STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 08/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

(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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		9/1/17

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

Electronically Signed | 08/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner, and physician interview the facility failed to notify the nurse practitioner or physician when a resident experienced a significant weight loss for 1 of 4 sampled residents (Resident #49). The findings included: Resident #49 was admitted to the facility on 12/23/14 and was most recently readmitted to the facility on 01/09/17 with diagnoses that included acute/chronic respiratory failure, irritable bowel syndrome, edema, chronic obstructive pulmonary disease, metabolic encephalopathy, dysphagia, depression, schizophrenia, and dementia. Review of Weight Exception report dated 02/03/17 through 08/03/17 revealed that Resident #49 had triggered a 3% weight loss on 05/24/17 from the previous weight on 03/15/17, he triggered a 10% weight loss on 06/28/17 over 6 months, and 10% weight loss on 07/26/17 over 6 months Review of the most recent quarterly minimum data set (MDS) dated 07/05/17 revealed that Resident #49 was severley cognitively impaired and required extensive assistance of 1 person	F 157	Westwood Hills Nursing and Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehab's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Westwood Hills Nursing and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident #49's Nurse Practitioner (NP) was notified of the weight loss on 2/8/2017 and the continuing weight loss on 7/27/2017. The weight committee	

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F 157	Continued From page 2 with eating. The MDS also indicated that Resident #49 was 72 inch tall. No weight was recorded on the MDS. The MDS also indicated that no significant weight loss had occurred. The MDS also revealed that resident #49 received a mechanically altered diet. Review of Weight Change Note dated 07/10/17 read, "-10% weight loss over 180 days that was unplanned. Resident #49 received beneprotein 2 scoops twice a day and ate 75-100% of meals per documentation. Will increase size of meal portion to improve weight status." The note was signed by the dietary manager (DM). Review of Resident #49's medical record on 08/01/17 revealed the follow weights: - 01/26/17: 178 lbs. - 02/09/17: 177 lbs. - 03/15/17: 176 lbs. - 05/24/17: 161 lbs. - 06/28/17: 157 lbs. - 07/26/17: 155 lbs. An interview was conducted with the DM on 08/02/17 at 5:11 PM. The DM confirmed that Resident #49 had experienced a significant weight loss. The DM stated that Resident #49 had been discharged from speech therapy on 02/15/17 and they recommended removing the meat from Resident #49's tray due to chewing/swallowing difficulties. She added at that time she replaced the meat with yogurt on his meal tray. The DM stated she had added large portions for Resident #49 in late July 2017. The DM stated that she had not recommended any supplement for Resident #49 because he ate 100% of his meals and had attributed his weight	F 157	meets on a monthly basis and any 5% or 10% gains or losses are reviewed by the committee, which includes the Dietary Manager, the QI Nurse, the DON or designee, and the nursing assistants who are on the weight team. All current residents with 5% or 10% weight losses will reviewed by the weight committee along with the Dietary Manager on 8/30/2017. They will be reviewed for possible interventions for their weight loss/gain. The MD/FNP will be notified with new orders, if any. The care plans will also be reviewed and updated as needed. The Director of Nursing (DON) retrained the weight committee on the importance of ensuring the MD/FNP are notified timely. This was completed on August 23, 2017. The DON or designee will audit weekly all residents identified for weight loss or gain to ensure MD/FNP notification. This will occur weekly x 6, then monthly x3. Any issues will be addressed at the time with retraining. The Quarterly Executive QA Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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F 157	Continued From page 3	F 157		

loss to his hospitalization. The DM confirmed that she had not reached out to the RD to see if she could help to accurately calculate Resident #49's needs. The DM also confirmed that she had not referred Resident #49 to his physician to see if there was any medical reason why Resident #49 was continuing to lose weight despite eating 100% of his meal trays.

An interview was conducted with the Nurse Practitioner (NP) on 08/03/17 at 4:39 PM. The NP stated that she could not recall being notified of any significant weight loss for Resident #49 and could not recall the last time she had evaluated the resident. The NP stated she certainly would have wanted to have been notified of Resident #49's weight loss so she could have evaluated him for an appetite stimulate and monitored his intake and determined if he needed a supplement. She added that generally the Registered Dietitian (RD) was involved with significant weight loss and made recommendations then she would approve those recommendations but the NP again stated she could not recall being notified of any weight loss that Resident #49 experienced.

An interview was conducted with the Director of Nursing (DON) on 08/03/17 at 6:00 PM. The DON stated that the staff was expected to notify the responsible party and the NP or physician of any significant weight gain or loss.

An interview was conducted with the physician on 08/04/17 at 10:15 AM. The physician stated that generally he was notified of any significant weigh loss via the monthly list provided by the weight committee. He added that Resident #49 had severe chronic obstructive pulmonary disease

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F 157	Continued From page 4 and would expect some weight loss with that diagnosis but he could not recall if he had been notified specifically about Resident #49's significant weight loss.	F 157		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		9/1/17

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F 278	Continued From page 5 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the minimum data set (MDS) to reflect a significant weight loss (Resident #49) and failed to accurately reflect a diagnosis of a fracture (Resident #25) for 2 of 5 sampled residents. The findings included: 1. Resident #49 admitted to the facility on 12/23/14 and most recently readmitted to the facility on 01/09/17 with diagnoses that included acute/chronic respiratory failure, irritable bowel syndrome, edema, chronic obstructive pulmonary disease, metabolic encephalopathy, dysphagia, depression, schizophrenia, and dementia. Review of Weight Exception report dated 02/03/17 through 08/03/17 revealed that Resident #49 had a 3% weight loss on 05/24/17 from the last weight on 03/15/17 and a 10% weight loss on 06/28/17 over the last 6 months. Review of the most recent quarterly minimum data set (MDS) dated 07/05/17 revealed that Resident #49 was severley cognitively impaired and required extensive assistance of 1 person with eating. The MDS also indicated that Resident #49 was 72 inch tall. No weight was recorded on the MDS. The MDS also indicated that no significant weight loss had occurred. Review of Resident #49's medical record on 08/01/17 revealed the following weights:	F 278	Resident #49's MDS dated 7/5/2017 was modified and submitted on 8/22/2017 by the MDS nurse to reflect the current weight at that time and the weight loss. Resident #25's Minimum Data Set was modified and submitted by the MDS nurse on 08/03/2017 to include the diagnosis of other fracture. All other residents' MDS who had weight loss and or fractures were audited for accurate coding on 8/25/2017 by the MDS nurses and the Dietary Manager. A retraining by the corporate MDS consultant was given on 8/21/2017. In attendance was the MDS nurses and the dietary manager. A random audit will be performed weekly x 6 by the corporate nurse consultant or designee to check for accurate coding of fractures and weight loss of the residents who are identified with fractures and weight loss. This information will come from the QI Nurse or designee and the Weight Committee reports. This will be completed weekly x 6, then monthly x3 starting in September, 2017, by the consultant. Issues, if any, will be corrected immediately with retraining to the staff involved. The Quarterly Executive QA Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of	

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F 278	Continued From page 6 - 01/26/17: 178 lbs. - 02/09/17: 177 lbs. - 03/15/17: 176 lbs. - 05/24/17: 161 lbs. - 06/28/17: 157 lbs. - 07/26/17: 155 lbs. An interview was conducted with the dietary manager (DM) on 08/02/17 at 5:11 PM. The DM confirmed that Resident #49 had experienced a significant weight loss and she should have coded the MDS dated 07/05/17 to reflect that weight loss. The DM stated that the weight obtained on 06/28/27 should have been used to complete the MDS which would reflect the significant loss. She was unsure why she did not use the weight to complete the MDS and could not recall why she had not captured the significant weight loss on the assessment. An interview was conducted with the Administrator on 08/03/17 at 12:30 PM and she stated she expected the MDS to be completed accurately. An interview was conducted with MDS Nurse #1 on 08/03/17 at 5:00 PM. MDS Nurse #1 stated that the DM completed the dietary section of the MDS and that they did not provide any oversight to the accuracy of the information that she coded. MDS Nurse #1 indicated that she expected the DM to complete the MDS as accurately as possible. 2. Resident #25 was admitted to the facility on 08/25/15. The annual Minimum Data Set (MDS) assessement dated 06/23/17 indicated that the resident was cognitively intact. The resident required extensive assistance of two persons for	F 278	continued QI monitoring.	

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bed mobility, for dressing, and personal hygiene. Resident #25 was dependent for transfers.

A record review revealed that the resident was taken to the Emergency department of a local hospital on 06/13/17 after a fall which resulted in an injury to a leg.

A review of the Emergency Department documentation dated 06/13/17 indicated that the resident had sustained a right distal femur fracture, and a right fibular and a tibia fracture.

The record review for Resident #25, indicated the care plan was updated on 06/15/17, with new interventions due to the new diagnosis of fractured right tibia, fibula, and femur on 06/13/17.

A review of the annual Minimum Data Set assessment dated 06/23/17 revealed that Section I: Active Diagnosis had item #14000 (other fracture) marked as "No."

On 08/03/17 at 12:09 PM an interview was conducted with the MDS Nurse who reviewed the Minimum Data Set assessment dated 06/23/17 and who confirmed that the area for documentation of "other fracture" was marked "No." The MDS Nurse stated that Resident #25 did have a fracture and the answer should have been marked "Yes."

An interview was conducted with the facility's Administrator on 08/03/17 at 12:30 PM. During the interview the Administrator stated that it was her expectation for the MDS assessment to be completed accurately.

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F 282	Continued From page 8	F 282		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and registered dietitian interview the facility failed to follow care plan interventions by not referring a resident with unintended significant weight loss to the registered dietitian for 1 of 3 residents sampled for weight loss (Resident #49). The Findings included: Resident #49 was admitted to the facility on 12/23/14 and was most recently readmitted to the facility on 01/09/17 with diagnoses that included acute/chronic respiratory failure, irritable bowel syndrome, edema, chronic obstructive pulmonary disease, metabolic encephalopathy, dysphagia, depression, schizophrenia, and dementia. Review of Weight Exception report dated 02/03/17 through 08/03/17 revealed that Resident #49 had triggered a 3% weight loss on 05/24/17 from his last weight on 03/15/17, he triggered a 10% weight loss on 06/28/17 over 6 months, and 10% weight loss on 07/26/17 over 6 months. Review of Weight Change Note dated 05/26/17 read, there was a -3% weight change from the	F 282	Resident #49 was referred to the Registered Dietitian (RD) on 8/2/2017 per the care plan. Recommendations were provided and implemented with changes as needed for this resident. The RD will be notified by the Dietary Manager monthly of any residents who have a need for referral for weight loss or gains as per the care plan. This will be completed via email/phone correspondence or consultative visit. The RD will review the medical records monthly or as needed for any recommendations for the residents. This will be addressed on the care plan. The RD retrained the dietary manager on the process for notifying the RD about documented referrals. This was completed on August 15, 2017. The Director of Nursing or designee will audit the identified residents for weight loss or gain weekly x6 weeks, then monthly x 3, to verify that any appropriate referrals to the RD have been made with recommendations. Any issues will be addressed with retraining.	9/1/17

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F 282	Continued From page 9 last weight. The weight loss was unplanned. Resident #49 ate 100% of meals and was very active in propelling his wheelchair around the facility. Will continue to monitor. If any further weight loss was noted will evaluate the need for larger portions of food. Signed by the dietary manger (DM). Review of the most recent quarterly minimum data set (MDS) dated 07/05/17 revealed that Resident #49 was severely cognitively impaired and required extensive assistance of 1 person with eating. The MDS also indicated that Resident #49 was 72 inch tall. No weight was recorded on the MDS. The MDS also indicated that no significant weight loss had occurred. The MDS also revealed that resident #49 received a mechanically altered diet. Review of a care plan that was revised on 07/05/17 read in part, Resident #49 was at risk for state of nourishment less than body requirement characterized by decreased appetite and weight loss related to history of dysphagia with a need for mechanically altered diet. The goal of stated care plan was Resident #49 would maintain or increase his weight in the next month, would be able chew food without difficulty, and Resident #49 would be provided enough protein to meet his daily requirements. The interventions included refer to dietitian for evaluation and recommendations as needed. Review of Weight Change Note dated 07/10/17 read, -10% weight loss over 180 days that was unplanned. Resident #49 received beneprotein 2 scoops twice a day and ate 75-100% of meals per documentation. Will increase size of meal portion to improve weight status. Signed by the	F 282	The Quarterly Executive QA Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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DM.

Review of Resident #49's medical record on 08/01/17 revealed no referral to the Registered Dietitian (RD) or any progress note from the RD in 2017.

An interview was conducted with the dietary manager (DM) on 08/02/17 at 5:11 PM. The DM stated that if a resident experienced weight loss that was unplanned or if the interventions in place were not effective then the resident would be referred to the RD. The DM also stated that if a resident triggered multiple times on the weight exception report then she would also refer the resident to the RD. The DM stated that Resident #49 had been discharged from speech therapy on 02/15/17 and that they recommended removing the meat from Resident #49's tray due to chewing/swallowing difficulties. She added at that time she replaced the meat with yogurt on his meal tray. The DM stated she had added large portions for Resident #49 in late July 2017. The DM stated that she had not recommended any nutritional intervention for Resident #49 because he ate 100% of his meals and had attributed his weight loss to his hospitalization. The DM stated that each puree meal consisted of 2567 calories and she did not how to remove part of those calories to reflect the removal of meat from his meal tray and then add the additional protein provided by the yogurt and beneprotein. The DM confirmed that she had not reached out to the RD to see if she could help to accurately calculate Resident #49's needs.

An interview was conducted with the RD on 08/03/17 at 11:03 AM. The RD stated she visited the facility at least 2 times a month but was

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always available by phone if needed. She added that when she visited the DM would provide her a list of residents that she needed to see. The RD stated the DM handled a lot of the needs of the high risk residents through the diet tray tracker system and through orders if it was a supplement that was needed. The RD stated she did not get involved with every resident that experienced weight loss, if the interventions that the DM implemented were effective then she would not necessarily see that resident. The RD confirmed she was not familiar with Resident #49 or the fact that his meat was being removed from his meal tray and extra protein added at each meal. The RD stated that if a resident was eating 100% of meals and continued to lose weight that would certainly warrant a referral to the RD. She stated that calculating Resident #49's needs would obviously be difficult by removing the meat from his tray and she could have certainly assisted the DM in doing this if she had been made aware of the issue.

An interview was conducted with the Administrator on 08/03/17 at 2:58 PM. The Administrator stated that she would have liked for the DM to have referred Resident #49 to the RD to get assistance in accurately calculating Resident #49's needs.

In a follow up interview with DM on 08/03/17 at 3:32 PM the DM confirmed that she had not reached out to the RD with any concerns she had for Resident #49. The DM stated "it did not concern me because he was eating so well and his labs looked good." She stated that she should have obviously started a nutritional intervention and referred Resident #49 to the RD.

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F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed to accurately assess and prevent the development of a pressure ulcer for one of three sampled residents (Resident # 25). The resident developed a Stage III pressure ulcer after the placement of a long leg immobilizer due to a femur, tibia, and fibular fracture on 06/13/17. The findings included: Resident #25 was admitted to the facility on 08/25/15 with diagnosis which included: chronic asthma, anxiety, depression, psychotic disorder, and hypertension. The resident sustained fractures of the right leg on 06/14/17 after a fall from her bed. The Minimum Data Set MDS)	F 314	Resident #25 continues to receive daily skin inspections by the nurses and the nursing assistants. Treatment to the wound is provided daily by the treatment nurse. A short leg immobilizer is now applied by the nursing staff when the resident is OOB only. A 100% skin observation of all residents with non-removable devices, such as immobilizers and casts was completed on 8/25/2017. Skin conditions if any, were documented with treatments initiated. All residents with non-removable immobilizers or casts will continue to have their skin observed daily by the licensed staff and the nursing assistants. Any areas of concern will be addressed	9/1/17

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F 314	Continued From page 13 annual assessment dated 06/22/17 indicated the resident required extensive assistance by two persons for bed mobility, dressing, and personal hygiene. Resident #25 required only supervision for meals. She was dependent for transfers and always incontinent for bowel and bladder functions. The MDS dated 06/23/17 indicated Resident #25 had one unstageable pressure ulcer which measured 1.5 centimeters in length, 3/6 centimeters in width, and 00.1 centimeter in depth and had yellow slough tissue in the base of the wound. The MDS assessment also indicated that the resident had a stage unstageable pressure ulcer. Record review for Resident #25, indicated the care plan was updated 06/15/17, with new interventions due to the new diagnosis of fractures right tibia, fibula, and femur. A record review of the Emergency Department (ED) MD note dated 06/13/17 revealed that the resident had sustained a right distal femoral fracture, right proximal tibia and fibular fracture. Resident #25 was determined to not be well enough for surgery and returned to the facility on 06/13/17 with a full leg immobilizer in place. The ED Provider note also stated that the resident was advised to stay in her knee immobilizer at all times and remain with no weight bearing. A review of a cast observation flow sheet dated 06/21/17 revealed Resident #25 had a leg immobilizer on right leg, and indicated surrounding skin was within normal limits, with edema in bilateral lower edema, and no open wound. The form dated 06/22/17 indicated that Resident #25 had a pressure ulcer to right upper inner thigh above immobilizer.	F 314	immediately with the supervisor/treatment nurse. Interventions such as padding the edge will be utilized at that time by the nursing staff as directed by the MD. All licensed nurses have been retrained on skin observation of residents with non-removable immobilizers or casts. These trainings were conducted by the SDC, the DON and the RN Supervisors. 100% training was completed by 8/27/2017. The DON or designee will audit weekly x6, then monthly x 3, the skin observations of 100% of the residents with a non-removable immobilizer or cast. Any areas of concern will be addressed immediately with retraining. The Quarterly Executive QA Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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A record review of form entitled Wound Ulcer flowsheet assessment flow sheet was completed by the wound treatment nurse and was dated 06/21/17 with time of 15:48. The form indicated resident with pressure ulcer which measured 1.5 centimeter in length, 3.6 centimeter in width and the wound bed surface was 90% covered with yellow slough. The pressure ulcer was assessed to be a Stage II wound. The Wound Ulcer Flow Sheet also stated MD had been notified on that date of the development of the pressure ulcer.

The physician was notified and an order was present on the medical record dated 06/21/17 for wound care to the pressure ulcer on the right upper leg by applying santyl ointment and dry dressing.

A record review of Wound Ulcer Flowsheet dated 06/27/17 revealed the resident had a pressure ulcer on the right inner thigh which measure 1.5 centimeters in length, 4.0 centimeters in width, and 0.5 centimeter in depth. The pressure ulcer was assessed to be an unstageable wound.

Record review of follow up orthopedic consultation note dated 07/12/17 indicated Resident #25 had an ulcer on right inner thigh related to pressure from immobilizer. At that time the resident was treated with antibiotics and immobilizer changed to a new one that did not rub the area of the wound.

On 08/02/17 11:14 AM Wound Treatment Nurse was observed performing wound care for pressure ulcer on right inner thigh of Resident #25. The Treatment Nurse cleaned the wound, applied Santyl debridement ointment, and

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covered the wound with dry dressing. The immobilizer remained on the leg during the treatment and covered the area from mid-thigh to the heel of right leg. The pressure ulcer on the upper thigh area was pink, without drainage and no signs of infection in the surrounding skin. Resident #25 denied having pain at the wound site but did request medication for knee pain. The medication was given.

On 08/02/17 at 11:32 AM and interview was conducted with Nursing Assistant (NA) # 1. The NA stated that the resident had received a bed bath when Resident #25 first had the leg immobilizer in place after the new fractures on 06/13/17. NA #1 also stated that she was to report any change in the resident's skin to the nurse. She stated that she had not been the one who first observed the wound on the resident's thigh. NA # 1 stated that the resident had pillows to position the leg and keep pressure off the metal part of the immobilizer.

An interview was conducted with Nursing Assistant (NA) #2 on 08/02/17 at 11:41 AM. NA #2 had stated that the immobilizer was very long and extended from the heel area to the upper thigh, almost into the groin of Resident #25. NA #2 also stated that the skin above the immobilizer was to be observed each time incontinence care was provided for the resident.

On 08/02/17 at 2:39 PM an interview was conducted with Nurse #3 who had cared for Resident #25 soon after she returned with the immobilizer on. Nurse #3 stated that the immobilizer had a stiff metal part on located on the upper, inner thigh. Nurse #3 had also stated that skin assessments were to be done daily and

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that the area of the inner thigh was to be visualized every day.

An interview was conducted on 08/02/17 at 4:55 PM with Nursing Assistant (NA) #3 who stated that she had cared for Resident #25. The Nursing Assistant stated that she had provided incontinence care for Resident #25 and assisted in repositioning her several times each day. The NA stated the immobilizer remained in place all the time and it had not interfered with provision of care.

An interview was conducted with the Treatment Nurse at 11:55 AM on 08/03/17, who stated that the wound was first assessed on 06/21/17. The Treatment Nurse stated that the wound had developed in an area of the thigh of Resident #25 where a metal piece extended above the fabric of the immobilizer high on the right thigh, nearly into the groin area. The Nurse also stated that the wound area developed in the area where the metal piece of the immobilizer was against the resident's skin. The Nurse also stated that the immobilizer was to be worn continuously by the resident and the nursing staff did not loosen or open the immobilizer because Resident #25 had been diagnosed with multiple fractures and was to wear the immobilizer at all times per the instructions from the orthopedic MD. The treatment nurse stated that the wound should have been documented as an unstageable ulcer on 06/27/17 because of the slough that was present in the wound. The wound treatment nurse stated that she had received education on assessment of wounds and their staging. She also stated that she had not made an addendum or entered corrected information into the record.

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F 314	Continued From page 17 On 08/03/17 at 12:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated during the interview that it was the expectation that the medical record be accurate. She also stated that the electronic nursing note could not be changed once it was entered into the medical record. An interview was conducted on 08/03/17 at 2:54 PM with the Director of Nursing and the Treatment Nurse. During the interview, it was stated that the MD had instructed that the long leg immobilizer remain on Resident #25 at all times. The DON stated that the immobilizer had a long metal pieces on the inner thigh which extended past the black fabric part of the immobilizer. The DON also stated that it was her expectation that the skin outside of the immobilizers be inspected during personal care and documented daily in the medical record. An interview was conducted on 08/04/17 with Medical Director who stated it was his expectation that the skin assessment be completed frequently due to the potential of pressure from the immobilizer on right leg of Resident #25.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 325		9/1/17

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F 325	Continued From page 18 (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to: implement timely interventions and consult with the registered dietitian when the resident experienced continued significant weight loss for 1 of 2 residents sampled for nutrition (Resident # 49). The findings included: Resident #49 was admitted to the facility on 12/23/14 and was most recently readmitted to the facility on 01/09/17 with diagnoses that included acute/chronic respiratory failure, irritable bowel syndrome, edema, chronic obstructive pulmonary disease, metabolic encephalopathy, dysphagia, depression, schizophrenia, and dementia. Review of physician order summary dated 01/09/17 revealed that Resident #49's diet was puree with honey thick liquids. Review of a Dietary Supplemental Assessment dated 01/11/17 revealed that Resident #49 required 2642 calories per day and 98 grams of protein per day. The assessment further revealed that Resident #49 was consuming 1946 calories per day and 97 gram of protein per day.	F 325	Resident #49 was referred to the Registered Dietician (RD) on 8/3/2017. She reviewed the resident information with the Dietary Manager and we received recommendations from her to implement on Resident #49. These were implemented and the resident will continue to be weighed weekly x 8 to monitor his weight loss or gain. All current residents with 5% or 10% weight losses will be reviewed by the weight committee along with the Dietary Manager on 8/30/2017. They will be reviewed for possible interventions for their weight loss. The MD/FNP will be notified with new orders, if any. The care plans will also be reviewed and updated as needed. The Weight Committee will continue to meet monthly to review weights. The weekly review of losses or gains will be discussed at this time along with any interventions that have been implemented, including the RD notification and referral. The Director of Nursing or designee will audit the residents weekly x 6, then	

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F 325	Continued From page 19 Review of a Weight Change Note dated 01/10/17 read, -5% weight change over 30 days. The resident was out of the facility during this time. Signed by the Dietary Manger (DM). Review of a physician order dated 01/24/17 read in part, beneprotein take 2 scoops by mouth twice daily at 9:00 AM and 10:00 PM. Review of a Dietary Progress note dated 02/03/17 read, Resident #49 was alert and able to make simple needs known. He ate 80% of meals and refused 1 meal during assessment period. Resident #49 received an extra 100 calories and 24 grams of extra protein from the beneprotein. His weight was down 12 pounds (lbs.) or 6% over 180 days. Signed by the DM. Review of Weight Exception report dated 02/03/17 through 08/03/17 revealed that Resident #49 had triggered a 3% weight loss on 05/24/17, he triggered a 10% weight loss on 06/28/17, and 10% weight loss on 07/26/17. Review of Weight Change Note dated 05/26/17 read, there was a -3% weight change from the last weight. The weight loss was unplanned. Resident #49 ate 100% of meals and was very active in propelling his wheelchair around the facility. Will continue to monitor. If any further weight loss was noted will evaluate the need for larger portions of food. Signed by the DM. Review of Dietary Progress note dated 07/05/17 read, Resident #49 was alert and able to make simple needs knowns. Resident #49 ate 100% of meals and he received an extra 100 calories and 24 grams of extra protein from the beneprotein.	F 325	monthly x 3, with a 5% or 10% weight loss to ensure appropriate interventions have been implemented. Any issues will be addressed immediately with the Dietary Manager. Retraining will be provided at that time. The Quarterly Executive QA Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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Signed by the DM.

Review of Weight Change Note dated 07/10/17 read, -10% weight loss over 180 days that was unplanned. Resident #49 received beneprotein 2 scoops twice a day and ate 75-100% of meals per documentation. Will increase size of meal portion to improve weight status. Signed by the DM.

Review of the most recent quarterly minimum data set (MDS) dated 07/05/17 revealed that Resident #49 was severley cognitively impaired and required extensive assistance of 1 person with eating. The MDS also indicated that Resident #49 was 72 inch tall. No weight was recorded on the MDS. The MDS also indicated that no significant weight loss had occurred. The MDS also revealed that resident #49 received a mechanically altered diet.

Review of Resident #49's medical record on 08/01/17 revealed the follow weights:

- 12/08/16: 200 lbs.
- 01/09/17: 180 lbs.
- 01/26/17: 178 lbs.
- 02/09/17: 177 lbs.
- 03/15/17: 176 lbs.
- 05/24/17: 161 lbs.
- 06/28/17: 157 lbs.
- 07/26/17: 155 lbs.

Review of the physician summary dated 08/01/17 revealed no nutritional supplement. Resident #49's medical record revealed no referral to the Registered Dietitian (RD) or any progress note from the RD in 2017.

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An observation was made on 08/01/17 at 8:50 AM of Resident #49 being assisted with his breakfast meal. There was a yogurt on the meal tray and Resident #49 was noted to eat 100% of his breakfast including the liquids.

An interview was conducted with Nursing Assistant (NA) #1 on 08/02/17 at 9:32 AM. NA #1 stated that she routinely cared for Resident #49. She stated that he was a good eater and would eat everything that was given to him. NA #1 stated that Resident #49 received puree diet with no meat. She added that he drank liquids very well and drank 100% of the liquids on his meal tray.

An observation was made on 08/02/17 at 1:09 PM of Resident #49 being assisted with his lunch tray. There was a yogurt on the meal tray and Resident #49 was noted to eat 100% of his lunch tray including the liquids.

An interview was conducted with the DM on 08/02/17 at 5:11 PM. The DM stated that she identified weight loss by reviewing the weight exception report that triggered 3, 5 and 10% weight loss. She added that she would calculate the resident's needs on a quarterly basis and after the resident triggered weight loss she would go and observe the resident and see how they were eating and see if they needed larger portions. If the resident was not eating well then she would determine if they had or needed a supplement. If the weight loss was unplanned or if the interventions were not effective then the resident would be referred to the RD. The DM also stated that if a resident triggered multiple times on the weight exception report then she would also refer the resident to the RD. The DM

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stated that Resident #49 had been discharged from speech therapy on 02/15/17 and that they recommended removing the meat from Resident #49 ' s tray due to chewing/swallowing difficulties. She added at that time she replaced the meat with yogurt on his meal tray. The DM stated she had added large portions for Resident #49 in late July 2017. The DM stated that she had not recommended any supplement for Resident #49 because he ate 100% of his meals and had attributed his weight loss to his hospitalization. She added that in addition to the yogurt Resident #49 also received extra protein in the beneprotein twice a day. The DM stated that each puree meal consisted of 2567 calories and she did not how to remove part of those calories to reflect the removal of meat from his meal tray and then add the additional protein provided by the yogurt and beneprotein. The DM confirmed that she had not reached out to the RD to see if she could help to accurately calculate Resident #49's needs. The DM also confirmed that she had not referred Resident #49 to his physician to see if there was any medical reason why Resident #49 was continuing to lose weight despite eating 100% of his meal trays.

An interview was conducted with the RD on 08/03/17 at 11:03 AM. The RD stated she visited the facility at least 2 times a month but was always available by phone if needed. She added that when she visited the DM would provide her a list of residents that she needed to see. The list consisted of new admissions, readmissions, residents with wounds, residents that triggered significant weight loss/gain, and any high risk residents. The RD stated the DM handled a lot of the needs of the high risk residents through the diet tray tracker system and through orders if it

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was a supplement that was needed. The RD stated she did not get involved with every resident that experienced weight loss, if the interventions that the DM implemented were effective then she would not necessarily see that resident. The RD confirmed she was not familiar with Resident #49 or the fact that his meat was being removed from his meal tray and extra protein added at each meal. The RD stated that if a resident was eating 100% of meals and continued to lose weight that would certainly warrant a referral to the RD. She stated that calculating Resident #49 ' s needs would obviously be difficult by removing the meat from his tray and she could have certainly assisted the DM in doing this if she had been made aware of the issue. The RD stated she would evaluate Resident #49 as soon as possible and get a supplement ordered to help prevent further weight loss.

An interview was conducted with the Administrator on 08/03/17 at 2:58 PM. The Administrator stated that she would have liked for the DM manager to pick up the initial 20 lb. weight loss after Resident #49's hospitalization and would have liked for her to start some kind of supplement and referred him to the RD.

In a follow up interview with DM on 08/03/17 at 3:32 PM the DM confirmed that she had not reached out to the RD with any concerns she had for Resident #49. She stated that when she removed the meat from Resident #49 ' s tray she was only concerned with replacing the protein and did not think of the calories or fat that the meat would have provided to the resident. The DM stated "it did not concern me because he was eating so well and his labs looked good." She stated that she should have obviously started a

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F 325	Continued From page 24 supplement and referred Resident #49 to the RD.	F 325		
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure fly reduction measures were effective for 1 of 2 Nurses stations and 2 of 5 hallways (300 and 200 hallway). The findings included: An observation was made on 08/1/17 at 8:59 AM of two airborne flies outside of room 310. One eventually landed on a resident sitting in a wheelchair. The fly was observed to move around on the resident for an extended period of time. An observation was made on 08/2/17 at 10:46 AM of a resident in a chair at the main nurse's station with a fly buzzing around him. The fly landed on the resident's ear multiple times resulting with the resident having to swat the fly away. An observation of two airborne flies was made on 08/2/17 at 10:58 AM around the main nurse's station at the entrance to the 200 hall. An observation of a flying insect was made on 08/3/17 at 8:14 AM in the main entrance hallway near the nursing station. An observation on 08/3/17 at 12:00 p.m. revealed two flies buzzing around in the kitchen near a	F 469	The contracted pest control company came on August 24, 2017, to do routine pest control with emphasis on flies. No flies were noted by them on this date. The contracted pest control company will continue to come on a routine monthly basis unless notified by the facility of increase in insects, including flies. The administrator or designee will make walking rounds looking specifically for flies in the facility 3x week x 3 weeks, then monthly x3, beginning the week of August 28, 2017. If any issues are detected thru observation that we have an increase in flies in the facility, the pest control company will be called out ASAP for further treatment. The Quarterly Executive QA Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	9/1/17

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food production table while food service was in process.

On 08/3/17 at 4:02 PM, an observation of two airborne flies near the front nurse's station at the end of 200 hall was completed.

On 08/3/17 at 4:16 PM, an observation of the front door to the facility revealed no fly fan attached to the front door with no other fly prevention noted. The front door was observed open with residents entering the building with no fly prevention measures in place.

Interview with a maintenance worker on 08/3/17 at 2:32 PM. He stated maintenance was informed not to spray for pests as the facility has hired an outside company to come into the facility on a monthly basis to spray for pests. He continued, stating maintenance does have the ability to contact the company to make additional visits as concerns arise.

On 08/3/17 at 3:48 PM an interview with the Administrator revealed that an outside pest control company comes out monthly and had been in the building the previous month. She stated concerns about flies were brought up at that time and that the company "sprayed" and she felt the treatment had remedied the problem. She further stated that flies tend to be an issue due to the proximity of a chicken processing plant to the facility. She continued, stating that fly fans were turned on in the back halls for a while the previous month when the flies became "bad" and have since been turned off. She stated there was a fly fan in the front of the building was not turned on due to "it blowing everyone's hair".

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F 469	Continued From page 26 On 08/3/17 at 4:54 PM an interview with the president of the corporation revealed that flies have been a problem due, in part, to the new door greeter holding the door open too long. He stated that the door greeter was currently being retrained in order to prevent flies from entering the building. He explained that due to the proximity of a chicken processing plant nearby, flies were an issue in the entire county. He continued, stating that there was a fly fan outside of the rear kitchen and demonstrated the fly fan and it was observed to be in operating condition.	F 469		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are	F 520		9/1/17

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F 520	Continued From page 27 necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following a recertification survey of June 2016. The repeat deficiency was in the area of resident assessment (F278). This deficiency was recited during the facility current recertification and complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to F-278: Based on record review and staff interviews the facility failed to accurately code the minimum data set (MDS) to reflect a significant weight loss	F 520	On August 15, 2017, the facility Executive QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On August 18, 2017, the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, social worker, activities director, QI nurse, rehab director, accounts payable, admissions coordinator, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and	

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F 520	Continued From page 28 (Resident #49) and failed to accurately reflect a diagnosis of a fracture (Resident #25) for 2 of 5 sampled residents. During the recertification survey of 06/16/16, this regulation was cited for failing to accurately code the Minimum Data Set assessment to reflect the resident received dialysis services for 1 of 1 residents (Resident #45). An interview was conducted with the Administrator on 08/03/17 at 5:30 PM. The Administrator stated that the Quality Assurance (QA) committee met routinely and consisted of the Administrator, Director of Nursing, Medical Director, Pharmacist, Dietary Manger, Housekeeping supervisor, Maintenance Director, and key management personnel. She stated that each individual contributed something different to the QA process and QA concerns lead to projects and overall improvement of quality measures. The Administrator stated that after the facility was cited in June 2016 for minimum data set accuracy they increased the monitoring of the assessments that were completed and reported those to the executive QA committee. She added that they committee would have to review other measures that would be helpful in maintaining compliance in this area.	F 520	assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 278 Assessment Accuracy. As of August 19, 2017, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The Facility Executive QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F 278 Assessment Accuracy as reflected in the plan of correction. The QI Committee will meet weekly x6,then monthly thereafter. The Executive QI committee meeting will be quarterly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for	

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F 520	Continued From page 29	F 520	ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	