DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING ______ B. WING ______	C 03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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 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 staff interviews and record reviews the facility failed to provide adaptive equipment to the wheelchair, and follow recommended transfer procedures for 1of 3 sampled residents which led to a fall and bruising for Resident #1. The findings included: Review of Resident #1's Occupational Therapy notes dated 04/06/15 indicated a footboard was placed on the foot pedals of the wheelchair to aid proper body alignment and positioning while seated in the wheelchair. It revealed the foot board helped Resident #1 achieve optimum positioning while eating. Resident #1 was re-admitted to the facility on 03/28/15 with diagnoses that included generalized weakness, abnormal posture, diabetes, and right-sided hemiplegia from a previous stroke. The quarterly Minimum Data Set dated 01/12/16 indicated Resident #1's cognition was not able to be assessed. Her functional status revealed she was totally dependent for most activities of daily living with 1-2 persons needed to assist; and she required 2 persons to	F 323	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s). F323 Corrective Action for residents found to have been affected by this deficiency: -A note was posted in the resident's room reminding staff of the need to apply foot pedals and foot board to wheel chair. -An immediate in-service was	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 3/16/16

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 Date: 3-11-16

DHSR Received MAR 1 8 2016 by: vcl

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F 323	Continued From page 1 assist with transfers using a mechanical lift. She did not receive therapy services at the time of the incident, but she did receive restorative care seven days a week to assist with bracing of her lower extremities, and passive range of motion for her upper extremities. Resident #1's care plan updated as recently as 01/30/16, indicated she had interventions to prevent falls that included monitoring for changes in safety awareness, use of 2-person lift for transfers, perimeter mattress on bed, and fall mats on floor when in bed.. She was also revealed to be at a high risk for falls and had no falls since re-admission to facility. An Occurrence Report dated 01/31/16 at 7:20 PM that indicated Resident #1 had been sitting in her wheelchair in her room and fell out of wheelchair, hitting her forehead and right knee causing bruising. It revealed she was found lying on the floor against the wall with her head resting on the floor. The report stated she was assessed where she laid and was found to be alert, verbally responsive, skin warm and dry, and neuro checks and vital signs were normal. She was wearing non-skid gripper socks. The medical staff on call was notified of the fall; and the Responsible Party was notified. Emergency Management (EMS) was called and she was sent to the Emergency Room for evaluation. Resident #1 had a hematoma to her forehead and a bruise to her right knee. She complained of pain in her right knee. When EMS arrived Resident #1 was placed in a cervical collar, and on a backboard for transport. The report further revealed Resident #1 was known to have poor safety judgement. A follow-up of the fall in the medical record	F 323	also completed with staff reminding them of the need to apply foot pedals and foot board any time resident is in her wheelchair. -Resident was placed on increased visual checks following her fall. **Corrective action for residents that may be affected by this deficiency:** -A mandatory in-service is scheduled for all direct care staff March 30th to educate on the proper use of patient lifts. -A mandatory care guide in-service will be completed in conjunction with the lift in-service on March 30th. **Measures that will be put into place to ensure that this deficiency does not recur:** -In-services will be completed with all direct care staff to address the care guides and appropriate use of lifts. -Care guides will be audited and	

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F 323	Continued From page 2 revealed Resident #1 had been assisted to the wheelchair on 01/31/16 by (Nursing Assistant #1) NA #1 prior to dinner being served, and her foot pedals and footboard were not placed on the wheelchair. NA #1 then left the room to assist other residents with dinner preparations. Resident #1 slid from the wheelchair and fell to the floor. The follow-up report further indicated Resident #1's x-rays were negative and she was returned to the facility. She was discharged from the facility on 02/11/16. On 03/01/16 at 1:30 PM an interview was conducted with the Director of Nursing (DON). She indicated the foot pedals and footboard intervention for Resident #1's wheelchair was implemented by the therapy department around March or April of 2015 to assist with positioning and was not a fall precaution. She stated Resident #1 had not had a fall since April of 2014. On 03/01/16 at 2:40 PM an interview conducted with Occupational Therapist #1 (OT #1) revealed the recommendation for the foot board for Resident #1 was made in April of 2015 for positioning to help keep her upright. He stated the footboard also aided in preventing her from falling from the wheelchair. OT #1 revealed Resident #1's problem with poor positioning led to a tendency to slide from the wheelchair, and the footboard could prevent that from happening. On 03/01/16 at 2:50 PM an interview was conducted with NA #2. She stated staff used care guides at the nurse's desk to know what interventions each resident needed. She stated the care guides were updated by the nurses and new interventions were passed on to the staff.	F 323	updated to ensure they accurately include appropriate equipment. -DON or designee will interview 5 staff members weekly for one month then interview 10 staff members monthly for 2 months to assess their knowledge of interventions necessary to care for their residents. -DON or designee will observe 5 resident transfers with a lift weekly for one month then observe 10 resident transfers with a lift for 2 months to assess proper usage of lifts. Immediate education will take place when staff are deemed to be using the lift inappropriately. -A 100% audit will be performed for all residents with wheelchairs needing adaptive equipment to determine if wheelchairs have appropriate adaptive equipment in place. -DON or designee will audit five wheelchairs daily for two weeks then five wheelchairs weekly for four weeks then five wheelchairs	

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F 323	Continued From page 3 She stated she had worked with Resident #1 and anytime she was up in her wheelchair, she was to have her foot board and leg attachments on her wheelchair to keep her up straight, and keep her from falling out of the wheelchair. On 03/01/16 at 3:00 PM an interview was conducted with NA #3. She stated she had worked in restorative for the past month, and had worked with Resident #1 daily with her leg braces and provided range of motion for her upper extremities. NA #3 revealed before she started restorative, she worked as an NA on the floors and worked with Resident #1. She stated whenever Resident #1 was up in her wheelchair, she had to have her foot board and attachments because her legs were contracted, and without the footboard on her wheelchair Resident #1 could pitch forward and fall out of her wheelchair. She also indicated Resident #1 required 2 persons for assistance and a mechanical lift to transfer her to the chair. On 03/01/16 at 3:20 PM an interview was conducted with NA #1. She stated she had worked at the facility since August of 2015. She stated she gets her information on interventions needed by her residents from the care guides. NA #1 indicated the guides provide information on transfers, adaptive equipment, bathing preferences, and any other special needs a resident may have. She revealed she was working the night Resident #1 fell from her wheelchair. She stated she went in Resident #1's room to check on her before dinner and she was sitting up in bed. NA #1 indicated Resident #1 preferred to eat in her chair, so she got the lift, placed her in her chair, and got her ready to eat. She stated when she left the room Resident #1	F 323	monthly for three months to ensure adaptive equipment is being used appropriately. Results of audits will be submitted to the QA committee for follow up. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** -Results of DON or designee interviews will be submitted to the QA committee for the appropriate months. -Results of lift observations will be submitted to the QA committee for the appropriate months. -Immediate education will take place when staff is not deemed to have insufficient understanding of the care needs of their assigned residents during interviews. **Anticipated date of Compliance:** Facility alleges compliance with this deficiency on 03/29/2016.	

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F 323	Continued From page 4 was sitting up straight in her chair ready to eat dinner. NA #1 acknowledged she knew Resident #1 required 2 persons to assist with transfer by the lift, but she got her up by herself. She stated she also was aware Resident #1 used the foot pedals and footboard when she was up in her wheelchair, but she did not put them on the chair because the over bed table slid over her feet better without the footboard. NA #1 indicated she left the room and did not see Resident #1 again. She stated she later heard she had fallen from her chair. On 03/01/16 at 3:40 PM an interview was conducted with Nurse #1. She stated she came on her shift at 7:00 PM the night Resident #1 had her accident. She indicated she did not see her prior to the accident, and approximately 7:20 PM she was called to the room. Nurse #1 revealed Resident #1 was lying against the wall with her head on the floor. She stated there was no foot pedals or footboard on Resident #1's wheelchair. Nurse #1 stated Resident #1 was not moved, was assessed, and EMS was called. She indicated EMS applied neck collar and backboard after their arrival. Nurse #1 indicated Resident #1 was alert and talking when she got to the room. She stated she was not aware how Resident #1 had been transferred because she was in her wheelchair before she started her shift. On 03/01/16 at 3:55 PM an interview was conducted with NA #4. She stated she had worked with Resident #1 and knew she was a 2-person assist with a mechanical lift. She stated when Resident #1 was up in her wheelchair, she was to have her foot pedals and footboard placed on the wheelchair because her legs were contracted and the footboard helped keep her	F 323		

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F 323	Continued From page 5 upright in the chair. NA #4 revealed the night Resident #1 fell from her chair, she had entered the room after Resident #1 had finished eating, and she removed her tray from the room. She stated Resident #1 was sitting upright in her chair at that time. NA #4 indicated she left the room and when she came back down the hall by her room she saw her feet on the floor and she was lying in the floor up against the wall. She stated Resident #1 was alert and spoke to her, so she ran from the room to get the nurse. On 03/01/16 at 4:10 PM an interview was conducted with the DON. She stated she was aware Resident #1 was transferred out of bed to her chair with only one person using the lift, and was placed in her wheelchair without applying her foot pedals and footboard. The DON revealed that use of the 2-person lift, and use of the footboard were on Resident #1's care guide to enable the NA's information to provide proper care for her. The DON revealed it was her expectation that the care staff followed individual resident interventions and provided appropriate care for all of the residents.	F 323		