STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____ APR 13 2011	C 03/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

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F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise a care plan to include interventions for weight loss for one (1) of three (3) residents reviewed for weight loss (Resident #2). Findings include: Resident #2 was originally admitted to the facility June 4, 2010. He was readmitted to the facility on February 23, 2011 following a hospitalization for Pneumonia and urinary tract infection. Cumulative diagnoses included: Anemia, Dementia, Depression, Chronic Obstructive Pulmonary Disease and Protein malnutrition with	F 280	Submission of a response to this statement of deficiencies does not constitute an admission that the deficiencies existed, were correctly cited and/or that corrections are required. However, this response is being submitted as a condition of participation. F280 1. Care plan for resident #2 was updated to include interventions for weight loss including nutritional supplements. 2. Care plans have been reviewed of current residents with significant weight loss for appropriate interventions with corrective action taken as indicated.	3-3-11 3-31-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Moore | TITLE: Administrator | (X6) DATE: 4-11-11

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 280	Continued From page 1 hypoalbuminemia (low albumin) and hypoproteinemia (low protein) as documented on the October 27, 2010 history and physical from (named) hospital. Resident's Significant Change Minimum Data Set (MDS) dated 1/5/2011 indicated cognition and decision-making was moderately impaired. Resident #2 required supervision and set-up help only with meals. His weight was 168 pounds with weight loss noted. Resident #2 was not on a physician-prescribed weight loss program. No swallowing disorders were noted. Care Plans for Resident #2 dated 6/14/2010 through 2/23/2011 were reviewed. All care plans indicated Nutrition and hydration risk was a problem due to leaving 25 % or more of food and fluids on his tray for most meals. Goals included Resident #2 would maintain weight within three pounds over ninety (90) days. Approaches included monitoring laboratory results, vital signs, percentages of meals eaten, weights, signs of change in medical condition, dehydration, constipation and dental problems. Care plan dated 8/18/2010 indicated goal was not met and continue for 90 days. On 11/18/10, goal was not met with a decrease of 23 pounds. Care plan dated 1/13/2011 was revised 2/23/2011 and included Dysphagia (difficulty swallowing) as a problem. Approaches added on 2/23/2011 included monitoring for swallowing problems and aspiration precautions. Nutritional supplements were not included as an approach on any of the care plans. Resident #2's weights were reviewed. Weight September 1, 2010-187.0 pounds, October 1, 2010-182.4 pounds, November 9, 2010-164.0	F 280	3. Current Licensed nurses have been re-educated, by the Director of Nursing, on updating resident care plans when orders are received for new/changed intervention. Interdisciplinary team will monitor care plans through weekly care management meeting for those experiencing weight loss with interventions implemented as indicated. Monthly and weekly weights will be monitored through this process.	3-31-11

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F 280	Continued From page 2 pounds, December 3, 2010-167.6 pounds, January 5, 2011-167.6 pounds, February 2, 2011-160.8 pounds, March 1, 2011-155.6 pounds. This was 16.79% weight loss for the past six months On 3/3/2011 at 11:20 AM., the Director of Nursing indicated all information written on Residents' care plan was done by the MDS Coordinator. She said the nursing staff did not usually write on the care plans. On 3/3/2011 at 11:30 AM., the MDS coordinator stated she kept the care plans updated and placed new interventions on the care plans. When asked regarding Resident #2's weight loss, she said she assumed he was still on the supplement (MED-Pass 2.0). She indicated she did not put supplements on as an approach because they added and discontinued supplements all the time. She stated the physician orders and medication administration record was also part of the resident care plan.	F 280	4. Will monitor care plan updates weekly to assure appropriate interventions are documented. Director of Nursing will report results of monitoring care plan updates and to identify trends and/or need for further education to the nurses monthly to RMQI (Risk Management Quality Indicator) committee for 12 months.	3-31-11
F 325	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to reorder a nutritional supplement for a four month period, (November through February) for one (1) of three (3) residents who were reviewed for weight loss (Resident #2). Resident #2 had significant weight loss over a six month period. Findings include: Resident #2 was originally admitted to the facility June 4, 2010. He was readmitted to the facility on February 23, 2011 following a hospitalization for Pneumonia and urinary tract infection. Cumulative diagnoses included: Anemia, Dementia, Depression, Chronic Obstructive Pulmonary Disease and Protein malnutrition with hypoalbuminemia (low albumin) and hypoproteinemia (low protein) as documented on the October 27, 2010 history and physical from (named) hospital. Resident's Significant Change Minimum Data Set (MDS) dated 1/5/2011 indicated cognition and decision-making was moderately impaired. Resident #2 required supervision and set-up help only with meals. His weight was 168 pounds with weight loss noted. Resident #2 was not on a physician-prescribed weight loss program. No swallowing disorders were noted. Two stage two pressure ulcers were documented with the date of the oldest pressure ulcer 12/30/2010. Care Plans for Resident #2 dated 6/14/2010 through 2/23/2011 were reviewed. Nutrition and hydration risk was a problem due to leaving 25 % or more of food and fluids on his tray for most meals. Goals included Resident #2 would maintain weight within three pounds over ninety	F 325	F325 1. Resident #2 is receiving nutritional supplement as ordered. 2. Current residents weights have been reviewed to identify significant weight loss with appropriate interventions initiated as indicated. 3. Current licensed nurses and Certified Dietary Manager have been re-educated, by Director of Nursing, on significant weight loss identification. Review of supplement orders will be reviewed monthly, by Director of Nursing or designee, at time of change over to identify those residents receiving nutritional supplements for appropriateness.	3-3-11 3-9-11 3-31-11

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F 325	Continued From page 4 (90) days. On 11/18/10, goal was not met with a decrease of 23 pounds. Nutritional supplements were not included as an approach on any of the care plans. On 3/2/2011 at 11:40 AM., Resident #2 was observed eating lunch. His meal tray was observed at 12:05 PM and he had eaten a few bites of ground meat, green beans, biscuit and mashed potatoes. Resident #2 had a magic cup for dessert and had eaten three teaspoons. He had consumed approximately 14 ounces of thickened liquids. On 3/3/2011 at 8:50 AM. and 9:35 AM.., NA #1 stated she encouraged Resident #2 to eat and he had improved with food and fluid intake. She stated he had eaten 25% of his breakfast tray, An observation of his breakfast tray revealed he had eaten his biscuit with sausage and gravy, 100% of a Magic Cup and 100% of his water and juice. NA #1 stated Resident #2 did not like the thickened liquids and his food and fluid intake varied from meal to meal. On 3/3/2011 at 9:35 AM., Resident #2 stated his appetite was better and he was trying to eat more. He said he did not like the thickened fluids but understood that he needed his liquids thickened so he would not choke on them. Meal intake (food and fluids) reports dated from 2/23/2011-3/1/2011 were reviewed. Nursing assistants documented that Resident #2 accepted less than 25% of food and fluids eight out of twenty meals offered. On 3/2/2011 at 3:15 PM., Resident #2's medical chart was reviewed and a readmission weight	F 325	4. Director of Nursing or designee will report results of weight loss and nutritional supplement use monthly to the RMQI committee members to identify trends and/or need for further education and/or monitoring.	3-31-11

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was not noted for 2/23/2011. Nurse #1 stated the readmission weight would be obtained by the shift that readmitted the resident or the next shift. Nurse #1 reviewed the chart and indicated the weight was not recorded.

On 3/2/2011 at 3:30 PM., Nurse #2 stated the facility had twenty four hours to obtain an admission/ readmission weight. She stated she did not obtain Resident #2's weight when he was readmitted 2/23/2011 and had asked the evening shift nurse to obtain the weight.

On 3/2/2011 at 3:20 PM., the Director of Nursing stated weights are done on admission/ readmission and if there was a recent weight on the hospital discharge summary, the facility sometimes used that weight for the admission/ readmission weight. She reviewed the chart. There was not a hospital discharge weight or a readmission weight noted in the medical record. She said she did not know the weight had not been obtained and the weight should have been recorded in the medical chart.

Resident #2's weights were reviewed. Weight September 1, 2010-187.0 pounds, October 1, 2010-182.4 pounds, November 9, 2010-164.0 pounds, December 3, 2010-167.6 pounds, January 5, 2011-167.6 pounds, February 2, 2011-160.8 pounds, March 1, 2011-155.6 pounds. This was 16.79% weight loss for the past six months.

Laboratory results were reviewed and revealed a total protein level of 5.7 and albumin level of 2.9 on 10/27/2010, total protein level of 6.0 and albumin level of 2.9 on 2/17/2011. On 3/2/2011, laboratory results revealed a total protein level of

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F 325	Continued From page 6 5.6 (normal 6.0-8.3) and albumin level of 3.1 (normal 3.5-5.2). On 3/2/2011 at 3:40 PM., the Dietary Manager indicated she had not completed the readmission note for Resident #2 because she did not have a readmission weight. She stated she notified the Director of Nursing or the evening shift nursing supervisor if a weight was not documented but could not remember if she notified anyone regarding the readmission weight. She said Resident #2 received Med Pass 2.0 two (2) ounces twice daily. The Dietary Manager stated a physician's order was required for Med Pass. The order would be transcribed on the Medication Administration Record (MAR) and administered by the nursing staff. She reviewed his physician orders and indicated there was not an order for Med-Pass 2.0. The Dietary Manager stated she thought it had been reordered when he returned from the hospital on 2/23/2011. A review of Resident #2's medical record revealed he received Med-Pass 2.0 (nutritional supplement) two ounces twice daily from 8/8/2010 through 10/27/2010 when he was discharged to the hospital. The Medication Administration Record for October indicated he consumed 100% of the supplement most of the time. Med-Pass 2.0 was not reordered on his readmission to the facility 11/5/2010. Nutrition notes written by the Dietary Manager from November, 2010 through March 1, 2011 were reviewed. On 11/5/2010, the Dietary Manager indicated, on the nutrition data collection tool, that Resident #2 was on Med-Pass 2.0 two ounces twice daily. His current weight was noted at 164 pounds with ideal body weight of 172	F 325		

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F 325	Continued From page 7 pounds. Nutrition progress note dated 11/10/10 stated Resident #2 weighed 164 pounds on 11/9/10 that resulted in a weight loss of 10.09% in one month and 11.92% in three months. The note indicated he was on a supplement twice daily and offered a snack three times daily He had a stage 2 pressure ulcer on his left heel and a skin tear on his right upper forearm. On 3/3/2011 at 11:00 AM., the Dietary Manager, when asked regarding the notation written 11/5/2010, stated she knew Resident #2 was on a supplement before he was hospitalized on 10/27/2010 and filled that area out before she saw his medical chart. Dietician notes from November through March 1, 2011 were reviewed. On 11/22/2010, the Registered Dietician indicated Resident #2 continued to receive MP (Med-Pass) twice daily and had a weight loss of 10% during his hospitalization (10/27-11/5/2010). On 1/27/2011, a nutrition progress note by the Registered Dietician stated Resident #2 had a stage 2 decubitus on the right and left gluteal (buttocks) area. His January weight was 167.6 pounds (down 10.4% for three months, 14.3 % for six months, up 2.2% for one month). Weight loss was during recent hospitalization (12/25-12/30/10). Current diet of No added salt was continued. On 1/3/2011, the nutrition progress note indicated a significant weight change of 13.64% in six months with resident eating 50-75% of meals and a snack accepted three times daily. The type of snack was not indicated. On 3/3/2011 at 3:00 PM., the Registered Dietician stated Resident #2 was in the hospital when she	F 325		

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F 325	Continued From page 8 visited the facility in February. When asked regarding the dietician note dated 11/22/2010, she indicated she looked at the intake of the resident, calculated the nutritional needs and would recommend a supplement based on that information. She stated Resident #2 not receiving Med-Pass would have affected her recommendations.	F 325		