

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews, the facility failed to provide privacy in the shower room for residents. (Resident #58, Resident #71, Resident #14, Resident #11, Resident #19) Findings Included:</p>	F 164	<p>F164 The identified showers had the privacy curtains replaced, and showers for the identified residents done subsequently were done with privacy protected. All the shower rooms were checked for</p>	2/25/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/19/2016

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: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 164	<p>Continued From page 1</p> <p>1. The Facility ' s Policy and Procedure for bathing and showering dated 11/30/14 stated to " escort resident to shower room and assure privacy. "</p> <p>The Packing List revealed that eight new shower curtains were ordered on 1/9/16.</p> <p>The invoice for the shipment of the product revealed that new shower curtains were scheduled to be shipped on 2/1/2016 and were on back order.</p> <p>Observation of the shower room on hall D was observed on 1/27/16 at 9:20 AM. There were 3 shower stalls and 1 toilet stall. All 4 stalls had shower curtains. There were 3 stalls in which the width of the curtains appeared to be too small for the shower entrance.</p> <p>The shower curtains on D hall were measured on 1/27/16 at 11:03 AM. The toilet stall had a 16 inch gap in which the curtain did not provide complete privacy. The first shower stall beside the toilet staff had a 25 inch gap in which the curtain did not provide complete privacy. The second shower stall had a 17 inch gap in which the curtain did not provide complete privacy. The third shower stall had a shower curtain that fit properly and provided complete privacy.</p> <p>a. Resident #58 was admitted on 10/30/14. The resident ' s Minimum Data Set (MDS) dated 10/7/15 revealed that the resident was cognitively intact and required total dependence with bathing. Resident #58 was interviewed on 1/27/16 at 3:54 PM. He stated that last night was the first time that shower curtains were observed up in D hall for over a year. The curtains that were in place were too small for the doorway and there needed to be 2 shower panels instead of one. He didn ' t like that others could see in the shower due to the gap in the curtains.</p> <p>Resident #58 was interviewed again on 1/28/16 at</p>	F 164	<p>privacy curtains and curtains were replaced where necessary.</p> <p>Staff will be inserviced to ensure where privacy cannot be met they are able to get this corrected.</p> <p>3 times per week for 8 weeks audits will be done of all shower rooms to ensure the setting can provide privacy. 3 residents per week for 8 weeks will be asked if they were afforded privacy on their recent showers. The audits will be done by the Executive Director. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>		

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 164	<p>Continued From page 2</p> <p>2:18 PM. The resident stated that there was no other curtains or any other kind of privacy screen provided for him when he showered on 1/27/16 since there was a gap in the shower curtains.</p> <p>b. Resident # 14 was admitted on 9/11/14. Resident #14 MDS dated 9/2/15 revealed that she was cognitively intact and required total dependence with bathing. Resident #14 was interviewed on 1/27/16 at 8:58 AM. She stated that she received showers on Wednesday and Saturdays on D hall. There were three shower stalls. There was no privacy because none of the 3 stalls had curtains. She has taken a shower this past Saturday and there were no curtains at all. The only thing there was for privacy was the door and it was closed. It bothered her that there was not a curtain because when staff entered they could see her bathing.</p> <p>c. Resident #11 was admitted on 1/12/13. Resident #11 MDS dated 9/4/15 revealed that the resident was cognitively intact and required total assistance with bathing. Resident #11 was interviewed on 1/28/16 at 12:26 PM. She stated that she noticed today that there were new curtains up and that she gets showers on Monday and Thursday. There were months that went by when there were no shower curtains. She stated that she brought this up at every resident council meeting. She also added there was no other kind of privacy curtain or screen for her and that she would be showered while other women were being showered in the same room.</p> <p>d. Resident #71 was admitted on 3/12/15. Resident #71 MDS dated 10/8/15 revealed that the resident was cognitively intact and required total dependence with bathing. Resident also used a walker and a wheelchair. Resident #71 was interviewed on 1/28/16 at 12:40 PM. She stated she gets shower on</p>	F 164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 164	<p>Continued From page 3</p> <p>Tuesdays and Fridays. The curtains were too short in the shower room and she would wrapped the curtain around her wheelchair while she changed. Many times the curtains would get stuck on the hooks or would be coming off of the hooks that were attached to the rod. They now have new curtains for the showers.</p> <p>e. On 1/27/16 at 9:25 AM, resident #19 was observed being showered in shower room D. The resident was in the third shower stall to the left. The Nursing Assistant provided privacy by shutting the door to the shower room and attempting to pull the shower curtain across the shower entrance. The shower curtain only covered the shower entry a half of the way. The resident was easily seen naked when standing in the shower room with the shower curtain pulled.</p> <p>The Nursing Assistant (NA) #1 was interviewed on 1/26/16 at 9: 13 AM. She stated that they only use the shower room on D hall and it had one toilet and 3 shower stalls. All the shower stalls are used. There was only one shower curtain on the right when you walk in and that sometimes resident ' s didn ' t like that. The women resident would be showered together sometimes.</p> <p>The NA #2 was interviewed on 1/26/16 at 3:36 PM. She stated that the residents do not use the shower room on hall A and that it was being repaired. All the showers work on hall D.</p> <p>The NA #3 was interviewed on 1/26/16 at 3:45 PM. He stated that resident use the showers on D hall. The stall with the toilet and the stall to the far right had shower curtains but the other 2 stalls haven ' t had shower curtains in a while. He stated that there was one big shower curtain that wrapped around the entire shower. He would try to use the stall that had a curtain unless they</p>	F 164			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 164	Continued From page 4 needed to use the middle stalls. The residents would only be in the shower room together if they were the same gender. He stated that he looked yesterday and there were only 2 shower curtains up and that they must had just put up new shower curtains since then. The Maintenance Director was interviewed on 1/28/16 at 10:10 AM. He stated that he ordered the new curtains for D hall. The curtains were ordered 2 weeks ago and came in during the snow storm. Staff must have thought the curtains for the rooms and not for shower. They were stored in the laundry room in a box. He stated that he could not remember if shower curtains were up on D hall when he had went in to complete repairs in the past. The housekeeping manager is responsible for the curtains in the shower room. The Housekeeping Manager was interviewed 1/28/16 at 10:22 AM. She stated that new shower curtains were ordered and were here. That there had been a shower curtain up in every stall on hall D since she had been here. That they wanted to replace the shower curtains but was unsure as of why. She had noticed that the shower curtains, which were up, width were a little short. She had never known of a time in which the shower curtains had not been up and was not aware of any issues residents may have had. That the shower room is check multiple times a day. The Administrator was interviewed on 1/28/16 at 5:26 PM. He stated that his expectation was for the residents to have the right to privacy and dignity when they showered.	F 164			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	<p>Continued From page 5</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with resident and staff, the facility failed to answer call bells from residents needing assistance for 3 of 3 residents (Resident # 3, Resident 11 and Resident 58) reviewed for dignity. The finding includes: 1. Resident #3 was admitted to the facility on 12/22/2015. Her diagnoses included dysphagia, muscle weakness and type 2 diabetes.</p> <p>The Minimum Data Set (MDS) dated 12/29/2015 indicated she was cognitively intact, deaf and vision adequate. She required extensive assistance of one person for toileting and two persons for bed mobility.</p> <p>During an interview with Resident #3 on 1/26/2016 at 10:00 am, Resident #3 stated her call bells were not being answered in a timely manner. Resident # 3 indicated on 1/1/2016 she was wet for an hour or longer before she was changed. She stated she got a rash since her placement at the facility. She stated she put her call bell on, waited over an hour over for someone to come in her room. Resident # 3 revealed that her family could verify this information. She stated she urinated on herself a lot because it took staff so long to help her. " That makes me feel bad and sad ". Resident's and Resident ' s family felt that the facility needed more staff. The family was present in room during</p>	F 241	<p>F241 Identified residents who are still in the facility had their call lights responded to. Training will occur for staff regarding the responding to of call lights. 5 call light interventions per week for 8 weeks will be audited for prompt service. These audits will occur on all three shifts. 5 residents per week for 8 weeks will be questioned for prompt call light answering by the Executive Director. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p> <p>F242 Utensils were procured for the identified residents. Additional utensils were procured for all residents who may need them. Dietary staff was inserviced on the need to provide utensils available, and how to purchase them. An audit of 5 meal trays per week for 8 weeks will be done by the Executive Director to ensure meals are served with the proper utensils. Residents will be asked at this time if they have received utensils with their meals. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	<p>Continued From page 6</p> <p>this interview on 1/26/ 2016. Resident # 3 needed incontinent care from staff</p> <p>During an interview with Nurse Aide # 5 on 1/28/2016 at 2pm indicated that she had only worked at the facility for 3 weeks. Nurse Aide # 5 revealed that she answered the call bell within 10 to 15 minutes. Nurse Aide # 3 had no knowledge of this resident waiting for an hour.</p> <p>During an interview with Nurse # 4 on 1/28/2016 at 2:15pm indicated the resident did not have a rash but received cream on her bottom after each incontinent change because of redness to her bottom. Nurse # 4 revealed Resident # 3 did not have the redness at admission. Nurse # 4 also indicated no knowledge of staff not answering her call bell.</p> <p>During an interview with the Interim Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 1/28/2016 at 10:45am it was revealed that DON had only been there since 1/22/2016 and ADON since 11/4/2015. But their expectations are for all staff to answer call bell within a timely manner (within 10 minutes) and for that to staff provide care to resident every two hours and/or as needed.</p> <p>During an interview with the Administrator on 1/28/2016 at 11:00am he indicated that his expectations were for staff to answer the call bell within 3 to 5 minutes. Administrator also stated that he knew this was a concern and one of the issues that was discussed in Resident council meeting, Resident indicated that no one addressed the call bell issues and we are still having problems with the call bell not being answered. He stated that he had just hired a new DON and she would be working on all the concerns within this building. Administrator also</p>	F 241	<p>monthly.</p> <p>F244</p> <p>The concerns noted by the identified resident council members were addressed. These resolutions were brought before the resident council. All the resident council minutes for the last 3 months were reviewed to ensure the listed concerns were addressed. All the resident council minutes will be presented to the Executive Director by the next working day to ensure the concerns are assigned to appropriate staff members. The resolutions will be written down and presented to the next resident council meeting. The next 6 months (until August 2016) of resident council meeting minutes will be audited for concerns and follow up. . The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	<p>Continued From page 7</p> <p>revealed that the review of the Resident Council Minutes dated 11/18/2015 and 12/16/2015 " Old Business indicated that call light response time still improving."</p> <p>2. Resident # 11 was admitted 1/12/2013. Her diagnoses included chronic kidney disease stage 2, Rheumatoid arthritis, Digestive Neoplasm Nos, and cerebrovascular disease.</p> <p>The Minimum Data Set (MDS) dated 12/03/2015 indicated she was cognitively intact, had adequate hearing and vision, clear speech, was able to be understood and understand others and was frequently incontinent of bladder and frequently incontinent of her bowels. She had impairment on lower extremities. She required extensive assistance of one person for toileting and one person for transfer from bed and to the wheelchair.</p> <p>During an interview with Resident #11 on 1/28/2016 at 9am, stated her call bell was not being answered. She stated last week January 20, 2016 she put her call bell on and it took about 40 minutes for someone to come help her to the bathroom. Resident # 11 also stated staff came in and cut off the bell and came back to help and she waited about 15 to 30 minutes for that. Resident # 11 revealed that she would be wet for about 1 hour or longer several days during the week before someone came and took her to the bathroom. She stated this was not a great feeling sitting in urine being wet for an hour. Resident # 11 indicated that the " staffing was short here, and it ' s only 2 or 3 nurse aides during the day and we all need a little help " . She stated it ' s been like this over a year. Resident # 11 stated you can talk about your concerns in Resident Council meeting and facility act like something</p>	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	<p>Continued From page 8</p> <p>was being done about our concerns and once the State came in things happen.</p> <p>An observation of the resident ' s # 11 room on 1/28/2016: revealed at 9am a digital clock on the wall in front of the resident's bed and above her TV, which indicated the correct time was observed. The clock was within view of the resident ' s bed and wheelchair. Resident indicated that was how she knew how long it took for staff to answer her call bell and provide care for her.</p> <p>A review of the Resident Council Meeting dated 10/21/2015 stated that Resident#58 asked if the facility could get more staff to help answer the call bell because staff are not answering the call bell. Resident # 11 was a part of this meeting.</p> <p>During an interview with the Interim Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 1/28/2016 at 10:45am it was revealed that DON had only been here since 1/22/2016 and ADON since 11/4/2015. But their expectations are for all staff to answer call bell within a timely manner (within 10 minutes) and that staff would provide care to residents every two hours and/or as needed.</p> <p>During an interview with the Administrator on 1/28/2016 at 11:00am he indicated that his expectations of staff answering the call bell within 3 to 5 minutes. Administrator also stated that he knew this was a concern and this issue was discussed in Resident council meeting, Resident indicated that no one addressed the call bell issue and we are still having problems with the call bell not being answered. He stated that he had just hired a new DON and he would be working on all the concerns within this building.</p>	F 241			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	<p>Continued From page 9</p> <p>Administrator also revealed that the review of the Resident Council Minutes dated 11/18/2015 and 12/16/2015 " Old Business indicated that call light response time still improving."</p> <p>3. Resident # 58 was admitted 12/6/2013. His diagnoses included low back pain, muscle weakness, and deep veins of unspecified lower extremity.</p> <p>The Minimum Data Set (MDS) dated 1/14/2015 indicated he was cognitively intact, had adequate hearing and vision, clear speech, was able to be understood and understand others and was frequently incontinent of bladder and frequently incontinent of his bowels. He had impairment on lower extremities. He required extensive assistance of two people for toileting and two people for transfer from bed and to the wheelchair.</p> <p>During an interview with Resident #58 on 1/28/2016 at 8am, he stated his call bell was not being answered. Resident #58 indicated just on Tuesday January 26, he put his call bell on and it took about 45 minutes for someone to come in his room. He also stated that staff cut off the bell and come back to help and he had to wait longer for that. He stated he waited 1 hour some days to be taken to the bathroom. He indicated the " staffing was short here, and it ' s only 2 or 3 nurse ' aides (NA) during the day and we all need a little help ". Resident #58 revealed that it ' s really bad on the weekend. He stated it ' s not a good feeling when you are waiting on staff for an hour or longer to help. " We just need more staff. An observation of the resident ' s #58 room on 1/28/2016: at 8am revealed a digital clock on the wall on the side of the resident's bed which</p>	F 241			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	<p>Continued From page 10</p> <p>indicated the correct time was observed. The clock was within view of the resident ' s bed and wheelchair. Resident indicated that was how he knew how long it took for staff to answer his call bell and provide care for him. He also revealed he had been up on Tuesday January 26, 2016 from 10:30am until midnight before he was put to bed and that ' s not good for his body to be up all day like that and revealed that this has been going on for months especially if one of the staff member was off.</p> <p>During an interview with Nurse # 6 on 1/28/2016 at 1pm indicated Resident# 58 refused care and treatment with NA ' s and Nurse ' s throughout the facility and has a bad attitude at times. Nurse # 6 revealed that he only wants certain people to give him a shower or touch him. Resident#58 does not want any male NA working with him. Nurse #6 also indicated " that if Resident # 58 was up until midnight it was because he wanted to be up that late " .</p> <p>A review of the Resident Council Meeting dated 10/21/2015 stated Resident #58 asked if the facility could get more staff to help answer the call bell because staff are not answering the call bell. Resident # 11 was a part of this meeting. Total of 13 residents were present and agreed and wanted this to take place.</p> <p>During an interview with the Interim Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 1/28/2016 at 10:45am it was revealed that DON had only been here since 1/22/2016 and ADON since 11/4/2015. But their expectations for all staff are to answer the call bell within a timely manner (within 10 minutes) and that staff provide care to resident every two</p>	F 241			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 241	Continued From page 11 hours and/or as needed. During an interview with the Administrator on 1/28/2016 at 11:00am he indicated his expectations were for staff to answer the call bell within 3 to 5 minutes. Administrator also stated that he knew this was a concern and this issue was discussed in Resident council meeting, Resident indicated that no one addressed the call bell issue and we are still having problems with the call bell not being answered. Administrator also indicated during this interview that Resident #58 refused care and treatment and does not want certain people to provide care for him. Administrator also indicated that it was hard to believe that a resident was up from 10:30am until after midnight. He stated he had just hired a new DON and she would be working on all the concerns within this building. Administrator also revealed that the review of the Resident Council Minutes dated 11/18/2015 and 12/16/2015 " Old Business indicated that call light response time still improving."	F 241			
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews the facility failed to provide a knife	F 242	F242 Utensils were procured for the identified	2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 242	Continued From page 12 utensil during the breakfast meal for 3 of 4 resident wings. (A - Wing, B -Wing and C -Wing). The findings included: Observation in the kitchen on 1/27/16 at 8:18 am revealed food plating from the steam table began for A - Wing, B -Wing and C -Wing. No knives were available by 8:31 AM. Residents #41, #58, #19, #31, #29, #66, #60, #76, #22, #4 and #51 were not afforded a knife on the tray for staff or resident use. On 1/27/16 at 8:35 am with Brandon indicated that the utensils do not come back to the kitchen and that why we do not have enough knives. Interview on 1/27/16 at 9 am with the dietary district manager during the test tray revealed a spoon could be used in place of a knife. Interview on 1/28/16 at 1 pm with Resident #29 (who was noted by the facility ' s social worker as interviewable) revealed she did not have a knife at breakfast and wanted one with her meals. Resident #29 also indicated that she often does not get salt and pepper on her tray. Interview on 1/28/16 at 1:06 pm with Resident #66 indicated he would like to have a knife with his meals. Interview on 1/28/16 at 1:09 pm with Resident #41 (who was noted by the facility ' s social worker as interviewable) indicated something was always missing on the food tray and would like all a spoon, knife and fork at all meals Interview on 1/28/16 at 1:23 pm with nursing assistant #5 revealed she used a spoon to butter toast. Interview on 1/28/16 at 5:43 pm with the food service manager, district manager of food services, corporate representative, and the administrator was held. The district manager of food services indicated she purchased more knives and all residents now would have a knife	F 242	residents. Additional utensils were procured for all residents who may need them. Dietary staff was inserviced on the need to provide utensils available, and how to purchase them. An audit of 5 meal trays per week for 8 weeks will be done by the Executive Director to ensure meals are served with the proper utensils. Residents will be asked at this time if they have received utensils with their meals. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 242	Continued From page 13 at meal time.	F 242			
F 244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interviews and staff interviews the facility failed to resolve grievances expressed during resident Council meeting concerning privacy curtains in the shower room, not using the privacy curtain in the resident ' s room and staff not answering call bells for 5 of 13 resident(Resident #71, Resident #58, Resident # 48, and Resident #11). Finding includes: 1. A review of grievance/complaint report forms from August 2015 until present revealed concerns from 13 residents regarding staff were not answering the call bell, staff were not providing privacy in the shower room related to no privacy curtains available, and staff were not using the privacy curtains in the resident ' s room.</p> <p>Review of the resident council meeting dated 8/19/2015 revealed that under the New Business section. " Shower rooms becoming a concern. "</p> <p>Resident council minutes dated 10/21/2015 revealed Issues, request privacy curtains in shower room, Action Taken Privacy curtain</p>	F 244	<p>F244</p> <p>The concerns noted by the identified resident council members were addressed. These resolutions were brought before the resident council. All the resident council minutes for the last 3 months were reviewed to ensure the listed concerns were addressed. All the resident council minutes will be presented to the Executive Director by the next working day to ensure the concerns are assigned to appropriate staff members. The resolutions will be written down and presented to the next resident council meeting.</p> <p>The next 6 months (until August 2016) of resident council meeting minutes will be audited for concerns and follow up. . The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>	2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 244	<p>Continued From page 14 reinstated in shower rooms.</p> <p>Resident Council minutes dated 11/18/2015 revealed under New Business Residents question privacy curtain rules, Action Taken: CNA and Staff spoken to about privacy curtain and resident rights.</p> <p>A. During an interview with Resident # 48 who was cognitively intact, stated on 1/27/2016 at 9am revealed grievance about shower room and not having privacy curtain had been a concern for 6 months or longer. Resident # 48 indicated she got her shower in the shower room with another female which was not a problem for her. She indicated she knew from the Resident Council meeting this was a problem for other residents at the meetings. She also revealed that during the Resident Council Meeting issues and concerns about the staff answering the call bell was discussed. However she revealed that " this was the same issues and concerns from last year and we just learn to deal with it and be thankful. "</p> <p>B. Resident #58 was admitted on 10/30/14. The resident ' s Minimum Data Set (MDS) dated 10/7/15 revealed that the resident was cognitively intact and required total dependence with bathing. Resident #58 was interviewed on 1/27/16 at 3:54 PM. He stated last night was the first time shower curtains were observed up in D hall for over a year. The curtains that were in place were too small for the doorway and there needed to be 2 shower panels instead of one. Other resident and staff could see in the shower due to the gap in the curtains.</p> <p>During an interview with Resident #58 on 1/28/2016 at 8am, Resident # 58 stated his call</p>	F 244			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 244	<p>Continued From page 15</p> <p>bell was not being answered. Resident #58 indicated on Tuesday January 26, he put his call bell on and it took about 45 minutes for someone to come in his room. He had a clock in his room beside his bed. He also stated staff would cut off the bell and come back later and he had to wait longer for help. He revealed he waited about 1 hour some days to be taken to the bathroom. Resident #58 indicated the " staffing was short here, and it ' s only 2 or 3 nurse ' aides (NA) during the day and we all need a little help " . He also revealed that it ' s really bad on the weekend. Resident stated that it ' s not a good feeling when you are waiting on staff for an hour or longer to help. " We just need more staff " . He also stated during Resident council meeting you can put all your concerns on the table but the facility does not do anything about them until the state walks in the door. Resident #58 indicated shower curtain has been an issue for months and when the state came in the door we got shower curtains up in the all the shower rooms. Resident #58 revealed that Tuesday, 1/27/2016 during the evening shift was the first time he had a shower in private in six months.</p> <p>Resident #58 was interviewed again on 1/28/16 at 2:18 PM. The resident stated there was no other curtains or any other kind of privacy screen provided for him when he showered on 1/27/16 since there was a gap in the shower curtains.</p> <p>C. Resident #11 was admitted on 1/12/13. Resident #11 MDS dated 9/4/15 revealed that the resident was cognitively intact and required total assistance with bathing.</p> <p>During an interview with Resident #11 on 1/28/2016 at 9am, stated her call bell was not being answered. Resident #11 indicated last week January 20, 2016 she put her call bell on</p>	F 244			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 244	<p>Continued From page 16</p> <p>and it took about 40 minutes for someone to come help her to the bathroom. She had a clock in front of her bed on the wall. She also stated staff came in and cut off the bell and came back to help and she waited an additional 15 to 30 minutes. She indicated she would be wet for about 1 hour or longer several days during the week before someone would come and take her to the bathroom.</p> <p>She stated this was not a great feeling sitting in urine for an hour. She indicated the " staffing was short here, and it ' s only 2 or 3 nurse aides (NA) during the day and we all need a little help " . She indicated it ' s been like this for over a year. She indicated you can talk about your concerns in Resident Council meeting and the facility act like something is being done about our concerns. It is not until the state comes in and things happen. Resident # 11 also indicated we have not had privacy curtains up in the shower room for a least 6 months. She stated on Monday January 25, 2016 The State came in and we got shower curtains on Tuesday. Resident # 11 " wants her privacy and never really had it because she had to take a shower with another female and that is not good. "</p> <p>Resident #11 was Interview on 1/28/16 at 12:26 PM. She stated she noticed today there were new curtains up and that she gets showers on Monday and Thursday. There were months that went by when there were no shower curtains. She stated that she brought this up at every resident council meeting. She also added there was no other kind of privacy curtain or screen for her and that she would be showered while other women were being showered in the same room.</p> <p>D. Resident # 14 was admitted on 9/11/14. Resident #14 MDS dated 9/2/15 revealed she</p>	F 244			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 244	<p>Continued From page 17</p> <p>was cognitively intact and required total dependence with bathing.</p> <p>During an interview with Resident #14 on 1/27/16 at 8:58 AM. She stated she received showers on Wednesday and Saturdays on D hall. There were three shower stalls. There was no privacy because none of the 3 stalls had curtains. She has taken a shower this past Saturday and there were no curtains at all. The only thing there was for privacy was the door and it was closed. It bothered her that there was not a curtain because when staff entered they could see her bathing.</p> <p>E. Resident #71 was admitted on 3/12/15. Resident #71 MDS dated 10/8/15 revealed the resident was cognitively intact and required total dependence with bathing. Resident also used a walker and a wheelchair.</p> <p>Resident #71 was interviewed on 1/28/16 at 12:40 PM. She stated she gets showers on Tuesdays and Fridays. The curtains were too short in the shower room and she would wrapped the curtain around her wheelchair while she changed. Many times the curtains would get stuck on the hooks or would be coming off of the hooks that were attached to the rod. They now have new curtains for the showers.</p> <p>The Nursing Assistant (NA) #1 was interviewed on 1/26/16 at 9: 13 AM. She stated they only use the shower room on D hall and it had one toilet and 3 shower stalls. All the shower stalls are used. There was only one shower curtain on the right when you walk in and that sometimes resident ' s didn ' t like that. The women resident would be showered together sometimes.</p> <p>The NA #2 was interviewed on 1/26/16 at 3:36 PM. She stated the residents do not use the shower room on hall A and that it was being repaired. All the showers work on hall D.</p> <p>The NA #3 was interviewed on 1/26/16 at 3:45</p>	F 244			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 244	<p>Continued From page 18</p> <p>PM. He stated resident use the showers on D hall. The stall with the toilet and the stall to the far right had shower curtains but the other 2 stalls haven ' t had shower curtains in a while. He stated that there was one big shower curtain that wrapped around the entire shower. He would try to use the stall that had a curtain unless they needed to use the middle stalls. The residents would only be in the shower room together if they were the same gender. He stated that he looked yesterday and there were only 2 shower curtains up and they must had just put up new shower curtains since then.</p> <p>Interview with the Activity Director (AD) on 1/28/2016 at 2:20pm stated grievance expressed during resident council meeting are given to each Department head to address that grievance. AD indicated that the department had 48 hours. To work on the concerns and/or issues of the resident and report back to them within 5 days. Staff revealed that the concerns and issues for call bell, shower curtain and curtain in residents ' rooms has been a concern for months. She also stated some residents had questions about how the privacy curtains are used in the rooms, Residents felt that the staff was not using the privacy curtains correctly for the residents. AD stated action taken was "CNA and Staff spoken to about privacy curtain and resident rights. Staff indicated no other action was taken with the privacy curtain in the resident ' s room that she could find. She also stated the last in-service for Call bell was done in September.</p> <p>During an interview with the Administrator on 1/28/2016 at 4:30pm stated that he was aware of these concerns that was discussed in Resident council meeting, Resident indicated that no one</p>	F 244			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 244	Continued From page 19 addressed the call bell issues and we are still having problems with the call bell not being answered and the privacy curtain in the shower. He stated that the shower rooms have curtains in them until Monday 1/26/2016. Administrator indicated that someone took all the shower curtains down. However he indicated that shower curtains were on back order. He stated that he had just hired a new DON and they would be working on all the concerns within this building. Administrator indicated that his expectation of grievance needs to be process within 24-72 hrs. Administrator also indicated " that some Residents you just cannot please no matter what you do. "	F 244			
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide shower curtains in the shower room and shower curtains that fit the shower areas to provide a homelike environment for one of two shower rooms (Shower room D). Findings Included: The Facility ' s Policy and Procedure for bathing and showering dated 11/30/14 stated to " escort resident to shower room and assure privacy. " The Packing List revealed that eight new shower	F 252	F252 The identified showers had the privacy curtains replaced, and showers for the identified residents done subsequently were done with privacy protected. All the shower rooms were checked for privacy curtains and curtains were replaced where necessary. Staff will be inserviced to ensure where privacy cannot be met they are able to get this corrected.	2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 252	<p>Continued From page 20</p> <p>curtains were ordered on 1/9/16. The invoice for the shipment of the product revealed that new shower curtains were scheduled to be shipped on 2/1/2016 and were on back order.</p> <p>Observation of the shower room on hall D was observed on 1/27/16 at 9:20 AM. There were 3 shower stalls and 1 toilet stall. All 4 stalls had shower curtains. There were 3 stalls in which the width of the curtains appeared to be too small for the shower entrance.</p> <p>The shower curtains on D hall were measured on 1/27/16 at 11:03 AM. The toilet stall had a 16 inch gap in which the curtain did not provide complete privacy. The first shower stall beside the toilet staff had a 25 inch gap in which the curtain did not provide complete privacy. The second shower stall had a 17 inch gap in which the curtain did not provide complete privacy. The third shower stall had a shower curtain that fit properly and provided complete privacy.</p> <p>The Nursing Assistant (NA) #1 was interviewed on 1/26/16 at 9: 13 AM. She stated that they only use the shower room on D hall and it had one toilet and 3 shower stalls. All the shower stalls are used. There was only one shower curtain on the right when you walk in and that sometimes resident ' s didn ' t like that. The women resident would be showered together sometimes.</p> <p>The NA #2 was interviewed on 1/26/16 at 3:36 PM. She stated that the residents do not use the shower room on hall A and that it was being repaired. All the showers work on hall D.</p> <p>The NA #3 was interviewed on 1/26/16 at 3:45 PM. He stated that resident use the showers on D hall. The stall with the toilet and the stall to the far right had shower curtains but the other 2 stalls haven ' t had shower curtains in a while. He stated that there was one big shower curtain that</p>	F 252	<p>3 times per week for 8 weeks audits will be done of all shower rooms to ensure the setting can provide privacy. 3 residents per week for 8 weeks will be asked if they were afforded privacy on their recent showers. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>		

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 252	Continued From page 21 wrapped around the entire shower. He would try to use the stall that had a curtain unless they needed to use the middle stalls. The residents would only be in the shower room together if they were the same gender. He stated that he looked yesterday and there were only 2 shower curtains up and that they must had just put up new shower curtains since then. The Maintenance Director was interviewed on 1/28/16 at 10:10 AM. He stated that he ordered the new curtains for D hall. The curtains were ordered 2 weeks ago and came in during the snow storm. Staff must have thought the curtains for the rooms and not for shower. They were stored in the laundry room in a box. He stated that he could not remember if shower curtains were up on D hall when he had went in to complete repairs in the past. The housekeeping manager is responsible for the curtains in the shower room. The Housekeeping Manager was interviewed 1/28/16 at 10:22 AM. She stated that new shower curtains were ordered and were here. There had been a shower curtain up in every stall on hall D since she had been here. That they wanted to replace the shower curtains but was unsure as of why. She had noticed that the shower curtains, which were up, width were a little short. She had never known of a time in which the shower curtains had not been up and was not aware of any issues residents may have had. That the shower room is check multiple times a day. The Administrator was interviewed on 1/28/16 at 5:26 PM. He stated that his expectation was for the residents to have the right to privacy and dignity when they showered.	F 252			
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 253 SS=D	<p>Continued From page 22</p> <p>MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain housekeeping and maintenance services to provide clean floors and walls in bathrooms and bedrooms for residents on three of six halls and for one of two shower rooms (Hall B, Hall C, Hall E and Shower Room D).</p> <p>Findings included:</p> <p>1. On 01/26/2016 at 9:42 AM room 117 A on hall C was observed. The wall in the bathroom was dirty with a gray substance on the bottom edge in front of the toilet. The mirror in the bathroom and sink were observed dirty with a dried white substance dripping down mirror onto the sink. On 1/26/16 at 2:40 PM room 112 A on hall B was observed. There was a stained bathroom floor tile in room 112A on hall B. There were 2 towel bars. One broken towel bar was missing the bar and anchor. One bar was partially attached from the wall. On 01/26/2016 at 2:54 PM Room 114 B on hall B was observed. The bathroom shared by rooms 114-116 had stained floor tiles and an accumulation of white colored substance on the cove molding and unfinished plaster in 3 areas with a hole in the center of one measuring approximately 1 inch. On 1/27/16 at 9:20 AM the shower room on D hall</p>	F 253	<p>F253</p> <p>The areas for the identified residents were repaired or cleaned. RM#117-118,109-111 repaired holes in wall and repainted.110-112 two handle towel rail was removed, walls repaired and painted. 114-116, 113-115, 121-123,125-127 repaired all walls and repainted. 130 removed baseboard, removed toilet, removed tile flooring, repaired wall, installed new tile flooring, baseboard painted, reinstalled toilet. 138-140 repaired wall and painted. D hall installed 2 curtain rods, installed 4 private shower curtain in shower stall, Installed large private curtain at shower room door entrance, and washed down wall with cleaner. 109 scraped corners and edges behind door, 122 scraped corners and edges behind door. 130 cleaned window sill.</p> <p>The building was checked for areas which may be in the same condition. Areas of great concern were immediately repaired or cleaned to be sanitary. Areas appearing unsightly will be scheduled for immediate repair.</p> <p>Resident rooms and shower rooms will be checked (for maintenance and cleanliness) 4 times per week by staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 253	<p>Continued From page 23</p> <p>was observed. In the bathroom stall on the wall to the left of the toilet a brown substance was spattered on the wall.</p> <p>On 1/28/16 at 9:25 AM Room 130 on hall E was observed. The wood on the bathroom door was observed to have multiple light horizontal stains across the door. In the bathroom, there was a brown ring observed around the base of the toilet. There were 6 tiles in the bathroom that had a black substance in between the tiles. There was approximately 1/2 Inch gap between 2 tiles to the right of the toilet, which consisted of a black substance. The bottom of the bathroom wall in front of the toilet had a gray and black substance on the lower part of the wall.</p> <p>On 1/28/16 at 9:58 AM, The shower room on D hall had a brown substance spattered on the wall to the left of the toilet.</p> <p>2. On 01/26/2016 at 2:30 PM room 115 B on hall B was observed. The wall near the heating and air-conditioning unit had chipped paint with a black marking measuring 44 inches in room.</p> <p>On 01/26/2016 at 2:33 PM in room 109 A on hall B, there was an accumulation of black substance in the floor corners behind the door and behind the bedside cabinet in the room.</p> <p>On 01/26/2016 at 2:42 PM in room 122A on hall B, there was a buildup of brown colored substance in the corners of the floor behind the entry door.</p> <p>On 1/26/16 at 3:00 PM in room 113 on hall B, there were three holes on the wall near bed A.</p> <p>On 1/28/16 at 9:25 AM, room 130 on hall E was observed. There were four holes above the resident ' s bed and one cob web was observed in the left corner of the resident ' s window.</p> <p>Resident Council Minutes dated 10/21/15 stated that the housekeeping ' s completion of</p>	F 253	<p>(room rounds) and the results brought to the Executive Director for follow up by priority. This will continue indefinitely. One day per week, these rounds will audited by the Executive Director for follow up and timely completion.</p> <p>The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly x3.</p>		

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 253	<p>Continued From page 24</p> <p>assignments was a concern. The action taken was the housekeeping staff had increased and they were trying to hire a floor tech. The person responsible was the housekeeping manager. Resident Council Minutes dated 1/20/2016 were reviewed and revealed that completion of housekeeping assignments were becoming a concern. The action taken was that staff were retrained on the cleaning of bathrooms. The person responsible was the housekeeping manager.</p> <p>The Maintenance Man provided a log dated 1/19/16 of room ' s inspections. The log did not include dates or plans of when the observed issues would be addressed.</p> <p>The Housekeeping Director was interviewed on 1/28/16 at 10:22 AM. She stated that the shower room is checked multiple times a day. She provided a log of " The shower room quality control inspection " for shower room D from 1/1/16 through 1/27/16. The log revealed there were no concerns.</p> <p>Housekeeper #2, housekeeper for hall D, was interviewed on 1/28/16 at 11:04 AM. She stated that she makes rounds on the resident ' s rooms in the morning, after breakfast and after lunch. In the morning, she would spot mop and then mop the entire floor once or twice a week. She mopped the bathrooms and shower rooms every day. They deep clean 1 room every day and had a deep clean list that tells them which rooms to clean. They also buff 3 halls every day and clean per resident or family request. The house keeper was shown the light brown stain around the toilets. She stated that the stain was in the tile and was unable to be scrubbed out.</p> <p>Housekeeper #1, housekeeper for hall E, was interviewed on 1/28/16 at 11:15 AM. She stated that she cleans each room 3 times a day. The</p>	F 253			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 253	Continued From page 25 bathrooms are mopped every day. The resident rooms are spot mop every day and every other day the rooms are completely mopped. They used a brush to attempt to scrub the brown substance up around the toilet but the substance will not come up. She stated that she changed the water used for mopping every 4 rooms unless the water is really dirty. The Housekeeping District Manager was interviewed on 1/28/16 at 11:26 AM. He stated that the black/gray substance in room 130 on the lower part of the wall was from the wheelchairs. It needed to be repainted and would not come off. The black substance between the tiles was from the tiles sliding apart and the tiles needed to be replaced. Maintenance was in charge of that task if a request was put in. The Maintenance Man was interviewed on 1/28/16 at 11:40 AM. He was shown room 130 and stated that he was in the process of repairing the tiles/floors and peeling the painting up. He stated he had logs of all the rooms that were assessed for damaged tiles and that they were like that throughout the facility. That his goal was to redo all the floors and had already completed painting and installing floors in one of the rooms. The Administrator was interviewed on 1/28/16 at 5:26 PM. He stated that the facility would continue to work on cleaning any area that is not sanitary and also work on any other area that they need to.	F 253			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough	F 322		2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 322	<p>Continued From page 26</p> <p>alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to check for feeding tube placement according to facility policy and procedure to prevent potential complications for 1 of 1 residents reviewed for receiving tube feedings (Resident #65). Findings included: The Minimum Data Set (MDS) dated 10/26/15 revealed that the resident was admitted on 10/14/15 with the following diagnosis of Diabetes, Dementia and a past stroke. The resident was severely cognitively impaired. Resident #65 required total dependence with bed mobility, transfers, locomotion, and personal hygiene. Resident received tube feedings. The care plan for Nutrition and Hydration was last updated on 1/20/16. The facility ' s Policies and Procedures dated 11/30/14 for checking placement of enteral tube</p>	F 322	<p>F322 The identified resident is no longer at the facility. Residents with tube feedings will have placement checked according to policy. All nurses were reeducated on facility policy and procedure regarding checking tube placement. Two nurses per week for 8 weeks randomly auditing all shifts, and all new hires upon orientation. Tube fed residents <input type="checkbox"/> care will be audited for correct procedure regarding tube feed placement according to policy. Errors will be corrected immediately with education. This will be done by the DCS and ADCS The results of these audits will be submitted to the QAPI committee at the next meeting. This will occur monthly x 5</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 322	<p>Continued From page 27</p> <p>revealed to confirm placement of the tube in the stomach before administrating medications and before feeding. The policy stated, " Attach a syringe to the end of tube and place stethoscope over the left quadrant of resident ' s stomach. Instill 10 to 30 ml of air into the tube and listen for swooshing sound in stomach and/or aspirate total stomach contents by attaching syringe to end of tube and gently pulling back on plunger. "</p> <p>The nurse ' s orientation packet was reviewed on 1/28/16 at 1:15 PM. It revealed there was no information on how to administer tube feedings to residents.</p> <p>Resident #65 had orders dated 1/11/16 to administer 120 milliliters (ml) of water flushes three times a day at 10:00 AM, 6:00 PM and 2:00 AM.</p> <p>On 1/27/16 at 10:38 AM nurse #1 was observed administrating a water flush for resident #65. Resident #65 had a gastrostomy tube (G tube), which is a tube inserted in the abdomen that delivers nutrition directly to the stomach. The Gastrostomy tube site was clean and dry. Nurse #1 sat resident #65 in the upright position. To check the placement of the G tube, Nurse #1 filled a syringe with 10 milliliters (ml) of water and attached it to the end of the G tube. Nurse #1 then instilled the 10 ml of water into the resident ' s tube while placing her stethoscope over the resident ' s left abdomen quadrant. Then Nurse #1 proceeded to aspirate the water instilled with the syringe and the resident ' s stomach contents by pulling back on the syringe ' s plunger. Ten ml of fluid were aspirated from the resident ' s G tube and then replaced into the resident ' s stomach. The nurse then administered 120 ml of water into the resident ' s G tube.</p> <p>Nurse #1 was interviewed on 1/27/16 at 2:28 PM about the technique used for administrating tube</p>	F 322			

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 322	Continued From page 28 feeds to this resident. She stated that she had unhooked resident #65 from her tube feeding pump. Then she installed 10 ml of water into the resident ' s G- tube and listened with her stethoscope to see if the water went in the stomach. Then she proceeded to check the resident ' s stomach for residual and got 10 ml out and replaced the stomach contents back into the resident ' s stomach. She then measured and poured 120 ml of water in the G tube, closed the G tube and washed her hands again. She stated that she was not aware of another way to do it. The resident was unable to be interviewed due to severe cognitive impairment. The Director of Nursing was interviewed on 1/28/16 at 4:26 PM. She stated she expected the policy and procedure for tube feedings to be followed each time that the resident ' s site was accessed.	F 322			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 329	<p>Continued From page 29</p> <p>record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, pharmacy consultant interview, resident interview and staff interview, the facility failed to continue a medication dose reduction in accordance with the pharmacy consultant recommendations and the physician ' s order for 1 of 5 residents reviewed for unnecessary drugs. (Resident #77).</p> <p>The findings included:</p> <p>Resident #77 was admitted to the facility on 6/30/15 with cumulative diagnoses which included depression and anxiety.</p> <p>A review of the resident ' s medical record revealed a physician medication order on 8/26/15 for Zolpidem (Ambien) 10 milligrams (mg) by mouth at bedtime. Zolpidem is a medication used for treating sleep problems (insomnia).</p> <p>Resident #77 ' s significant change Minimum Data Set (MDS) assessment dated 12/11/15 indicated the resident was alert and oriented. Under Section D (Mood) revealed no trouble falling or staying asleep.</p> <p>Review of the pharmacy consultation report dated</p>	F 329	<p>F329</p> <p>The Physician was notified of the medication dose reduction on 1/28/16 and an order was written to decrease the medication on 1/28.</p> <p>The Pharmacist reviewed all residents and their medication regimen on 2/16/16. The DCS (director of clinical services) or ADCS (assistant DCS) will reeducate all licensed nurses by 2/25/16 on the procedure for pharmacy recommendations and writing orders once the MD signed to include transcribing orders to the medication administration record.</p> <p>The DCS or ADCS will audit 10 pharmacy recommendations per month for 3 months to validate pharmacy consultations completed by MD and orders transcribed as written.</p> <p>The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>		

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 329	<p>Continued From page 30</p> <p>11/11/15 revealed a recommendation to consider a gradual dose reduction (GDR) of Zolpidem 10 mg to 5 mg because Zolpidem 10 mg was greater than the recommended dose per the January 2013 United States Food and Drug Administration (FDA) Safety communication. Further review of the pharmacy consultation report revealed the physician ' s response on 11/13/15 was "I accept the recommendation (s) above, please implement as written." Continued review of the pharmacy consultation report dated 1/14/16 revealed a repeated recommendation to have a GDR of Zolpidem.</p> <p>Review of the physician orders for November 2015, December 2015 and January 1 through January 27, 2016 revealed Zolpidem 10 mg was ordered and not reduced to 5 mg.</p> <p>Review of the November 2015, December 2015 and January 1 through January 27, 2016 Medication Administration Record (MAR) revealed the resident continued to be administered Zolpidem 10 mg by mouth at bedtime.</p> <p>Interview on 01/28/2016 at 9:11AM with Nurse #10 revealed the practice of the facility for pharmacy recommendations was the pharmacist submitted to the Director of nurses (DON). The DON then distributed to the charge nurses. Nurse #10 indicated she did not remember seeing the recommendation for Zolpidem dose reduction but would call the physician immediately. Further interview revealed the previous DON would have been the person to have been provided the recommendation. Attempts to contact the previous DON were unsuccessful.</p> <p>Interview on 01/28/2016 at 11:39 AM with Resident # 77 revealed not feeling well due to</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 329	Continued From page 31 catching a cold and did not choose to continue the interview. Interview on 01/28/2016 at 11:48 AM via the phone with the consultant pharmacist revealed he generally will email to the DON his recommendations and the DON would forward a copy to attending physician. The interview continued with the pharmacist who indicated that he spoke with the previous DON in December 2015 (no specific date stated) and the DON indicated she would take care of it. Further dialogue revealed during his pharmacy review January 1/14/16 he noticed that the Zolpidem had not been reduced so he submitted a repeated recommendation for the GDR of the Zolpidem Attempts to contact the attending physician and attending physician were unsuccessful Interview with the administrator and regional director of clinical services was conducted on 1/28/16 at 5:43 pm. The administrator indicated his expectation was to follow through with the physician's recommendations.	F 329			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with residents	F 364		2/25/16	
			F364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 364	<p>Continued From page 32</p> <p>and staff the facility served juice frozen and bacon that was partially cooked. This was evident in 1 of 1 breakfast meal observed. The findings included: Started plating on 1/27/16 at 7:56 AM for the residents eating in the dining room. Cook #1 plated a partially cooked piece of bacon. When an inquiry was made about the status of the bacon strip Cook #1 removed the strip of bacon from the plate and replaced with a fully cooked strip of bacon. There were several pieces of uncooked bacon remaining on the steam table to be served to the residents. On 1/27/16 food trays for F Wing left the kitchen at 8:40am and arrived on the unit per nursing assistant (NA) #6 at 8:50 AM. The last food tray was served to the residents at 8:52 am. A test tray was performed on 1/27/16 at 8:53 AM with the District manager of Food services. The apple juice was still frozen and the orange sherbet was soft, melting and liquefying. The bacon was brown on one end suggestive of being cooked. The other end was white and pink colored and not cooked. Interview on 1/27/16 at 4:45 PM with Resident #58 revealed the food was not tasty (no description) often hot foods were cold and cold foods were warm. Interview on 01/28/2016 at 11:39 AM with Resident #77 revealed the food was not good. The bacon was never served fully cooked. Resident #77 indicated today my bacon was not fully cook " still white looking. " Interview on 1/28/16 at 5:43 pm with the food service manager, district manager of food services, corporate representative, and the administrator was held. The administrator indicated he expected the food items to be palatable.</p>	F 364	<p>Meals for the identified residents will be cooked and served appropriately. Meals for all residents will be cooked and served to provide palatable and attractive food. The dietary manager will reeducate the Dietary Staff by 2/25 on the manner to provide and serve palatable food to include cooked bacon and frozen snacks served appropriately. The dietary manager will audit at least 10 trays per week for 8 weeks to ensure bacon is cooked correctly, frozen foods are served correctly and drinks are served at the proper temperature. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility: A. Failed to date 6 opened foods and close 1 food item package when opened. B. Failed to maintain clean floors and equipment. Failed to maintain equipment, water faucet, walls and floor tiles in good repair in 3 of 3 kitchen observations. C. Failed to correctly calibrate a food thermometer. Failed to measure the temperature of the milk correctly on 1 of 1 observation of the food line. D. The facility failed to place a thermometer in the nourishment refrigerator located on the resident unit. The facility failed to maintain a clean floor and clean refrigerator shelf in 1 of 1 observation. The findings included: A. Observation on 1/25/16 at 2:17 pm during the initial tour of the kitchen with the Food Service Manager (FSM) revealed: · In the freezer there was a 20 pound (½ full) box containing an open, unsealed plastic bag of uncooked peanut butter cookies. · 5 lbs. (pound) open container of peanut butter undated. · 6 quart container with appropriate inch of</p>	F 371	<p>F371 No residents were found to be affected by the practice. The identified areas were corrected (undated food discarded, floors were cleaned, thermometers were calibrated, and the thermometer was placed in the refrigerator). The Dietary manager will reeducate the dietary staff by 2/25 related to the above items. The dietary manager will audit food storage and kitchen cleanliness at least 3 times per week for 8 weeks to ensure the changes have taken effect. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs monthly.</p>	2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 371	<p>Continued From page 34</p> <p>corn flakes out of the original container undated.</p> <ul style="list-style-type: none"> · 57 ounce open container of potato pearls undated. · Honey nut toasted oats store out of the original container into a 35 ounce container (½ full) in a box opened and undated. · A box containing Parboiled rice 25 pound (lb.) in a plastic bag was not closed or sealed. <p>Interview with DA #1 on 1/27/16 at 9:50 pm revealed once an item is opened it must be dated when opened and labeled.</p> <p>Interview on 1/27/16 at 9:55am with DA #2 revealed once an item is opened it must be labeled and dated.</p> <p>Interview on 1/28/16 at 5:43 pm with the FSM, district manager for dietary services, administrator and corporate representative was held. The FSM indicated his expectation was foods to be labeled and dated when opened.</p> <p>B. Observation on 1/25/16 at 2:17 pm during the initial tour of the kitchen with the Food Service Manager (FSM) revealed:</p> <ul style="list-style-type: none"> · There were broken and missing tile from the floor in the walk in refrigerator. · There were two thick buildup of an ice sickle. One measured approximately 5 inches long and 2 ½ inches thick. The second measured approximately 2 inches long and ½ inch thick. · In the dry storage room there were 2 plastic gallon size bags containing white napkins on the floor behind the containers of flour and thickener wedge in the bottom of the wheels. · Dry spillage of an orange/brown colored substance was noted on the wall behind the shelving in the dry storage area. · In the dry storage area there was an accumulation of a brown/black colored substance in the corners of the floor. · In the dry storage area there were rust 	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 371	<p>Continued From page 35</p> <p>colored stained marks on the floor under the base of the 12 shelves.</p> <ul style="list-style-type: none"> · Floor Entrance to the dry storage area near the refrigerator had brown colored dried spills. Observation on 1/25/16 at 2:50 pm revealed: · The entrance way near the walk in-refrigerator had an accumulation of brown/black substance with chipped paint. · There are 4 holes in the wall across from the walk in refrigerator. · Chipped paint corners of the wall between the stove and refrigerator. · Broken handle on the right door of the stove. · Missing knob for the grill. The grill has a grease collector with an accumulation of black colored grease. A white drinking cap was partially embedded in the grease. · Both of the ovens had an accumulation of burned food debris and dripping burned in the bottom of both ovens. · Convention oven had dried burnt food debris. · Behind and on the sides of the ice machine had an accumulation of a dark brown colored substance. · The corners of the entrance way into the kitchen had an accumulation and buildup of a black colored substance. · The perimeter of the kitchen floor had a heavy accumulation of a brown/black colored substance. · Behind the stove was an accumulation of dust and crumbs. <p>Continued observation on 1/27/16 at 7 am of the kitchen revealed:</p> <ul style="list-style-type: none"> · The floor in the dry storage area had a plastic cup lid under the shelves along with an accumulation of dust and dirt. The rusted colored stains remained. · The condition of the floors remained dirty. 	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 371	<p>Continued From page 36</p> <ul style="list-style-type: none"> · The accumulation dirt and crumbs remained behind the stove. · Perimeter of the floor remained with an accumulation of dirt and buildup of brown/black colored substance. · The floor of the walk in refrigerator remains cracked with missing pieces. · The holes in the walls remain. · The faucet at the hand washing sink was loose from the base of the sink. · There was a hole in the wall measuring 30 inches length by 2 inches in depth. · The silver panel from the front portion of the stove was partially detached. <p>On 1/27/16 at 9:40 am an interview with the district manager indicated that this panel would not stay up and looked like a bracket was broken. Further interview revealed she wet mopped the floor in the dry storage area but never mopped under the shelves. When asked about who was responsible for detailed cleaning the response was no one was assigned if a staff member sees the floors dirty they are the person to clean it up. Interview on 1/28/16 at 5:43 pm with the FSM, district manager for dietary services, administrator and corporate representative was held. The district manager for dietary services indicated for the last 5 weeks (from the date of the survey) she audited the status of the kitchen. She indicated that she noted the status of the stoves, pots and pans but had not notified the administrator. The district manager for dietary services revealed a better job must be done regarding a follow-up with the audits.</p> <p>C. Record review for the standard method of calibrating food thermometer revealed: Method 1: Ice Water Fill a glass with ice cubes, then top off with cold water.</p>	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 371	<p>Continued From page 37</p> <ol style="list-style-type: none"> 1. Stir the water and let sit for 3 minutes. 2. Stir again, then insert your thermometer into the glass, making sure not to touch the sides. 3. The temperature should read 32°F (0°C). Record the difference and offset your thermometer as appropriate. <p>Method 2: Boiling Water</p> <ol style="list-style-type: none"> 1. Boil a pot of distilled water. 2. Once the water has reached a rolling boil, insert your thermometer, making sure not to touch the sides or bottom of the pot. 3. The temperature should read 212°F (100°C). Record the difference and offset your thermometer as appropriate. <p>On 1/27/16 at 7:26 am a request was made to calibrate the facility ' s thermometer. Cook #1 took the thermometer and placed the probe under running water for less than a minute then indicated that she had calibrated the thermometer. An interview at 7:27 am with Cook #1 indicated that was the method she calibrated the thermometer. The FSM became involved and instructed the cook to obtain water and ice. The FSM then assisted the cook to correctly calibrate the thermometer.</p> <p>On 1/27/16 at 7:40 am dietary aide #1(DA) placed the thermometer between 2 cartons of milk on the cart to measure the temperature of the milk. An inquiry was made with DA #1 about obtaining the temperature of the milk revealed he usually does that way. A second attempt to measure the milk temperature was done. The carton of milk was opened and the milk temperature was measured. Interview on 1/28/16 at 5:43 pm with the FSM, district manager for dietary services, administrator and corporate representative was held. The FSM indicated his expectation was for the staff to follow the standard procedure for calibration.</p>	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 371	Continued From page 38 D. Observation on 1/25/16 at 3:13 pm of the nourishment room with the current director of nurses revealed no thermometer in the freezer. The floor tile was stained especially at the entrance to the refrigerator. The shelf on the door to the freezer had sticky spills on the base.	F 371			
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to private each resident with full visual privacy in 3 of the 4 resident care units. (A, B, C Wings). The findings included: Observations during Stage 1 (one) revealed the following: · Observation on 1/26/16 at 2:15 PM and 2:30 PM revealed 48 inches of insufficient privacy curtains in Room #114 B on Wing B. · Observation on 1/26/16 at 2:22 PM revealed 36 inches of insufficient privacy curtains between Room 113 A and B on the Wing B. · Observation on 1/26/16 at 2:33 PM revealed 72 inches of insufficient privacy curtains between 109 A and B on Wing B. · Observation on 1/26/16 at 2:42 PM revealed	F 460	F460 Privacy curtains for the identified residents were supplied and installed. All resident rooms were inspected to ensure privacy curtains were appropriate and changes made where necessary. Resident rooms will be checked (for privacy curtains) 4 times per week by staff (room rounds) and the results brought to the Executive Director for follow up by priority. This will continue indefinitely. One day per week, these rounds will audited by the Executive Director for follow up and timely completion. The results of these audits will be submitted to the QAPI committee at the next meeting. The meeting occurs	2/25/16	

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 460	<p>Continued From page 39</p> <p>36 inches of insufficient privacy curtains between 112A and B beds on Wing B.</p> <p>Continued observation of the privacy curtains with the housekeeping supervisor and manager (who are responsible for privacy curtains) revealed:</p> <p>On 1/27/16 at 3:37 PM of the E-Wing had rooms with insufficient privacy curtains:</p> <ul style="list-style-type: none"> · Room 129b had a gap of 36 inches around the bed. · Room 131 had a gap of 36 inches between A and B bed. · Room 132 A had a 12 inch gap. There were 48 inches of a gap between A and B bed. <p>On 1/27/16 at 3:52 PM of the D-Wing had rooms with insufficient privacy curtains:</p> <ul style="list-style-type: none"> · Room 119 A had a 36 inch gap. · Room 119 B had a 42 inch gap. · Room 123 A and B had a 36 inch gap between the beds. <p>On 1/27/16 at 4 PM of the C-Wing had rooms with insufficient privacy curtains:</p> <ul style="list-style-type: none"> · Room 117 had a 48 inch gap between beds A and B. · Room 118 had a 48 inch gap between beds A and B <p>Interview on 1/28/16 at 4:40 pm with the administrator revealed he had purchased additional privacy curtains starting November 2015 with some on back order.</p> <p>Observation on 01/27/2016 at 4:45 pm of the laundry department with the administrator, housekeeping manager, and Laundry aides #3 and #4 was conducted. In the clean laundry area 20 blue privacy panels, and 6 beige privacy panels were stored on the shelf for use.</p> <p>Interview on 01/28/2016 at 6:24 PM with the administrator and regional director of clinical services was conducted. The administrator</p>	F 460	monthly.		

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

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 460	Continued From page 40 indicated his expectation was to provide residents with full visual privacy.	F 460			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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 observations, record review and facility staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place in January, 2015. This	F 520	F520 No residents were identified in this citation. The Executive Director was educated on the changes to the Quality Assurance	2/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2016
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	
F 520	<p>Continued From page 41</p> <p>was for the recited deficiency which was originally cited on a recertification survey in January, 2015 and on the current recertification survey. The deficiency was in the area of housekeeping and maintenance service. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program.</p> <p>The findings included: This tag is cross referenced to: F 520 Based on observations and staff interviews, the facility failed to maintain housekeeping and maintenance services to provide clean floors and walls in bathrooms and bedrooms for residents on three of six halls and for one of two shower rooms (Hall B, Hall C, Hall E and Shower Room D). This was originally cited during the January, 2015 recertification survey when the facility failed to provide maintenance and cleaning services necessary to maintain a safe, orderly and comfortable environment in resident rooms and shower rooms. Interview on 1/28/16 at 5:24 PM with the Administrator revealed that during November, 2015 the facility began ordering shower curtains and room curtains. When there was a problem identified, the curtains were replaced. They replaced the curtains that were soiled. They never identified it as a problem because they were resolving the issue by identifying the curtains that needed to be replaced.</p>	F 520	<p>Performance Improvement meeting and follow through. The Quality Assurance Performance Improvement committee will meet on a monthly basis identifying new concerns as well as reviewing past identified concerns with a member of the corporate team will be present in person or via telephone for each of the meetings for at least 3 months. Items identified in the meetings will be audited for follow through and these audits will be reported to the next QAPI meeting for at least 3 months.</p>		