then monthly transfers of residents requiring a mechanical lift to ensure the care plan is followed,after which periodic	

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F 689	Continued From page 2 An interview with NA #1 was conducted on 2/13/19 at 2:57 pm. NA #1 was one of 2 nurse aides who transferred Resident #1 at the time of the injury. NA #1 stated the facility requires 2 (two) people to transfer a resident using a mechanical lift. NA#1 stated that she and another NA got Resident #1 up using the mechanical lift. Resident #1 was positioned into the wheelchair and then repositioned while still in the sling. When Resident #1 was lowered back into the wheelchair is when the laceration of the right lower leg occurred. NA #1 stated she was not sure what cut Resident #1's leg. NA #1 stated that prior to the incident, she was verbally instructed to make sure the area was clear when Resident #1 was transferred. NA #1 stated that after the incident, she attended training which instructed her how to transfer Resident #1 using a mechanical lift. On 2/13/19 at 6:15pm, a call was made to the second nurse aide, who assisted NA #1 with the transfer of Resident #1 on 1/25/19. The second nurse aide failed to return the call. An interview with the Director of Nursing (DON) was conducted on 2/14/19 at 9:07 am. The DON stated she reviewed the incident report. The DON further stated that, during the facility's investigation, she checked the lift and maintenance checked the wheelchair. The DON nor maintenance saw any blood anywhere on the wheelchair to indicate what the resident's leg hit. The DON stated that after the incident, she initiated a Performance Improvement Plan which instructed the nurse aides not to obstruct a transfer when using a mechanical lift. The DON stated the resident's leg hit something that caused the injury during the transfer. The DON	F 689	evaluations will occur by Director of nursing/designee to ensure continued compliance.The results of these audits, will be monitored to ensure on going compliance, data collection to be analyzed and reviewed at monthly Quality Assessment and Assurance Committee (QAA)meeting x 3 months with subsequent POC as needed. 5. The Nursing Home Administrator and Don are responsible to maintain and follow this plan of correction.	

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F 689	Continued From page 3	F 689		

stated this was an isolated event and she had not identified anything that the staff could have done differently to have prevented the injury.

An interview with RN #1, who was working the unit at the time of the incident, was conducted on 2/14/19 at 9:30 am. RN #1 confirmed she completed the incident report but did not witness the incident.

An interview with the facility physician was conducted on 2/14/19 at 11:14 am. He confirmed he was familiar with Resident #1 and he assessed the laceration shortly after the incident occurred. The physician stated that Resident #1 denied she felt anything touch her leg when the injury occurred. Resident #1 has a diagnosis of Sarcoidosis which causes lots of swelling and takes medication that causes the skin to be very thin. He stated the contact with the resident's lower leg had to have been very quick with a sharp or blunt object. He stated that the incident was accidental and, with Resident #1's diagnosis, the injury was the result of pressure and her leg coming into contact with something that caused the laceration. The physician further stated that the patient is very vocal and observant and there was no indication or warning that this injury could occur.

An interview with the Administrator was conducted on 2/14/19 at 1:00 pm. The Administrator stated they had completed an investigation of the incident that occurred on 1/25/19 and determined that they were not able to identify how the resident was injured and that the incident was an accident.