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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTR
	555143	A. BUILDING _____ B. WING _____

NAME OF PROVIDER OR SUPPLIER	STREET ADDRE
WESTLAND HOUSE	100 BARNET MONTEREY

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during investigation of an entity reported incident conducted on 2/13/12. Entity Reported Incident CA00297454 regarding Quality of Care/Treatment, Resident Safety/Falls, Federal deficiencies were identified (see Federal Code of Regulation F-279 and F-309)). The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health. 29765, Health Facilities Evaluator Nurse.	F 000	This plan of correction is the facility's response to deficiencies found during the investigation of an incident that occurred 01-26-12.	
F 279 SS=D	483.20(d), 483 20(k)(1) DEVELQP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	1. Resident 1 expired on 02-07-12.	

[redacted] NTATIVE'S SIGNATURE RN NHA | TITLE 3-6-12 | (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555143	A. BUILDING _____ B. WING _____	C 02/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAND HOUSE	100 BARNET SEGAL LANE MONTEREY, CA 93940

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F 279	Continued From page 1 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise and develop the care plan for one of one sampled resident (1). Resident 1 fell and injured her left wrist and acquired a bump at the back of her head. No new care plan or revision of existing care plan were done after the fall to address how to care for the fractured wrist or to assess for a head injury. Failure to revise a care plan affects the necessary care and services needed to attain the highest practicable physical, mental and psychosocial well-being of the resident. Findings: Resident 1 was admitted to the facility with diagnoses including pneumonia (infection of the lungs) and required rehabilitation (restoration to normal or near normal function after a disabling disease). Minimum Data Set (MDS, assessment tool) dated 1/30/12, indicated Resident 1 was confused on and off but easily reoriented. On 2/13/12 during record review of the discharge order plan dated 2/8/12, it indicated Resident 1 expired on 2/7/12. The nurse's notes dated 1/26/12 at 3:48 a.m., indicated Resident 1 was found on the floor trying to get up. According to the notes Resident 1 obtained a bump at the back of her head and her left wrist was swollen. Resident 1 was sent to the emergency room for further observation. She returned to the facility with a cast on her left forearm after being	F 279	If a patient falls at the facility 2. Comprehensive care plans for falls will be maintained and updated on residents at this facility. This is to ensure the highest level of well-being for the residents. 3. We will continue to care plan falls and keep the information current. If a fall occurs a new care plan will be revised as to those needs. 4. The DON will be monitoring all residents charts who have had falls for comprehensive care plans. 5. The licensed staff will be inserviced by March 23 on updating and maintaining care plans. The inservice will also include review of the facility's current Fall Prevention Policy. The inservice will be conducted by the DON.	3/23/12 [redacted]

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F 279	Continued From page 2 diagnosed with a fractured wrist. During record review on the same day, it indicated Resident 1 returned from the emergency room on the same day (1/26/12). A review of the fall risk care plan indicated it was revised with the words, "fall 1/26/12" but had no new goals or interventions. The head and wrist injuries were not listed. There was no plan as to assessing either injury and no plans for cast care or the need for additional assistance in activities of daily living. During an interview on 2/13/12 at 10:40 a.m. with the director of nursing, she stated there was no documented revised care plan made after the fall. The undated facility's policy, "Fall Prevention Procedure" indicated a re-evaluation of all residents on an on-going basis to identify residents at risk and document personalized plan of care in the resident care plan.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care for one	F 309		

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F 309	Continued From page 3 resident (1) when she fell and fractured her left wrist and hit her head, and was discharged to an emergency room (ER). Upon Resident 1's return to the facility, there was no policy or procedure in place for residents post fall or for residents who had head injuries. The facility failed to assess for complications caused by the injuries or to care plan for her injuries after the fall. Resident 1 had a known history of disconnecting her TABS unit (a portable alarm unit attached to the resident which sounds when a resident pulls it out) prior to her fall. After her fall she became non-compliant with medications, became progressively confused and agitated after the fall. The facility failed to have a care plan for her noncompliance. Failure to assess for complications or to have a care plan for her post fall needs and deterioration of her condition had the potential to affect her reaching her highest practical physical and mental well being. Findings: Resident 1 was admitted to the facility with diagnoses including pneumonia (lung infection) requiring rehabilitation (restoration of normal or near normal function after a disabling disease). Her Minimum Data Set (MDS, an assessment tool) dated 1/30/12, indicated Resident 1 was confused on and off but easily reoriented She responded appropriately. The record indicated she expired on 2/7/12. On 2/13/12, record review of the nurse's note dated 1/26/12 at 3:48 a.m., indicated Resident 1 was found lying on the floor on her left side and trying to get up. A swollen left wrist and a bump on the back of the head were assessed by the licensed nurse. Resident 1 was transferred to the acute care hospital emergency room (ER) where	F 309	1. Resident 1 expired 02-07-12. 2. Resident will be assessed and monitored following injury due to a fall. A comprehensive care plan will be initiated as to the individual needs. 3. Patients will be assessed and monitored per Fall Prevention Policy and care plans will be maintained. 4. The DON will be monitoring all residents' charts who have had falls for comprehensive care plans. 5. The licensed staff will be inserviced by March 23 on updating and maintaining care plans. The inservice will also include review of the facility's current Fall Prevention Policy. The inservice will be conducted by the DON.	3/23/12 [redacted]

WESTLAND HOUSE ADMINISTRATIVE POLICIES AND PROCEDURES	CODE: RI PAGE: 1 OF 4
SECTION: RESIDENT RIGHTS AND ORGANIZATIONAL ETHICS	
POLICY TITLE: FALL PREVENTION PROCEDURE	

I. **PURPOSE:** To proactively prevent falls; to identify patients at risk for falls; and to provide a safe environment for all patients.

II. **EQUIPMENT:**

KEY POINTS

A. Rising Star magnetic sign
B. TABS unit
C. Night light
D. Bed/chair pad
E. View Room

III. **ESSENTIAL STEPS IN PROCEDURE:**

A. Method

1. Identify all patients who may be at risk for falling:
   a. patients with a prior history of falling;
   b. altered level of consciousness, memory impairment, disorganized thinking, lacking awareness, agitation;
   c. altered elimination frequency, urgency, ineontinence, nocturia, catheter in plaee;
   d. Instability of gait or requiring ambulatory aid (inability to ambulate without assistance, bed rest).
   e. Patients who are taking prescribed medications including: Antiarrhytlimics, Anticonsulsants, Benzodiazepines, neuroleptics Antidepressants.

Assessment is to be done on admission, with any change in patient status and weekly.

Consider providing bedside commode, Foley eatheter may give a false sense of urgency.

Have walker available and encourage to call for assistance whcnever getting out of bed for chair.

All patients given a sedative, opiate, benzodiazepine or *sleeper* at bedtime are at risk for falls.

2. The following may also increase a patient's risk of falling:
   a. lower extremity weakness, history of gait or balance disorders.

Evaluate leg strength with first out of bed order.

III. ESSENTIAL STEPS IN PROCEDURES: (Cont.)

A. Method (cont.)

b. Dizziness and/or postural hypotension.	Assess for orthostatic hypotension before getting
c. With sensory dysfunction, visual or hearing impairment	Be sure patients have access to their hearing aids and/or glasses.
d. 65 years of age or older.	

B. Clinical Record

1. Document
   a. Patient assessments identifying them as being at risk
   b. Patient teaching regarding risk, include family and/or significant other in teaching
   c. In Patient Care Plan, document personalized plan of care
   d. Document falls precautions initiated, reinforced, and actions taken

C. Re-evaluate all patients on an on-going basis to identify patients at risk. Record weekly on Fall Risk Assessment Sheet or if change in patients' condition.

D If a patient falls:

1. Assess for injury by completing a head to toe assessment and assess for loss of conscieousness
2. Take a full set of vital signs. Include neuro checks if the patient hit their head
3. Call 911 if necessary
4. Notify the physician, charge nurse, and family
5. Document description and location of fall. Note your observations, patient statements and environmental factors
6. Monitor patient's status per MD order and document in chart
7. Complete post fall care plan
8. Complete EM2 report

FALL RISK ASSESSMENT

Instruction: Upon admit and weekly, assess the resident status in the eight clinical condition parameters listed below by assigning the corresponding score which best describes the resident in the appropriate column. Add the column numbers to obtain the total score. If the score is ten or less or greater than ten, initiate the action listed on back of sheet.

PARAMETER	SCORE	Resident/status/condition	ASSESS. DATE			
			ADMIT	1st week	2nd week	3rd week
LEVEL OF CONSCIOUSNESS/ MENTAL STATUS	0	ALERT (ORIENTED X 3) OR COMATOSE				
	2	DISORIENTED X 3 AT ALL TIMES				
	4	INTERMITTENT CONFUSION OR POOR SAFETY AWARENESS				
HISTORY OF FALLS	0	NO FALLS IN PAST 90 DAYS				
	2	ONE TO TWO FALLS IN 30 DAYS				
	4	THREE OR MORE FALLS PAST 180 DAYS				
AMBULATION/ELIMINATION	0	AMBULATORY/CONTINENT				
	2	CHAIR BOUND/INCONT				
	4	AMBULATORY/INCONTINENT				
VISION STATUS	0	ADEQUATE (WITH/WITHOUT GLASSES)				
	2	POOR (WITH/WITHOUT GLASSES)				
	4	LEGALLY BLIND				
GAIT/BALANCE THIS SECTION ONLY TO BE DONE BY REHAB	0	GAIT & BALANCE NORMAL				
	1	BALANCE PROBLEM WHILE STANDING				
	1	BALANCE PROBLEM WHILE WALKING				
	1	DECREASED MUSCULAR COORDINATION				
	1	CHANGE IN GAIT PATERN WHEN WALKING THROUGH DOORWAY				
	1	JERKING OR UNSTABLE WHEN MAKING TURNS				
	1	REQUIRES USE OF ASSISTIVE DEVICES (CANE, W/C ETC)				
BLOOD PRESSURE	0	NO HISTORY OF HYPER/HYPOTENSION				
	2	HISTORY OF HYPER/HYPOTENSION				
	4	HISTORY OF ORTHOSTATIC HYPOTENSION				
RESPOND BELOW BASED ON THE FOLLOWING TYPES OF MEDICATIONS: ANESTHETICS, ANTIHISTAMINES, ANTIHYPERTENSIVES, ANTISEIZURE BENZODIAZEPINES, CATHARTICS, DIURETICS, HYPOGLYCEMICS, NARCOTICS, PSYCHOTROPICS, SEDATIVES/HYPNOTICS						
MEDICATIONS	0	NONE OF THESE MEDICATIONS TAKEN CURRENTLY OR LAST 7 DAYS				
	2	TAKES 1-2 OF MEDS CURRENTLY OR WITHIN LAST 7 DAYS				
	4	TAKES 3-4 OF MEDS CURRENTLY OR WITHIN LAST 7 DAYS				
	*	IF RESIDENT HAS HAD CHANGE IN MEDICATION AND/OR CHANGE IN DOSAGE IN PAST 5 DAYS – SCORE 1 ADDITIONAL POINT				
RESPOND BELOW BASED ON THE FOLLOWING PREDISPOSING CONDITIONS: VERTIGO, CVA, TIA, PARKINSONS DISEASE, LOSS OF LIMB (S) SEIZURES, ARTHRITIS, OSTEOPOROSIS, EXISTING FRACTURES						
PREDISPOSING DISEASES	0	NONE PRESENT				
	2	1-2 PRESENT				
	4	3 OR MORE PRESENT				
		TOTAL FALL RISK SCORE:				

PATIENT LABEL		NURSING	REHAB
	ADMIT SIGNATURE/DATE:		
	1ST WEEK SIGNATURE/DATE:		
	2ND WEEK SIGNATURE/DATE:		
	3RD WEEK SIGNATURE/DATE:		

If fall risk is 10 or less:

Institute the following action if a patient is assessed at risk for falls with a score of less than on the Fall Assessment sheet.

a. Insure bed is kept in lowest position.
b. Keep call bell and telephone within reaeh
c. Keep room orderly and floor uncluttered
d. Provide adequate lighting in the room
e. Provide non skid footwear for use when ambulating.
f. Reinforce to call for assistanee when getting up, unless cleared by physical therapy.
g. Toileting offered at least every 2 hours

If fall risk is greater than 10:

Institute the following action if a patient is assessed at risk for falls with a score of greater than 10 on Fall Assessment Sheet.

a. Evaluate need for view room and/or sitter
b. Place rising star "Fall Precaution" sign on door
c. Keep room door open
d. Use TABS and/or bed and chair pad.
e. Maintain safety measures used for patient with seore of less than 10 on Fall Assessment Sheet.

Re-evaluate all patients on an on-going basis to identify patients at risk. Record weekly on Fall Risk Assessment Sheet or if ebange in patients' condition.

If a patient falls:

a. Assess for injury
   1. Look for lacerations, abrasions of obvious deformities.
   2 .Note any deviation from patient baseline condition
   3. Do not move if you suspeet spinal eord injury
b. Call 9-911 if necessary
c. Notify M.D. charge nurse and family
d. Maintain fall risk precautions
e. Complete EM2 Incident Reporting in computer. .