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WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

(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 resident and staff interviews, policy review and record reviews the facility failed to determine if Resident #8 was safe to smoke unsupervised for one of four sampled residents that smoked, the facility failed to supervise Resident #10 outside the facility for one of four sampled residents with the potential for elopement (Resident #10) and the facility failed to implement fall interventions to prevent falls for Resident #10 for one of five sampled residents with falls. The findings included: Review of the policy and procedure dated 1/1/09 " Smoking Policy " indicated each resident would be assessed on admission and quarterly to determine if the resident was a safe smoker. The " Procedure " included the following: 1. Residents will be evaluated for safety regarding smoking upon admission and quarterly .... 4. The facility will establish designated Smoking Areas .... 5. The ability of a resident to have in their	F 323	1. Resident # 8 had been discharged from the facility to home. Resident #10 has a wander guard in place with placement checked every shift and function checked every day. Resident # 10 has an up dated care plan for fall interventions and all interventions are in place. Resident # 10 has a call light that has been wrapped in green tape. Resident # 11 has been discharged to home. 2. Current resident smokers have accurate and up to date smoking assessments completed. All current interviewable residents have been asked if they intend to smoke and assessments have been completed if they responded yes. All smoking residents have been re educated as to the smoking times agreed on by the resident council and that all smoking materials will be kept by nursing staff and locked in the med room. Facility staff will be assigned to assist with smoking materials and supervision of smoking at the assigned times. Smoking aprons have been ordered on 7/4/2013. Current residents have been re evaluated for risk of elopement. Any resident who has a risk for elopement will have a picture and demographic information in the elopement book at the nurses station completed and a wander guard will be placed with the placement checked each shift and the function checked each day. All residents with fall interventions care planned have been evaluated for the presence of those stated interventions. All residents who sustain a fall will have an immediate intervention utilized to prevent further falls.	7/4/13 7/4/13

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

Alicia Bowers, LNHA | Executive Director | 7-5-2013

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 323	Continued From page 1 possession smoking materials (cigarettes, cigars, lighters, matches, etc) will be identified in the resident care plan. Smoking materials will be retained and stored by the nursing staff for residents identified by their care plans as not being responsible to possess materials without supervision. 6. Designated staff will supervise smoke times for residents needing supervision .... 7. A resident will be allowed to smoke without supervision if they are deemed appropriate by the care plan. Unsafe smokers will wear smoking aprons while smoking. 8. Visitors will be allowed to assist residents smoking needs only if they have been approved by the facility and the approval is in the resident care plan. 1. Resident #8 was admitted to the facility on 3/18/13. Diagnoses included anemia, anxiety, and respiratory failure. The admission assessment dated 3/18/13 indicated Resident #8 was not a " current smoker. " Resident #8 was sent to a local emergency room due to falling and hitting her head on the side of the bathroom wall. She was admitted to the hospital on 5/1/13. Per the discharge summary dated 5/7/13, diagnosis included syncope (passed out) with mechanical fall complicated by dementia. During her stay in the hospital, psychiatry followed the resident. A new diagnosis of moderate to severe dementia with hallucinations/psychosis was made. Treatment with an antipsychotic medication was started. Review of the readmit assessment dated 5/7/13 revealed the " Safe Smoking Evaluation " was	F 323	2. Current facility staff has been re educated by the Director of Clinical Services or the Executive Director concerning the smoking polices and procedures. This includes the responsibilities associated with smoking supervision. Current facility staff has been re educated by the Director of Clinical Services or the Executive Director concerning the elopement policy and procedures, including notification process in the event of an elopement. The licensed staff has been re educated concerning the elopement assessment process and appropriate interventions. Current staff has been re educated by the Director of Clinical Services or the Executive Director concerning the consistent use of fall interventions and that the interventions will be listed on the CNA Cardex. The Licensed nursing staff has been re educated to initiate an immediate intervention after each fall. The department heads have been given a list of each resident's interventions and re educated to monitor for the presence of these interventions during their rounds. 3. The Executive Director will monitor the smoking schedule and adherence to supervision including the maintenance of the smoking materials by the staff daily x 2 weeks, weekly x 6 weeks and then monthly x 10 months, completing the PI monitoring tool for smoking supervision. The Director of Clinical Services or Unit manager will review the new admission charts in the next morning meeting after the admission, to review the presence of a completed elopement assessment. The Director of Clinical Services or Unit Manager will also monitor to ensure that the elopement assessment is done on any resident with a change in behavior that includes exit seeking. This will be documented on the PI Monitoring tool for elopement assessments.	7/4/13 7/4/13

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F 323	Continued From page 2 not completed. The instructions read " Current smoker - If Yes, complete Safe Smoking Eval. (evaluation) " The answer " Yes " was circled. The remaining five questions to determine if the resident was safe were not answered. The determination of safe or unsafe was not made, and the degree of supervision was not identified. Review of the Minimum Data Set (MDS) dated 5/19/13 assessed the resident with cognitive problems of long and short term memory impairment. The BIMS score was 3. This MDS assessed a change in her cognition and BIMS score from the MDS completed in April 2013. The BIMS score had been 12. The care plan team identified a decline in cognition for Resident #8 as evidenced by the " Care Plan Signature Legend " that was not dated. A significant change MDS was to be completed due to decrease in continence, cognition, ADLs (define?) and new order for antipsychotic medications. This entry was after 4/4/13 and before 5/28/13 care plan meetings. Review of the care plan dated 5/15/13 revealed a problem of cognitive impairment, required assistance with ADLs due to weakness, chronic pain and oxygen use. A second problem related to risk for fall or injury due to problems with standing balance, psychotropic med use, dizziness and smokes. The interventions for risk for fall or injury included staff were to supervise the resident during smoking, Smoking Screen to determine smoking safety precautions and the smoking equipment was to be kept by the nurse. The care plan did not address friends assisting with smoking.	F 323	3. The Director of Clinical Services or Unit Manager will review each fall investigation in the morning meeting following the fall to ensure that an intervention was immediately placed and that the care plan reflects the intervention. She will go to the resident and identify that the intervention is in place and verify on the PI Monitoring tool for Fall Interventions. 4. The Executive Director will report the findings of the PI monitoring of the adherence to the smoking policy. The Director of Clinical Services will report the monitoring of the completion of the elopement assessments with admission and upon change of behavior that includes exit seeking and the implementation and execution of fall interventions appropriately. These reports will be given to the QAPI meeting monthly x 12 months. 5. The Allegation of Compliance date for this plan is 7/4/2013	7/4/13 7/4/13

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F 323	Continued From page 3 Review of a social worker ' s progress notes dated 5/28/13 revealed a meeting had been held with a family member and the resident. The social worker documented " Resident presents well socially, but is unable to recall times and events. She does not keep O2 (oxygen) on consistently, but believes she can manage her care needs independently ... Resident was unable to tell correct year, month, day or recall three items after five minutes. Resident also had recent psych unit admit with dementia moderate to severe with behavioral changes ... " The process to obtain guardianship was explained to the family member. Resident # 11 had a BIMS score of 15, which indicated he would be able to recall recent and past events correctly. This resident was a smoker. Interview on 6/5/13 at 10:10 AM with Resident #11 revealed staff did not stay with the residents when they smoke until the past 2 days (6/4/13 and 6/5/13). He was aware of Resident #8, and she did come out to smoke. " She rolled herself out here to smoke. " Resident #11 was asked if she had her own cigarettes or if someone had to give them to her. He stated " she had her own. " Resident #11was asked if someone (visitor) was with Resident #8, he stated " not always. " Resident # 16 was interviewed on 6/5/13 at 11:10 AM. Resident #16 had a BIMS score of 15 and would able to recall recent and past events correctly. This resident was a smoker. Interview revealed Resident #8 was outside smoking unattended last week on 5/25/13.	F 323		

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Interviews were conducted on 6/5/13 at 4:30 PM with the five aides who had worked on 5/23/13 on the 3-11 shift. (Aides # 7, 8, 9, 10 and 11.) Interview with all five aides revealed they were not assigned to supervise residents that took smoke breaks. During interviews, the aides stated Resident #8 would go outside to smoke unassisted and without supervision.

Interview on 6/5/13 at 9:48 AM with the Director of Nursing revealed the smoking assessment should have been completed.

Interview on 6/5/13 at 3:30 PM with the MDS nurse and Social Worker revealed Resident #8 had declined in her safety awareness, ability to make decisions and memory. The two staff members were asked if Resident #8 should have been supervised during smoking and responded " Yes. " During this interview, the MDS nurse stated the smoking assessment should have been completed upon readmission.

Interview on 6/6/13 at 11:50 AM with nurse #1 revealed the admission assessments are completed by all shifts within 48 hours after admission. The nurse on duty when a resident is admitted starts the admission, and each shift completes the assessments. This nurse did not know why the smoking assessment had not been completed. Nurse #1 was aware Resident #8 did go outside to smoke.

Interview on 6/6/13 at 2:09 with nurse #3 revealed Resident #8 had friends that took her out to smoke. Resident #8 was given smoking materials by friends that came to visit. This nurse did not remember when Resident #8 started

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F 323	Continued From page 5 smoking. Resident #8 and her visitors knew to let the staff know when she went out to smoke. Staff would remove the oxygen tank from the wheelchair before she went outside to smoke. Resident #8 did not keep cigarettes or lighter on her person. Resident #8 left the facility on 5/31/13 against medical advice (AMA). 2. Resident #10 was initially admitted to the facility on 4/5/13 with diagnoses of a fracture of Left wrist with cast. On 4/15/13 Resident #10 was hospitalized for a subdural hematoma (bleeding on the brain) after a fall. Upon readmission to the facility on 4/18/13 diagnoses included Parkinson ' s dementia. Review of the Elopement Risk Assessment dated 4/19/13 revealed Resident #10 was assessed as an elopement risk. The instructions on the assessment included " If the resident is deemed at risk, a prevention protocol should be implemented immediately and documented on the Care Plan. " Interview on 6/6/13 at 2:26 PM with Administrative nursing staff #1 revealed the nurse who completed the Elopement Risk Assessment on 4/19/13 had completed it incorrectly. Resident #10 was not at risk for elopement until staff observed her talking about getting her keys and leaving. It was explained, the Wanderguards are not placed on a resident until behaviors of exiting are exhibited. Resident #10 had not had those behaviors until later. Review of the Minimum Data Set (MDS) dated	F 323		

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F 323	Continued From page 6 4/25/13 documented Resident #10 had short and long term memory impairment with a BIMS score of 4. Assistance of one staff was required for transfer, ambulation and toileting. Supervision and cueing with set up assistance was required for locomotion off of the unit by Resident #10. Telephone order dated 5/2/13 documented a " Wanderguard due to elopement risk. Check wanderguard placement Q (every) shift, Check wanderguard function Q D (every day). The order was placed on the Treatment Administration Record (TAR) on 5/2/13 as " Wanderguard d/t (due to) elopement risk. " The care plan dated 5/2/13 addressed a problem of risk of fall or injury due to problems sitting/standing balance, tremors, poor safety awareness, left side neglect and visual difficulty. This care plan included an update dated 5/2/13 of " wanderguard. " The approaches included staff to monitor/report wandering, exit seeking behaviors, supervise activity until resident can safely perform, wanderguard per physician orders and wanderguard due to elopement risk. Check wanderguard function every day and check placement every shift. Review of the TAR for May 2013 revealed the checks for Wander guard did not begin until 5/5/13 on 7-3 shift. Nurses ' initials for the checks every shift were missing for the 11-7 shift all month. The 3-11 shift checks were missing nurses ' initials for 12 days. The 7-3 shift checks were missing nurses ' initials for 4 days. On the dates of 5/15/13, 5/25/13 and 5/26/13 the TAR was missing nurses ' initials for every shift checks for all three shifts.	F 323		

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The nurse ' s note dated 5/24/13 at 3:00 AM documented Resident (#10) found outside with another resident this past evening without staff members present. Brought resident inside. " Signed by nurse #1.

Interview with nurse #1 on 6/4/13 at 9:00 AM revealed she was looking for her (Resident #10). A staff member (she could not remember who) informed her Resident #10 was outside. Nurse #1 went to the front door and found Resident #10 outside. She was sitting with another resident (Resident #8) outside the door at the main entrance. Nurse #1 could not remember the exact time she found Resident #10, but thought it may have been around 8:00 or 8:30 PM. It was on the evening shift during bedtime meds. Further interview revealed nurse #1 was not sure if Resident #10 had a wanderguard on that day. The alarm did not sound when Resident #10 was brought back inside. This nurse was asked if she checked for the wanderguard and she responded she " did not see it. Don ' t think I was thinking about it, didn ' t enter my mind. " Nurse #1 was not sure how Resident #10 was able to get out the door. She thought Resident #8 may have held the door and let her out. Nurse #1 stated Resident #10 was " Not trying to leave, leave. " If a resident was not accounted for she would have contacted the Director of Nursing or administrator. That was not done because the resident was found. Nurse #1 was questioned about Resident #10 ' s behaviors. Her response was Resident #10 " All the time chatters about a car, she is not supposed to be there (at the facility), she was staying for the night. " Nurse #1 was aware the nurses were to check

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wanderguards and test their functioning. Nurse #1 could not remember if Resident #10 ' s wanderguard was checked.

Interview with Administrative nurse #1on 6/4/13 at 10:00 AM revealed there was no incident report completed for the incident of Resident #10 getting outside unsupervised by staff. When asked if one should be completed, she replied " I would think so. " Administrative nurse #1 was not aware Resident #10 had been outside the facility unsupervised and staff was not aware she was outside.

Interview with nurse #4 on 6/4/13 at 9:30 AM revealed the process for assessment for elopement included the assessment form completed on admission. The assessments are started on admission by the nurse working at that time. The assessments are completed within 24 to 48 hours after admission by all nurses who have worked. When the resident has scored at risk for elopement, the nurse places a wanderguard bracelet on the resident. The bracelets are kept in the medication room or at the nurses ' desk. An order would be written for the wanderguard, and placed on the treatment record for daily checks for functioning and every shift checks for placement.

Interview with aide #12 on 6/4/13 at 10:40 AM revealed Resident #10 had made statements about wanting to leave, but was easily directed. This staff member was not aware of any attempts by Resident #10 to exit the building. She was aware Resident #10 was at risk for elopement and " kept an eye on her. "

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F 323	Continued From page 9 Observations of Resident #10 on 6/3/13 at 4:47 PM were made of her talking with a male resident. Resident #10 asked if he was busy, she needed him to help her go outside and find her car. Interview with nurse #5 on 6/5/13 at 2:18 PM revealed this nurse did not know why the Wanderguard was placed on Resident #10 on 5/2/13 when she was assessed as an elopement risk on 4/10/13. She checked the care plan and nurses ' notes and provided the following reason: " On 5/1/13 she was observed going up and down hall, needing keys to car, and the wanderguard was put on for that episode. " Interviews were conducted on 6/5/13 4:30 PM with the five aides who had worked on 5/23/13 on the 3-11 shift. (Aides # 7, 8, 9, 10 and 11.) Each aide was asked if they had knowledge of Resident #10 being outside the facility on 5/23/13. Their response was " no. " Aide # 10 was assigned to Resident #10 and reported she had seen the resident in the dining room about 6:00 PM. Aide #10 was not aware the resident had gone outside unsupervised. Interview on 6/6/13 at 1:00 PM with aide #13 revealed she was driving into the parking lot of the facility to come to work at 7:00 PM. She saw Resident #10 on the front sidewalk with Resident #8 unsupervised. Nurse #1 was observed coming to the door and attempting to get Resident #10 inside the door. By the time aide #13 arrived at the front door, Resident #10 had been taken inside by nurse #1. Aide #12 expressed her knowledge Resident #10 should not be outside unsupervised.	F 323		

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F 323	Continued From page 10 3. Resident #10 was initially admitted to the facility on 4/5/13 with diagnoses of a fracture of Left wrist with cast. On 4/15/13 Resident #10 was hospitalized for a subdural hematoma (bleeding on the brain) after a fall. Upon readmission to the facility on 4/18/13 diagnoses included Parkinson ' s dementia. Review of the Fall Risk Assessment dated 4/19/13 revealed Resident #10 was high risk for falls. Review of the nurses ' notes revealed Resident #10 had eight falls from 4/13/13 to 5/23/13. Review of the fall report dated 4/13/13 revealed Resident #10 had fallen and was found on the floor. The intervention after this fall was to place a fall mat beside bed. Review of the nurses ' notes dated 4/15/13 Resident #10 was found on the floor. Resident was alert and verbal. Aware of person and place, complains of left hip and lower back pain. Order was obtained to send resident to hospital. Resident #10 was found at 5:15 PM. Resident #10 was sent to the hospital with diagnosis of subdural hematoma. Review of the Minimum Data Set (MDS) dated 4/25/13 documented Resident #10 had short and long term memory impairment with a BIMS score of 4. Assistance of one staff was required for transfer, ambulation and toileting. Supervision and cueing with set up assistance was required for locomotion off of the unit by Resident #10. This MDS assessed Resident #10 as having	F 323		

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F 323	Continued From page 11 balance problems sitting, standing and transferring. Review of the care plan dated 5/2/13 for a problem of risk of fall or injury due to problems sitting/standing balance, tremors, poor safety awareness, left side neglect and visual difficulty. This care plan included updates for interventions after each fall. There was not an intervention on the care plan for the fall written as " 4/14/13 fall in room " The intervention for the fall on 5/5/13 included " may wrap call light in green to make easier to see. " Review of the nurses ' note for 5/6/13 Resident fell at 7:30 AM on 5/5/13. There were no apparent injuries. She was found on the floor on her buttocks. Review of the fall investigation for this fall revealed the intervention included therapy would use yellow tape to wrap on the call light. Observations on 6/5/13 at 2:20 PM revealed Resident #10 in bed with no fall mat on either side of the bed. The call light was not wrapped in a green or yellow tape. Interview with aide #12 on 6/4/13 at 10:40 AM revealed Resident #10 was on a scheduled toileting for fall prevention. Resident #10 did have bed and chair alarms, but those have been discontinued. Aide #12 did not remember if she had a mat on the floor at any time. Observations on 6/4/13 at 10:40 AM revealed no mat at bedside in Resident #10 ' s room. The call light was not wrapped in green or yellow tape. Interview with housekeeper cleaning Resident	F 323		

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F 323	Continued From page 12 #10 ' s room revealed there had not been a mat on the floor in that room. This staff member responded " Some residents had a mat on the floor, but not Resident #10. " Interview with aide #14 on 3-11 6/5/13 at 4:28 PM revealed Resident #10 did not have a mat by bedside. Aide #14 came to the desk and reviewed the " devices " list. Resident #10 was not on the list for a fall mat. Interview with the MDS nurse on 6/6/13 at 10:45 AM revealed the mat was removed and she was not aware of the reason. The intervention for the use of the mat was missed on the admission care plan. Falls are reviewed each morning in a meeting each day. The care plans would be updated after that meeting. Interview with the therapy manager on 6/6/13 at 10:45 AM revealed she would call the physical therapist regarding the use of a colored tape on Resident #10 ' s call light. Follow up interview with therapy on 6/6/13 at 11:10 AM revealed they did not know what happened to the colored tape. It had been placed on the call light initially. She would apply colored tape to the light cord.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	1. Resident # 14 now has a behavior monitoring sheet that speaks specifically to the target behaviors associated with his prescriptions for anti anxiety and anti psychotic medications. This is being used to document any targeted behaviors. Medications are not being given unless there are documented behaviors that indicate the need. Medication is not being given if there are signs and symptoms of over sedation.	7/4/13

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F 329	Continued From page 13 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, therapy interview and record review the facility failed to monitor the use of an antipsychotic medication for Resident #14 for one of one sampled residents on antipsychotic medications. The facility failed to identify the indications for use, monitor for side effects and record behaviors for use of an anti-anxiety medication for Resident #14 for one of one sampled residents on an anti-anxiety medication. The findings included: Resident #14 was admitted to the facility on 4/3/13. The Klonopin (used for anxiety conditions) was ordered on 4/30/13. Resident #14 was to receive	F 329	1. A review of medications has been conducted by the attending physician to evaluate the appropriateness of an attempted gradual dose reduction. The physician has stated the resident is appropriately medicated and that the increased lethargy is related to his advancing disease process. 2. Current residents that are receiving anti anxiety and/or anti psychotic medications have behavior sheets that indicate the target behaviors that the medications are prescribed to assist with for that resident. Current licensed staff has been re educated to document on the behavior sheets at least every shift as well as documentation of any prn anti anxiety and/or anti psychotic to have the response to the medication documented either on the behavior sheet or in a narrative note in the resident chart. Current licensed staff has been re educated to identify that anti anxiety and anti psychotic medication often have a sedating effect and to monitor for over sedation. 3. The Director of Clinical Services or Unit Manager will document the monitoring of the behavior monitoring sheets of all residents prescribed anti anxiety and/or anti psychotic medications for completion daily x 7 days, 5 days a week x 11 weeks, and then weekly x 9months on the QI Monitoring tool for Behavior Monitoring sheets. 4. The Director of Clinical Services will report the findings of this monitoring to the QAPI committee monthly for review and recommendations. 5. The allegation of compliance for this plan is 7/4/2013.	7/4/13 7/4/13 7/4/13 7/4/13

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F 329	Continued From page 14 Klonopin .125 milligrams (mg) every night at 9:00 PM. Klonopin .125 mg was ordered to be given every day as needed. Review of the May 2013 monthly orders revealed the other medications included Zyprexa (an antipsychotic used for behaviors. Review of the Minimum Data Set (MDS) dated 5/5/13 for a Significant Change in condition assessed Resident #14 with impaired short and long term memory, severely impaired for daily decision making abilities, and a behavior of wandering. There were no other behaviors documented as occurring for this assessment. Resident #14 required extensive assistance to total dependence of one staff for all activities of daily living. Per this MDS assessment, Resident #14 did not ambulate. Review of a 30 day MDS dated 5/28/13 revealed Resident #14 had behaviors of rejection of care for one to three days per week and continued to have wandering behaviors. Review of the care plan dated 5/9/13 included the problem of psychotropic drug use with problems of fall risk and impaired cognition. The behaviors listed with these problems were combativeness, refusal of care and medications. The goal for this problem included no adverse effects from the psychotropic medication usage. The approaches included monitor and report adverse effects, monitor for lethargy, confusion and restlessness. Review of the record for the month of May revealed no behavior monitoring sheets for the use of the antipsychotic medication. Review of	F 329		

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F 329	Continued From page 15 the behavior monitoring sheet for the month of June revealed the target behavior of combativeness. There were no behaviors documented as occurring. Review of the documentation on the Medication Administration Record (MAR) for the month of June revealed the following dates and times Klonopin PRN was given: - 6/1/13 at 10 AM - 6/2/13 - not doc as to time. Review of the narcotic count sheet documented the Klonopin .125mg as being given on scheduled times at 9:00 PM and as needed (PRN) on the following dates and times: - 6/1/13 at 11:00 AM, - 6/1/13 at 9:00 PM, - 6/2/13 at 10:00 AM, - 6/2/13 at 9:00 PM, - 6/3/13 at 230 AM, - 6/3/13 at 9:00 PM, and - 6/4/13 at 2:30 AM. Review of the nurses ' notes for documentation of the reason the Klonopin PRN was administered was as follows: - 6/1/13 10 AM OOB up in wheelchair. Frequently standing and attempting to ambulate unassisted and requires frequent staff monitoring and reminders to remain in chair and ambulate with assist of staff only. - 6/2/13 There was no note as to why Klonopin given at 10:00 AM. At 11:00 AM the nurse ' s note documented Resident #14 was " resting in bed this AM. No agitation at present. "	F 329		

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F 329	Continued From page 16 Documentation recorded at 2:00 PM " resident agitated continues to attempt unassisted ambulation. Requires close and frequent staff monitoring. " - 6/3/13 1:30 AM no acute changes noted no c/o (complaints) at this time. Res (resident) sleeping with call bell within reach. " There were no other notes documented by the 11-7 nurse for 6/3/13. - 6/4/13 2:20 AM no acute changes noted, no c/o at this time. Res in bed sleeping at this time.. " Observations on 6/4/13 at 1:05 PM revealed Resident #14 was seated in a wheelchair with ½ lap tray positioned in a hallway. His eyes were closed and he was leaning to the left side of the wheelchair. The Director of Nursing approached the resident at 1:09 PM, spoke to him and repositioned his arms. Resident #14 sat upright after she left but kept his eyes closed. Aide # 14 went to Resident #14 ' s wheelchair and spoke with therapy standing by his side. Therapy staff member attempted to wheel Resident #14. Resident #14 was unable to lift his feet and they were dragging on the floor. Continued observation at 1:11 PM the therapist wheeled Resident #14 into the therapy room. Resident #14 was unable to stay awake to participate in a ball toss activity. The therapy staff member was observed giving sternal rubs to his chest with her knuckles. She was asking the resident to wake up, telling him to catch the ball. When tossed from the therapist to the resident, it landed on his lap and he did not participate. The therapist did sternal rubs one more time and Resident #14 opened his eyes and looked around.	F 329		

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F 329	Continued From page 17 Interview with the Physical Therapist who attempted to provide therapy during the observations on 6/4/13 at 1:11 PM was conducted. Interview with the therapist on 6/4/13 at 1:53 PM revealed Resident #14 was usually lethargic and did not participate in therapy. She had picked him up three times for physical therapy and he was being discharged that day. Resident #14 did have some episodes of being alert, but was unable to follow commands. Has no purposeful movement and described his movements as " reaches up/down, picks at the air. " An interview was conducted on 6/6/13 at 11:35 with nurse #5 who worked on 6/4/13 during the day shift. Nurse #5 was not aware of the sedating side effects of the Klonopin and had not noticed Resident #14 was lethargic and difficult to arouse that day. During interview this nurse stated no one had reported these side effects to her and she was not aware the therapist had to do sternal rubs to attempt to wake the resident up to participate in therapy. Nurse # 5 explained Resident #14 usually was good in the mornings, but later in the afternoon had behaviors like sun downing, more restless and agitated. Interview with Administrative nurse #1 on 6/6/13 at 2:35 PM revealed behavior sheets should be done on admission by the nurses or when an order is received for a new antipsychotic medication. This was an oversight by the nurses in May.	F 329		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive	F 463	1. The call bell was immediately replaced for Resident #11 as soon as facility staff was made aware on 6/4/2013.	7/4/13

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F 463	Continued From page 18 resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to provide an alternate method of calling for assistance for 1 of 64 residents (Resident #11) while the bedside call light was not functioning. The findings included: Resident #11 was originally admitted to the facility to the facility on 3/26/13 and readmitted on 4/11/13 with a cumulative diagnosis of: Traumatic Fracture of the Hip, Fracture of Femur, Anemia, Hypertension, Surgical complication of the digestive system, and hyposmolality. The MDS (Minimum Data Set) dated 5/7/13 revealed Resident #11 required limited assistance with Activities of Daily Living (ADL ' s). The MDS further identified the resident as being cognitively intact. A review of residents care plan dated 3/06/13 revealed the resident was care planned for ADL ' s. The Care Plan indicated the resident had a goal for risk for falls due to standing balance, smoking, and use of corrective eyewear. Approaches identified with ADL ' s were to keep call light within easy reach, and reorient resident to call light as needed. A review of Resident #11 medical record revealed	F 463	2. All call bells were immediately tested for all residents in the facility. Department Heads have been re educated by the Executive Director concerning the new requirement to check all call bells in their assigned rooms daily for placement and function. The department heads have been re educated to ensure any call bell in a non working order is immediately repaired or replaced with an alternative manual call bell and report their findings in the morning meeting. Facility staff has been re educated by the Executive Director, the Director of Clinical Services, or Department Heads to report any mal functioning call bell to a department head or supervisor to ensure that it is immediately remedied. 3. The Executive Director or designee will complete a PI Monitoring tool for Call Bell reports during the morning meeting daily 5 days a week x 4 weeks, weekly x 2 months, and then monthly x 9 months. 4. The Executive Director will report the findings of the monitoring to the QAPI committee monthly x12 months for review and recommendations. 5. The allegation of compliance for this plan is 7/4/2013. Westwood Health and Rehabilitation has written a response to the Statement of Deficiencies in the form of a Plan of Correction. This does not denote agreement with the Statement of Deficiencies nor does it constitute an admission of any fact or that any deficiency is accurate.	7/4/13 7/4/13 7/4/13

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Resident #11 was provided education about the facility call light function on 4/11/13. The Resident Education Record identified the resident understood the technique provided by Nurse #2.

Observation on 6/3/13 at 2:56 pm revealed Resident #11 ' s call light was not functioning when tested. No alternate method of calling for assistance was identified.

Interview with Resident on 6/3/13 at 4:25 pm revealed the facility did have manual call bells due to the call bell system being out. Resident #11 stated that the facility removed the manual call bells about a week ago. Resident #11 further indicated that his call bell had not been functioning since his admission. The resident revealed he had communicated to nursing staff that his call bell was not functioning. Resident #11 stated he had communicated his call light not functioning to the Director of Nursing (DON) but could not recall the names of other nursing staff that were informed.

Observation on 6/4/13 at 9:00 am revealed Resident #11 call bell did not function when tested. When tested the call bell did not alarm and the call bell indicator located outside of the resident room did not illuminate when tested.

The Maintenance Director was told that Resident #11 call bell was not functioning on 6/4/13 at 9:04 am. The Regional Clinical Director stated Resident #11 call bell was replaced and was functioning on 6/4/13 at 9:07 am.

Interview with the Maintenance Director on 6/3/13 at 3:03 pm revealed that the facilities call bell

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F 463	Continued From page 20 system was temporarily down for 11 days. The Maintenance Director indicated that the facility immediately implemented manual bells for residents affected by the inoperable call bell system. The Maintenance Director indicated the date the call bell issue began was 5/11/13 and was corrected on 5/21/13. The power control module for the nurse call system had to be replaced. The Maintenance Director indicated the part needed to correct the problem had to be ordered, and an outside agency provided the maintenance to the nurse call system. An invoice was reviewed. The invoice dated 5/21/13 indicated, " the power control module was replaced for the nurse call system; wired up all hallways and tested. System is working for now. Service call taken 5/20/13. " Interview with NA #2 on 6/3/13 at 4:35 pm revealed that manual bells were put into place when the call light system was not functioning. Nurse #2 stated that the facility provided extra staff during that time period to ensure all residents requests were met and call bells were answered timely. Nurse #2 stated that the facility did check the call bells periodically. A member of management would routinely mash 3 call lights in an effort to time staff on response times. Nurse #2 further indicated that in the instance a call light is found not to be operable a work order was to be completed and submitted to the Maintenance Director for repair. Interview with Nurse #2 on 6/4/13 at 12:45 pm indicated the Resident #11 received his call bell orientation on 4/11/13. Nurse #2 indicated upon admission on 4/11/13 she determines whether a	F 463		

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F 463	Continued From page 21 resident is alert and oriented. Nurse #2 indicated that Resident #11 was alert and oriented. Nurse #2 further indicated that she demonstrated how to push the call bell down when assistance was needed and communicated that the call bell would either be connected to the residents clothing or attached to the residents bed. Nurse #2 indicated she could not recall if the facility call bell system wasn ' t functioning on the day Resident #11 was admitted. Nurse #2 stated in the instance the call bell system was not functioning on the day of admission she would have educated the resident to manual bell system that was temporarily in place. Nurse #2 indicated Resident #11 was not re-oriented to the call bell system when it was fixed. Nurse #2 further indicated Resident #11 would come out into the hallway or go to the nurse ' s station to tell the Nurse what he wanted. Interview with NA #1 on 6/4/13 at 1:26 pm revealed Resident #11 used his call light to request assistance. NA #1 indicated Resident #11 would use the restroom on his own and was independent with his urostomy care. NA #1 further indicated that Resident #11 never communicated that this call light wasn ' t functioning. The NA stated that she does not check the call bells for function. Interview with the Housekeeping Supervisor on 6/4/13 at 2:45 pm revealed housekeeping staff clean resident rooms daily. The Housekeeping Supervisor indicated that in the instance housekeeping staff locates an issue with call lights they are to fill out a work order. The Housekeeping Manager indicated that it is not one of the responsibilities of housekeeping to	F 463		

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check the function of resident call bells.

Interview with Nurse #1 on 6/4/13 at 3:04 pm indicated that daily skilled nurse ' s notes are to be completed for each shift. Nurse #1 further indicated that it is a normal practice to document the placement of the resident call light. Nurse #1 stated that she does not check the call bell for function. Nurse #1 revealed Resident #11 routinely would yell out to staff passing by when he wished to request something or Resident #1 would come to the nurses station. Nurse #1 indicated Resident #11 had never communicated that his call bell was not functioning. Resident #11 was an independent resident and did not ask for assistance often. Nurse #1 stated the facility call lights were not functioning for a little over a week. Extra staff members were provided to assist with ensuring call lights were answered timely. Nurse #1 could not recall responding to Resident #11 due the resident use of the call bell.

Interview with NA #6 on 6/4/13 at 4:10 pm revealed Resident #11 would occasionally use his call light. NA# 6 further revealed Resident #11 would most often call out to NA #6 when she passed by his door or was going down the hall. NA #6 stated Resident #11 was an independent resident and only required limited assistance for his ADL needs.

Interview with the Director of Nursing on 6/6/13 at 3:03 pm revealed Resident #11 had never communicated that his call bell wasn ' t functioning. The DON indicated that she talks to Resident #11 daily. The DON stated that in the instance a call bell is found to be not working it is to be documented on a work order form that is

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F 463	Continued From page 23 submitted to the Maintenance Director. The DON revealed that it is her expectation that all residents have a means of calling for assistance.	F 463		