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	345359	A. BUILDING _____ B. WING _____	C 07/12/2018

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ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 7/10/18 through 7/12/18. Past Non-Compliance was identified at: CFR 483.25 at tag F-689 at a scope and severity (J) An extended survey was conducted.	F 000		
F 689 SS=J	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 record reviews, observations and resident and staff interviews, the facility failed to ensure the lift platform of the facility's transport van was in the elevated position before unloading a resident from the van for 1 of 3 residents reviewed for accidents (Resident #1). When unloading Resident #1, who was seated in a wheel chair, from the facility's transport van, the staff failed to raise the van's lift platform to floor level which resulted in Resident #1 falling from the transportation van. Resident #1 was transported to the hospital for evaluation and treatment and sustained a subarachnoid hemorrhage and posterior scalp abrasion. The findings include:	F 689	Past noncompliance: no plan of correction required.	7/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2018

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The manufacturer's instructions for unloading a passenger from the facility's transportation van was reviewed. The manufacturer's instructions read in part, "To unfold platform stand clear until the platform stops (reaches floor level-unfolds fully) release switch. To unload passenger, Note: Outer barrier must be fully unfolded (ramp position) until the entire wheelchair (or standee) has crossed the outer barrier. Load passenger onto platform and lock wheelchair brakes. Note: Outer barrier must be up. Press down switch until the entire platform reaches ground level and the outer barrier unfolds fully (ramp position). Release switch. Unlock wheelchair brakes and unload passenger from platform."

Resident #1 was originally admitted to the facility on 1/3/18, with diagnoses including Diabetes Mellitus, End stage renal disease on hemodialysis. According to the most recent Admission Minimum Data Set (MDS) dated 5/25/18, Resident #1's cognition was intact. The resident needed extensive assistance with transfers and required physical assistance of one person. Resident #1 was totally dependent with locomotion (use of wheelchair) both inside and outside the facility.

Resident #1's care plan dated 5/29/18 identified her as being at risk for falls related to gait/balance problem and incontinence. The goal was for Resident #1 to be free from falls and not sustain serious injury through the next review date. The interventions included assist with all transfers and locomotion. Follow facility protocol for fall. Patient evaluation and treatment as ordered or as needed. On 6/6/18, other goals were for Resident #1 to be free of minor injury through the next

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review date.

Review of a Nurse's note dated 6/25/18 at 5:48 PM, read in part, "Resident had a witnessed fall this shift. This writer observed a hematoma to the middle back area of her head. She also had some bruising to the top of her back from shoulder to shoulder. Resident denies any pain. Resident has some confusion but not loss of consciousness. Resident's family members made aware. Doctor notified. Emergency medical services was contacted and the resident is off of the facility grounds at this time. They have resident as DNR (do not resuscitate) and all significant paperwork for transport to the hospital."

Review of a note written by the Administrator on 6/25/18 at 8:10 PM revealed she contacted Resident #1's family member regarding the resident's fall and informed the family member that an investigation was in progress and the family member would be informed of the investigation outcome.

Review of a nurse's note dated 6/25/18 at 9:00 PM revealed a report was received from the hospital emergency room staff stating Resident #1 was being sent to the medical center due to a head injury.

Review of another Administrator's note dated 6/25/18 at 9:39 PM revealed she spoke with Resident #1's family member to provide an update on how Resident #1 was doing and provided an update on the investigation surrounding the fall. The Administrator explained there was no mechanical or operational failure with the wheelchair or van lift gate and the fall

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was the result of human error.

Review of Resident #1's hospital discharge summary dated 6/26/18, which was written by a trauma nurse practitioner in the hospital, revealed in part, "Active hospital problems: Diagnosis: Accidental fall from wheelchair - Resident is a female patient trauma green presenting from hospital by ground. Patient was coming back from dialysis being transported in a wheelchair out of the side and landed on her back on the loading ramp. She did strike her occipital skull but does not remember if she had level of consciousness. She was otherwise neurologically intact and did not complain of nausea, emesis, or headache. She was taken to hospital where a Computed Tomography Scan (CT scan) of her head identified subarachnoid hemorrhage and she was noted to have a small abrasion to her posterior cranium."

During an interview on 7/10/18 at 12:50 PM Resident #1 said she did not remember what happened. She stated when she came to she was on the ground and she saw people around her. She revealed there was a problem with the back of her head and she said she felt it the other day and it was bleeding a little bit. Resident #1 revealed other than that she was fine.

During an interview on 7/10/18 at 2:52 PM, Nursing Assistant (NA)#1 stated the Assistant Director of Nursing (ADON) wanted her to pick up residents with the facility van from the dialysis center on 6/25/18. She revealed she transported two residents from the dialysis center, Resident #1 and a male resident, to the facility. NA#1 reported that the male resident was in the back of the van with a soda and turned his soda over on

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the floor of the van. She said Resident #1's wheelchair got stuck on the wheelchair anchor on the floor of the van. NA#1 stated she was standing in front of Resident #1's wheelchair trying to get it unstuck. She stated she had to push Resident #1's wheelchair back and she slipped. NA #1 explained as she slipped she had the lift control in her hand and she must have fallen forward and when she did she accidentally pushed the lift control button. NA #1 stated she fell into the wheelchair and she held the wheelchair with her right hand as much as she could to prevent it from falling. She said the wheelchair was turned sideways up in the air. NA#1 stated she did not know how far the lift had gone down. She said there was no one there to help her and she did the best that she could. NA #1 stated the lift did not go all the way down and it did not hit the pavement. She said she held onto the wheelchair as much as she could and got the wheelchair upright before she got out of the van. NA#1 said she had to go outside the van to get the lift down on the ground safely. She stated she made sure Resident #1 was secure and would not fall anymore before she went inside the facility to get help. NA#1 emphasized no part of Resident #1's body touched the ground. NA #1 had been trained to transport residents in the facility van but had not transported residents for seven or eight months. NA#1 reported she was trained to transport residents in wheelchairs.

During an interview on 7/10/18 at 4:20 PM, Staff Nurse #1, who assessed Resident #1, after her fall on 6/25/18 revealed she was called outside from the building. She stated Resident #1 was lying on her back and her wheelchair was still under her. She revealed she took the resident's her vital signs and called 911 to get emergency

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medical services. Staff Nurse #1 said she made sure Resident #1's head was stable. She revealed Resident #1 was conscious the entire time. She stated the lift on the van was down and the wheelchair had come out from under resident half way. Staff Nurse #1 stated Resident #1 was lying on her back and her knees were bent. She said Resident #1 was lying in her wheelchair on the lift facing the back of the van. She said the ramp was between the resident and the pavement. Staff Nurse #1 explained Resident #1's head was on the lift ramp and her feet were dangling under the seat of the wheelchair. Staff Nurse #1 stated Resident #1 denied pain the entire time. She reported that Resident #1 had some bleeding from the back of her head. She stated she waited until emergency medical services (ems) arrived and she did not move Resident #1. Staff Nurse #1 revealed Resident #1 was conscious and was able to tell staff her name and where she was.

During an interview on 7/10/18 at 4:41 PM, the Administrator stated on 6/25/18 NA #1 came in the building hollering brake failure, brake failure! She stated she ran outside and observed Resident #1 was lying on top of the lift gate from waist up and from waist down she was leaning up against the bumper of the van. The Administrator said she got onto the van to see if she could figure out what happened. She stated the Assistant Director of Nursing and Activity Assistant also came out to assist. She stated the brake on the van was operating properly. The Administrator revealed she looked at the floor of the van to see if there was anything out of the ordinary and after checking out the van she went back inside the building to talk to NA#1. She stated NA#1 said the brakes on the wheelchair

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failed. The Administrator stated about that time, the maintenance man showed up and they checked out the wheelchair and the van. The Administrator revealed both the lift and the wheelchair brakes were operating properly. She stated she told NA#1 the brakes on the wheelchair were working fine. She stated NA#1 said it happened so fast that she did not know what happened. She stated she told NA#1 to tell her step by step what happened. The Administrator stated NA#1 said she took the male resident inside the building and she went back outside to get Resident #1. NA#1 said she got back on the van by going around the van to the passenger side and got back in the van. NA#1 stated after she got back on the van, she unstrapped the belts from the security device on the floor of the van as well as undoing the shoulder harness and seat belt on Resident #1. She said NA#1 stated Resident #1's wheelchair started rolling backwards and she tried to hold onto the wheelchair as best she could, but she could not stop Resident #1 from falling out of the back of the van. The Administrator said asked NA#1 to write a statement the next day, which was different from what NA#1 reported the previous day. The Administrator stated as part of her investigation, she re-enacted the scene. She explained, in order for the lift to lower you had to have your finger on the control button continuously. She stated NA#1 said when she could not stop the wheelchair from rolling backwards, she held onto the wheelchair as hard as she could and she lowered the wheelchair as soft as she could so Resident #1 would not land so hard.

The Administrator further revealed the resident was sent went to the hospital and she suspended

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NA#1. She stated after she got all the statements after the investigation and reviewed them, she stated everything pointed to the lift was never put back in position to lower Resident #1 to the ground in her wheelchair. She stated when NA#1 brought the male resident in the building, she never put the lift gate back up. She stated the lift gate was working fine and nothing was wrong with the equipment. The Administrator stated the lift gate was down on the ground instead of in the up position, therefore the Resident #1's wheelchair rolled back off the van and NA#1 tried to catch it to prevent it from falling. The Administrator said she wrote a plan of correction. She stated maintenance does the training and oversees it. She stated the plan of correction was discussed in the small QAPI meeting and they will review the plan again with the big QAPI meeting to see what changes were needed and whether the plan was effective or not. She stated there was nothing created regarding monitoring. She stated the most effective thing was to have a second person to assist when residents returned from dialysis appointments.

The Administrator explained after the maintenance man checked the equipment and got with staff, she stated van drivers always rode the lift gate back up after taking one wheelchair off the van. She stated if a person went around the passenger side, then it was too late. The Administrator stated she revised the check list form to make sure everything was operating properly. The Administrator revealed the van drivers got a second training to make sure safety precautions were followed and for new drivers to have more in-depth training. The Administrator reported that NA#1 had been driving handicapped vans for over ten years. She stated the incident

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was human error and to minimize opportunities for the situation happening again she said two sets of eyes would be required before any other resident's wheelchairs were detached or unsecured. The Administrator stated after she finished getting all the statements during the investigation she determined that the incident was operator error. She stated the staff person neglected to put the lift gate back up and that is what resulted in the fall. She stated NA #1 was terminated. The Administrator stated she went back through risk records and it was the first incident they have had on a van. She stated the incident was a result of staff error.

During an interview on 7/10/18 at 5:37 PM, the Maintenance Director revealed he was not there when the incident happened, he was off. He stated he was called to come in after hours. He said he assessed the lift and wheelchair, they were inspected properly and the brakes on the wheelchair worked fine. The Maintenance Director said he wrote a statement and gave it to the Administrator. He said he did training for van drivers. He explained after the incident he did observations and there had been extra precautions since the incident. The Maintenance Director said the lift was working totally fine on 6/25/18. He said it was operator error from what he saw. He said he got in the van and there were no spills. He said new drivers do an inspection report and turn it in before they leave. He stated he observed van drivers several times to make sure they were safe. He stated he completed observation sheets when he conducted his observations. The Maintenance Director could not provide documentation of the last time NA#1 was last observed or evaluated for transport van and transporting a resident in a wheelchair for the

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facility.

During an observation on 7/11/18 at 10:25 AM Resident #1 was being assisted on van to go to a dialysis appointment. Resident #1 was placed on the wheelchair. One NA used remote control outside the van to lift Resident #1's wheelchair on to the van and the other NA was inside the van in front of the wheelchair, secured the wheelchair front and back to the floor anchors and placed a shoulder harness and seat belt securely on the resident.

1. During an observation on 7/11/18 at 12:20 PM Resident #1 returned from her dialysis appointment on the van. The van driver unhooked the belts from the floor that were attached to Resident #1's wheelchair and shoulder harness and seat belt on Resident #1. After releasing the seat belt and harness, another NA went to the back of Resident #1's wheelchair and pulled the wheelchair onto the lift gate which was already in the up position. Resident #1 remained on lift and held onto the bars on lift gate as the NA pushed the control button to lower the lift gate to the ground. Once the wheelchair and the lift was on the ground, the NA rolled the wheelchair from the lift, which was on the ground and took resident back in the building.

During an interview on 7/12/18 at 1:52 PM, Resident #1's doctor said he was aware of Resident #1's fall from the facility's transport van on 6/25/18. He said it was an accident. He said he saw her yesterday (7/11/18) and she was fine. The doctor said as a result of the fall Resident #1 had a subarachnoid hemorrhage which was bleeding in the lining of the brain, not the brain itself. He stated he had not noticed any significant

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changes. The doctor revealed Resident #1 already had a blood disorder and she was on blood thinners, which she had a risk for bleeding, not necessarily because of the injury, but because of the blood disorder.
On 7/12/18 the facility provided an acceptable plan of correction with a correction date of 6/27/18. The plan of correction included:

The plan for correcting the specific deficiency:

"The deficient practice of failing to prevent an accident occurred when a C.N.A. (trained and experienced in the transporting of residents) failed to follow the proper policy and procedure for safely transporting residents, including the proper management of the transport vehicle lift-gate." On June 25th while un-boarding a resident returning back from dialysis, the C.N.A./transport aide failed to put the transport bus lift gate in the up position prior to disengaging the wheelchair from the transport vehicle security straps. She was unable to control the wheelchair from rolling and with the gate in the down position, there was no barrier to stop the fall. This failure to follow both facility safety transport policy and the manufacturers' safety recommendations, resulted in the residents fall from the back of the transport vehicle.
"An analysis of the incident was initiated immediately and included a thorough inspection of the scene, re-enactment of the C.N.A.s account of what transpired (she attributed the fall to "brake failure" on the resident's wheelchair) and gathering statements from all staff members who responded to the incident). When investigating as to why the lift-gate was in the down position, we discovered that after the C.N.A. had already un-boarded one resident and

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returned him safely into the facility, she re-boarded the transport vehicle through the passenger entrance, versus riding the lift-gate back up to its' secured position."

The resident's wheelchair and the transport vehicle were locked-out/tagged out until checked by the Maintenance Director who arrived at the facility approximately 6:30 p.m. Equipment failure was ruled out as a contributing factor to the fall.
"The C.N.A. was immediately removed from all duties and responsibility and was sent home as soon as we were able to have a family member come pick her up at the facility (due to her emotional state it would not have been safe for either herself or other drivers to allow her to drive)
At the conclusion of the completed investigation she was subsequently terminated on June 27th for findings of failure to follow protocol, safety procedures and failure to prevent an accident."
On June 26th we implemented having a second person to assist in the process of un-boarding residents returning from appointments or activity functions.
"On June 27th in a meeting between the Administrator and Maintenance Director, the process for the training of any new personnel responsible for resident transport was restructured to include a more detailed and extensive real-life training experience and observation of safe driving skills. Employees must be signed-off by the Maintenance Director prior to being assigned the responsibility of driving or riding as a transport assistant.
1. Implementing the plan of correction was completed through the following corrective actions:
"On the evening of June 25th the Administrator developed a revised resident transport skills

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safety assessment and presented it to members of the QA Committee the morning of June 26th. It was adopted as our new process and the new resident transport safety assessments were initiated that afternoon."
The Maintenance Director utilized the transport safety checklist for all authorized drivers and transportation assistants to be reassessed for skill competency in transportation. On June 26th transport and activities staff were re-educated regarding the importance of returning the lift-gate back to its upright position after un-boarding a resident. Education consisted of verbal instruction, securing the wheelchair and participation in real-life on the road, safe transport skills driving training. In addition to boarding and un-boarding procedures, all participants were required to be observed driving and securing/unsecuring wheelchairs, all safety components i.e location and use of the fire extinguisher, first aid kit, safety cones, etc.

2. Monitoring the plan of correction for compliance with safety standards and the policy and procedures for preventing accidents include the following:
"Random un-boarding observation audits were initiated by the Maintenance Director and conducted by the Maintenance Director or his Assistant beginning on June 26th to ensure two (2) staff members were engaged in the un-boarding process. These observation audits were implemented by the Maintenance Director to verify the staff were following process expectations and training protocols. An observation tool was created to formally document the safety observation audits."
Audit tools will be reviewed bi-weekly by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	**604 STOKES STREET EAST AHOSKIE, NC 27910**

(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	Continued From page 13	F 689		

Administrator and during QAPI meetings for three months or until sustained compliance is achieved
3. The Administrator and Maintenance Director were accountable for initiating all corrective actions immediately following the incident on June 25th and completing the process on June 27th.

The facility alleges full compliance with this plan of correction effective 6/27/18.

As part of the validation process on 7/12/18, the plan of correction was received including the re-education of van drivers and observations and interventions put into place to ensure two staff members were engaged in the process of unboarding of residents. Interviews with transport drivers revealed they were retrained to ensure two staff assisted in the process of unboarding residents. Residents who were transported in the van were interviewed to make sure they felt safe.

A review of the monitoring tool revealed that the facility completed the audits and re-training of van drivers. The plan was verified for compliance effective 6/27/18.