DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011
FORM APPROVED
OMB NO. 0938-0391

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	08/11/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to administer the Protein powder used for wound healing twice a day as ordered for 1 of 2 sampled residents with pressure ulcers. The finding includes: Resident #57 was admitted to the facility on 07/22/05 with multiple diagnoses including Dementia, Alzheimer ' s disease, Dysphagia, Congestive Heart Failure (CHF), Hypertension, and Cerebrovascular Accident (CVA). The significant change in status Minimum Data Set (MDS) assessment dated 07/22/11 indicated that Resident #57 had memory and decision making problems and has a stage IV pressure ulcer. One of the care plan problems was " anticipated decline with risk of skin breakdown due to problems with mobility, chronic venous insufficiency, bilateral lower extremity edema, incontinent of bowel/bladder, history of refusing ted hose and history of poor po (per orem) intake ". The goal was " unstageable ulcer to sacrum	F 314	F-314 #1 Resident #57 no longer resides in the facility. #2 Current residents receiving protein powder have been reviewed by the Director of Nursing for appropriate administration as ordered with corrective action taken as indicated at time of review. #3 Licensed nurses,on all shifts, Including weekends, have been re-educated by the Director of Nursing related to following the physician orders. Medication pass and following physician orders will be reviewed during orientation for new licensed employees. The Director of nursing/designee will complete a quality Improvement tool documenting medication pass competency with 2 nurses daily x 5 days per week x 2 weeks, weekly x 4 then monthly x 3. #4 The Director of Nursing/designee will report findings of the quality Improvement reviews to the Quality Improvement/ risk Management committee monthly x 4 to identify trends and need for further education and/or monitoring.	8-9-11 8-24-11 8-24-11 8-31-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Nancy Moore, Administrator 8-30-11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	08/11/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 1 will show signs/symptoms of healing as evidenced by decrease in size x (times) 30 days " . The approaches included weekly skin audits and quarterly Braden assessment and Protein powder 1 scoop twice a day in apple sauce or pudding for wound healing (8/1/11). Review of the nurse ' s notes dated 8/1/11, revealed an unstageable pressure ulcer to sacrum measuring 5 x 4 x 1.5 cm (centimeter) with yellow slough throughout ulcer bed, foul odor and with moderate amount of yellowish drainage. On 08/01/11, there was a doctor ' s order for Protein powder 1 scoop twice a day for wound healing. Review of the Medication Administration Record (MAR) for August, 2011 revealed that the Protein powder was administered once a day instead of twice a day as ordered from 08/01/11 to 8/11/11. On 08/10/11 at 12:15 PM, Resident #57 was observed during the dressing change. The pressure ulcer on the sacrum was deep with no necrosis/slough noted. The treatment nurse was observed to clean the ulcer with Normal Saline and Santyl ointment was applied and was covered with dry dressing. On 08/10/11 at 4:30 PM, Nurse #1 was interviewed. She acknowledged that the Protein powder was only administered once a day instead of twice a day as ordered and stated that this was a medication error and would inform the doctor.	F 314		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011
FORM APPROVED
OMB NO. 0938-0391

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 ____	08/11/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 2 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to clean 1 of 1 nourishment freezer. The findings included: The facility policy from the Nutritional Services Manual entitled " Cleaning and Sanitizing Refrigerator, Cooler and Freezer, " revised on 11/06, read in part, " Refrigerators, coolers, and freezers are reviewed and cleaned as needed on a daily basis. " On 8/9/11 at 8:15 AM and on 8/10/11 at 10:55 AM, the freezer compartment of the nourishment refrigerator was observed to have an orange/yellow substance and brown substance frozen to the bottom surface. During an interview on 8/10/11 at 11:00 AM, the director of housekeeping indicated that the housekeeper assigned to the D and E halls was responsible for checking the nourishment refrigerator and freezer daily and cleaning it as needed. The director of housekeeping acknowledged that the freezer should have been cleaned yesterday.	F 371	F-371 #1 Nourishment freezer has been cleaned. #2 A review of freezers has been completed, by the Director of Housekeeping, with cleaning done as indicated. #3 Housekeeping staff have been re-educated, by the Director of Housekeeping, on timely and following appropriate schedule of cleaning of nourishment freezers. Freezers are checked and cleaned daily. Schedule for cleaning freezers and checking daily will be part of orientation for new hires. The Housekeeping Director will complete a Quality Improvement tool for cleanliness of nourishment freezers daily x 5 days per week x 2 weeks, weekly x 4 weeks, then monthly X 10 months. #4 The Housekeeping Director or designee will report findings of the Quality Improvement reviews to the Quality Improvementt/Risk Management committee monthly x12 to identify trends and need for further education and/or monitoring.	8-10-11 8-24-11 8-24-11 8-31-11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011
FORM APPROVED
OMB NO. 0938-0391

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 ______	08/11/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/07/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 9/9/11 at approximately noon the building construction type was non-compliant, specific findings include; A. Penetration in the 1-hr. rated ceiling in the sprinkler riser room where a pipe had been replaced. B. Plywood access door in the exterior overhang in the path of the kitchen back exit. Penetrations in ceiling must be sealed with approved material and caulk, to maintain the rating of the ceiling assembly.	K12	#1 (A) Penetration in the 1-hr. rated ceiling in the sprinkler riser room has been repaired. (B) The penetration in the exterior overhang in the path of the kitchen back exit has been repaired. #2 All exterior overhangs will be checked for penetrations in ceiling with repairs as needed. #3 Maintenance Director will be inserviced on compliance of building construction type: penetration in ceiling must be sealed with approved material and caulk, to maintain the rating of the ceiling assembly. Maintenance Director will complete a quality improvement tool documenting construction compliance on exterior overhangs monthly X 6 months then quarterly. #4 Maintenance Director will report findings of the Quality Improvement Tool to the Risk Management Quality Improvement(RMQI) Committee monthly to identify trends and the need for further repair.	9-19-11 9-21-11 9-21-11 10-12-11
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/7/11 at approximately noon the following exit discharge illumination was observed as non-compliant, specific findings include; lack of lighting on the exit path from the	K45	#1 Exterior, double lamp light, connected to the generator, has been installed at E hall. #2 Exit discharge illumination has been checked on A, B, C, D, F halls and front entrance with needed repairs completed.	10-22-11 10-22-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Moore
TITLE: Administrator
(X6) DATE: 9-23-11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER: WESTWOOD HEALTH AND REHABILITA

STREET ADDRESS, CITY, STATE, ZIP CODE: 625 ASHLAND STREET, ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 1 E-ball. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.		#3 Maintenance Director will inservice staff on the importance of illumination at exit pathways leading to public way. Maintenance Director will complete a quality improvement tool documenting proper functioning of exterior lights illuminating exit pathways monthly X 12 months. #4 Maintenance Director will report findings of the Quality Improvement review to the RMQI committee monthly X12 months to identify needed repairs.	9-30-11 10-12-11
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By document review on 9/7/11 at approximately noon the following fire drills were non-compliant, specific findings include; the last four fire drills on third shift for 2010 & 2011 were held between 11:05 PM and 11:20 PM only. Fire drills are to be held at unexpected times.	K50	#1 Fire drill for 11-7 shift has been conducted at 5:00 AM. #2 Fire drills will be conducted at unexpected times under varying conditions at least quarterly on each shift. #3 Maintenance Director will be inserviced on the importance of varying times and conditions when conducting fire drills. Maintenance Director will complete a quality improvement tool documenting performance of staff when fire drill conducted monthly X 3 then quarterly X 12 months. #4 Maintenance Director will report staff performance with fire drills to the RMQI committee monthly to identify the need for further education to the staff.	9-24-11 9-24-11 9-21-11 10-12-11
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/07/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 9/9/11 at approximately noon the items related to the fire alarm system was non-compliant, specific findings include; A. Smoke detector sensitivity had not been conducted since 2007. B. Two smoke dampers at the end of B-hall did not function properly when tested.	K52	#1 (A) Smoke detector sensitivity has been conducted. (B) Two smoke dampers at the end of B hall have been repaired. #2 Smoke dampers have been checked by Maintenance Director to assure proper functioning. #3 Administrator will re-educate the maintenance director on the importance of properly functioning smoke dampers. Maintenance Director will complete a quality improvement tool documenting proper function of smoke dampers monthly X 3 months then quarterly. #4 Maintenance Director will report findings of the quality improvement review to the RMQI committee monthly X 3 months then quarterly to identify needed repairs.	10-22-11 10-22-11 9-21-11 10-12-11