PRINTED: 03/07/2016 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245040	1	·				
		345216	B. WNG			02/	24/2016	
NAME OF PE	NAME OF PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTEIFI	WESTFIELD REHABILITATION AND HEALTH CENTER			3	100 TRAMWAY ROAD		İ	
***************************************	D REHADIEHAHOR AR	D HEALIN GENTER		5	SANFORD, NC 27332		•	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
					DETICIENCY			
,								
F 201	483.12(a)(2) REASO	NS FOR	F	201	The statements made on this	plan of	Ì	
SS=D	TRANSFER/DISCHA	RGE OF RESIDENT			correction are not an admission to	and do		
					not constitute an agreement w	ith the		
	The facility must pern	nit each resident to remain in			alleged deficiencies. To rem	ain in		
		ansfer or discharge the			compliance with all federal ar	d state		
		lity unless the transfer or			regulations the facility has taken			
	discharge is necessa	ry for the resident's welfare			take the actions set forth in this		!	
	and the resident's ne	eds cannot be met in the			correction. The plan of co			
,	facility;				1	tion of		
	,				compliance such that all	alleged		
		arge is appropriate because			deficiencies cited have been or			
		has improved sufficiently so			corrected by the date or dates indica			
	the resident no longe	r needs the services			corrected by the date of dates indica	neu.	.	
'	provided by the facilit	ty;			·			
	The safety of individu	ials in the facility is						
	endangered;							
		uals in the facility would						
	otherwise be endang	ered;						
		ed, after reasonable and					4	
		pay for (or to have paid						
		edicaid) a stay at the facility.						
		ecomes eligible for Medicaid						
		nursing facility, the nursing						
		resident only allowable	*					
	charges under Medic	eald; or						
		- 1						
	The facility ceases to	operate.						
	·							
	This DECUMENTS	er salar garangan salar						
		Γ is not met as evidenced						
	by:							
		iews, staff interviews and						
		facility failed to assure the						
		campled residents meets						
	criteria. (Residents #	197 and Residents # 196)						
							,	
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	1	TITLE	1	(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.

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	DF DEFICIENCIES GORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345216	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 TRAMWAY ROAD SANFORD, NC 27332	02/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 201	4/30/2014 with the di Hypothyroidism, Epilvenous insufficiency, disorder, leukocytosi Hypoxemia, organic Altered mental status disorder. Social services note documented "Disculoking into secured near future due to exof possible facilities adaughter." Social services note documented "I calle s power of the attorn regarding the availabunit and of the limited be open. He is plann and then give me a concept of the physical documented "Patien (assisted living) memore Review of Resident (FL2) dated 8/18/2010 discharged to assisted diagnoses: Nonpsyclorganic brain damagnistory of fall, adult fand Coronary Artery discharge form also	as admitted to the facility on agnoses which includes epsy, Esophageal reflux, Cataract, Dysthymic s, Adult failure to thrive, brain damage, Dysphasia, s, Dementia and seizure dated 8/12/2015 ssed the importance for units which is needed in the it seeking behavior. Names was shared with the dated 8/17/2015 dand spoke to the resident 'ey and informed him bility of beds in the secured datime in which the beds may ing to talk to his sister today call. " ian order dated 8/18/2015 and to be discharged to hory care unit. " # 197 's discharge form 5 revealed the resident was ad living facility with following motic mental disorder, ie, Epilepsy, Dementia, ailure to thrive, Hypoxemia	F 2	For resident #196 and #197 both a were discharge from the faci 08/20/15. Corrective Action for I Potentially Affected All resident have the potential affected by the alleged deficient On 03/14/16, all current resident reviewed by the Administrate	desident to be practice. Its were or and ischarge is were ischarge serviced ADON, Director, ctor and following and not from the harge is and the in the large is ealth has dent no liby the in the latth of therwise ed, after to pay

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IOCNITICIO ATIONI NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345216	B. WING			02/:	24/2016
	ROVIDER OR SUPPLIER	ID HEALTH CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 100 TRAMWAY ROAD ANFORD, NC 27332	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 201	During the interview	oladder and was non -ambulatory. view on 2/23/2016 at 2:00 PM, the		201	Medicaid) a stay at the facility. resident who becomes eligible for Mafter admission to a nursing facil nursing facility may charge reside allowable charges under Medicaid;	fedicaid lity, the ent only	
	under hospice service to assisted living fact stated the assisted li appropriate for the redid not have a hospiconcentrator which the resident was admitted Resident # 197 was living facility to a skill	esident because the facility tal bed and oxygen hey had do order once the d. She also reported that discharged from assisted led facility on 9/18/2015 d living facility could not			facility ceases to operate. Any administrative team member we not receive in-service training by Ma 2016 will not be allowed to wor training has been completed, information has been integrated in	who did arch 18, k until This anto the for all wed by	
	Responsible party remeeting with him indischarged to a secutive the facility the facility the facility the facility the reside was an assisted livin party further added to admitted to the assist the residents 'need decided to move the another town. During the interview the Director of Nursi Resident # 197 had facility decided to memory unit facility. decision was made to facility was under im	on 2/23/2016 at 1:00 PM, eported that the facility had a licating Resident # 197 will be staff did not inform him that ent was being discharged to g facility. The Responsible hat after Resident # 197 was sted living facility, he realized is were not being met so he resident to a skilled facility in on 2/24/2016 at 10:00 AM, ing (DON) reported that behavioral problems so the ove her to an assisted living She added at the time the to discharge the resident, the pression that the step down was skilled and was able to dents ' needs.				nitoring rom the ensure criteria mpleted cly x 4 or until Quality will be fe- QA iated as Life istrator, N, Unit	03/18/14

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLETI	RVEY
		345216	B. WING		C 02/24/ 2	2040
	PROVIDER OR SUPPLIER LD REHABILITATION A	ND HEALTH CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 100 TRAMWAY ROAD SANFORD, NC 27332	02/24/	2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE CO	(X5) DMPLETION DATE
F 201	Continued From pag	ge 3	F 201			1
	the Administrator rel have any idea that to locked unit was not accommodate Resid further added that no discharged from the that they are being	on 2/24/2016 at 10:15 AM, ported that the facility did not the assisted living facility skilled and was not able to dent # 197's needs. She ext time a resident is being facility she will make sure admitted to a facility that will date the residents' needs.				
	4/30/2014 with follow mental disorder, organismental disorder, organismental disorder, organismental disorder, organismental disorder, organismental disorder, Dysthydisease (CAD), Hypodisease (CAD), Hypo	mic disorder, coronary artery othyroidism, and Dementia. Data Set (MDS) date the resident's cognition was ad no behavioral symptoms, we assistance with bed				
	Review of the discha 8/18/2015 revealed F discharged to an ass 8/20/2015 with follow mental disorder, orga obstruction pulmonar hypertension, dysthyldisease (CAD), hyporathe discharge form a discharge the resider	rge form (FL2) dated Resident # 196 was isted living facility on ing diagnoses: nonpsychotic unic brain damage, chronic y disease (COPD), mic disorder, coronary artery thyroidism, and Dementia. Ilso revealed at the time of ut was incontinent of bowel				
	Review of the interdis summary dated 8/20/					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345216	B. WING				
	ROVIDER OR SUPPLIER		- !	STREET ADDRESS, CITY, S' B100 TRAMWAY ROAD SANFORD, NC 27332	TATE, ZIP CODE	02	2/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
	verbally. Medication I counted with son and unit " During the interview of Hospice nurse report. Resident # 197 were assisted living memoral facility on 9/18/2015 to facility could not proving the interview of Responsible party representing with him indicand Resident # 197 were assisted living and Resident # 197 were assisted living party further added the Resident # 197 were assisted living facility, he realized were not being met so to a skilled facility in a During the interview of the Director of Nursing Resident # 197 was diswith Resident # 196 be and they wanted to state time the decision were sidents, the facility were facility wanted to state time the decision were sidents, the facility was an assisted to state time the decision were sidents, the facility was displayed to state time the decision were sidents, the facility was an assisted to state time the decision were sidents, the facility was an assisted to state time the decision were sidents, the facility was an assisted to state time the decision were sidents, the facility was an assisted to a state time the decision were sidents, the facility was an assisted to a state time the decision were sidents, the facility was an assisted to a state time the decision was an assisted to a state time the decision was an assisted to a state time the decision was an assisted to a state time the decision was an assisted to a state time the decision was an assisted to a state time the decision was an assisted to a state time the decision was an assisted to a state time the decision was a state time the decision was an assisted to a state time the decision was a state time the dec	is given to son in writing and ist given also. Medication I sent via son to step down on 2/23/2016 at 2:00PM, the ed Resident # 196 and both discharged from the ary unit facility to a skilled because the assisted living de skilled services to both on 2/23/2016 at 1:00 PM, borted that the facility had a cating both Resident # 196 are facility. He added the form him that the facility were being discharged to a facility. The Responsible at after Resident # 196 and admitted to the assisted ed the residents ' needs he decided to move them nother town. on 2/24/2016 at 10:00 AM, in (DON) reported that scharged at the same time excause they were a couple by together. She added at was made to discharge the reas under impression that are unit facility was skilled and	F 201		SEL (SIENO!)		
	During the interview or	2/24/2016 at 10:15 AM,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345216	B. WING	,	02/2	4/2016
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/2	
WESTELL	D REHABILITATION AN	D HEALTH CENTER	3	100 TRAMWAY ROAD		
WESTIEL	D REHABILITATION AN	D IILALIII GENTER	s	ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E .	(X5) COMPLETION DATE
F 201	Continued From page	÷ 5	F 201			
	the Administrator reput discharged to a secul behavioral problems. facility did not have a living facility locked u not able to accommon Resident # 197 's ne next time a resident is facility she will make	orted Resident # 197 was red unit because of her She further stated that the n idea that the assisted nit was not skilled and was odate Resident # 196 and eds. She further added that s being discharged from the sure that they are being				
F 204 SS=D	admitted to a facility t accommodate 483.12(a)(7) PREPAI SAFE/ORDERLY TR	RATION FOR	F 204			
	orientation to residen	e sufficient preparation and ts to ensure safe or discharge from the facility.		F 204 Corrective Action for Resident Aff	fected	
	the administrator of the written notification pri to the State Survey A ombudsman, residen	closure, the individual who is ne facility must provide for to the impending closure gency the State LTC ts of the facility, and the of the residents or other		•		
	responsible parties, a transfer and adequate as required at §483.7 This REQUIREMENT by: Based on record rev family interview, the foreparation for safe a	as well as the plan for the e relocation of the residents,		All resident have the potential affected by the alleged deficient p On -3/14/16, all current resident reviewed by the Administrato Interdisciplinary team for di planning needs. No residents identified as meeting criteria for di from the facility at present.	oractice. s were or and scharge were	
	The findings included	t: 				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENIER	S FUR MEDICARE &	MEDICAID SERVICES			OIND INC	<i>).</i> 0930-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
		345216	B. WING			C 24/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		"". " " " " " " " " " " " " " " " " " "
				3100 TRAMWAY ROAD		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		SANFORD, NC 27332		
						
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI		DATE
17.0				DEFICIENCY)		
F 204	Continued From page	e 6	F 20	4		
	o o managa r rom pag		1 20			
	1 Resident # 197 ws	as admitted to the facility on		Systemic Changes		
		agnoses which includes				
		epsy, Esophageal reflux,		On 03/14/16, the Administrator i		
	venous insufficiency,			the Administrative team (DON		
		s, Adult failure to thrive,		SW, MDS Coordinator, Therapy		
		brain damage, Dysphasia,		Admission Nurse, Admissions Di		Ì
		s, Dementia and seizure		Business Office Manager) on the		
	disorder.			topics: When a resident is issued	•	
		•		discharge notice for the followin		
	Social services note	dated 8/12/2015		the transfer or discharge is necess		
	documented "Discu	ssed the importance for		residents welfare and the reside		
	looking into secured	units which is needed in the		cannot be met in the facility; the		
		it seeking behavior. Names		discharge is appropriate bed		
	of possible facilities v	was shared with the		residents health has improved s		
	daughter. "			so the resident no longer needs the provided by the facility; the		
	Social services note	dated 8/17/2015		individuals in the facility is endar		
	1	ed and spoke to the resident '		health of individuals in the faci		•
	s power of the attorn			otherwise be endangered; the re		
•		pility of beds in the secured		failed, after reasonable and a		
		d time in which the beds may		notice, to pay for (or to have p		
		ing to talk to his sister today		Medicare or Medicaid) a stay at		
	and then give me a	call. "		1110010010 01 1110010111 1111 1111		
	D : 60		4			
		ian order dated 8/18/2015 nt to be discharged to				
	1					
	(assisted living) men	lory care unit.				
	Review of Resident	# 197 's discharge form				
		15 revealed the resident was				
		ed living facility with following				
		hotic mental disorder,		,		
		je, Epilepsy, Dementia,				1
		ailure to thrive, Hypoxemia				
	and Coronary Artery					
		indicated the resident				
		with dressing, incontinent				
	with bowel and blade	der and was non -ambulatory.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING __ B. WING 345216 02/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 TRAMWAY ROAD **WESTFIELD REHABILITATION AND HEALTH CENTER** SANFORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 204 Continued From page 7 F 204 or the facility ceases to operate, preparation must be made for a safe and orderly During the interview on 2/23/2016 at 2:00 PM, the discharge. This will include having an Hospice nurse reported Resident # 197 was interdisciplinary team meeting (IDT) with under hospice services when she was discharged the resident and responsible party to discuss to assisted living facility on 8/20/2015. She further discharge planning needs to ensure that the stated the assisted living facility was not resident is transferred to a location that appropriate for the resident because the facility will meet the residents level of care needs did not have a hospital bed and oxygen as ordered by the physician. This meeting concentrator which they had do order once the resident was admitted. She also reported that will take place at the time the resident and Resident # 197 was discharged from assisted responsible party are issued the 30-day living facility to a skilled facility on 9/18/2015 discharge notice. Documentation of the because the assisted living facility could not IDT meeting and all other discharge provide skilled services. planning will be made by the Social Worker into the progress notes section of During the interview on 2/23/2016 at 1:00 PM. the residents chart. Responsible party reported that the facility had a meeting with him indicating Resident # 197 will be Any administrative team member who did discharged to a secured unit in another facility. not receive in-service training by March 18, He added the facility staff did not inform him that 2016 will not be allowed to work until the facility the resident was being discharged to training has been completed. was an assisted living facility. The Responsible information has been integrated into the party further added that after Resident # 197 was standard orientation training for admitted to the assisted living facility, he realized administrative staff and will be reviewed by the residents' needs were not being met so he the Quality Assurance Process to verify that decided to move the resident to a skilled facility in the change has been sustained. another town. During the interview on 2/24/2016 at 10:00 AM. the Director of Nursing (DON) reported that Resident # 197 had behavioral problems so the facility decided to move her to an assisted living memory unit facility. She added at the time the decision was made to discharge the resident, the facility was under impression that the step down memory unit facility was skilled and was able to take care of the residents ' needs.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
t.						С
		345216	B. WING		02	/24/2016
	ROVIDER OR SUPPLIER LD REHABILITATION AN	D HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 TRAMWAY ROAD SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 204	the Administrator reprhave any idea that the locked unit was not succommodate Reside further added that need is charged from the function that they are being a be able to accommodate. 2. Resident # 196 was	on 2/24/2016 at 10:15 AM, orted that the facility did not e assisted living facility killed and was not able to ent # 197's needs. She xt time a resident is being facility she will make sure idmitted to a facility that will date the residents' needs.	F 204	Quality Assurance The Administrator will monitor thusing the "Survey Quality Assuran for discharge planning. The mowill audit all residents discharging facility for reasons for discharge to reason for discharge meets the mentioned above and to ensu discharge planning has occur specified above. This will be compall residents' discharging weekly x	ce Tool nitoring from the ensure criteria re that red as letted on	
	mental disorder, orga obstructive pulmonar hypertension, Dysthy disease (CAD), Hypo Quarterly Minimum D 7/10/2015 indicated t severely impaired, ha and required extension mobility, dressing and Review of the discha 8/18/2015 revealed F discharged to an ass 8/20/2015 with follow mental disorder, orga obstruction pulmonar hypertension, dysthyldisease (CAD), hypo The discharge form a discharge the resider	anic brain damage, chronic y disease (COPD), mic disorder, coronary artery othyroidism, and Dementia. Data Set (MDS) date the resident's cognition was ad no behavioral symptoms, we assistance with bed dipersonal hygiene. Arge form (FL2) dated Resident # 196 was isted living facility on ring diagnoses: nonpsychotic anic brain damage, chronic ry disease (COPD), mic disorder, coronary artery thyroidism, and Dementia. Also revealed at the time of the was incontinent of bowel disassistance with dressing tory.	•	then monthly x two months of resolved by Quality Of Life Assurance Committee. Reports given to the monthly Quality of L committee and corrective action in appropriate. The Quality of Committee consists of the Admir Director of Nursing, Assistant DC Support Nurse, MDS Coordinator, I	or until /Quality will be ife- QA tiated as f Life histrator, N, Unit Business ormation	31814
	summary dated 8/20/					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG			, GOW	C	
		345216	B. WING				02	2/24/2016	
	PROVIDER OR SUPPLIER LD REHABILITATION AN	ID HEALTH CENTER		310	REET ADDRESS, CITY, STATE, ZIP O TRAMWAY ROAD NFORD, NC 27332	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE	
F 204	counted with son and unit "	ist given also. Medication I sent via son to step down	F2	204	· ·				
	Hospice nurse reports Resident # 197 were assisted living memo facility on 9/18/2015 b	on 2/23/2016 at 2:00PM, the ed Resident # 196 and both discharged from the ory unit facility to a skilled because the assisted living ide skilled services to both							
	Responsible party representing with him indicand Resident # 197 was ecured unit in another facility staff did not infinity which both residents was an assisted living party further added the Resident # 197 were a living facility, he realize	on 2/23/2016 at 1:00 PM, ported that the facility had a cating both Resident # 196 were being discharged to a per facility. He added the facility. He added the facility were being discharged to facility. The Responsible at after Resident # 196 and facility additional to the assisted fed the residents ' needs to he decided to move them nother town.							
	the Director of Nursing Resident # 197 was d with Resident # 196 be and they wanted to sta the time the decision v residents, the facility w	ischarged at the same time ecause they were a couple ay together. She added at was made to discharge the was under impression that y unit facility was skilled and							
		n 2/24/2016 at 10:15 AM,							

			(X3) DATE SURVEY COMPLETED	.		
			A. BUILDING	· ·	С	ĺ
		345216	B. WING		02/24/2016	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIELD REHABILITATION AND HEALTH CENTER				3100 TRAMWAY ROAD		.
			SANFORD, NC 27332			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIO	NC
F 204	Continued From page	e 10	F 20			
F 354 SS=C	behavioral problems. facility did not have a living facility locked unot able to accommon Resident # 197 's ne next time a resident is facility she will make admitted to a facility to accommodate 483.30(b) WAIVER-FULL-TIME DON Except when waived this section, the facility registered nurse for a a day, 7 days a week	under paragraph (c) or (d) of ty must use the services of a at least 8 consecutive hours	F 3:	F 354 Corrective Action for Resident Action for Resident Action for Residents identification id	ntified as	
	nursing on a full time			deficient practice.		
		ng may serve as a charge facility has an average daily ewer residents.		Corrective Action for Potentially Affected	Resident	-
	by: Based on record rev facility failed to sched	is not met as evidenced riew and staff interviews, the dule a registered nurse (RN) for 8 consecutive hours.		All resident have the potenti affected by the alleged deficien On March 14, 2016, the Adraudited all staffing postings a schedules to ensure that an RN for 8 consecutive hours 7 days a v February 24 th , 2016. This a completed on 03/14/16.	t practice. ninistrator and nurse was used week since	
		nade of the nurse staffing 09/26/15 and there were no				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING CB. WING 345216 02/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 TRAMWAY ROAD WESTFIELD REHABILITATION AND HEALTH CENTER SANFORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY **Systemic Changes** F 354 Continued From page 11 F 354 On February 24, 2016, the Administrator hours for a registered nurse. in-serviced the Nursing Administrative During an interview on 02/24/16 at 1:30 PM, the team (DON, ADON, MDS Coordinator, Director of Nursing (DON) verified that there was Nurse Secretary) on the following topics: no RN on the schedule for 09/26/15. She further the facility must use the services of a stated that the facility hired a RN to work on Registered nurse for at least 8 consecutive weekends and this person is off two weekends a hours a day, 7 days a week. In the event the year and she did not know how it was missed on RN scheduled calls off or is scheduled off 09/26/15. The DON stated she is on call on the then another RN must be called into to the weekends. facility to provide coverage. If one cannot be obtained, the RN on call must come into During an interview on 02/24/16 at 2:00 PM, the the facility to provide coverage. Assistant Director of Nursing (ADON) stated that she was still fairly new and came from a hospital Any administrative team member who did background and was not aware that a RN had to not receive in-service training by March 18, be scheduled for at least eight consecutive hours 2016 will not be allowed to work until per day on the weekends. The ADON further training has been completed. stated that sometimes she completes the nurse staffing data sheet and sometimes it is completed information has been integrated into the standard orientation training for all by the 11-7 shift nurse. administrative nursing staff and will be reviewed by the Quality Assurance Process During an interview on 02/14/16 at 2:25 PM, the Administrator stated that it is her expectation that to verify that the change has been a RN is schedule for 8 consecutive hours a day, 7 sustained. days a week. Quality Assurance The Administrator will monitor this issue using the "Survey Quality Assurance Tool for RN services. The monitoring will audit all staffing postings and schedules daily Monday thru Friday to ensure that an RN was scheduled for 8 consecutive hours a day 7 days a week. This will be completed on all residents' discharging weekly x 4 weeks then monthly x two months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 982H11

given to the monthly Quality of Life- QA committee and corrective action initiated as

Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business

Manager, Dietary Manager and Social

Office Manager, Health

The Quality

of

Information

appropriate.

Worker.