STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345205	A. BUILDING: _____ B. WING _____	3/1/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HILLS NURSING AND REHABILITATION CE	1016 FLETCHER ST WILKESBORO, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 282	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, staff interviews and record review, the facility failed to follow fall precautions as specified on the care plan for 2 of 3 residents (Resident # 94 and #41).

The findings include:

1. Resident #94 was admitted to the facility on 07/25/12 with diagnoses that included dementia. The Care Area Assessment (CAA) dated 08/07/12 specified the resident was at risk for falls characterized by a history of falls.

Review of Resident #94's medical record revealed a nurses' entry dated 09/16/12 that specified the resident was found on the floor beside his wheelchair and Dycem (anti-slip mat) was placed in his wheelchair for additional safety.

Resident #94's care plan for falls updated 09/24/12 specified interventions to ensure the resident would not sustain a fall related injury that included:

- Dycem to wheelchair

The most recent Minimum Data Set (MDS) dated 01/15/13 specified the resident was cognitively impaired and required extensive assistance with Activities of Daily Living (ADL). The MDS also specified the resident was not steady moving from seated to standing position. According to the MDS the resident had not fallen since the previous assessment.

The following observations were made of Resident #94:

- On 02/26/13 at 8:50 AM Resident #94 was seated in his wheelchair without a Dycem mat in place.
- On 02/27/13 at 3:50 PM Resident #94 was seated in his wheelchair without a Dycem mat in place.
- On 2/28/13 at 8:45 AM observations made of Resident #94's wheelchair revealed there was no Dycem mat in the seat of the wheelchair or under the seat.

On 03/01/13 at 8:45 AM the Quality Improvement (QI) nurse was interviewed and reported that she reviewed residents' falls daily to ensure interventions were developed to prevent further falls. She stated that it was her responsibility to ensure all falls preventions were in place. She also stated that the facility's administrative staff made daily rounds to observe residents to ensure that fall interventions were in place. The QI nurse reported that Resident #94 was to have dycem in his wheelchair at all times to prevent the resident from

The above isolated deficiencies pose no actual harm to the residents

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sliding out of his wheelchair. During the interview the QI nurse observed Resident #94's wheelchair and confirmed that he did not have a Dycem mat in place. She offered no explanation why the mat was not in place and stated it should be in the wheelchair.

On 03/01/13 at 10:30 AM the Director of Nursing (DON) was interviewed and reported that the facility utilized rounds to ensure that individual interventions were in place for residents. She stated that staff members were assigned residents and used a checklist to verify that interventions were in place according to the care plan. She confirmed that Resident #94 was to have a dycem mat in his wheelchair and that she expected staff to have observed this during the daily rounds.

2. Resident # 41 was admitted to the facility on 06/21/12 with diagnoses which included diabetes, muscle weakness and contractures' (a chronic loss of joint motion due to structural changes in non-bony tissue which include muscles, ligaments and tendons).

A review of a facility document titled "Resident Care Guide" with an admission date of 06/21/12 indicated under a section titled Special Precautions for Resident #41 to wear non-skid footwear and provide a Dycem mat to his wheelchair.

A review of care plans that were dated 07/04/12 indicated Resident #41 was at risk for falls characterized by a history of falls and had multiple risk factors related to incontinence and impaired mobility. The goals were for Resident #41 to be free of falls through the next review and the interventions were listed in part to place a Dycem mat to his wheelchair and wear proper and non skid footwear.

A review of a Care Area Assessment dated 08/18/12 indicated Resident #41 was at risk for falls.

The most recent quarterly Minimum Data Set (MDS) dated 12/03/12 indicated Resident #41 had problems with short term and long term memory and was severely impaired with cognition for daily decision making. The MDS further revealed Resident #41 was totally dependent on staff for transfers.

A review of an Incident Report dated 02/09/13 at 8:15 AM indicated Resident #41 was found on the floor on his elbows in front of a wheelchair by a Nurse Aide. Resident #41 stated "these big old boots made me fall." The report indicated he was wearing bunny boots (heel protective boots), which made his feet slide when he attempted to stand unassisted. Retraining was done with staff to ensure when Resident #41 was not in bed, that bunny boots were removed and non skid footwear was placed on the resident's feet.

During an observation on 02/26/13 at 10:49 AM Resident #41 was observed sitting in his wheelchair in the hallway with bare feet.

During an observation on 02/27/13 at 10:25 AM Resident #41 was sitting in his wheelchair in the hallway without a Dycem mat in his wheelchair.

During an observation on 02/28/13 at 12:39 PM Resident #41 was sitting in his wheelchair in the hallway without a Dycem mat in the wheelchair and he had a bunny boot on his left foot.

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During an observation on 02/28/13 at 12:45 PM Resident #41 was sitting in the hallway in his wheelchair without a Dycem mat in his wheelchair and he had a bunny boot on his left foot.

During an observation on 02/28/13 at 2:52 PM Resident #41's wheelchair was parked in his room and there was no Dycem mat in Resident 41's wheelchair.

During an interview on 03/01/13 at 8:45 AM the Quality Improvement (QI) nurse reported she reviewed residents' falls daily to ensure interventions were developed to prevent further falls. She stated that it was her responsibility to ensure all fall prevention's were in place. She also stated that the facility's administrative staff made daily rounds to observe residents to ensure that fall interventions were in place. The QI nurse reported that Resident #41 was to have Dycem in his wheelchair at all times to prevent the resident from sliding out of his wheelchair. During the interview the QI nurse observed Resident #41's wheelchair and confirmed that he did not have a Dycem mat in place. She offered no explanation why the mat was not in place and stated it should be in the wheelchair.

During a follow up interview on 03/01/13 at 4:45 PM the QI nurse verified Resident #41 had bunny boots on his feet this morning while up in his wheelchair and stated he should have had non-skid footwear on instead. She explained she had met with all Nurse Aides on all shifts after Resident #41 fell on 02/09/13 and retrained them to provide care according to the "Resident Care Guide" and specifically instructed them that Resident #41 should wear non skid footwear and should not wear bunny boots when he was sitting in his wheelchair.

During an interview on 03/01/13 at 10:30 AM the Director of Nursing (DON) reported that the facility utilized rounds to ensure that individual interventions were in place for residents. She stated that staff members were assigned residents and used a checklist to verify that interventions were in place according to the care plan. She confirmed that Resident #41 was to have a Dycem mat in his wheelchair and he should wear non-skid footwear and she expected staff to have observed this during the daily rounds.