STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to accommodate residents ' needs for 2 of 3 residents reviewed (Residents #1 and #40). The findings included: 1. Resident #1 was initially admitted to the facility on 12/12/16 and most recently readmitted on 12/17/16 with diagnoses that included left hemiparesis (weakness of one side of the body) following cerebrovascular accident and left-hand contracture. The annual Minimum Data Set (MDS) assessment dated 11/1/17 indicated Resident #1 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #1 was assessed as dependent on 1 staff for assistance with transfers, toileting, and bathing. She required the extensive assistance of 2 or more staff with bed mobility and the extensive assistance of 1 staff with dressing, eating, and personal hygiene. Resident #1 had impairment on one side of her upper and lower extremities. Resident #1 ' s plan of care dated 11/14/17 included, in part, the focus category of Activities of Daily Living (ADLs). Resident #1 was noted with a self-care performance deficit,	F 558	F558 Reasonable Accommodations Needs/Preferences CFR(s):483.10(e)(3) A root cause analysis was completed and based on the findings the deficiency occurred as a result of a broken clip on call light and failure to communicate bedside commode was for use when discharged home. 1. A new clip was placed on resident # 1 call light on 2-15-18 by charge nurse. Resident #40 was discharged from facility on 2-21-18. 2. Residents call lights were observed to ensure call light within reach, clip present and clip functioning properly by the maintenance director on 2-23-18. Residents with bed side commodes were reviewed to ensure appropriate for use and bucket present for use on 2-23-18 by the Director of Nursing. 3. The Director of Nursing by 2-27-18 re-educated nursing staff on: ensuring call light within reach and clip present and functioning on call light and use of bedside commode, ensuring bed side commode appropriate and bucket present on bedside commode.	3/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/27/2018

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F 558	Continued From page 1 cerebrovascular accident with left hemiparesis, and left-hand contracture. Interventions included keeping Resident #1 ' s call light within her reach. An observation and interview was conducted with Resident #1 on 2/12/18 at 9:42 AM. Resident #1 was laying on her back in bed and her call light was not visible. Resident #1 indicated she needed assistance from staff with most ADLs as she was paralyzed on the left side from a stroke she had in the past. She reported she rang her call light when she needed assistance with things such as incontinence care and/or if she was experiencing pain. Resident #1 stated she could not find her call bell at that present time. She indicated that happened a lot. Resident #1 reported when she couldn ' t find her own call bell she sometimes asked her roommate, Resident #28, to ring her call bell for her. The area around Resident #1 ' s bed was observed. The call light was found pinned behind the headboard of Resident #1 ' s bed between the headboard and the wall. The call light had no clip attached to it. Resident #1 stated her call light previously had a clip on it that allowed it to be attached to her bed sheet so it was easily kept within her reach. She was unable to recall how long her call light had been without a clip. An interview was conducted with Resident #28, Resident #1 ' s roommate, on 2/12/18 at 9:45 AM. (Resident #28 ' s most recent MDS assessment dated 1/5/18 indicated her cognition was fully intact.) Resident #28 confirmed that Resident #1 sometimes asked her to ring her call light for her when Resident #1 was unable to reach her own call light. An observation was conducted of Resident #1 on	F 558	The Director of Nursing or Unit Manager will complete quality monitoring on 10 residents weekly for 12 weeks, then monthly using the quality improvement monitoring tool to ensure call light within reach and clip present and functioning on the call light. The Director of Nursing or Unit Manager will also complete quality monitoring on 3 residents with bedside commodes weekly for 12 weeks, then monthly using the quality improvement monitoring tool to ensure beside commode appropriate and bucket present. Opportunities will be corrected by the Director of Nursing or Unit Manager as identified during quality reviews. 4. The results of these quality reviews will be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Clinical Services for review by the Interdisciplinary members each month. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 558	Continued From page 2	F 558		

2/14/18 at 9:55 AM. Resident #1 was sitting up in bed eating her breakfast. Her call light was observed on the floor on the left side of her bed. There was no clip attached to the call light.

An observation was conducted of Resident #1 on 2/15/18 at 7:45 AM. Resident #1 ' s call light was observed on the floor on the left side of her bed. There was no clip attached to the call light.

An interview was conducted with Nurse #1 on 2/15/18 at 7:47 AM. Nurse #1 indicated she was familiar with Resident #1. She reported Resident #1 had limited range of motion on her left side. She stated Resident #1 was able to use her call light to ask for assistance. She indicated the call light was kept clipped to the bed sheet so Resident #1 was able to reach it. Nurse #1 was informed Resident #1 ' s call light had no clip attached to it and it was observed on the floor. She stated she had not known that Resident #1 ' s call light had no clip. She indicated she was going to address the issue.

An observation and interview was conducted with Resident #1 on 2/15/18 at 8:50 AM. Resident #1 was sitting up in bed eating her breakfast. Her call light was observed clipped to her bed sheet. Resident #1 stated she was able to reach her call light.

An interview was conducted with the Director of Nursing (DON) on 2/15/18 at 9:23 AM regarding Resident #1 ' s call light not being placed within her reach. The DON indicated her expectations were for staff to place resident call lights within the resident ' s reach at all times.

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2. Resident # 40 was admitted to the facility on 1/20/18 with multiple diagnoses including displaced fracture of left tibia and fibula. The admission Minimum Data Set (MDS) assessment dated 1/27/18 indicated that Resident #40's cognition was intact. The assessment also indicated that Resident #40 needed limited assistance with transfer and she was occasionally incontinent of bowel and bladder.

Resident #40's care plan dated 2/2/18 was reviewed. One of the care plan problems was " occasional bowel and bladder incontinence". The goal was for the resident to be continent through the next review date. The approaches included a bedside commode.

Resident #40's nurse's notes were reviewed. The notes dated 1/31/18 at 7:00 PM revealed that Resident #40 went to the orthopedic clinic for follow up and she came back with a new order for a bedside commode.

On 1/31/18, Resident #40 had a doctor's order for a bedside commode.

On 2/12/18 at 10:39 AM, Resident #40 was interviewed. She stated that she had been asking for a bedside commode and somebody brought the commode in her room with no bucket in it. She added that she had to go to the bathroom when needed and it was so hard for her due to her fractured leg. Resident #40 indicated that the orthopedic doctor had written an order for her to have a bedside commode in her room.

On 2/12/18 at 10:40 AM, 2/13/18 at 10:35 AM and on 2/14/18 at 9:33 AM, Resident #40's room was observed. There was a bedside commode chair

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F 558	Continued From page 4 in the room with no bucket in it. On 2/14/18 at 9:33 AM, Nursing Aide (NA) #1 was interviewed. She stated that she was assigned to Resident #40. She indicated that Resident #40 did not use a bedside commode, she used a bedpan. NA #1 added that she didn't know why there was a bedside commode with no bucket in her room. ON 2/15/18 at 9:20 AM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the staff to provide the bedside commode for Resident #40 as ordered by the doctor.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of behaviors (#27) and pressure ulcers (Resident #37) for 2 of 16 residents reviewed. The findings included: 1. Resident #27 was most recently admitted to the facility on 7/26/15 with multiple diagnoses that included bipolar disorder, psychotic disorder, depression, and dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/5/18 indicated Resident #27 had severely impaired cognition. Section E, the	F 641	F641 Accuracy of Assessments CFR(s):483.20(g) A root cause analysis was completed and based on the findings the MDS quarterly assessments were miscoded due to oversight by the social worker and Minimum Data Set Nurse Coordinator. 1. The MDS coordinator corrected resident #27□s 2-5-18, quarterly MDS dated 2-5-18 prior to transmission on 2-14 -18 to reflect behaviors. The MDS coordinator completed a modification on 2 -15-18 for resident # 37 to reflect pressure ulcer care.	3/7/18

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F 641	Continued From page 5 Behavior Section, indicated Resident #13 had no behavioral symptoms during the seven-day MDS look back period (1/30/18 through 2/5/18). Section E of this MDS was completed by the facility ' s previous Social Worker (SW). A review of the Behavior/Intervention Monthly Flow Record during the seven day look back of the 2/5/18 quarterly MDS (1/30/18 through 2/5/18) for Resident #27 revealed the following behaviors: - 1/30/18: social inappropriateness - 2/1/18: insomnia and agitation - 2/2/18: insomnia and agitation - 2/3/18: agitation - 2/5/18: agitation An interview was conducted with the Director of Nursing (DON) on 2/14/18 at 4:50 PM. The Behavior/Intervention Monthly Flow Record for Resident #27 during the seven day look back of the 2/5/18 quarterly MDS (1/30/18 through 2/5/18) was reviewed with the DON. She confirmed that Resident #27 was assessed with social inappropriateness on 1/30/18, insomnia and agitation on 2/1/18 and 2/2/18, and agitation on 2/3/18 and 2/5/18. An interview was conducted with the MDS Coordinator on 2/14/18 at 4:57 PM. She stated the SW was generally responsible for completing Section E of the MDS. She reported the previous SWs last day was 2/9/18. She indicated she was able to answer questions regarding the accuracy of the MDS assessments. Section E of the 2/5/18 quarterly MDS for Resident #27 that indicated she had no behaviors during the seven day look back period (1/30/18 through 2/5/18)	F 641	2. The MDS Coordinator completed on 2-28-18, a review of current residents MDSs for behaviors and pressure ulcers to validate the most recent MDS assessment have been coded accurately to reflect the status of the residents. 3. The Minimum Data Nurse Coordinator and Social Worker was re-educated on 2-22-18, by the Regional MDS Nurse on accurately coding of behaviors and pressure ulcers. on 2-22-18 The Director of Nursing to complete quality monitoring on 5 residents MDS weekly for 12 weeks, then monthly using the quality improvement monitoring tool to ensure behaviors Section E and pressure ulcer care Section M is coded accurately. Opportunities to be corrected by the MDS Coordinator as identified during the quality reviews. 4. The results of quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Nursing for review by the interdisciplinary members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Quality monitoring schedule modified based on findings.	

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was reviewed with the MDS Coordinator.
The Behavior/Intervention Monthly Flow Record that indicated Resident #27 was assessed with social inappropriateness on 1/30/18, insomnia and agitation on 2/1/18 and 2/2/18, and agitation on 2/3/18 and 2/5/18 was reviewed with the MDS Coordinator. She revealed Resident #27 ' s 2/5/18 MDS was coded inaccurately for behaviors.

A follow up interview was conducted with the DON on 2/15/18 at 9:23 AM. She reported her expectation was for the MDS to be coded accurately.
2. Resident # 37 was admitted to the facility on 1/21/15 and was readmitted on 6/16/17 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 1/20/18 indicated that Resident #37 had a pressure ulcer. The assessment also indicated that Resident #37 was not receiving pressure ulcer care.

The weekly pressure ulcer assessments were reviewed. The assessments dated 1/12/18, 1/19/18 and 1/26/18 indicated that Resident #37 had deep tissue injury (DTI) pressure ulcer on the left heel.

The Treatment Administration Records (TARs) for January 2018 revealed that Resident #37's pressure ulcer on the left heel was treated daily with betadine.

On 2/15/18 at 8:58 AM, the MDS Nurse was interviewed. She stated that Resident #40 had a DTI pressure ulcer to her left heel. The MDS Nurse reviewed the quarterly MDS assessment dated 1/20/18 and indicated that the pressure

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F 641	Continued From page 7 ulcer care was not coded accurately. On 2/15/18 at 9:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessment to be coded accurately.	F 641		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		3/7/18

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F 755	Continued From page 8 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and Nurse Practitioner, facility, dialysis and pharmacy staff interview, the facility failed to administer medications as ordered by the physician and not ensuring consistent dispensing of medications to meet resident's needs for 2 of 3 sampled residents reviewed (Resident # 25 & # 28). Findings included: 1. Resident #25 was originally admitted to the facility on 10/16/12 and was readmitted on 11/29/17 with multiple diagnoses including chronic kidney disease (CKD). The quarterly Minimum Data Set (MDS) assessment dated 1/10/18 indicated that Resident #25's cognition was intact and she was receiving dialysis. Resident #25's doctor's orders were reviewed. On 1/31/18, there was a doctor's order for Sensipar (drug used to treat chronic kidney disease on patients who are on dialysis) 30 milligrams (mgs) by mouth at bedtime. On 2/3/18, there was an order to hold Sensipar until it arrived from the pharmacy. Resident #25's Medication Administration Records (MARs) were reviewed. The February 2018 MAR revealed that Resident # 25 had received Sensipar on February 1, 2, 5, 6, 7, 8, 9, 10, 11 (9 days). The MAR also revealed that Resident #25 did not receive Sensipar on February 3, 4 and 12 (3 days) due to "not available". On 2/13/18 at 11:30 AM, a Pharmacy staff was	F 755	F755 Pharmacy Srvs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) The deficiency occurred as a result of facility not ensuring process for obtaining hard /paper script from physician timely and communication breakdown between pharmacy and facility. 1. Resident #25 Sensipar was discontinued by Dr. Nwobu, physician at High Point Kidney Center, on 2-14-18. Resident #28 receives Tramadol as ordered. 2. A Quality Review of current residents Medication Administration Records (MAR)has been completed on 2-28-18 by Director of Nursing and Unit Manager for circling of medication and or medication documented unavailable to ensure medications are being administered as ordered. Follow up based on findings of review. 3. The Director of Nursing re-educated nurses including weekend nurses and as needed nurses by 3-1-18, on pharmacy procedures: notification to pharmacy for any medication(s) not available and notification of Director of Nursing for follow-up. Nurses including weekend nurses and as needed nurses will be educated prior to working on 3-1-18. (Document medications not available on 24 Hour Report.) The Director of Nursing re-educated nurses including weekend	

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interviewed. The Pharmacy staff stated that only 5 tablets of Sensipar were sent to the facility on 2/4/18 because Sensipar was considered a non-covered medication and the facility's instruction and agreement was to send a 5 day supply and billed to facility. The Pharmacy staff also indicated that Sensipar should be provided by the dialysis center to be covered by the insurance company.

On 2/13/18 at 11:56 AM, the Dialysis staff was interviewed. She stated that Resident #25 had an order for Sensipar and the facility was responsible to administer it at the facility. She revealed that dialysis clinic did not administer the Sensipar to Resident #25 during dialysis days.

On 2/14/18 at 3:55 PM, Nurse #2 was interviewed. She stated that she did not administer the Sensipar to Resident #25 on February 1 and 2 because it was not available.

On 2/14/18 at 4:05 PM, The Director of Nursing (DON) was interviewed. The DON stated that she was not aware until 2/13/18 that Sensipar was a non-covered medication and the pharmacy had sent only 5 tablets since it was ordered. She indicated that the pharmacy was supposed to send her the "Non-Covered Medication Notification" but she did not receive the form until 2/13/18. The DON stated that she would call the doctor and the dialysis center.

ON 2/15/18 at 8:43 AM, the Nurse Practitioner (NP) was interviewed. The NP stated that he expected his orders to be followed by the facility.

On 2/15/18 at 9:20 AM, the DON was interviewed. The DON further stated that she had

nurses and as needed nurses by 3-1-18 on obtaining prescription(s) for controlled medications when only 5 days of medication supply is remaining. Nurses including weekend nurses and as needed nurses will be educated prior to working by 3-1-18. The Director of Nursing/ Unit Manager to complete quality monitoring on 10 residents medication administration records weekly for 12 weeks then monthly to ensure medications are available and are administered per physician order with no missing documentation, circling of medications without explanation or medication unavailable. The Director of Nursing/Unit Manager to complete quality monitoring on 10 residents controlled medication utilization record weekly for 12 weeks then monthly to ensure prescription obtained when only 5 days of medication supply remains. Opportunities to be corrected by the Director of Nursing and or Unit Manager as identified during these reviews. Quality review modified based on findings.
4. The results of quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Nursing for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed.

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been having issues with the pharmacy for not dispensing medications on time for various reasons. She indicated that she had discussed this issue with the pharmacy in the past and it continued to be an issue.
2. Resident #28 was admitted to the facility on 2/25/10 with multiple diagnoses that included osteoarthritis, neuromuscular dysfunction of bladder, and chronic kidney disease.

A physician ' s order dated 10/2/17 indicated Tramadol Hydrochloride (narcotic pain medication) 50 milligrams (mg) three times daily for Resident #28.

A review of the controlled medication utilization record for Resident #28 ' s routine Tramadol indicated Resident #28 ' s Tramadol supply was depleted on 11/1/17 after her third dosage. Resident #28 received no Tramadol on 11/2/17 or 11/3/17 (6 missed doses of Tramadol in total). On 11/3/17 a new hard copy prescription refill was written by the Nurse Practitioner (NP) for the same dosage and frequency of Tramadol (50 mg three times daily) for Resident #28. On 11/4/17 Resident #28 began receiving the routine Tramadol as ordered.

The November 2017 Medication Administration Record (MAR) for Resident #28 was reviewed. Resident #28 ' s hard copy MAR had handwritten "hold" on 11/2/17 for her Tramadol. On 11/3/17 the hard copy MAR had handwritten "out" for Resident #28 ' s Tramadol.

The quarterly Minimum Data Set (MDS) assessment dated 1/5/18 indicated Resident #28 ' s cognition was intact. She was noted to be on routine pain medications and received opioids on

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7 of 7 days during the MDS review period.

The plan of care for Resident #28 included, in part, the focus category of pain/comfort initiated on 4/12/17 and most recently reviewed on 1/10/18. Resident #28 was noted with complaints of chronic kidney pain, history of cervical spine surgery, history of carpal tunnel release, history of knee surgery, and arthritis.

An interview was conducted with the Director of Nursing (DON) on 2/13/18 at 4:15 PM. The controlled medication utilization record that indicated Resident #28 ' s Tramadol supply was depleted on 11/1/17 resulting in Resident #28 not receiving Tramadol as ordered on 11/2/17 and 11/3/17 (6 missed doses) was reviewed with the DON. The hard copy prescription refill for Resident #28 ' s routine Tramadol dated 11/3/17 was reviewed with the DON. The DON revealed the nurse had failed to obtain a hard copy prescription refill in advance of running out of Resident #28 ' s Tramadol. She indicated this resulted in a delayed receipt of the hard copy prescription refill, a delay in the prescription being filled, and 6 missed doses of routine Tramadol for Resident #28. The DON stated she expected any of the nurses who had administered Resident #28 ' s Tramadol in the 5 days prior to the supply being depleted should have put in a request with the physician to obtain a new hard copy prescription refill. She reported the nurses have a book that they write in to request narcotic hard copy prescription refills. The DON located the book and indicated a request for the routine Tramadol prescription refill was entered on 11/1/17. She was unable to explain why the request was not entered into the book prior to Resident #28 ' s supply of Tramadol being

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F 755	Continued From page 12 depleted. She was also unable to explain why the hard copy prescription was not obtained until 11/3/17 and why the Tramadol was not administered until 11/4/17. An interview was conducted with the Physician's Assistant (PA) on 2/15/18 at 8:45 AM. He indicated he expected medications to be administered as ordered. A follow up interview was conducted with the DON on 2/15/18 at 9:23 AM. She acknowledged the facility had an issue with acquiring and dispensing of medications as ordered.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		3/7/18

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F 758	Continued From page 13 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and facility and hospice staff interview, the facility failed to discontinue the Ambien (sedative/hypnotic drug) as ordered and failed to ensure scheduled Ativan (antianxiety drug) has indication for its use and failed to monitor the side effects and behavior of a resident on scheduled Ativan for 2 of 6 sampled residents reviewed (Residents #40 & # 5). Findings included: 1. Resident #40 was admitted to the facility on 1/20/18 with multiple diagnoses including	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use CFR(s):483.45 The deficiency occurred as a result of licensed nurses having a knowledge deficit regarding Psychotropic medications. 1. Resident #40 was discharged from the facility on 2-21-18. Resident #5 Ativan was discontinued on 2-19-18. 2. A Quality Review of current residents□ physician□s orders with	

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F 758	Continued From page 14 insomnia and poisoning by unspecified narcotic. The admission Minimum Data Set (MDS) assessment dated 1/27/18 indicated that Resident #40's cognition was intact and she had received hypnotic medication 6 times during the last 7 days. The hospital discharge summary dated 1/20/18 included an order for Ambien 10 milligrams (mgs) 1 tablet by mouth at bedtime as needed (PRN) for sleep for up to 5 days. The facility's admission physician orders for Resident #40 were reviewed. The orders dated 1/20/18 included Ambien 10 mgs 1 tablet by mouth PRN for sleep x (times) 5 days. The Medication Administration Records (MARs) of Resident #40 were reviewed on 2/12/18. The January 2018 MARs revealed that Resident #40 had received Ambien 9 times (January 21, 22, 23, 25, 26, 27, 28, 29 & 30). The February 2018 MARs revealed that Resident #40 had received Ambien 7 times (February 1, 5, 7, 8, 9, 10 & 11). On 2/13/18 at 3:45 PM, Nurse # 4 (Unit Manager) was interviewed. She stated that she had called the doctor and the doctor stated that he changed the order on admission for the PRN Ativan to be given indefinitely and not 5 days. Nurse #5 stated that she could not find the order to give Ativan PRN indefinitely in the records so she had written a clarification order dated 2/13/18. On 2/13/18 at 3:50 PM, the Director of Nursing was interviewed. The DON stated that she expected the nurse to write the order on admission if the doctor had changed the order of the PRN Ativan from 5 days to indefinite. She	F 758	sedative/hypnotics and/or antianxiety drugs has been conducted by Director of Nursing and Unit Manager on 2-28-18, for ensuring medications given/discontinued per order and each has indication for use and monitoring of side effects and behaviors. Follow up based on findings of review. 3. The Director of Nursing by 3-1-18, re-educated nurses including weekend and as needed nurses on: ensuring medications discontinued per orders and transcribing those orders to medication administration record with start and stop date by blocking off medication administration record; ensuring antianxiety medications have an indication for use and monitoring of side effects and behaviors noted on behavior/intervention monthly flow record. Nurses including weekend nurses and as needed nurses will be educated prior to working by 3-1-18. The Director of Nursing/ Unit Manager to complete quality monitoring on 10 residents medication administration record with sedative/hypnotics to ensure medications given/discontinued per order. The Director of Nursing/Unit Manager to complete quality monitoring on 10 residents medication administration record with antianxiety medications weekly for 12 weeks then monthly to ensure antianxiety medication have an indication for use and monitoring of side effects and behaviors noted on behavior/intervention monthly flow record. Opportunities to be corrected by the Director of Nursing and or Unit Manager as identified during these reviews. Quality	

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F 758	Continued From page 15 also stated that her expectation was PRN psychotropic medication was only good for 14 days so she would call the doctor to discontinue the Ambien. 2. Resident # 5 was originally admitted to the facility on 3/31/17 and was readmitted on 5/11/17 and 10/29/17 with multiple diagnoses including dementia without behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated 11/8/17 indicated that Resident #5's cognition was intact, she was dependent on the staff for transfer and she had no falls. Resident #5's doctor's orders were reviewed. On 12/4/17, there was an order to discontinue Ativan (antianxiety drug) 0.5 milligrams (mgs) twice a day (BID) as needed PRN for anxiety. On 1/4/18, there was an order for Ativan 0.5 mgs BID PRN for anxiety and to be discontinued in 14 days. On 1/19/18, there was another order to discontinue Ativan 0.5 mgs BID PRN and to start Ativan 0.5 mgs every 6 hours PRN for anxiety/agitation and must be reassess by the doctor in 14 days before reordered. On 1/24/18, there was another order to discontinue the PRN Ativan and to start Ativan 0.5 mgs twice a day (scheduled). The January 2018 nurse's notes of Resident #5 were reviewed. The notes did not indicate that Resident #5 was displaying any behaviors or anxiety. There was no behavior monitoring form found for January 2018 to monitor the behavior or the side effects of Ativan. The notes revealed that Resident #5 had a fall on 2/4/18 at 11:15 AM and on 2/10/18 at 2:30 PM. The January 2018 Medication Administration	F 758	review modified based on findings. 4. The results of these quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Nursing for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed.	

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Records (MARs) were reviewed. The MARs revealed that Resident #5 had received Ativan three times (January 5, 12 and 13) for anxiety.

On 2/14/18 at 10:01 AM, the Director of Nursing (DON) was interviewed. The DON stated that she could not find the January 2018 behavior monitoring form for Resident #5. She stated that her expectation was residents receiving psychotropic medications should have a behavior monitoring form to document the behavior and side effects of the medications.

On 2/14/18 at 11:03 AM, Nurse #5 (assigned to Resident #5) was interviewed. She stated that Resident #5 had no behavior problems, she has depression and she cried at times.

On 2/14/18 at 11:05 AM, NA# 1 (assigned to Resident #5) was interviewed. She stated that Resident #5 had no behavior problems.

On 2/14/18 at 11:20 AM, the Hospice Nurse was interviewed. She stated that she was the one who wrote the order to start the Ativan twice a day round the clock. She stated that the resident had chronic depression and she cries a lot and she was end of life and for her not to have suffering. The Hospice Nurse further stated that it was problematic for the doctor if Ativan was ordered PRN because the doctor has to come and reassess the resident.

On 2/15/18 at 9:20 AM, the Director of Nursing (DON) was interviewed. The DON stated that her expectation was psychotropic medication was only ordered if there was an indication for its use and behavior and side effects should be monitored.

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		3/7/18

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F 842	Continued From page 18 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and facility and pharmacy staff interview, the facility failed to have an accurate clinical records for 1 of 3 sampled residents reviewed (Resident # 25). Findings included: Resident #25 was originally admitted to the facility on 10/16/12 and was readmitted on 11/29/17 with multiple diagnoses including chronic kidney disease (CKD). The quarterly Minimum Data Set (MDS) assessment dated 1/10/18 indicated that	F 842	F842 Resident Records □ Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) 1. Resident #25 Senispar was discontinued on 2-14-18. Nurse #2 was re-educated by the Director of Nursing on 2-27-18 on proper documentation expectation to circle any medication not administered with explanation on back of medication administration record.	

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F 842	Continued From page 19 Resident #25's cognition was intact and she was receiving dialysis. Resident #25's doctor's orders were reviewed. On 1/31/18, there was a doctor's order for Sensipar (drug used to treat chronic kidney disease on patients who are on dialysis) 30 milligrams (mgs) by mouth at bedtime. Resident #25's Medication Administration Records (MARs) were reviewed. The February 2018 MAR revealed that Resident # 25 had received Sensipar on February 1, 2, 5, 6, 7, 8, 9, 10, 11 (9 days). The MAR also revealed that Resident #25 did not receive Sensipar on February 3, 4 and 12 (3 days) due to "not available". On 2/13/18 at 11:30 AM, a Pharmacy staff was interviewed. The Pharmacy staff stated that only 5 tablets of Sensipar were sent to the facility on 2/4/18 because Sensipar was considered a non-covered medication and the facility's instruction and agreement was to send a 5 day supply and billed to facility. On 2/14/18 at 3:55 PM, Nurse #2 (assigned to Resident #25 on February 1 and 2) was interviewed. She stated that she did not administer the Sensipar to Resident #25 on February 1 and 2 and she forgot to circle her initial to indicate that it was not administered because it was not available. On 2/15/18 at 8:33 AM, attempted to call Nurse #3. Nurse #3 was assigned to Resident #25 on February 10 and 11 and had initialed the MAR that she had administered the Sensipar. Nurse #3 did not return the call.	F 842	2. A Medication Administration Record to Medication Cards Quality Review was completed on 2-27-18, by Omnicare Pharmacy Consultant on current residents to ensure ordered medications are available and in medication cart. Follow up based on findings of review. 3. The Director of Nursing (DON)re-educated nurses including weekend and as needed nurses on proper documentation expectation to circle any medication not administered with explanation on back of medication administration record by 3-1-18. Nurses including weekend nurses and as needed nurses will be educated prior to working by 3-1-18. The Director of Nursing/ Unit Manager to complete quality monitoring on 10 residents medication administration record and medication cart for 12 weeks then monthly to ensure current resident□s medications available for administration. Opportunities to be corrected by the Director of Nursing and or Unit Manager as identified during these reviews. Quality review modified based on findings. DON and or Unit Managers to be notified of medications not available to ensure follow up with Omnicare. 4. The results of quality reviews to be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Nursing for review by the Interdisciplinary members each month. The QAPI committee to evaluate the effectiveness and amend as needed. Quality monitoring schedule modified based on findings.	

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F 842	Continued From page 20 On 2/15/18 at 9:20 AM, the DON was interviewed. The DON stated that she expected Nurse #2 to circle her initial and to document at the back of the MAR the reason why she did not administer the Sensipar. The DON also stated that the pharmacy had sent only 5 tablets of Sensipar and she didn't know why it was documented that it was administered for 9 days. The DON stated that she expected the resident's clinical records to be accurate.	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility ' s Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the	F 865	F865 QAPI program/Plan, Disclosure/Good Faith Attempt CFR(s): 483.75(a)(2)(h)(i)	3/7/18

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F 865	Continued From page 21 interventions that the committee put into place in January 2017. This was for one (1) recited deficiencies (Minimum Data Set (MDS) accuracy) that was originally cited during the recertification/complaint investigation of 1/6/17 and on the current recertification/ complaint investigation of 2/15/18. The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: F641-Accuracy of Assessments: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of behaviors (#27) and pressure ulcers (Resident #37) for 2 of 16 residents reviewed. During the recertification survey of 1/6/17, the facility was cited F278 for failure to accurately code the Minimum Data Set (MDS) for two of two residents reviewed with level II Preadmission Screening and Resident Review (PASRR). On 2/15/18 at 9:37 AM, an interview was conducted with the Administrator and Director of Nursing. When asked regarding the repeat deficiency in accuracy of MDS assessments, the Director of Nursing stated the facility plan of correction was perhaps too specific and focused on that section of the MDS and not the whole MDS. She said the monitoring tool was very specific as to PASSAR. Both the Administrator and Director of Nursing indicated the facility had a change in the social worker position and had 2 social workers in the past year. The facility has had a problem in attaining and retaining quality	F 865	1. The Executive Director held a Quality Assurance Performance Improvement meeting on 2-23-18 with the Interdisciplinary Team including the Director of Nursing, Unit Manager, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director and Business Office Manager focusing on the citation Minimum Data Set Accuracy. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 2-23-18 the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of any identified deficiency to assure compliance and quality are maintained. 3. The Quality Assurance Performance Improvement Committee to continue to meet on at least a monthly basis and as needed identifying new areas of improvement as well as reviewing current PoC and PIPs with updated interventions as required. The Regional Vice President of Operations and or the Regional Director of Clinical Services to attend the Quality Assurance Performance Improvement meeting for 3 months for validation. 4. The results of Performance Improvement plans and PoC to be submitted to the QAPI Committee by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 02/15/2018

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

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F 865	Continued From page 22 employees.	F 865	Executive Director for review by IDT members each month for 12 months. The QAPI Committee to evaluate the effectiveness and amend as needed.	