STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345450	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/12/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must 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 observations, record review, staff interviews and resident interview the facility failed to follow a care plan approach for use of a pressure relieving cushion in a chair, for preventing further skin breakdown for one (Resident #13) of four sampled residents with existing pressure ulcers.

The findings included:

Resident #13 was admitted to facility on 10/18/13 with diagnoses of pressure ulcer, lack of coordination, and abnormality of gait.

The Minimum Data Set (MDS) dated10/25/13 assessed Resident #13 as requiring limited assistance of one staff for bed mobility, limited assistance with supervision for transfers and ambulation and extensive assistance for hygiene and toileting. The resident was alert and oriented with no short or long term memory impairment. This assessment documented a pressure ulcer of stage IV, which involves the deep muscle and tissues.

On the 10/18/13 admission assessment of the left hip pressure ulcer wound, measurements were obtained at 7:00 PM and revealed a length of 3.0 centimeters (cm), a width of 5.0 cm and a depth of 4.5 cm. Subsequent pressure ulcer measurements dated 11/26/13 revealed a length of 3.0 cm, a width of 4.6 cm and a depth of 2.6 cm. Review of the wound flow sheet dated 11/26/13 revealed the following interventions were in place for wound healing: incontinence care, pressure relieving mattress and chair cushion for the wheelchair.

The care plan updated on 12/5/13 included a stated problem for a stage IV pressure ulcer on the left hip. Approaches for this problem included a " pressure relieving mattress/chair/cushion. "

Review of the Treatment Administration Record (TAR) for the month of December 2013 revealed documentation by the nurses that a pressure reducing wheelchair cushion was in place. The nurses had initialed in the boxes for each day from 12/1/13 to 12/12/13 indicating the cushion was in the wheelchair.

Observations on 12/10/13 at 11:10 AM revealed Resident #13 was in the wheelchair without the cushion in the seat.

Observations on 12/12/13 at 8:30 AM during breakfast revealed Resident #13 was in the wheelchair without the cushion in the seat.

Observations on 12/12/13 at 12:06 PM of Resident #13 revealed he was in his wheelchair in the dining room

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345450	A. BUILDING: _____ B. WING _____	12/12/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 282	Continued From Page 1

without cushion in seat.

Interview with aide #2 on 12/12/13 at 2:15 PM revealed she knew what care Resident #13 required by looking at the "kardex." The kardex was reviewed with aide #2 and it instructed staff to keep a cushion in his wheelchair. Aide #2 explained she did not have him today, but thought she remembered a cushion in his wheelchair. Aide #2 and the surveyor asked permission to look at his wheelchair seat. Resident #13 was assisted by aide #2 to stand. At that time, there was no pressure relieving cushion in the wheelchair seat.

Interview on 12/12/13 at 2:20 PM with Resident #13 revealed the cushion was removed to be cleaned, and he not had it back. Resident #13 explained the cushion had been removed two weeks ago.

Interview with the wound nurse on 12/12/13 at 2:40 PM revealed she had provided Resident #13 with wound care, but he was ambulatory and not in the wheelchair. The wound nurse explained she did not visualize the wheelchair for the pressure relieving cushion. She thought he had a " thin cushion in the wheelchair " and was not aware the pressure relieving cushion had not been in the wheelchair for about two weeks.

An interview was conducted with the Director of Nursing on 12/12/13 at 4:20 PM. Her expectations would be the cushion should be in the wheelchair and the staff should observe the wheelchair for the cushion before signing off the TAR.

JAN 15 2014

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

PRINTED: 12/31/2013
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 _____	C 12/12/2013

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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to keep the call light in of 35 sampled residents observed for call light accessibility. (Resident #9). The findings included: Resident #9 had a readmission to the facility on 10/20/13 with diagnoses including blindness of the left eye, The Minimum Data Set dated 10/31/13 assessed Resident #9 with impaired vision, and required extensive assistance with activities of daily living. Resident #9 was assessed with no short or long term memory impairment. The care plan dated 11/6/13 included a problem Resident #9 was at risk for falls/injury. The left eye blindness was an associated risk factor for falls. The approaches included keeping the call light in easy reach. Observations on 12/9/13 at 1:00 PM revealed Resident #9 was in bed and his call light was out of his reach. The resident ' s call light was	F 246	1. Resident #9 had the call light placedat his right side to accommodate the lindness of the left eye. 2. All residents were observed to ensure that their call bells were placed within reach. Nursing staff was re educated to place the resident call light within reach of the resident and to read the kardex to understand the individual needs of the residents. All resident kardex have been reviewed to ensure that the information is current and complete for each resident. 3. Rounds inspecting every resident's call bell placement will be made by the Executive Director, Director of Clinical Services, the Nursing Unit Manager, Charge Nurses, and/or all other department heads every 2 hours for 24 hours, every 4 hours for 24 hours, every shift x 7 days, twice daily x 5 days a week x 3 weeks, twice daily x 3 days a week x 4 weeks. At the end of this monitoring term, the call bells will be observed by department heads prior to morning meeting and reported to the morning meeting x 10 months. This monitoring will be recorded on the Call Bell QI Monitoring form.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	C 12/12/2013

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 246	Continued From page 1 observed to be underneath the bed, resting on the bed frame. Resident #9 asked for assistance from the surveyor in donning a sock to his foot. Resident #9 was asked where his call light was and he responded he didn ' t know. Observations on 12/10/13 at 3:35 PM revealed the call light remained under the bed, resting on the bed frame. Resident #9 remained in bed and could not reach the call light. Observations on 12/11/13 at 3:56 PM revealed the call light was located at the head of the bed on the pillow. It had been placed on the resident ' s left side. Resident #9 was in bed and could not see the call light positioned on his left side, above his head. Interview with nursing assistant #3 on 12/12/13 at 2:30 PM revealed she was not aware Resident #9 was blind in his left eye. She further stated the call light should have been placed on the resident ' s right side or in the middle of his body. Interview on 12/12/13 at 2:33 PM with Resident #9 revealed he would use his call light if he needed assistance from staff. When he was asked to find his call light, he touched his sheets trying to locate the call light. Nursing assistant # 3 had placed the call light at his mid chest and he was able to find the call light and push the button. Interview with the unit 2 coordinator on 12/12/13 at 2:37 PM revealed the unit 2 coordinator revealed she was not aware Resident #9 was blind in his left eye. That information should have been added to the kardex. The staff would be expected to place the call light in his reach.	F 246	4. The Director of Clinical Services will report the findings of the monitoring to the Quality Assurance/ Performance Improvement committee monthly for review and recommendations. 5. The Allegation of Compliance for this plan 1/15/2014.	1/15/2014

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 _____	C 12/12/2013

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 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with the resident, a family member, and staff, the facility failed to provide range of motion services as ordered for 1 of 3 residents (Resident #18) reviewed for range of motion. Findings included: Resident #18 was admitted on 3/12/13 with diagnoses including cerebral palsy and joint contractures. The occupational therapy (OT) note dated 7/29/13 indicated the restorative nursing aide was trained regarding range of motion and gentle stretch (as tolerated) in both upper extremities and placing wash cloths in both hands to reduce risk for contractures. The Restorative Nursing Agreement for Resident #18, developed by OT and dated 7/29/13, indicated the resident was to receive bilateral upper extremity range of motion, prolonged stretch, and a washcloth placed in both hands. The agreement was signed by the Restorative Aide and OT.	F 318	1. Resident #18 was given her range of motion and wash clothes were rolled into her left hand. Immediately. 2. All residents assigned to restorative nursing programs have been reviewed to ensure that the plans were being carried out. The restorative nursing assistant has been re educated by the Director of Clinical Services to inform the Director of Clinical Services if any restorative program is not completed as assigned. The Director of Clinical Services will ensure that the plan will be carried out as written. 3. The Director of Clinical Services will monitor the documentation of the minutes of the restorative programs assigned to the restorative nursing assistant to ensure the completion of all assigned programs. This monitoring will be documented on the Restorative Nursing QI Monitoring form. It will be monitored 5 days a week x 4 weeks, 3 days a week x 4 weeks, weekly x 8 weeks, then monthly x 8 months. 4. The Director of Clinical Services will report the results of the monitoring to the Quality Assurance/Performance Improvement committee for review and recommendations. 5. The Allegation of Compliance for this plan is 1/15/2014.	1/15/2014

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 _____	C 12/12/2013

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 318	Continued From page 3 The care plan dated 8/6/13 indicated the resident was at risk of skin breakdown related to contractures and the resident declined splinting. Interventions included: "may use wash cloth hand rolls to hand, honor resident's choice of no splinting." The Restorative Aide notes dated 8/16/13, 9/20/13, and 11/9/13 indicated range of motion was done for Resident #18. The Resident Restorative Chart dated 9/14/13-12/12/13 indicated Resident #18 did not receive any passive range of motion or rolled washcloths placed in her hands during that time period while care was being provided by nurse aides. The quarterly Minimum Data Set dated 10/28/13 revealed Resident #18 was moderately cognitively impaired, did not reject care, had a range of motion impairment in both upper extremities, and did not receive passive range of motion. During an interview on 12/12/13 at 11:42 am with the Therapy Manager, she stated, "The family member stated it was too painful for splinting and we went in there and the resident said it was painful. We were trying to do range of motion to open the hand. She was tolerating the rolled washcloth with restorative when we discharged her. The washcloth was to prevent her from closing more. They should be attempting the range of motion daily and the wash clothes should be rolled in her hands." During an interview on 12/12/13 at 11:57 am with	F 318		

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 _____	C 12/12/2013

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F 318	Continued From page 4 the resident's family member/power of attorney, she stated, "[Resident #18] will not have any part of a splint. It was my understanding they would do passive range of motion. I saw [the restorative aide] in here doing it some, but it has been a while. I would say at least several weeks." During an interview on 12/12/13 at 12:03 pm, Resident #18 stated it had been "about a month, maybe more" since she received passive range of motion or a wash cloth rolled in her hand. During an observation on 12/12/13 12:05 pm NA#4 placed a rolled wash cloth in the resident's left hand. The resident grasped the cloth. During an observation on 12/12/13 3:00 pm a wash cloth remained rolled in Resident #18's left hand. She was holding on to the cloth with her fingers wrapped around the cloth. During an phone interview on 12/12/13 at 3:15 pm with the Restorative Aide, she stated, "I massage her arms and put a washcloth in her left hand. She won't let me put it in the right hand. I am the only restorative aide. I think the last time it was done was last month. It is supposed to be done every day. The [nurse aides] are supposed to be doing it too." She indicated when she does restorative therapy with a resident she documents the therapy on the Restorative Aide notes and if there was not a note then therapy was not done by herself. During an interview with the Director of Nursing on 12/12/13 at 3:30 pm, she stated the Restorative Aide "manages her own workload. If she gets overwhelmed she will come to me and we will look at the caseload. The aids should do	F 318		

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 _____	C 12/12/2013

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WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

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F 318	Continued From page 5 the restorative care if she cannot do that. It should be done daily."	F 318		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure the medication error rate was less than 5% as evidenced by 2 medication errors being made during 27 opportunities for error, which resulted in an error rate of 7.4 percent. (Residents # 49 and 60) The findings included: 1. Resident #49 was admitted to the facility on 4/28/13 with diagnoses of hypertension, myocardial infarct and heart bypass graft. Review of the physician ' s monthly orders for December 2013 revealed an order for Lasix 20 milligrams, one tablet every day. Observations on 12/11/13 at 8:22 AM, during medication pass with nurse #1, revealed Resident #49 received multiple medications. Record review for Resident #49 revealed the Medication Administration Record indicated Lasix to be administered at 9:00 AM. Reconciliation of the medications administered revealed the Lasix	F 332	1. Resident #49 received the lasix according to physician orders. Resident #60 received the cogentin according to physician orders. 2. Nurse #1 was re educated by the Director of Clinical Services concerning proper medication pass technique. Licensed nursing staff has been re educated according to the 5 "R'S" of medication administration and has been observed in medication pass to ensure that proper technique is present.	

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 _____	C 12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 332	Continued From page 6 had not been given with the other medications. did not receive 9:00 AM dose of Lasix. Interview with nurse #1 on 12/12/13 at 11:00 AM revealed she was not aware the medication had been missed. She stated she would administer the medication. Interview on 12/12/13 at 4:20 PM with the Director of Nursing revealed her expectations would be for all of the medications for that time frame to be given. 2. Resident #60 was admitted to the facility on 12/26/11 with diagnosis of parkinson ' s disease. Review of the physician ' s monthly orders for December 2013 revealed an order for Cogentin 0.5 milligrams one tablet every day for parkinson ' s disease. Observations on 12/12/13 at 8:33 AM, during medication pass with nurse #1, revealed Resident #60 received multiple medications Record review for Resident #60 revealed the Medication Administration Record indicated Cogentin was to be administered at 9:00 AM. Reconciliation of the medications administered revealed the Cogentin had not been given with the other medications. Interview with nurse #1 on 12/12/13 at 11:00 AM revealed she was not aware the medication had been missed. She stated she would administer the medication. Interview on 12/12/13 at 4:20 PM with the Director of Nursing revealed her expectations	F 332	3. The Director of Clinical Services or Unit Manager will observe a licensed nurse in demonstrating the proper technique during their medication administration pass q shift x 3 shifts, one varying shift daily x 7 days, one varying shift daily 5 days a week x 1 week, one varying shift daily 3 days a week x 1 week. One varying shift a week once a week x 5 weeks, and then one varying shift a month x 10 months. This monitoring will be documented on the Medication Administration QI monitoring tool. 4. The Director of Clinical Services will report the monitoring to the Quality Assurance/Performance Improvement committee monthly for review and recommendations. 5. The Allegation of Compliance date for this plan is 1/15/2014.	1/15/2014

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 _____	C 12/12/2013

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 332	Continued From page 7 would be for all of the medications for that time frame to be given.	F 332		

FEB 06 2014

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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 01 - MAIN BUILDING 01 B. WING _____	01/16/2014

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 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is type III(211) construction , one story with a complete automatic sprinkler system.with a locking system. The Deficiencies determined during the survey area s follows:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 01/16/2014 the door to B Hall (beside the 02 storage room) oiled utility room (storing trash) failed to latch when closed. B .There was no closer on the Central Supply room (had been removed). C. The water heater room just out side the laundry (fuel fired) failed to close and latch.	K 029	K 029 1. The doors to B Hall (beside the O2 storage room, soiled utility room (storing trash), and the water heater room just outside the laundry have had the closer repaired to ensure that the door closes completely with the self closing mechanism. The door on the Central Supply room has had a new closer installed and is now self closing. 2. The Executive Director has re educated the Maintenance Director as to the necessity of ensuring that all self closing doors completely latch. All doors in the building have been inspected to ensure each door closes completely with the self closing mechanism. 3. The Maintenance Director will inspect all doors to ensure they are closing completely with the self closing mechanism once a week x 4 week, every other week x 4 weeks, then monthly for 10 months. 4. The Maintenance Director will report the results of this monitoring to the QAPI committee for review and recommendation monthly for the duration of the monitoring period. 5. The allegation of compliance date for this plan is February 28, 2014	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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

Executive Director 2/5/14

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.

CD

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

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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 _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	825 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 038	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 01/16/2014 the exit door(delayed egress) at room 127 failed to release when pressure was applied. 42 CFR 483.70 (a)	K 038	K 038 1. A company qualified to repair the exit door at room 127 has been contacted. That company has arranged for the repair to the door and it is scheduled 02/07/2014 2. The Executive Director has re educated the maintenance Director concerning the requirement that all exit doors release when pressure is applied. All other exit doors have been inspected to ensure that they release when pressure is applied 3. The Maintenance Director will inspect all exit doors to ensure that they release when pressure is applied once a week x 4 weeks, every other week x 4 weeks, and then monthly x 10 months 4. The maintenance Director will report the results of the monitoring to the QAPI committee monthly for review and recommendations for the duration of the monitoring period. 5. The allegation of compliance date for this plan is February 28, 2014	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 01/16/2014 there was no heat in the sprinkler riser room. 42 CFR 483.70 (a)	K 056	K 056 1. A baseboard heater has been installed in the sprinkler riser room. 2. The Executive Director re educated the Maintenance Director concerning the requirement that there is sufficient heat the sprinkler riser room. 3. The Maintenance Director will check the sprinkler riser room to ensure the baseboard heater is properly functioning. 4. The Maintenance Director will report the installation of the baseboard heating to the QAPI committee at the next scheduled meeting. The issues with the baseboard heater in the sprinkler riser room on an ongoing basis to the QAPI committee for review and recommendation. 5. The allegation of compliance for this plan is 2/28/2014.	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 061		

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

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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 _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARGHDALE, 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 061	Continued From page 2 Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 01/16/2014 the high and low air pressure switch had a valve up stream of it, that was not electrically supervised. 42 CFR	K 061	K 061 1. The repair of the valve found upstream from the high and low pressure switch and the lack of electronic supervision is scheduled for repair during the first week of February. 2. The repair company has agreed to inspect for this flaw in all area where it could potentially be present. 3. The maintenance Director will receive the report of the inspection from the repair company to document that the inspection has been completed and any other issue of this nature have also been repaired 4. The maintenance Director will report that the repair to the affected area has been completed and that the documentation has been received to the QAPI committee at the next scheduled meeting after these issues are resolved. 5. The allegation of compliance date for this plan is February 28, 2014	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 01/16/2014 the five(5) year obstrucyion test on the sprinkler was out of date. 42 CFR 483.70 (a)	K 062	K 062 1. The 5 year obstruction test will be performed on the sprinkler system as soon as the weather is warm enough. The repair company who will be performing that service stated that it would be most effective the first week of April. 2. The 5 year obstruction test next due date will be place on the QAPI master calendar for carry over to ensure that there is not another lapse of this service. 3. The Administrator will ensure that this required service is on the Master QAPI calendar each month when the monthly calendar is created upon. 4. The Master QAPI calendar will be reviewed by the QAPI committee each month on an ongoing basis to ensure it is complete. 5. The allegation of compliance for this plan is 2/28/2014.	