STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER ST WILKESBORO, NC 28697

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F 000	INITIAL COMMENTS No deficiencies cited as a result of Complaint Investigation Survey Event ID# WIXP11.	F 000	Westwood Hills Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, WWHNRC reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interviews the facility failed to implement swallowing precautions for one (1) of two (2) sampled residents during medication administration. (Resident #106) The findings are: Resident #106 was admitted to the facility with diagnoses including Alzheimer's disease, Dementia and Dysphagia. The most recent Minimum Data Set (MDS) dated 12/08/11 revealed Resident #106 was severely impaired cognitively for daily decision making and was totally dependent, requiring one staff assist with eating. A physician order dated 12/02/11 revealed the following: Resource Arginaid (nutritional supplement) one packet by mouth twice daily in four ounces of honey water to be given with	F 309	Physical assessment completed of Resident #106 on 1/26/12 per RN. Assessment revealed no signs/symptoms of aspiration or otherwise. MD informed of incident with no new orders received. RP made aware. ST eval requested, although RP denied. Current thickened liquid order written on the Medication Administration Record (MAR) clearly to ensure accurate liquid administration during med passes.	1/26/12

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

James S Sm — Administrator — 2-15-12

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.

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F 309	Continued From page 1 medication pass. A nursing care plan last updated 12/08/11 identified Resident #106 required assistance for the potential to restore or maintain maximum function for self sufficiency for eating related to dysphagia. The stated goal was to have no choking or aspiration episodes through the next review. Interventions included no straws and provide thickened fluids and supplements using honey. On 01/25/12 at 9:25 a.m. during a medication pass, LN #2 was observed mixing one packet of Arginaid in 120 milliliters (ml) of free water and administering the supplement using a straw to Resident #106. Resident drank the contents of the cup using the straw and was noted to cough twice. Resident #106 cleared his throat with the two coughs. LN #2 was interviewed on 01/25/12 at 9:45 a.m. and acknowledged the Arginaid was mixed with unthickened water and Resident #106 was given a straw. LN #2 also indicated there was usually a paper on the Medication Administration Record (MAR) indicating if a resident was on thickened liquids. LN #2 further revealed since there was not a paper indicating residents on thickened liquids on the MAR and the order handwritten on the MAR was faint, she did not realize Resident #106 required honey thick liquids. An interview was conducted with the Director of Nursing (DON) on 01/25/2012 at 11:45 a.m. The DON acknowledged the physician's order specifically stated honey thickened and her expectation was for the nurse to administer the	F 309	All residents requiring thickened liquids reviewed by QI Nurse on 2/9/12 to ensure appropriate liquid consistency written as ordered on MAR legibly. Bright colored signage indicating appropriate ordered liquid consistency to be used additionally placed to MAR on 2/9/12 for all residents requiring thickened liquids, to include Resident #106. As new orders are received for changes to liquid consistencies- the order will be noted on the MAR by the Ward Clerk and checked for accuracy by a Licensed Nurse. Additionally signage will be added or removed at that time to correspond with the new order. This process will be checked again by an Administrative Nurse to ensure correct signage is in place, as well as the consistency has been appropriately listed on the MAR legibly. Retraining conducted regarding changes in the process of communication of newly ordered or discontinued thickened liquids with all nursing staff and completed on 2/17/12. Retraining on specific expectations of staff involved, including ward clerks and licensed nurses, of the new process, conducted and completed on 2/17/12.	2/9/12 2/9/12 2/17/12 2/17/12

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F 309	Continued From page 2 supplement mixed with honey thickened water to Resident #106.	F 309	Audits will be conducted by the QI Nurse on a weekly basis to ensure the current Physician Order for thickened liquids is appropriately listed on the MAR, legible and bright colored signage is in place indicating the correct liquid to be used. These audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time. The Executive QI Committee will review audits weekly x 4, monthly x 2 and on a Quarterly basis x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	2/17/12
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observation, medical record review and staff interviews the facility failed to provide nail care for one (1) of four (4) sampled residents. Resident #62. The findings were: Resident #62 was admitted to the facility with diagnoses including a fractured hip, bipolar disease, peripheral vascular disease, diabetes, and a history of cerebral vascular accident. The significant change Minimum Data Set (MDS) dated 12/30/11 coded Resident #62 as requiring extensive assistance with dressing and hygiene. The Care Area Assessment (CAA) dated 1/4/12 for activities of daily living skills described Resident #62 with inattention, behaviors of yelling, memory problems, and needing staff assistance with dressing. The CAA stated no care plan would be developed for dressing or hygiene as Resident #62 needed extensive assistance with these areas and he was not expected to improve those abilities.	F 312	Resident #62 was provided nail care to include cleaning and trimming on 1/26/12. All In-house Diabetic residents were provided nail care to include cleaning and trimming with completion on 2/17/12 by Licensed Nurses.	1/26/12 2/17/12

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F 312	Continued From page 3 On 1/25/12 at 9:58 AM, Resident #62 was returned to his room from therapy. His fingernails were long and there was dark debris under each nail on his right hand. On 1/25/12 at 11:51 AM, Nurse Aide (NA) #1 was observed pushing Resident #62 down the hall in his wheelchair. She stated she had just shaved Resident #62. Resident #62 still had long nails with debris under the nails on his right hand. On 1/26/12 at 8:30 AM, Resident #62 was in his wheelchair in the lounge with long nails on both hands and debris under the nails on his right hand. On 1/26/12 at 11:06 AM the treatment nurse #1 stated the treatment nurses trim diabetic residents' fingernails. She further stated there was a list from which the treatment nurses referred during weekly checks. On 1/26/12 at 11:11 AM interview with NA #2, who provided morning care to Resident #62 this date, stated nurse aides were to check nails on shower days. She further stated Resident #62 received a shower yesterday during second shift. NA #2 observed Resident #62's nails at this time and confirmed his nails were long and needed to be cleaned. On 1/26/12 at 11:25 AM, the treatment nurse #1 stated she was supposed to check Resident #62's nails weekly and trim as needed. She stated she was due to check his nails tomorrow (1/27/12). At this time she observed Resident #62's nails and confirmed the nails were due to be trimmed and had debris under them. She stated nurse aides were to keep his nails clean.	F 312	All residents will be assessed for needed nail care on a weekly basis. Cleaning and trimming of nails will be provided by Certified Nurse Assistants weekly as needed. Diabetic residents will receive nail care per the Assigned Hall Nurse weekly. Administrative Staff will perform weekly rounds to ensure nail care has been completed as needed on all residents. Any identified concerns with nail care during rounds will be forwarded to the Administrative Nurse to be addressed at that time. Checklists will be completed per the staff member to verify that cleaning and/or trimming of nails has been accomplished upon task completion. Nail Care Checklists and Administrative Rounds Tools will be turned into the QI Nurse upon task completion for review. Retraining conducted with all staff regarding changes in the process of nail care and completed on 2/17/12. Retraining conducted with Administrative and Nursing Staff on the new process of providing needed nail care to include removal of debris and/or trimming, as well as performance monitoring during rounds, with completion on 2/17/12. Audits will be performed on a weekly basis by the QI Nurse to ensure all residents have received nail care to include cleaning and/or trimming, to include residents who are Diabetic. These audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time.	2/17/12 2/17/12

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F 312	Continued From page 4 On 1/26/12 at 11:36 AM, the Director of Nursing provided documentation that Resident #62's fingernails were last trimmed on 12/28/11. She further stated the treatment nurse was due to check them tomorrow (1/27/12) and that nurse aides should keep them clean.	F 312	The Executive QI Committee will review audits weekly x 4, monthly x 2 and on a Quarterly basis x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	2/17/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	NA #4 was immediately retrained on infection control, specifically hand washing after incontinence care, on 1/26/12. New Trash Receptacles were ordered 2/9/12 with open top capability to prevent contact with container while properly disposing of trash. Containers will be distributed to all dining areas upon arrival to facility.	1/26/12 2/9/12

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F 441	Continued From page 5 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to wash hands after providing incontinent care for one (1) of five (5) sampled residents and failed to wash hands after disposing of trash and before feeding a resident in one (1) of four (4) dining rooms. Resident #150. The findings were: 1. On 1/25/12 at 10:21 AM, Resident #150 was observed coming out of his bathroom with his pants partially down. At 10:22 AM, Nurse Aide (NA) #4 saw him and assisted him to a chair in his room. NA #4 then put on gloves and obtained wipes. NA #4 assisted the resident to the commode and wiped his buttocks. With the same gloves, NA #4 assisted Resident #150 to dress in a clean incontinent brief and pants. When the resident requested to wear shorts instead of the pants, NA #4 removed the pants and put shorts on him while wearing the same gloves she had on during incontinent care. NA #4 continued to wear the same gloves as she bagged the soiled linen, assisted Resident #150 to bed, fluffed his pillow and picked up his glasses. Once at the sink to wash Resident #150's glasses, she removed her gloves and	F 441	Random audits will be performed on a weekly basis by the QI or SDC Nurse to ensure proper infection control/hand washing techniques are performed and observed. Observations will be performed after incontinence care, during meals, and random routine care by staff. Observation of at least 5 different employees will be performed weekly. Any concerns during observations will be addressed at that time with 1 on 1 retraining conducted as needed. Retraining conducted with all staff regarding Infection Control, to include hand washing, with completion on 2/17/12. Retraining included re-education of NA's #4 and #3. Audits will be turned into the Administrator weekly for review. Any concerns will be addressed at that time. The Executive QI Committee will review audits weekly x 4, monthly x 2 and on a Quarterly basis x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	2/17/12 2/17/12

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F 441	Continued From page 6 washed her hands. After washing her hands, she put on new gloves and washed Resident #150's glasses. During interview on 1/25/12 at 10:34 AM, NA #4 stated there was a small stool smear on the disposable wipe she used to wipe Resident #150's buttocks. NA #4 stated she should have changed her gloves as soon as she finished wiping the resident's buttocks. On 1/26/12 at 2:47 PM an interview was conducted with the Staff Development (SD) personnel. SD stated they expected NA #4 to wash their hands after cleaning a resident during incontinent care and before touching other items in the room. 2. On 1/23/12 at 12:39 PM Nurse Aide (NA) #3 was observed feeding a resident in the main dining room. While feeding the resident, NA #3 stood and removed two tray covers that were sitting on the table. NA #3 took the tray lids which had trash inside and turned the lids over on top of the trash receptacle prior to placing them in the soiled tray area. NA #3 then picked up a piece of trash from the floor and using the hand with the trash, pushed open the swivel lid to the trash receptacle and deposited the trash inside. NA #3 returned to the same resident and without cleaning her hands in any manner, fed the resident the remainder of her meal. At 12:49 PM, once the resident was finished eating, NA #3 got a tray lid from the soiled area, placed it on the resident's tray and wiped the resident's mouth with the clothing protector. NA #3 then placed the soiled tray on the cart with other soiled trays and took the resident to her room without cleansing	F 441		

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F 441	Continued From page 7 her hands. On 1/23/12 at 12:59 PM, NA #3 stated during interview she should have washed her hands after discarding the trash. She further stated she was trained to wash her hands all the time. On 1/26/12 at 2:47 PM an interview was conducted with the Assistant Director of Nursing (ADON) and Staff Development (SD) personnel. ADON and SD stated they expected staff to sanitize their hands between residents in the dining room whenever they have touched a resident. SD stated NA #3 should have used the sanitizing wipes or sanitizing gel located in the dining room after disposing of trash and before feeding any resident.	F 441		