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 01/18/2019

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=D	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 Emergency Medical Services (EMS) personnel interviews and record review, the facility failed to investigate the causative factors for a resident that shifted position in the wheelchair while the wheelchair was secured correctly to the transportation van. The facility stopped the van and repositioned the resident during transport for 1 of 3 residents (Resident #1) reviewed for accidents. Findings included: Resident #1 was admitted to the facility on 7/25/18 with diagnoses that included, in part, sarcoidosis, diabetes and ataxic gait. A review of the quarterly Minimum Data Set (MDS) assessment dated 1/8/19 revealed Resident #1 was cognitively intact. She needed extensive assistance of two persons for transfers and used a wheelchair. She did not have a pressure reducing device for her wheelchair. Review of care plans updated 12/27/18 revealed a care plan problem of "at risk for falls." Care plan interventions included, "Anticipate and meet the resident's needs, follow facility fall protocol	F 689	Corrective action for the resident 1. On 1-18-2019 the interdisciplinary team investigated the potential contributing factors that may have caused resident #1 to change her position in the wheelchair during transport via facility van to medical appointment. The intervention based upon the potential factors for resident #1 was to place dycem in the wheelchair under the mechanical lift pad to help ensure the pad stayed in place during transport and to have two certified nursing assistants to transport of which one will be seated in the back of the van with resident #1 Corrective action taken for those residents having the potential to be affected 2. Residents that require a mechanical lift pad or cushion during a van transport will be audited by the Director of Nursing and or designee to determine if the residents are seated correctly, if the residents can independently reposition themselves and if their position changed	1/31/19

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

Electronically Signed | 01/31/2019

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F 689	Continued From page 1 and physical therapy evaluate and treat as ordered or as needed." On 1/15/19 at 10:24 AM an interview was completed with Resident #1. She reported she went to a doctor's appointment on 1/8/19 in the facility van. She said while in her wheelchair she sat on a mechanical lift pad and wheelchair cushion. She said that on the way to the appointment the van stopped three times to reposition her in the wheelchair since she felt she was sliding down. Resident #1 stated the third time the van stopped she had slid on the wheelchair cushion and slid down in the wheelchair but had not completely slid out of the wheelchair. The resident said the Transportation Aide called EMS and they came and repositioned her in the wheelchair. Resident #1 said she was not injured when she slid in the wheelchair. A review of the EMS Incident Report dated 1/8/19 revealed, "Arrived to find patient leaning on her wheelchair and driver. Patient reported no pain. Patient had slid off her cushion in her wheelchair. Patient was assisted to the floor of the van and her lift pad was placed below her and she was lifted into her wheelchair. Patient was secured back in her wheelchair and assessed further. Patient vitals obtained. Patient did not feel the need to go with EMS to the hospital because she was not hurt ..." On 1/16/19 at 3:01 PM an interview was completed with the EMS Paramedic who assisted Resident #1 when she slid in her wheelchair. He stated when he arrived on the scene Resident #1 had slid down in her wheelchair and the Transportation Aide had placed herself in front of Resident #1. The EMS Paramedic reported	F 689	while in the wheelchair. If unable to reposition themselves interventions will be put into place for continuation of correct seating position. Measures put into place or systemic changes 3. Current nursing staff including licensed nurses and certified nursing assistants and transportation aides will be re-educated by the licensed nursing home administrator and Director of Nursing on the use of mechanical lift pads, the pad position under a resident and the use of wheelchair cushions and ensuring they are secure if used. Prior to transporting a resident that requires a mechanical lift pad or wheelchair cushion the resident will be evaluated by the director of nursing or designee to determine if the residents can maintain correct positioning,and if they are able to reposition themselves.Dycem will be placed under each resident requiring a lift pad and or cushion in their wheelchair. Residents identified as unable to maintain correct positioning will be accompanied by 2 staff members to monitor positioning during transport and will be available to reposition resident as necessary. If the transport is interrupted for any event pertaining to the residents seating position the driver will call the administrator of the building and 911 non emergent assistance if needed. Monitor 4. residents requiring transportation that	

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F 689	Continued From page 2 Resident #1's buttocks was still partially on the seat of the wheelchair and there was a black wheelchair cushion that had slid with the resident to the front of the wheelchair. The EMS Paramedic stated he and his partner lowered Resident #1 to the floor of the van and then lifted the resident back into the wheelchair. He further stated Resident #1 had not complained of any pain or injuries and upon assessment no injuries were found. On 1/15/19 at 11:49 AM an interview was completed with the Transportation Aide who drove Resident #1 to the doctor's appointment. She stated during the transport Resident #1 slid down in her wheelchair when she (Resident #1) attempted to adjust herself. The Transportation Aide said she stopped three times and checked on Resident #1's positioning in the wheelchair. On the third stop the Transportation Aide said she observed Resident #1 had slid in the wheelchair. She said the resident's buttocks was still on the wheelchair and because of her size and weight the Transportation Aide notified the Administrator of the situation and then called non-emergent EMS for assistance in having Resident #1 repositioned in her wheelchair. When EMS arrived they secured the mechanical lift pad under Resident #1, lifted her up and placed her back into the wheelchair. The Transportation Aide stated Resident #1 had no injury. Since the van was around the corner from the location of the doctor's appointment she proceeded to the doctor's office and took Resident #1 to the scheduled appointment. The Transportation Aide stated she did not know why Resident #1 slid down in the wheelchair. On 1/15/19 at 2:47 PM an interview was	F 689	require a lift pad or any other assistive device while in or on the wheelchair will be evaluated by Director of Nursing/Designee to observe and evaluate resident□s correct positioning in the wheel chair, for both physical and cognitive ability to move and or reposition themselves.To ensure correct positioning of residents in wheelchair prior to transport.Dycem will be placed under each resident requiring a lift pad and or cushion in their wheelchair. Residents identified will be accompanied by 2 staff members to monitor positioning during transport and will be available to reposition resident as necessary. Evaluations by Director of nursing and or designee to observe and determine residents ability to maintain correct seating position while in wheel chair will occur daily prior to any van transportation for a period of 4 weeks, then three times weekly times 4 weeks, then once a week x 4 weeks ,after which periodic 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		

completed with Nurse Aide (NA) #1. She was the NA who provided care to Resident #1 on the morning of the doctor's appointment. She said that typically Resident #1 sat on a mechanical lift pad and then on the wheelchair itself and normally there was not a wheelchair cushion on the wheelchair. NA #1 said she was unable to recall if she placed a wheelchair cushion on the wheelchair that day. She further stated that once Resident #1 was in her wheelchair she typically did not have any issues with positioning in the chair and had not observed any instances when the resident slid out of the wheelchair.

On 1/15/19 at 3:36 PM an interview was completed with the Administrator. She said she thought Resident #1 was uncomfortable when she sat in the wheelchair and that she moved around to make herself more comfortable. She further stated EMS was called because the resident's weight prevented the Transportation Aide from lifting her up and repositioning her in the wheelchair. The Administrator stated an investigation into why Resident #1 slid was not completed because she didn't consider it an issue since the resident only slid down in the chair and didn't come into contact with the floor of the van.

On 1/15/19 at 1:58 PM an interview with the Administrator revealed the Transportation Aide had called her after she stopped the van the third time and told the Administrator she needed to call 911 for assistance in having Resident #1 repositioned in the wheelchair. The Administrator stated she thought Resident #1 had tried to reposition herself while being transported in the van and had slid down in the wheelchair.

A review of Resident #1's medical record

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F 689	Continued From page 4 revealed no documentation or investigation was completed related to Resident #1 sliding in her wheelchair during facility transport on 1/8/19. On 1/15/19 at 12:36 PM an interview was completed with the Administrator. She stated an investigation of the incident during transport was not completed since Resident #1 only slid down in her wheelchair and there was no contact with the floor of the van. On 1/18/19 at 1:13 PM an interview with the Administrator revealed the facility should have investigated why Resident #1 slid in the wheelchair during transport and should have determined the root cause in order to prevent it from happening again.	F 689		