STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 02/24/2016

NAME OF PROVIDER 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and family interview, the facility failed to assure the discharge for 2 of 2 sampled residents meets criteria. (Residents # 197 and Residents # 196)	F 201	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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

Rhonda Andrews — Administrator — 3/14/16

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.

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F 201	Continued From page 1 The findings included: 1. Resident # 197 was admitted to the facility on 4/30/2014 with the diagnoses which includes Hypothyroidism, Epilepsy, Esophageal reflux, venous insufficiency, Cataract, Dysthymic disorder, leukocytosis, Adult failure to thrive, Hypoxemia , organic brain damage, Dysphasia, Altered mental status, Dementia and seizure disorder. Social services note dated 8/12/2015 documented " Discussed the importance for looking into secured units which is needed in the near future due to exit seeking behavior. Names of possible facilities was shared with the daughter. " Social services note dated 8/17/2015 documented " I called and spoke to the resident ' s power of the attorney and informed him regarding the availability of beds in the secured unit and of the limited time in which the beds may be open. He is planning to talk to his sister today and then give me a call. " Review of the physician order dated 8/18/2015 documented " Patient to be discharged to (assisted living) memory care unit. " Review of Resident # 197 ' s discharge form (FL2) dated 8/18/2015 revealed the resident was discharged to assisted living facility with following diagnoses: Nonpsychotic mental disorder, Organic brain damage, Epilepsy, Dementia, history of fall, adult failure to thrive, Hypoxemia and Coronary Artery Disease (CAD). The discharge form also indicated the resident required assistance with dressing, incontinent	F 201	**F 201** **Corrective Action for Resident Affected** For resident #196 and #197 both residents were discharge from the facility on 08/20/15. **Corrective Action for Resident Potentially Affected** All resident have the potential to be affected by the alleged deficient practice. On 03/14/16, all current residents were reviewed by the Administrator and Interdisciplinary team for discharge planning needs. No residents were identified as meeting criteria for discharge from the facility at present. **Systemic Changes** On 03/14/16, the Administrator in-serviced the Administrative team (DON, ADON, SW, MDS Coordinator, Therapy Director, Admission Nurse, Admissions Director and Business Office Manager) on the following topics: Reasons for transfer/discharge of a resident. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the residents welfare and the residents needs cannot be met in the facility; the transfer or discharge is appropriate because the residents health has improved sufficiently so the resident no longer needs the services provided by the facility; the safety of individuals in the facility is endangered; the health of individuals in the facility would otherwise be endangered; the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or	

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F 201	Continued From page 2 with bowel and bladder and was non -ambulatory. During the interview on 2/23/2016 at 2:00 PM, the Hospice nurse reported Resident # 197 was under hospice services when she was discharged to assisted living facility on 8/20/2015. She further stated the assisted living facility was not appropriate for the resident because the facility did not have a hospital bed and oxygen concentrator which they had do order once the resident was admitted. She also reported that Resident # 197 was discharged from assisted living facility to a skilled facility on 9/18/2015 because the assisted living facility could not provide skilled services. During the interview on 2/23/2016 at 1:00 PM, Responsible party reported that the facility had a meeting with him indicating Resident # 197 will be discharged to a secured unit in another facility. He added the facility staff did not inform him that the facility the resident was being discharged to was an assisted living facility. The Responsible party further added that after Resident # 197 was admitted to the assisted living facility, he realized the residents ' needs were not being met so he decided to move the resident to a skilled facility in 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.	F 201	Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge resident only allowable charges under Medicaid; or the facility ceases to operate. Any administrative team member who did not receive in-service training by March 18, 2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all administrative staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Administrator will monitor this issue using the "Survey Quality Assurance Tool for discharge planning. The monitoring will audit all residents discharging from the facility for reasons for discharge to ensure reason for discharge meets the criteria mentioned above. 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 given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	03/18/16

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F 201	Continued From page 3 During the interview on 2/24/2016 at 10:15 AM, the Administrator reported that the facility did not have any idea that the assisted living facility locked unit was not skilled and was not able to accommodate Resident # 197 ' s needs. She further added that next time a resident is being discharged from the facility she will make sure that they are being admitted to a facility that will be able to accommodate the residents ' needs. 2. Resident # 196 was admitted to the facility on 4/30/2014 with following diagnoses: nonpsychotic mental disorder, organic brain damage, chronic obstructive pulmonary disease (COPD), hypertension, Dysthymic disorder, coronary artery disease (CAD), Hypothyroidism, and Dementia. Quarterly Minimum Data Set (MDS) date 7/10/2015 indicated the resident ' s cognition was severely impaired, had no behavioral symptoms, and required extensive assistance with bed mobility, dressing and personal hygiene. Review of the discharge form (FL2) dated 8/18/2015 revealed Resident # 196 was discharged to an assisted living facility on 8/20/2015 with following diagnoses: nonpsychotic mental disorder, organic brain damage, chronic obstruction pulmonary disease (COPD), hypertension, dysthymic disorder, coronary artery disease (CAD), hypothyroidism, and Dementia. The discharge form also revealed at the time of discharge the resident was incontinent of bowel and bladder, required assistance with dressing and was non ambulatory. Review of the interdisciplinary discharge summary dated 8/20/2015 documented "	F 201		

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F 201	Continued From page 4 discharge instructions given to son in writing and verbally. Medication list given also. Medication counted with son and sent via son to step down unit " During the interview on 2/23/2016 at 2:00PM, the Hospice nurse reported. Resident # 196 and Resident # 197 were both discharged from the assisted living memory unit facility to a skilled facility on 9/18/2015 because the assisted living facility could not provide skilled services to both residents. During the interview on 2/23/2016 at 1:00 PM, Responsible party reported that the facility had a meeting with him indicating both Resident # 196 and Resident # 197 were being discharged to a secured unit in another facility. He added the facility staff did not inform him that the facility which both residents were being discharged to was an assisted living facility. The Responsible party further added that after Resident # 196 and Resident # 197 were admitted to the assisted living facility, he realized the residents ' needs were not being met so he decided to move them to a skilled facility in another town. During the interview on 2/24/2016 at 10:00 AM, the Director of Nursing (DON) reported that Resident # 197 was discharged at the same time with Resident # 196 because they were a couple and they wanted to stay together. She added at the time the decision was made to discharge the residents, the facility was under impression that the step down memory unit facility was skilled and was able to meet both residents ' needs. During the interview on 2/24/2016 at 10:15 AM,	F 201		

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F 201	Continued From page 5 the Administrator reported Resident # 197 was discharged to a secured unit because of her behavioral problems. She further stated that the facility did not have an idea that the assisted living facility locked unit was not skilled and was not able to accommodate Resident # 196 and Resident # 197 ' s needs. She further added that next time a resident is being discharged from the facility she will make sure that they are being admitted to a facility that will be able to accommodate	F 201		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and family interview, the facility failed to provide preparation for safe and orderly discharge for 2 of 2 sampled residents . (Residents # 197 and Residents # 196) The findings included:	F 204	**F 204** **Corrective Action for Resident Affected** For resident #196 and #197 both residents were discharge from the facility on 08/20/15. **Corrective Action for Resident Potentially Affected** All resident have the potential to be affected by the alleged deficient practice. On -3/14/16, all current residents were reviewed by the Administrator and Interdisciplinary team for discharge planning needs. No residents were identified as meeting criteria for discharge from the facility at present.	

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F 204	Continued From page 6 1. Resident # 197 was admitted to the facility on 4/30/2014 with the diagnoses which includes Hypothyroidism, Epilepsy, Esophageal reflux, venous insufficiency, Cataract, Dysthymic disorder, leukocytosis, Adult failure to thrive, Hypoxemia , organic brain damage, Dysphasia, Altered mental status, Dementia and seizure disorder. Social services note dated 8/12/2015 documented " Discussed the importance for looking into secured units which is needed in the near future due to exit seeking behavior. Names of possible facilities was shared with the daughter. " Social services note dated 8/17/2015 documented " I called and spoke to the resident ' s power of the attorney and informed him regarding the availability of beds in the secured unit and of the limited time in which the beds may be open. He is planning to talk to his sister today and then give me a call. " Review of the physician order dated 8/18/2015 documented " Patient to be discharged to (assisted living) memory care unit. " Review of Resident # 197 ' s discharge form (FL2) dated 8/18/2015 revealed the resident was discharged to assisted living facility with following diagnoses: Nonpsychotic mental disorder, Organic brain damage, Epilepsy, Dementia, history of fall, adult failure to thrive, Hypoxemia and Coronary Artery Disease (CAD). The discharge form also indicated the resident required assistance with dressing, incontinent with bowel and bladder and was non -ambulatory.	F 204	**Systemic Changes** On 03/14/16, the Administrator in-serviced the Administrative team (DON, ADON, SW, MDS Coordinator, Therapy Director, Admission Nurse, Admissions Director and Business Office Manager) on the following topics: When a resident is issued a 30-day discharge notice for the following reasons: the transfer or discharge is necessary for the residents welfare and the residents needs cannot be met in the facility; the transfer or discharge is appropriate because the residents health has improved sufficiently so the resident no longer needs the services provided by the facility; the safety of individuals in the facility is endangered; the health of individuals in the facility would otherwise be endangered; the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility	

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F 204	Continued From page 7 During the interview on 2/23/2016 at 2:00 PM, the Hospice nurse reported Resident # 197 was under hospice services when she was discharged to assisted living facility on 8/20/2015. She further stated the assisted living facility was not appropriate for the resident because the facility did not have a hospital bed and oxygen concentrator which they had do order once the resident was admitted. She also reported that Resident # 197 was discharged from assisted living facility to a skilled facility on 9/18/2015 because the assisted living facility could not provide skilled services. During the interview on 2/23/2016 at 1:00 PM, Responsible party reported that the facility had a meeting with him indicating Resident # 197 will be discharged to a secured unit in another facility. He added the facility staff did not inform him that the facility the resident was being discharged to was an assisted living facility. The Responsible party further added that after Resident # 197 was admitted to the assisted living facility, he realized the residents ' needs were not being met so he decided to move the resident to a skilled facility in 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.	F 204	or the facility ceases to operate, preparation must be made for a safe and orderly discharge. This will include having an interdisciplinary team meeting (IDT) with the resident and responsible party to discuss discharge planning needs to ensure that the resident is transferred to a location that will meet the residents level of care needs as ordered by the physician. This meeting will take place at the time the resident and responsible party are issued the 30-day discharge notice. Documentation of the IDT meeting and all other discharge planning will be made by the Social Worker into the progress notes section of the residents chart. Any administrative team member who did not receive in-service training by March 18, 2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all administrative staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 204	Continued From page 8 During the interview on 2/24/2016 at 10:15 AM, the Administrator reported that the facility did not have any idea that the assisted living facility locked unit was not skilled and was not able to accommodate Resident # 197 ' s needs. She further added that next time a resident is being discharged from the facility she will make sure that they are being admitted to a facility that will be able to accommodate the residents ' needs. 2. Resident # 196 was admitted to the facility on 4/30/2014 with following diagnoses: nonpsychotic mental disorder, organic brain damage, chronic obstructive pulmonary disease (COPD), hypertension, Dysthymic disorder, coronary artery disease (CAD), Hypothyroidism, and Dementia. Quarterly Minimum Data Set (MDS) date 7/10/2015 indicated the resident ' s cognition was severely impaired, had no behavioral symptoms, and required extensive assistance with bed mobility, dressing and personal hygiene. Review of the discharge form (FL2) dated 8/18/2015 revealed Resident # 196 was discharged to an assisted living facility on 8/20/2015 with following diagnoses: nonpsychotic mental disorder, organic brain damage, chronic obstruction pulmonary disease (COPD), hypertension, dysthymic disorder, coronary artery disease (CAD), hypothyroidism, and Dementia. The discharge form also revealed at the time of discharge the resident was incontinent of bowel and bladder, required assistance with dressing and was non ambulatory. Review of the interdisciplinary discharge summary dated 8/20/2015 documented " discharge instructions given to son in writing and	F 204	**Quality Assurance** The Administrator will monitor this issue using the "Survey Quality Assurance Tool for discharge planning. The monitoring will audit all residents discharging from the facility for reasons for discharge to ensure reason for discharge meets the criteria mentioned above and to ensure that discharge planning has occurred as specified above. 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 given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	3/18/16

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F 204	Continued From page 9 verbally. Medication list given also. Medication counted with son and sent via son to step down unit " During the interview on 2/23/2016 at 2:00PM, the Hospice nurse reported Resident # 196 and Resident # 197 were both discharged from the assisted living memory unit facility to a skilled facility on 9/18/2015 because the assisted living facility could not provide skilled services to both residents. During the interview on 2/23/2016 at 1:00 PM, Responsible party reported that the facility had a meeting with him indicating both Resident # 196 and Resident # 197 were being discharged to a secured unit in another facility. He added the facility staff did not inform him that the facility which both residents were being discharged to was an assisted living facility. The Responsible party further added that after Resident # 196 and Resident # 197 were admitted to the assisted living facility, he realized the residents ' needs were not being met so he decided to move them to a skilled facility in another town. During the interview on 2/24/2016 at 10:00 AM, the Director of Nursing (DON) reported that Resident # 197 was discharged at the same time with Resident # 196 because they were a couple and they wanted to stay together. She added at the time the decision was made to discharge the residents, the facility was under impression that the step down memory unit facility was skilled and was able to meet both residents ' needs. During the interview on 2/24/2016 at 10:15 AM, the Administrator reported Resident # 197 was	F 204		

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F 204	Continued From page 10 discharged to a secured unit because of her behavioral problems. She further stated that the facility did not have an idea that the assisted living facility locked unit was not skilled and was not able to accommodate Resident # 196 and Resident # 197 ' s needs. She further added that next time a resident is being discharged from the facility she will make sure that they are being admitted to a facility that will be able to accommodate	F 204		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a registered nurse (RN) on Saturday, 09/26/15 for 8 consecutive hours. The findings included: Record review was made of the nurse staffing data sheet dated on 09/26/15 and there were no	F 354	**F 354** **Corrective Action for Resident Affected** There were no residents identified as having been affected by this alleged deficient practice. **Corrective Action for Resident Potentially Affected** All resident have the potential to be affected by the alleged deficient practice. On March 14, 2016, the Administrator audited all staffing postings and nurse schedules to ensure that an RN was used for 8 consecutive hours 7 days a week since February 24th, 2016. This audit was completed on 03/14/16.	

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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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 11 hours for a registered nurse. During an interview on 02/24/16 at 1:30 PM, the Director of Nursing (DON) verified that there was no RN on the schedule for 09/26/15. She further stated that the facility hired a RN to work on weekends and this person is off two weekends a year and she did not know how it was missed on 09/26/15. The DON stated she is on call on the weekends. During an interview on 02/24/16 at 2:00 PM, the Assistant Director of Nursing (ADON) stated that she was still fairly new and came from a hospital background and was not aware that a RN had to be scheduled for at least eight consecutive hours per day on the weekends. The ADON further stated that sometimes she completes the nurse staffing data sheet and sometimes it is completed by the 11-7 shift nurse. During an interview on 02/14/16 at 2:25 PM, the Administrator stated that it is her expectation that a RN is schedule for 8 consecutive hours a day, 7 days a week.	F 354	**Systemic Changes** On February 24, 2016, the Administrator in-serviced the Nursing Administrative team (DON, ADON, MDS Coordinator, Nurse Secretary) on the following topics: the facility must use the services of a Registered nurse for at least 8 consecutive hours a day, 7 days a week. In the event the RN scheduled calls off or is scheduled off then another RN must be called into to the facility to provide coverage. If one cannot be obtained, the RN on call must come into the facility to provide coverage. Any administrative team member who did not receive in-service training by March 18, 2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all administrative nursing staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **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 given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	3/18/16