STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN NORTH CAROLINA BAPTIST HOME	213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews, the facility failed to institute fall interventions that were identified in the care plan, of mobility alarms on the bed/recliner/wheelchair and a non-slip material in the wheelchair for two (2) of three (3) sampled residents (Resident #60 and #31). The findings are: 1. Resident #60 was admitted to the facility with diagnoses of dementia (Alzheimer's type), dizziness, and depression. The most recent Minimum Data Set (MDS), dated 12/13/12, indicated that for the Brief Interview for Mental Status (BIMS) the resident was moderately impaired. Resident stated she did need assistance with transfers, bed mobility, and most activities of daily living. Resident requires mobility devices of walker and wheelchair. The MDS also revealed the resident had a history of falls prior to admission and two falls since admission without injury. A review of the resident's medical record revealed a care plan dated 01/23/13 which addressed a history of frequent falls. One intervention included the use of a mobility alarm	F 282	A) Resident 31 and #60's interventions were immediately implemented per the care key and the care plan by the certified nursing assistant assigned to them. Residents #31's non-slip material was placed in her wheel chair and the wheel chair alarm was placed in #60's wheel chair. The charge nurses, certified nursing assistants and the nurse supervisors were in-serviced as to the importance of reviewing and implementing the care keys and care plans each shift in order to familiarize themselves to the residents information in regards to their individual risks of falling and those interventions recommended and documented by the care plan team and the falls committee. The care plan team consists of the care plan coordinator, social worker, activity director and the dietary manager. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2-18-13

DHHS NC Black Mountain WRO Received FEB 20 2013 by: MMH

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.

Original signature 2-19-13 mh

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F 282	Continued From page 1 on the bed and wheelchair "to alert staff to attempts to rise unassisted." On 01/28/13 at 2:37 PM resident #60 was observed in her room sitting in her recliner without a mobility alarm attached. On 01/29/13 at 8:45 AM PM resident #60 was observed in her room sitting in her wheelchair without a mobility alarm attached. On 01/30/13 at 1:15 PM resident #60 was observed in her room sitting in her wheelchair without a mobility alarm attached. On 01/31/13 at 2:57 PM resident #60 was observed in her room sitting in her wheelchair without a mobility alarm attached. On 01/31/13 at 4:45 PM Licensed Nurse #1 was interviewed. She stated she was unaware of any alarms for Resident #60. She stated she would need to check with her supervisor in reference to the alarms. On 02/1/13 at 10:20 AM Resident #60 was observed in her room, unaccompanied by staff, sitting in her wheelchair without a mobility alarm attached. On 02/1/13 at 10:30 AM NA #1 was interviewed. She stated that each resident has a "resident care key" that is to be looked at and followed when caring for a resident. NA stated she did not realize that Resident #60 was to have an alarm in place. On 02/1/13 at 10:45 AM Licensed Nurse #2 was	F 282	Falls committee consists of the nursing home administrator, the director of nursing, the care plan coordinator, the activity director, the social worker, the therapy manager and the dietary manager. B) All residents could be affected. All residents at risk for falls will have their care keys reviewed each shift by the charge nurses and the certified nursing assistants. All residents are evaluated for fall risks at the time of admission, each week for the first four weeks after admission and quarterly and or as needed thereafter by the registered nurse supervisor. All nursing staff were in-serviced in this regard as of 25 February 2013. C) The nursing supervisor will review the fall interventions on the care keys and the care plans for accuracy, communicate with the charge nurse and the certified nursing assistants any and all fall interventions and ensure the correct implementation of those interventions by conducting physical checks each shift. None of the nursing staff will be allowed to work prior to	

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F 282	Continued From page 2 interviewed. She stated she knew of Resident #60 having an un-witnessed fall on 01/23/13 but there had been no communication with her that resident should have an alarm in place. She stated that the fall committee meets and makes suggestions for an intervention on care plans, writes an order for the intervention, and when the nurse receives the order it would be implemented. At that time no alarms were observed on resident's bed, wheelchair, or recliner with NA #1 and Nurse #2. On 02/01/13 at 12:10 PM the MDS Coordinator was interviewed. She stated she attends the fall committee meetings. She stated she updates the care plans for the nursing staff and the resident care keys for the nursing assistants. She also stated her; being a Licensed Nurse, are responsible for informing staff when an intervention is recommended and/or when there has been a change to the resident's plan of care. On 02/01/13 at 12:20 PM the Director of Nursing was interviewed. She stated that she writes an order for alarms after the fall committee agrees. She stated she communicates this to the staff as well as having it added to the care key, and then she expects for the alarms to be placed. She stated that it is her expectations that NA's review the Residents Care Keys at the beginning of each shift and follow Care Key when providing care to the residents.	F 282	Being retrained in the in-services. D) The director of nursing will review the care keys and care plans with the care plan team and the falls committee to ensure accuracy, and perform . physical weekly spot checks in regards to the residents at fall risk and their accompanying interventions and brief the quality assurance committee quarterly. This will be on going. The quality assurance committee consists of the medical director, the administrator, the director of nursing, the care plan coordinator, the social worker, the activity director, the dietary manager, the therapy manager, the and the pharmacy consultant. E) 28 February 2013	

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F 282	Continued From page 3	F 282		

2. Resident #31 was admitted to facility on 01/19/07. The active cumulative diagnoses include: Osteoporosis, Recent Urinary Tract Infection (UTI), Alzheimer's disease, and Anxiety. The most recent Minimum Data Set (MDS) for a significant change was completed on 01/10/13. The score for the Brief Interview for Mental Status indicated resident's cognitive skills for daily decision making was severely impaired. Resident never/rarely made decisions. Resident required maximum assist with transfers and activities of daily living. The mobility device required is a wheelchair for this Resident.

The Care Area Assessment (CAA) dated 01/10/13 showed that the Resident #31 was at risk for falls. The MDS dated 01/10/12 showed that the resident had one fall in the last thirty (30) days.

A review of Resident #31 nurses notes dated 01/08/13 at 12:00 PM documented that a fall was reviewed by the interdisciplinary team and a non-slip material will be placed in the resident's wheelchair.

A review of the residents care plan dated 01/17/13 revealed an intervention for a non-slip material placed in the resident's wheelchair.

The facility form titled "Resident Care Key" used to inform the nurse assistants what a resident needs are revealed under the section titled "interventions for safety" a non-slip material was to be placed in the wheelchair.

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F 282	Continued From page 4 On 02/01/13 at 1:15 PM resident was observed sitting in her wheelchair and there was no non-slip material in the wheelchair. On 02/01/13 at 1:16 PM an interview with NA #2 revealed she was not aware that a non-slip material was to be used for Resident #31. She also revealed that she did not see it listed on resident care key. On 02/01/13 at 1:18 PM an interview with Licensed Nurse #2 she indicated that a non-slip material should be placed in the wheelchair when resident is up. On 02/01/13 at 1:20 PM during an interview with Director of Nursing she stated that the resident was seated on a specialty cushion but did not see the non-slip material in the resident's wheelchair. On 02/01/13 at 1:43 PM an interview with the Therapist revealed that the MDS Nurse had approached her and asked her to check on Resident #31 to see if another piece of the non-slip material needed to be cut. The Therapist indicated that when she went to the resident's room the non-slip material was lying in the resident's recliner and was not in the wheelchair the resident was sitting in. The Therapist also stated when a fall occurs the interdisciplinary team meets the following morning and reviews the circumstances of the fall and establishes the need for a new intervention. The MDS Nurse is responsible for updating the Resident's Care Plan and the Resident Care Key. If there is a need for a non-slip material to be placed in a resident's wheelchair the Therapist is responsible for providing the non-slip material. Then the	F 282		

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F 282	Continued From page 5 Therapist informs the Nurse and the Nurse Aide; responsible for that resident's care, that the material is in place.	F 282	A) Resident #60 and resident #31's interventions were immediately implemented per the care key and care plan by the certified nursing assistants assigned to them. Resident #31's non-slip material was placed in her wheel chair and the wheel chair alarm was placed in #60's wheel chair. The charge nurses, the certified nursing assistants and the nurse supervisors were in-serviced as to the importance of reviewing and implementing the recommendations documented by the care plan team and the falls committee. The care plan team consists of the care plan coordinator, the social worker, the activity director and the dietary manager. The falls committee consists of the administrator, the director of nursing, the care plan coordinator, the activity director, the social worker, the dietary manager, and the therapy manager.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to implement preventive measures for a resident with multiple falls (Resident #60), and failed to ensure interventions in place for a resident with multiple falls (Resident #31). The findings are: 1. Resident #60 was admitted to the facility with diagnoses of dementia (Alzheimer's type), dizziness, and depression. The most recent Minimum Data Set (MDS), dated 12/13/12, indicated that for the Brief Interview for Mental Status (BIMS) the resident was moderately impaired. Resident stated she did need assistance with transfers, bed mobility, and most activities of daily living. Resident requires mobility devices of walker and wheelchair. The MDS also revealed the resident had a history of falls prior to admission and two falls since admission without	F 323		

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F 323	Continued From page 6 injury. A review of the resident's medical record revealed a care plan dated 01/23/13 which addressed a history of frequent falls. One intervention included the use of a mobility alarm on the bed and wheelchair "to alert staff to attempts to rise unassisted." On 01/28/13 at 2:37 PM resident #60 was observed in her room sitting in her recliner without a mobility alarm attached. On 01/29/13 at 8:45 AM PM resident #60 was observed in her room sitting in her wheelchair without a mobility alarm attached. On 01/30/13 at 1:15 PM resident #60 was observed in her room sitting in her wheelchair without a mobility alarm attached. On 01/31/13 at 2:57 PM resident #60 was observed in her room sitting in her wheelchair without a mobility alarm attached. On 01/31/13 at 4:45 PM Licensed Nurse #1 was interviewed. She stated she was unaware of any alarms for Resident #60. She stated she would need to check with her supervisor in reference to the alarms. On 02/01/13 at 10:20 AM Resident #60 was observed in her room, unaccompanied by staff, sitting in her wheelchair without a mobility alarm attached. On 02/01/13 at 10:30 AM NA #1 was interviewed. She stated that each resident has a "resident	F 323	B) All residents could be affected. All residents care keys and care plans for those residents at falls risk are to be reviewed each shift for their accuracy and implementation by the charge nurses and certified nursing assistants. All nursing staff were in-serviced in this regard. All nursing staff were in-serviced in this regard as of 25 February 2013. C) The registered nurse supervisor will review the care keys and care plans for all residents who need interventions regarding falls to ensure the facilities correct implementation of those interventions and communicate with the charge nurses and certified nursing assistants as well as perform physical checks of those interventions each shift. None of the nursing staff will be allowed to work prior to being retrained in the in-service. D) The administrator and the director of nursing will review the care keys and care plans with the care plan team and falls committee to ensure accuracy as well as conduct physical spot checks in regards to the resident's supervision	

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F 323	Continued From page 7 care key" that is to be looked at and followed when caring for a resident. NA stated she did not realize that Resident #60 was to have an alarm in place. On 02/01/13 at 10:45 AM Licensed Nurse #2 was interviewed. She stated she knew of Resident #60 having an un-witnessed fall on 01/23/13 but there had been no communication with her that resident should have an alarm in place. She stated that the fall committee meets and makes suggestions for an intervention on care plans, writes an order for the intervention, and when the nurse receives the order it would be implemented. At that time no alarms were observed on resident's bed, wheelchair, or recliner with NA #1 and Nurse #2. On 02/01/13 at 12:10 PM the MDS Coordinator was interviewed. She stated she attends the fall committee meetings. She stated she updates the care plans for the nursing staff and the resident care keys for the nursing assistants. She also stated her; being a Licensed Nurse, are responsible for informing staff when an intervention is recommended and/or when there has been a change to the resident's plan of care. On 2/01/13 at 12:20 PM the Director of Nursing was interviewed. She stated that she writes an order for alarms after the fall committee agrees. She stated she communicates this to the staff as well as having it added to the care key, and then she expects for the alarms to be placed. She stated that it is her expectations that NA's review the Residents Care Keys at the beginning of each shift and follow Care Key when providing care to the residents.	F 323	And assistive devices to prevent accidents weekly and report to the falls committee and the quality assurance committee quarterly on an on going basis. The quality assurance committee consists of the medical director, the administrator, the director of nursing, the care plan coordinator, the social worker, the activity director, the dietary manager, the therapy manager, the pharmacy consultant and the medical records clerk. E) 28 February 2013	

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F 323	Continued From page 8	F 323		

2. Resident #31 was admitted to facility on 01/19/07. The active cumulative diagnoses include: Osteoporosis, Recent Urinary Tract Infection (UTI), Alzheimer's disease, and Anxiety. The most recent Minimum Data Set (MDS) for a significant change was completed on 01/10/13. The score for the Brief Interview for Mental Status indicated resident's cognitive skills for daily decision making was severely impaired. Resident never/rarely made decisions. Resident required maximum assist with transfers and activities of daily living. The mobility device required is a wheelchair for this Resident.

A review of Resident #31 nurses notes dated 01/8/13 at 12:00 PM documented that a fall was reviewed by the interdisciplinary team and a non-slip material will be placed in the resident's wheelchair.

A review of the residents care plan dated 01/17/13 revealed an intervention for a non-slip material placed in the resident's wheelchair.

The facility form titled "Resident Care Key" used to inform the nurse assistants what a resident needs are revealed under the section titled "Interventions for Safety" a non-slip material was to be placed in the wheelchair.

On 02/01/13 at 1:15 PM resident was observed sitting in her wheelchair and there was no non-slip material in the wheelchair.

On 02/01/13 at 1:16 PM an interview with NA #2 revealed she was not aware that a non-slip

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F 323	Continued From page 9 material was to be used for Resident #31. She also revealed that she did not see it listed on resident care key. On 02/01/13 at 1:18 PM an interview with Licensed Nurse #2 she indicated that a non-slip material should be placed in the wheelchair when resident is up. On 02/01/13 at 1:20 PM during an interview with Director of Nursing she stated that the resident was seated on a specialty cushion but did not see the non-slip material in the resident's wheelchair. On 02/01/13 at 1:43 PM an interview with the Therapist revealed that the MDS Nurse had approached her and asked her to check on Resident #31 to see if another piece of the non-slip material needed to be cut. The Therapist indicated that when she went to the resident's room the non-slip material was lying in the resident's recliner and was not in the wheelchair the resident was sitting in.	F 323		