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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITATION	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
E 000	Initial Comments An unannounced recertification survey was conducted on 08/13/23 through 08/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#: 5PMB11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey were conducted 08/13/23 through 08/16/23. The following intakes were investigated: NC00202250 and NC00205031. Two of the 11 complaint allegations resulted in a deficiency. Event ID#: 5PMB11	F 000		
F 641 SS=B	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 reviews, observation, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the area of nutrition for 2 of 20 resident records reviewed (Residents #9 and #36). The findings included: 1) Resident #9 was admitted to the facility on 9/3/09 with diagnoses that included Alzheimer's disease and type 2 diabetes. Resident #9's weight data revealed the following weights: - 6/22/23 was 181.3 pounds (lbs.) - 7/5/23 was 164.8 lbs.	F 641	1. Resident #9 and Resident #36 Minimum Data Sets (MDS) were corrected in the area of nutrition to accurately reflect the residents and submitted by the MDS Coordinator by 09/01/2023. Resident #9 MDS was corrected to include the weight loss to accurately reflect the resident and submitted by the MDS Coordinator on 09/01/2023. Resident #36 MDS was corrected to include the feeding tube to accurately reflect the resident and submitted by the MDS Coordination on 08/15/2023. 2. A quality review was completed on the	9/7/23

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

Electronically Signed | 09/03/2023

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F 641	Continued From page 1 A quarterly Minimum Data Set (MDS) assessment dated 7/19/23 indicated Resident #9's weight was coded as 181 lbs. On 8/15/23 at 2:36 PM, an interview occurred with the Dietary Manager. She verified she had completed the nutritional section for Resident #9's 7/19/23 MDS assessment. After reviewing Resident #9's weight history she stated she should have entered the weight as 165 lbs. and not 181 lbs. and it was an oversight. In addition, she would have coded Resident #9 for weight loss that she was aware of. During an interview with the Director of Nursing and Administrator on 8/16/23 at 9:34 AM, they indicated the Dietary Manager was still learning the MDS coding process but would expect the assessment to be coded correctly. 2) Resident #36 was admitted to the facility 04/13/23 with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction (stroke) and Gastroesophageal Reflux Disease. Resident #36's care plan dated 05/16/23 indicated a focus area of Resident #36 had a Percutaneous Endoscopic Gastrostomy (PEG) tube due to dysphagia from a stroke. A quarterly Minimum Data Set (MDS) assessment dated 07/28/23 indicated Resident #36 was not coded as having a feeding tube. On 8/15/23 at 2:45 PM, an interview occurred with the Dietary Manager. She verified she had completed the nutritional section for Resident #36's 07/28/23 MDS assessment. She stated she	F 641	current residents MDSs in the area of nutrition to validate the most recent MDS assessment have been coded to accurately reflect the status of the residents by the Regional MDS Coordinator on 09/01/2023. 6 Minimum Data Sets identified. Most current MDS will be corrected and submitted by 09/05/2023. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 09/06/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Regional MDS Coordinator educated the MDS Coordinator and the Dietary Manager on accurately coding of nutrition on 09/01/2023. 4. The MDS Coordinator will conduct random Quality reviews of 5 residents MDS assessments of section K nutrition coding to ensure MDS coded accurately on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 641	Continued From page 2 knew Resident #36 had a feeding tube, and she should have marked Resident #36's MDS as having a feeding tube. She stated the incorrect coding was due to human error. During an interview with the Director of Nursing and Administrator on 8/16/23 at 9:34 AM, they indicated the Dietary Manager was still learning the MDS coding process but would expect the assessment to be coded correctly.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #24 and #44). This was for 2 of 6 residents reviewed for activities of daily living (ADL). The findings included: 1) Resident #24 was admitted to the facility on 4/3/22 with diagnoses that included Alzheimer's disease, muscle weakness and lack of coordination. A significant change in status Minimum Data Set (MDS) assessment dated 7/17/23, indicated Resident #24 had severe cognitive impairment and required extensive assistance with personal hygiene tasks.	F 677	1. Resident #24, #44 were provided nail care to include trimming and cleaning their nails on 08/15/2023. 2. A quality review was completed by the Director of Nursing on current residents on Activities of Daily Living (ADL) care specific to nail care on 08/16/2023. Identified residents were provided nail care to include cleaning and trimming at that time. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 09/06/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing and/or Nurse Manager re-educated nursing staff on all	9/7/23

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F 677	Continued From page 3 A review of Resident #24's active care plan, last reviewed 8/8/23, revealed a focus area for having an ADL self-care performance deficit related to limited functional abilities and cognitive deficits. A review of Resident #24's nursing progress notes from 2/1/23 until 8/14/23 revealed no refusals of nail care documented. On 8/13/23 at 12:00 PM, Resident #24 was observed lying in bed. He was noted to have a dark brown substance under his fingernails to both hands. His fingernails were short in length. Resident #24 was observed sitting at the nurse's station on 8/14/23 at 10:00 AM. His nails remained with a dark brown substance underneath them. On 8/14/23 at 3:30 PM, an interview occurred with Nurse Aide (NA) #1. She was familiar with Resident #24 and cared for him on the evening shift (3:00 PM to 11:00 PM). She explained nail care should be completed with personal care, showers and as needed. She was unaware his nails needed to be cared for. Resident #24 was observed while lying in bed on 8/15/23 at 9:50 AM. His fingernails were short in length and had a dark brown substance under the nails to both hands. On 8/15/23 at 9:57 AM, an observation of Resident #24's fingernails occurred with NA #2. She verified his nails had a dark brown substance under them to both hands. She stated she wasn't scheduled to care for Resident #24 but would ensure his nails were addressed. NA#2 added nail care was to be completed when personal	F 677	shifts, including part-time and prn on ADL care specific to nail care by 09/06/2023. 4. The Director of Nursing and/or Nurse Manager will conduct random Quality Reviews of residents to ensure residents are provided nail care with Activities of Daily Living (ADL) care on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 677	Continued From page 4	F 677		

care and showers were provided or whenever there was a need.

The Director of Nursing (DON) was interviewed on 8/15/23 at 11:15 AM and stated it was her expectation for nail care to be provided during personal care tasks and if a NA was unable to complete the task, she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #24.

2) Resident #44 was admitted to the facility on 8/1/22 with diagnoses that included a history of a stroke with left sided paralysis, muscle weakness and lack of coordination.

An annual Minimum Data Set (MDS) assessment dated 7/5/23 indicated Resident #44 had moderately impaired cognition and received extensive assistance for personal hygiene tasks.

Resident #44's active care plan, last reviewed 7/19/23, included a focus area for an ADL self-care performance deficit related to activity intolerance, fatigue, shortness of breath, and stroke with left sided paralysis. One of the interventions included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.

A review of Resident #44's nursing progress notes from 2/1/23 until 8/14/23 revealed no refusals of nail care documented.

On 8/13/23 at 11:50 AM, Resident #44 was observed while lying in bed watching TV. She was noted to have long fingernails to both hands. Resident #44 stated she couldn't recall the last

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F 677	Continued From page 5 time her nails were attended to, but they were "longer than I like to have them". On 8/14/23 at 11:26AM, Resident #44 was sitting at her bedside and stated that no one had offered to cut her fingernails yet. An observation of Resident #44's nails occurred with Nurse Aide (NA) #2 on 8/14/23 at 11:28AM. She was familiar with the resident and was assigned to care for her on the day shift (7:00 AM to 3:00 PM). She stated was unaware Resident #44's fingernails were that long or that Resident #44 wished for them to be trimmed. NA #2 added that nail care was to be completed with personal care, showers and as needed. On 8/15/23 at 11:15 AM, the Director of Nursing (DON) was interviewed and stated she would expect nail care to be provided during personal care tasks and if a NA is unable to complete the task, she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not been provided for Resident #44.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		9/7/23

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F 695	Continued From page 6 Based on record reviews, observations and staff and resident interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident reviewed for respiratory care (Residents #31). The findings included: Resident #31 was admitted to the facility on 10/21/22 with diagnoses that included chronic respiratory failure with hypoxia, obstructive sleep apnea, and heart failure. A review of the physician orders for Resident #31 included an order dated 11/07/22 for continuous oxygen at 2 liters per minute by nasal cannula every shift related to acute and chronic respiratory failure with hypoxia. A quarterly Minimum Data Set (MDS) assessment dated 07/07/23 indicated Resident #31's cognition was intact. He was coded with the use of oxygen. Resident #31's care plan dated 07/25/23 indicated a focus area of Resident #31 had oxygen therapy related to ineffective gas exchange and respiratory failure. The goal indicated Resident #31 would have no signs or symptoms of poor oxygen absorption through the review date. Interventions included, in part, Resident #31 would have oxygen administered via nasal cannula at 2 liters per minute continuously. Resident #31's oxygen saturations were documented in his Electronic Medical Chart as follows:	F 695	1. Nurse #1 adjusted the flow to administer oxygen as ordered on 08/15/2023 for Resident #31. 2. A quality review was completed by the Director of Nursing of current residents with oxygen to ensure oxygen administered as ordered on 08/31/2023. No concerns identified. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 09/06/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing and/or Nurse Manager educated licensed nurses on respiratory care related to oxygen orders and ensuring resident receiving oxygen as ordered by 09/06/2023. 4. The Director of Nursing and/or Nurse Manager will conduct random Quality reviews of residents with oxygen to ensure residents receiving oxygen as ordered on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 695	Continued From page 7 08/02/23 - 94% via nasal cannula 08/09/23 - 94% via nasal cannula In an interview and observation with Resident #31 on 08/13/23 at 11:37 AM revealed he was sitting in a recliner chair with his eyes opened. He did not appear to be in distress. Resident #31 stated he had been on oxygen since September 2022 and thought the oxygen concentrator should be set to 1 liter per minute. An observation of the oxygen regulator on the concentrator showed the concentrator was set at 0.5 liters flow when viewed horizontally, eye level. Resident #31 was observed to be sitting in a recliner chair with his eye opened on 08/14/23 at 8:33 AM. He did not appear to be in distress. The oxygen regulator on the concentrator was set at 0.5 liters flow when viewed horizontally at eye level. On 08/14/23 at 1:44 PM, Resident #31 was observed sitting in a recliner chair with his eyes opened. He did not appear to be in distress. The oxygen regulator on the concentrator was set at 0.5 liters flow when viewed horizontally at eye level. An observation was made with Nurse #1 of Resident #31's oxygen concentrator on 08/15/23 at 10:30 AM, who stated the oxygen regulator on the concentrator was set at 0.5 liters when viewed horizontally at eye level. Nurse #1 adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #1 stated that oxygen rates were checked at least one time per shift. Resident #31 did not appear to be in distress during the observation with Nurse #1.	F 695		

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F 695	Continued From page 8 During an interview with the Director of Nursing on 08/16/23 at 9:12 AM, she indicated the concentrator could have gotten bumped when staff transferred the resident; however, it was her expectation for oxygen to be delivered at the ordered rate.	F 695		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		9/7/23

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F 867	Continued From page 9 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health	F 867		

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outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data

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F 867	Continued From page 11 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following an annual recertification and complaint survey completed on 04/12/22. This was for two deficiencies that was cited in the areas of Activities of Daily Living Care Provided for Dependent Residents and Respiratory/Tracheostomy Care and Suctioning. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This citation is cross referenced to: 1. F677 - Based on record reviews, observations, resident and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #24 and #44). This was for 2 of 6 residents reviewed for dependency on staff for Activities of Daily Living (ADLs). During the facility's recertification survey of 04/12/22 the facility failed to trim and clean dependent residents' nails. This was for 4 of 17 residents reviewed for dependency on staff for Activities of Daily Living (ADLs). In an interview with the Administrator on 08/16/23	F 867	1. The Executive Director will hold an Ad hoc Quality Assurance Performance Improvement meeting on 09/06/2023 with the Interdisciplinary Team including the Director of Clinical Services, Assistant Director of Clinical Services, Infection Preventionist, MDS Coordinator, Social Services Director, Admissions Director, Business Office Manager, Activity Director, Maintenance Director, Medical Records Coordinator, Dietary Manager, Housekeeping Manager, Director of Rehab, and Staffing Coordinator focusing on the areas of F641 Accuracy of Minimum Data Set in the area of nutrition (Section K); F677 ADL Care provided for Dependent Residents related to nail care; and F695 Respiratory/Tracheostomy Care and Suctioning related to administering oxygen at the prescribed rate. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 09/06/2023 the Regional Director of Clinical Services along with the Executive Director will re-educate the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. 3. The Quality Assurance Performance	

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12 at 9:35 AM, he felt the repeat citation in Activities of Daily Living Care Provided for Dependent Residents was related to the resident not having Activities of Daily Living refusals on their care plan. It would not have been a repeat citation if the refusals were documented on their care plan. 2. F695 - Based on record reviews, observations and staff and resident interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident reviewed for respiratory care (Residents #31). During the facility's recertification survey of 04/12/22 the facility failed to administer supplemental oxygen as ordered and to clarify an oxygen order. This was for 1 of 1 resident reviewed for respiratory care. In an interview with the Administrator on 08/16/23 at 9:35 PM, he felt the repeat citation in Respiratory/Tracheostomy Care and Suctioning was related to the resident's oxygen concentrator possibly being bumped when staff transferred the resident.	F 867	Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. 4. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 12 months. The QAPI Committee will evaluated effectiveness and amend as needed.	