STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews and physician interview, a staff member failed to attach footrests onto a wheelchair prior to transporting a resident in her wheelchair and staff instructed the resident to hold her feet up while she was being rolled in her wheelchair for one of one resident (Resident #1) reviewed for accidents. Findings included: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] noted Resident #1 was cognitively intact and needed total assistance for transfers and locomotion on and off unit. The MDS noted impairment of the left upper and lower extremities. Special treatments included occupational therapy three to five times a week through therapeutic activity, Activates of Daily Living (ADLs) self-care management and orthotic management. The care plan dated 7/11/2019 noted Resident #1 had an ADL self-care deficit related to limited mobility and weakness. The goal was Resident #1 would receive appropriate staff support for personal hygiene and transfer. Interventions included: Resident #1 was dependent on two staff regarding transfer and locomotion on and off the unit. A nursing note dated 7/14/2020 at 2:36 PM, written by Nurse #1, specified Resident #1 complained of left knee pain and she stated it had been throbbing since going to rehab yesterday when her leg went back behind the wheelchair. The Nurse Practitioner was contacted on 7/14/2020 at 2:36 PM and orders were given for x-ray of left knee. A radiology report dated 7/14/2020 at 8:41 PM revealed Resident #1 ' s knee joint was in alignment and no acute fractures or dislocation were noted. Physician orders [REDACTED].#1 specified for staff to apply icepacks for 10 minutes as needed to left knee for 48 hours for swelling and pain. Resident #1 was on scheduled [MEDICATION NAME] 50mg twice daily for chronic pain and received all scheduled doses as ordered during the look back period. An interview with Resident #1 on 7/28/2020 at 10:45 AM, revealed on 7/13/2020 an Occupational Therapy Assistant (OTA) entered her room to take her to therapy. Resident #1 stated she was sitting in a wheelchair without footrests and the OTA asked her to hold her right leg up with the left leg resting on it and she then began pushing her wheelchair. Resident #1 stated she asked the OTA to attach the wheelchair ' s footrests, but the OTA stated she would return to get the footrests for the resident ' s return trip after her therapy session. The resident explained during the transport to the therapy gym, her left leg fell off her right leg and went under one of the wheelchair ' s wheels. Resident #1 stated she yelled ouch and asked the OTA to please stop the wheelchair. Resident #1 stated the OTA stopped the wheelchair, propped her left leg onto her right leg and proceeded to roll her in her wheelchair the rest of the way to the gym. Resident #1 stated she completed the therapy session, the OTA retrieved the wheelchair footrests, attached them and rolled her in her wheelchair back to her room. She stated she did not experience any pain during her therapy session on 7/13/20, but noticed the pain the following day. She explained she experienced swelling and pain to her left knee for about a week after the incident and received ice packs and medication for the pain. An interview with the OTA on 7/29/2020 at on the day of 7/13/2020 around 1:20 PM, she entered Resident #1 ' s room to take her to the gym for her occupational therapy treatment. Resident #1 was sitting in her wheelchair when she arrived. She stated she put Resident #1 ' s left foot onto her right foot as support and she began pushing the resident ' s wheelchair. She stated Resident #1 asked her to attach the wheelchair ' s footrests, but she didn ' t attach the footrests. The OTA stated she wasn ' t sure why she chose not to attach the footrests other than she thought Resident #1 could make it all the way to gym holding her feet up. She stated as they approached the lobby of the facility, Resident #1 ' s left foot fell from her right foot and her left foot went under the wheel of the wheelchair. She stated Resident #1 yelled, ouch, and she stopped the wheelchair and looked at her foot and didn ' t see any apparent injury. She stated she placed the resident ' s left foot onto her right foot and proceeded to roll the resident in her wheelchair to the gym for therapy. She stated she went to Resident #1 ' s room to retrieve the wheelchair footrests and attached them to her wheelchair for the return trip to her room. Interview with an Occupational Therapist on 7/28/2020 at 1:15 PM revealed he began working with Resident #1 on 7/14/2020, one day after the wheelchair incident occurred. He stated he only worked with her upper body and she experienced no pain during his session with her over the next few days after the incident. Interview with a Nurse #1 on 7/29/2020 at 7:35 PM revealed she worked with Resident #1 on 7/13/2020, during the 3:00 PM to 11:00 PM shift, and was not informed by Resident #1 of pain or swelling after she returned from her therapy session. The nurse stated she did not remember if the OTA informed her of the incident of Resident #1 ' s left leg going under the wheelchair when they returned from therapy on 7/13/2020. She stated her interactions with Resident # 1 on 07/13/2020, were pleasant for the remainder of her shift. Interview with a Nurse #2 on 7/30/2020 at 8:47 AM revealed Resident #1 complained of pain and swelling to her knee during the 7:00 AM to 3:00 PM shift on 7/14/2020. Nurse #2 stated she assessed Resident #1 and observed swelling and slight bruising to her left knee. Nurse # 2 contacted the Nurse Practitioner and obtained an order for [REDACTED]. An x-ray was completed on 7/21/2020 and revealed there were no fractures or dislocation to Resident #1 's left ankle or foot. Interview with the Director of Nursing on 7/31/2020 at 10:49 AM revealed the facility procedure for safe resident transport was to attach footrests to wheelchairs prior to transport. Interview with the Administrator on 7/31/2020 at 11:25 AM revealed the proper facility practice to transport a resident safely by wheelchair was to attach the footrests to the resident 's wheelchair each time prior to transporting the resident.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, staff interviews and review of the facility's infection control and COVID-19 policies, the facility failed to implement their COVID-19 screening policy by not screening 1 of 1 visitors upon entrance to the facility. The facility also failed to implement their COVID-19 policy for face masks to be worn at all times when a personal care aide did not wear a facemask while passing ice and entered the rooms of 2 of 2 residents (Residents #2 and #3). These failures occurred during the COVID-19 pandemic. The findings included: 1. The facility's COVID-19 Policy/Plan for Facilities updated on 5/26/2020 stated all venders, providers, and visitors permitted into the building were to follow all screening processes: sign in and out on the log, check temperature, screen and use hand hygiene at entrance and exit. On 7/28/20 at 8:18 pm, Nurse #5 unlocked the front door of the facility and permitted a surveyor to enter the building. When the surveyor entered the facility, Nurse #5 did not perform any of the facility's COVID-19 screening processes on the surveyor. Nurse #5 was observed to walk by the receptionist desk in the front lobby, where the facility conducted its COVID-19 screening, and only asked if the surveyor needed to get into the conference room. When the surveyor informed Nurse #5, that she would be at the nurse's station, Nurse #5 proceeded out of the front lobby area and down the left hallway. On 7/28/20 at 8:20 pm, Nurse #5 was observed standing at the B-Hall medication cart. Nurse #5 informed the surveyor there was no supervisor in the building. When Nurse #5 was informed the surveyor planned to visit with residents, Nurse #5 did not offer to screen the surveyor. On 7/28/20 at 8:50 pm, an interview was conducted with Nurse #5. When Nurse #5 was asked, what was the facility's

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

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) screening process, Nurse #5 stated I know, I didn't screen you when you came in. I forgot. Do I need to screen you now? Without the surveyor answering the question, Nurse #5 directed the surveyor to the front lobby receptionist desk to conduct the COVID-19 screening: checked temperature, asked the screening questions and recorded information and time in the building on the visitor log. On 7/30/20 at 1:05 pm, during a phone interview, Nurse #5 stated someone was scheduled at the receptionist desk to screen employees and visitors until 8:00pm. Nurse #5 stated after 8:00pm the nursing staff were responsible for screening the visitors and were trained to conduct the screening process for visitors the same way the staff were screened. The Director of Nursing (DON) was interviewed on 7/28/20 at 10:37pm. The DON stated the screening log was completed on all persons entering the building which included a temperature check and the screening questions. During a follow up phone interview with the DON on 7/31/20 at 12:57pm, the DON stated all staff and visitors entered through the front door and were to be screened. The DON stated the screening process started in March 2020, and all staff had received training on the screening process. The DON stated after 8:00pm, the person unlocking the door was responsible to screen the visitor. During a phone interview on 7/21/20 at 1:43 pm, the Administrator stated all staff and visitors were to be screened entering the facility and after 8:00pm, the nursing staff were responsible for screening persons entering the building. 2. The facility's COVID-19 Policy/Plan for Facilities updated on 5/26/2020 stated all staff will be required to wear a surgical or isolation mask at all times in the facility. On 7/28/20 at 8:32 pm, Personal Care Aide (PCA) #2 was observed not wearing a face mask and entered Resident #2's room carrying a cup of ice. PCA #2's nose and mouth were not covered. Resident #2 was observed in bed and the PCA placed the cup of ice on the resident's bedside table. On 7 /28/20 at 8:35 pm, Personal Care Aide #2 was observed in Resident #3's room and she was not wearing a face mask. PCA #2's nose and mouth were uncovered. Resident #3 was observed in bed and the PCA placed the cup of ice on the resident's bedside table. On 7/28/20 at 8:38 pm, Personal Care Aide #2 was observed in the hallway with an ice container wearing no facial covering and an interview was conducted. Personal Care Aide #2 stated she received COVID training in orientation and was informed staff were to wear a facial mask at all times in the facility. Personal Care Aide #2 stated she had just finished eating and forgot to reapply her mask. Personal Care Aide #2 reached into her right shirt pocket of her uniform and applied a face mask covering the nose and mouth. The Director of Nursing (DON) was interviewed on 7/28/20 at 10:37 pm. The DON stated staff were to wear a facial mask at all times while in the building. During a phone interview with the Administrator on 7/31/20 at 1:43 pm, the administrator stated the personal protective equipment requirement of the facility was for all staff to wear a face mask properly at all times in the facility.