PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ODATE SURVEY COMPLETED C 03/06/2019 (X5) COMPLETION DATE
		345450	B. WING				
		343430	D. WING_			03/	06/2019
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD HEALTH AND REHAI	RII ITA		62	5 ASHLAND STREET		
"201110	OD HEAEIN AND REHA			ΑI	RCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
E 000	Initial Comments		EC	000			
F 000		3.73, Emergency t ID #2RY711.	FO	000			
	_	ered the facility on 1/7/19 for complaint investigation 1/10/19.					
	Per CMS and manage Immediate Jeopardy	ement review of the 2567, was identified at:					
	CFR 483.12 at tag F	600 at a scope and severity					
	CFR 483.25 at tag F	686 at a scope and severity					
	Tags F 600 and F686 Quality of Care	constituted Substandard					
	and conducted an ext	ered the facility on 3/6/19 tended survey. On 3/6/19 tified Immediate Jeopardy					
	CFR 483.35 at tag F	725 at a scope and severity					
	CFR 483.70 at tag F	835 at a scope and severity					
		for F600, F686, F725, and 18 and were removed on					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

Electronically Signed

03/25/2019

MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345450	B. WING		C 03/06/2019
	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 33/35/23 13
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
Continued From pag	e 1	F 00	00	
Resident Rights/Exe	rcise of Rights	F 58	50	4/3/19
The resident has a riself-determination, as access to persons ar	ght to a dignified existence, nd communication with and nd services inside and			
with respect and digr resident in a manner promotes maintenan- her quality of life, rec individuality. The faci	nity and care for each and in an environment that ce or enhancement of his or cognizing each resident's fility must protect and			
access to quality care severity of condition, must establish and m practices regarding to provision of services	e regardless of diagnosis, or payment source. A facility naintain identical policies and ransfer, discharge, and the under the State plan for all			
The resident has the rights as a resident of	right to exercise his or her fthe facility and as a citizen			
resident can exercise	e his or her rights without			
	ROVIDER OR SUPPLIER OD HEALTH AND REHA SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag The exit date was ch Resident Rights/Exe CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a ri self-determination, a access to persons ar outside the facility, in this section. §483.10(a)(1) A facili with respect and digr resident in a manner promotes maintenan her quality of life, rec individuality. The faci promote the rights of §483.10(a)(2) The fa access to quality can severity of condition, must establish and re provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident of or resident of the Uni §483.10(b)(1) The fa resident can exercise interference, coercion	ROVIDER OR SUPPLIER OD HEALTH AND REHABILITA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 The exit date was changed to 3/6/19. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	ROVIDER OR SUPPLIER OD HEALTH AND REHABILITA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 The exit date was changed to 3/6/19. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) \$483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. \$483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. \$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. \$483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. \$483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	ROWDER OR SUPPLIER OD HEALTH AND REHABILITA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 The exit date was changed to 3/6/19. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) \$483.10(a) (Resident Rights.) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. \$483.10(a)(1) A facility must brovide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. \$483.10(b) Exercise of Rights. The resident has a right to exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal

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		345450	B. WING _			C 3/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		3/00/2019	
				625 ASHLAND STREET			
WESTWO	OD HEALTH AND RE	HABILITA		ARCHDALE, NC 27263			
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 550	Continued From p	age 2	F 5	550			
	, , , , ,	resident has the right to be					
		e, coercion, discrimination, and					
		acility in exercising his or her					
	_	upported by the facility in the					
		her rights as required under this					
	subpart.	ENT is not met as evidenced					
	by:	LIVI IS NOT MET as evidenced					
	·	review, observation, resident		F550- Resident Rights/ Exerc	cise of		
		nent of Social Services (DSS)		Rights			
	interview, and sta	ff interview, the facility failed to		1. On 3/12/19 and 3/13/19 Re	esident #'s		
		a dignified manner as evidenced		32 and 49 were interviewed b	-		
		taff to resident verbal		Service Director (SSD) and the	•		
		lent #32 and #49) and by not		Director of Clinical Services to			
	_	ght related to a request for		lights are answered timely and			
		(Resident #49). This failure #49 to cry and to feel		verbally appropriate. No conc regarding care at this time. Re			
		helpless". The facility also		no longer resides at the facilit			
		sident #47 's urinary catheter		The forigon recides at the facility	y .		
		romote dignity for 3 of 5		2. The Social Services Direct	or and or		
	sampled residents	reviewed for dignity and		the Regional Director of Clinic	al Services		
	respect.			conducted resident interviews	of all		
				interviewable residents to ens			
	The findings inclu	ded:		residents' call lights are answ			
	1 Decident#40	una admitta di ta tha facility an		and staffs are verbally approp			
		vas admitted to the facility on		3/19/19. On 3/14/19 the Regi			
		noses that included isease, major depressive		of Clinical Services completed monitoring (audit) of residents			
		ent disorder with depressed		catheters to ensure privacy co			
	mood, and anxiety	•		catheter bags are provided ar			
				No issues identified during au	-		
	A Social Work (SV	V) note dated 12/6/18 indicated					
		admitted from an acute		3. The Regional Director of C			
	•	g taken to the Emergency		Service (RDCS), Executive D			
		ult Protective Services (APS)		Director of Nursing (DON) and			
	_	h of her spouse who was her		provide re-education to facility			
	primary caregiver	at nome.		contracted staffs, including all			
	A Dovobiatria Ni	on Dractitioner (DND) Note		part-time and prn, on the fede			
	A PSYCHIATRIC NURS	se Practitioner (PNP) Note		regulations and guidelines rel	aung wume	1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			71. 5012511				С
		345450	B. WING _			03/	06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		62	REET ADDRESS, CITY, STATE, ZIP CODE 5 ASHLAND STREET RCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	through the normal death of her spouse diagnoses of adjustrand worsening diagrinsomnia, and anxies. The admission Miniral assessment dated 1 #49 's cognition was behaviors and no rerequired the extensi mobility and toileting. She was frequently always incontinent of administered antian antidepressant med period. The Care Area Asservinary incontinence admission MDS indicand able to make deneeds. Resident #4 of incontinence and sensation in her black hold. A SW note dated 12 #49 was on antidepressant medicantianxiety medicati become tearful when who recently passed. The active care plan part, the following an electronic resident #49 h (ADL) self-care perfectives.	cated Resident #49 was going grieving process related to the s. She was noted with new ment disorder and grieving noses of major depression, ety. mum Data Set (MDS) 2/13/18 indicated Resident s fully intact. She had no jection of care. Resident #49 we assistance of 1 for bed g and 2 or more for transfers. incontinent of bladder and of bowel. She was exiety medication and ication during the MDS review resident #49 s 12/13/18 cated she was alert, oriented, ecisions and communicate so indicated she had a history that she could feel a dder, but it was difficult to 12/13/18 indicated Resident ressant medication and on. She was noted to a speaking about her spouse d away. In for Resident #49 included, in	F 5	550	resident's right to a dignified existence self-determination and exercise of right and, nursing staff in regard to answerin call lights timely, being verbally appropriate to residents and providing privacy covers for catheter bags, by 3/21/19. Staff will not be allowed to ret to work until education complete. 4. The ED, DON and/or SSD will cond quality monitoring (audit) of five reside and/or their representative interviews 3 times per week for 4 weeks, then week for 3 months, to ensure residents are provided care in a dignified manner, the ability to exercise their rights is respect call lights are answered timely and staff are verbally appropriate. The DON will conduct quality monitoring (audit) of residents with catheters 3 times per we for 4 weeks, then weekly for 3 months, ensure residents with catheters privacy maintained with a privacy cover. This quality monitoring (audit) will include all shifts and some weekends. The SSD a DON will report on the results of the quality monitoring (audit) and report to QAPI committee. Findings will be reviewed by QAPI committee monthly a Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	urn uct nts, ly eir ed, fs to is	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From page		F 5	50		
	part, assistance with adjusting clothes, and toilet use. Resident #49 har related to CVA with ricontractures of the right #49 was noted to repurine. The intervention pan, mechanical lift for communication of netoileting. Resident #49 utiliand antidepressant in to be grieving the los diagnosis of adjustment tearfulness. The intermonitoring and side entoileting and side entoileting.	ne interventions included, in tasks of washing hands, in cleaning self in relation to did altered bladder elimination ght sided hemiplegia and ght hand and wrist. Resident ort difficulty holding her ons included, in part, bed or transfers, and encourage eds for assistance with dized antianxiety medication nedication. She was noted so fher husband, she had a cent disorder, and episodes of reventions included behavior effect monitoring.				
	oriented with no impa asked if she had any stated that several we shift (3:00 PM to 11:0 and requested for states she could urinate. So preferred to urinate in 2 staff members came them said the bed part Resident #49 stated said to her, "do it in yever gone in your part the staff she hadn't was a baby. Resident taken the bed pan with she had to urinate in recall the names of e	desident #49 was alert and aired cognition noted. When concerns with her care she eeks ago during the second (10 PM) she rang her call bell off to adjust her bed pan, so the explained that she in her bed pan. She reported e into her room and 1 of in was too small for her. It that this staff member then our pantshaven 't you ints?" She reported she told gone in her pants since she in #49 indicated the staff had the them out of her room and her brief. She was unable to ither staff member and was long it took for incontinent				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		DATE SURVEY COMPLETED	
		345450	B. WING				06/ 2019	
	ROVIDER OR SUPPLIER	BILITA		6	STREET ADDRESS, CITY, STATE, ZIP CODE 325 ASHLAND STREET ARCHDALE, NC 27263	1 001	00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 550	stated she felt "humil crying after the incide that she had lost her and she lost her inde that she felt like the sif she were a child. In had reported this inci (unable to recall the rebelieved the Director aware. She indicated the 2 staff members a incident to the nurse concern and fear of rebeing investigated as "make anyone angry" A complaint/grievanc communicated by Re Resources Coordinated resident was concern waited for her call light form had been review assigned to the DON A follow up interview Resident #49 on 1/9/#49 stated that she cowanted the incident so 1/7/19 interview to be she located her personal had been review that read, "2 [staff] came about the bed par pants. They took the this interview the gried by the HRC that discontinuations.	o her after this incident. She iated" and she recalled ent occurred. She reported husband, she lost her home, pendence. She indicated staff were speaking to her as Resident #49 stated that she dent to one of the nurses name of the nurse) and she of Nursing (DON) was also d she had not seen either of again after she reported this Resident #49 expressed eprisal with this incident a she had not wanted to ". The report dated 1/8/19 esident #49 to the Human for (HRC) indicated that the fined about how long she int to be answered. This wed by the SW and was for investigation.	F	550				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345450	B. WING		03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 550	be answered was rev. She stated that in the pressed her call bell. She indicated it took to be answered. She brief during that time her urine. She revea was soaked with urin answered by the HR this incident made he the DON then provid. A phone interview was Department of Social phone on 1/9/19 at 8 Resident #49 reported that she had request and they said someth the bed pan and told wanted to use the bed on herself". She state "tearful and upset" we information. DSS state Resident #49 again yresident told her she for over 2 hours after assistance. An interview was cortifely and the state of the she for over 2 hours after assistance.	viewed with Resident #49. e early morning on 1/8/19 she because she had to urinate. over 2 hours for her call bell e stated she urinated in her as she had difficulty holding led she sat in her brief that e until her call bell was C. Resident #49 indicated er feel "helpless". She stated ed her with incontinent care.	F 55		
	room and asked the something she could informed her she had needed "cleaned up"	light on, so she entered the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 550	7:10 AM when she ed the call light. She stood of urine in the received received and Administrator to the stood of the speaking to Resident and Administrator to the An interview was conditional to the stood of the Resident #49 or was reported by the Resident #49 was vistime she spoke with not asked Resident #49 was vistime she spoke with not asked Resident #40 has to her during the 1/8 investigation was one knowledge of any provided incontinent care for Ferrica An interview was conditionally after the HRC resident 's call light had been on for over that Resident #49 has reported Resident #40 has reported Resid	estimated it to be around intered the room to answer ated there was no obvious from. She indicated that sibly upset and was crying in her. She said that after it #49 she went to the DON report the information. Inducted with the SW on She indicated she spoke in 1/8/19 after the grievance HRC. She revealed that sibly upset and tearful at the her. She stated that she had it show the incident made focused on trying to find out first were that were assigned in 1/9 incident. She stated the going. The SW denied evious incidents related to	F 5	50			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		345450	B. WING		C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 550	at that time. She could the 1/8/19 grievance. The DON stated she staff member she he also unable to recal revealed there was this incident and not The DON reported resident to be told to indicated she experiment of the DON confirmation of DON confirmation of Assistant (NA) #5 whom 12/14/18 during and NA #1 were assisted that the site of the size of the resident was considered as the signed to Reside she had worked with telling Resident #45 additionally denied to the size of the resident period of the side to Reside beginning 1/7/19 are that 2 NAs were we entire building and Resident #49. Nurs Resident #49 is call extended period of	ey were unable to change her onfirmed that this was prior to be and was a separate incident. What eard this from and she was all when this occurred. She no grievance written related to investigation was conducted. It was a dignity issue for a courinate in their brief. She otted residents to be treated pect. The nursing schedule and on 1/9/19 at 2:45 PM, Nursing was assigned to Resident #49 the second shift and Nurse #2 signed to the resident for the beginning at 11:00 PM and 7:00 AM. Inducted with NA #5 on 1/9/19 ated she was not frequently at #49 but acknowledged that the her in the past. She denied of to urinate in her brief and making any statement related	F 55		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	answered. He exploonly 2 NAs working answer call lights timeeting the resider. An interview was coat 3:15 PM. He corn Resident #49 during 1/7/19 and ending working a double the second shift 1/7/19 shift ending 1/8/19. 2 NAs working the feach had about 30 had not recalled Reform for an extended morning on 1/8/19, surprise to him. He difficulty meeting rethere were only 2 NHe stated he was uform had been filed concern about how light to be answered hours of 1/8/19. An interview was conditionally and to wait a long time answered. He addifficulty in he answered a staff could just "go" in he to wait. The Administrator on 1/9 in he answered. He addifficulty in he answered. He addifficulty in he answered. The Administrator on 1/9 in he answered. The Administrator on 1/9 in he and to wait a long time answered. He addifficulty is a long time and the administrator on 1/9 in he and to wait. The Administrator on 1/9 in he and to wait. The Administrator on 1/9 in he and to wait. The Administrator on 1/9 in he and to wait. The Administrator on 1/9 in he and the	t #49 's call light to be ained that when there were it was difficult for them to mely which caused a delay in its 'needs. Inducted with NA #1 on 1/9/19 of the third shift beginning 1/8/19. He stated he was at day beginning on the and working through the third. He reported that he was 1 of hird shift that day and they residents. NA #1 indicated he sident #49 's call light being period of time during the early but revealed it was not a explained that he had sidents 'needs timely when As working on the third shift. In aware a complaint/grievance related to Resident #49 's long she waited for her call diduring the early morning	F 55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345450	B. WING		03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA	6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET ARCHDALE, NC 27263	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 550	care or dignity for Re Administrator stated resident to be told to additionally stated it	ents related to incontinent	F 550		
	1/2/14 and most rec with diagnoses that Pulmonary Disease dysphagia, and Diab The quarterly Minim assessment dated 7 s cognition was fully and no rejection of cassessed with no sw	e admitted to the facility on ently readmitted on 10/11/18 included Chronic Obstructive (COPD), respiratory failure, betes Mellitus Type II. um Data Set (MDS) /2/18 indicated Resident #32' intact. He had no behaviors eare. Resident #32 was vallowing disorders. He was litered and therapeutic diet.			
	Facility Reported Incabuse that occurred involving Resident # reviewed. The alleg Resident #32 overhed him a muffin but if the not on us." The sur investigation indicate overheard by staff a Cook #1 was immediated was terminated investigation was coand the allegation of substantiated by the	nd residents being "rude". liately sent out of the facility the same day (8/12/18). The nducted by the Administrator is staff to resident abuse was facility.			
	A written statement	dated 8/12/18 that was			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	<u>'</u>	90,00,20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	1/9/19 at 10:15 AM I statement was comp statement indicated muffin in the dining r muffin from dietary s resident was unable wasn ' t on his meal spoke with Nurse #1 stated that Resident muffin. NA #4 indicareturned to the kitch Resident #32 was alwrote that Cook #1 sthen it was on [nursi A phone interview w 1/10/19 at 8:17 AM. completed the writte She reported that Re room and he asked She stated she went Cook #1 for a muffin reported that Cook # Resident #32 a muffin meal ticket. She stated Nurse #1 and Nurse #32 was able to hav Nurse #4 reported the muffin he could be gindicated she went be informed Cook #1 the said Resident #32 costated that Cook #1 chokes it 's on you.' #1 meant that it was Resident #32 choke that she was holding	led by the Administrator. On the stated this written soleted by NA #4. The Resident #32 had asked for a com. NA #4 requested the taff and Cook #1 told her the to have the muffin because it ticket. NA #4 wrote that she and Nurse #4 and they #32 was able to have a sted she and Nurse #1 ten and informed Cook #1 that tole to have a muffin. NA #4 tole to have a muffin. NA #4 tole to have a muffin. NA #4 ton NA #4 confirmed she had in statement dated 8/12/18. The scident #32 was in the dining ther if he could have a muffin. It into the kitchen and asked for Resident #32. NA #4 to she wouldn't give in because it wasn't on his ted she went to speak with #4 and asked if Resident #32 wanted a tif Resident #32 wanted a	F 5	50		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA	6	STREET ADDRESS, CITY, STATE, ZIP CODE 525 ASHLAND STREET ARCHDALE, NC 27263	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 550	She reported Reside statement. She indic Resident #32 after th NA #4 stated she rec	ere within hearing distance. Int #32 had overheard the cated she spoke with the incident and he was upset. It is alled him say something like, why she doesn't like me'	F 550			
	Nurse #1 indicated N Resident #32 wanted and Cook #1 refused reported that she we Cook #1 to give Res wrote that Cook #1 r gonna be on [nursing she informed Nurse statement regarding	Resident #32. She I that Resident #32 had				
	on 1/9/19 at 10:42 A recalled the 8/12/18 that involved Reside additionally confirme written statement da reported that she wa specifics of the incidone of the kitchen st directed at Resident spoke with Resident	as conducted with Nurse #1 M. She stated that she incident related to the muffin Int #32 and Cook #1. She Id she had completed the Ited 8/12/18. Nurse #1 Is unable to recall all of the Itent, but that remembered Interpretation of the lent, but that remembered Interpretation of the lent lent lent lent lent lent lent len				
	on 1/9/19 at 5:58 PN recalled the 8/12/18	as conducted with Nurse #4 I. She stated that she incident related to the muffin ht #32 and Cook #1. She				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		_	C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STA 625 ASHLAND STREET ARCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 550	Nurse #1. She adde been given a muffin indicated that he was diet and his swallowing Resident #32 was all understood the risks his swallowing issues that it was Resident # muffin as long as he #4 reported she was Nurse #1 returned to #1 to give Resident # A phone interview was on 1/9/19 at 3:36 PM was terminated on 8/ involving the muffin areported that she was Aide (DA) #1 and DA kitchen and said that muffin. Cook #1 stat muffin was not on his choking issues and hinstead of the muffin. NA #4 she was not g Cook #1 said that NA nurses over and they #32 a muffin. She st NA #4 that if Resider and died that it was on the that NA #4 was holdi when this exchange stated she was unsuloverheard the conve	ation provided by NA #4 and d that Resident #32 had not because his meal ticket is to have toast based on his ng issues. Nurse #4 stated ent and oriented and that he of eating a muffin related to is. She additionally stated #32's right to receive the understood the risks. Nurse not present when NA #4 and the kitchen to instruct Cook	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		7370072013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	A phone interview wa 1/9/19 at 11:03 AM. Sthe 8/12/18 incident rinvolved Resident #32 reported that she was and Cook #1 on 8/12/incident. DA #2 state #4, "if the [mfer] chhere on the kitchen le explained that Cook # dietary staff were not choked on the muffin. A phone interview wa 1/9/19 at 2:05 PM. Sthe 8/12/18 incident rinvolved Resident #32 reported that she was and Cook #1 on 8/12/incident. DA #1 reporthat it was not on the choked on the muffin. holding the kitchen dowere in the dining roo indicated she was unsoverheard the convertant was considered the incide Cook #1 and the muffin the Administrator. Content with this resolindicated that this incided that this	s conducted with DA #2 on She stated that she recalled elated to the muffin that 2 and Cook #1. She in the kitchen with DA #1 18 at the time of the d that Cook #1 said to NA okes, don't bring it back ave it out there". She if wanted to make sure to blame if Resident #32 and Cook #1. She in the kitchen with DA #1 on the stated that she recalled elated to the muffin that 2 and Cook #1. She in the kitchen with DA #2 18 at the time of the ted that Cook #1 told NA #4 kitchen staff if Resident #32. She stated that NA #4 was nor open and that residents m during this incident. She sure if any residents sation. ducted with Resident #32 on the was alert and oriented tive impairment. He stated int on 8/12/18 that involved in. He reported that Cook the to him and she was fired the indicated he was lution. Resident #32 dent no longer bothered dditional concerns with staff	F	550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG		(3	
		345450	B. WING				06/2019	
	ROVIDER OR SUPPLIER	HABILITA		62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 550	he completed the in allegation of staff to 8/12/18. He stated weekend and he witime it happened. It is phoned him to report he had Cook #1 le immediately upon he came into the fair his investigation. To interviewed Resider resident reported to kitchen say that the statement. He indicated him and an expected him and an expected residents respect at all times. 3. Resident #47 wore readmitted 3/26/18 chronic pressure under the statement of the statement of the staff was unatexpected residents respect at all times. 3. Resident #47 wore readmitted 3/26/18 chronic pressure under the staff was unatexpected at all times. 3. Resident #47 wore readmitted 3/26/18 chronic pressure under the staff was unatexpected at all times. 3. Resident #47 wore readmitted 3/26/18 chronic pressure under the staff was unatexpected at all times. 4. Review of Resider Set dated 12/7/18 intact and exhibited for an indwelling under the staff was unatexpected for an indwelling under the st	conducted with the /9/19 at 10:20 AM. He stated investigation related to an oresident verbal abuse on a ras not present at the actual. He stated one of the staff ort the incident. He indicated ave the facility grounds receipt of the report. He stated acility that same day to begin the Administrator stated he ent #32 on 8/12/18 and the hat he heard someone in the ey "hope he chokes on the [m esident #32 told the ad not seen who made the icated the resident said this made him angry. The red that based on Resident and corroborating interviews with obstantiated the allegation and 1. He stated that this behavior cceptable and that he is to be treated with dignity and is. The stated that this behavior cceptable and that he is to be treated with dignity and is. The stated that this behavior cceptable and that he is to be treated with dignity and is. The stated that this behavior cceptable and that he is to be treated with dignity and is. The stated that this behavior cceptable and that he is to be treated with dignity and is. The stated that this behavior cceptable and that he is to be treated with dignity and is. The stated that this behavior cceptable and that he is to be treated with dignity and is.	F	550				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345450	B. WING				C 06/2019
	ROVIDER OR SUPPLIER			62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263	03/	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	The care plan did not privacy bag for dignity. In an interview and of PM, Resident #47 was wheelchair. His urinar was observed coveredignity. Resident #47 and unable to move had unable	rap to anchor his catheter. include the intervention of a y. Disservation on 1/7/19 at 1:40 Is sitting up in his room in a ry catheter drainage bag d in a privacy bag for stated he was paralyzed his lower extremities. 1/9/19 at 4:20 PM, Residenting in bed with his urinary oward the hall with his door observed privacy bag larainage bag. 1/10/19 at 8:30 AM, served lying in bed with his facing toward the hall with was no observed privacy ary drainage bag. 1/10/19 at 9:00 AM, served lying in bed with his facing toward the hall with was no observed privacy ary drainage bag. Disservation on 1/10/19 at 1/2 was observed lying in bed age bag facing toward the hal airary drainage bag that was chair. He stated he was not	F	550			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345450	B. WING_		 -	03/	06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHAE	BILITA		6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	covered but expresses from it being exposed requested that staff color in an interview on 1/1 was shown the uncover from the hall into Resstated it should be converted in an interview on 1/1 was stated whose to bed must have forgung on his wheelchair stated Nursing Assistance Resident #47. In an interview on 1/1 Director of Nursing (Dileave work due to a faunavailable for interviex pectation that Resident was a languaged by a covered at all self-Determination CFR(s): 483.10(f)(1)-(1)-(1)-(2)(1)-(3)(1)-(3)(1)(1)(1)-(3)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	d no psychological ill affect at present. Resident #47 ome and address it. 0/19 at 9:45 AM, Nurse #3 ered urinary drainage bag ident #47's room. She vered always for dignity. Ever put Resident #47 back gotten to move the privacy of to his bed. Nurse #3 ant (NA) 9 was assigned 0/19 at 11:15 AM, the DON) stated NA #9 had to amily emergency and was ew. She stated it was her dent #47's urinary collection times for dignity. (3)(8) mination. right to and the facility must be resident self-determination sident choice, including but its specified in paragraphs (f) is section. dident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other		550			4/3/19

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345450	B. WING		03/06/2019
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 561	\$483.10(f)(3) The rewith members of the community activities facility. \$483.10(f)(8) The reparticipate in other a religious, and comminterfere with the rigifacility. This REQUIREMENT by: Based on record reobservation, Nurse staff interview, the fathonor a resident's chis preferred time in who required extens (Resident #32) and resident's nails (Resident #32) and resident's nails (Resident and resident and res	cts of his or her life in the ficant to the resident. sident has a right to interact a community and participate in both inside and outside the sident has a right to activities, including social, unity activities that do not hats of other residents in the T is not met as evidenced view, resident interview, Practitioner interview, and acility failed to consistently noice of getting out of bed at the morning for a resident view assistance with transfers failed to trim, clean and file ident #30) for 2 of 2 residents as Resident #30's nails were and the left thumb nail was down past the nail bed. d:	F 56	F561- Self Determination 1. The Social Services Director interviewed Resident #32 in regard to preferences and to ensure his preferr time to get up out of bed is being hon on 3-13-19. Resident #30 nails were trim and cleaned on his shower day on 3-16-19 by the Certified Nursing Assis 2. The facility Social Services Director and or Regional Director of Clinical Services completed resident interview	ed ored med stant. or
	Obstructive Pulmona Resident #30's quar 11/2/18 indicated he exhibited no behavior impaired vision and personal hygiene.	admitted 6/7/18 with Chronic ary Disease and Dysphagia. terly Minimum Data Set dated was cognitively intact and ors. He was coded for limited assistance with #30's activities of daily living		current interviewable residents to ensidents' preference related to gettin of bed is being honored and nail care being provided by 3-19-19. Care Planand Kardex updated to reflect resider choice. No negative findings were identified during interviews. The SSD/DCS will make observation of residents' preference on getting out of and ensure nail care complete and	g out is ns nts
		ed last revised 11/13/18		honored as resident prefers.	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		13/00/2019	
				625 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 561	Continued From pag	e 19	F 5	61			
	indicated he required bathing, eating and lo indicated staff assistat hygiene. Review of Resident # Information Kardex in assistance with brush hair, perineum care a nail care was not che In an observation on #30 was sitting on the television. His finger appeared approxima jagged and dirty. He offered to assist him have a pair of nail cli Resident #30 stated trimmed and they we stated he had not rectrimming his nails. In an observation on Resident #30 was obstill appeared long, do In an interview on 1/S Assistant (NA) #9 co Resident #30. She stassistance with his A independent. In an interview and o AM, Resident #30 was bed. His nails appear	I staff assistance with percomotion. There was no ance noted with his personal at 30's undated Nurse Technolicated he required staff ning his teeth, combing his and shaving. Assistance with ecked for assistance. 1/7/19 at 3:30 PM, Resident eside of his bed watching nails were observed. They tely 3/4 of an inch long, stated the staff had not with nail care and he did not pers in his possession. The preferred his nails to be are too long for his liking. He quested staff assistance in 1/8/19 at 11:10 AM, preved lying in bed. His nails irty and jagged. 2/19 at 8:05 AM, Nursing nails irty and jagged. 2/19 at 8:05 AM, Nursing nails irty and jagged. 3/19 at 8:05 AM, Nursing nails irty and jagged. 3/19 at 8:05 AM, Nursing nails irty and jagged.	F 5	3. The RDCS, ED and or SS re-educate facility staff, inclupart-time and prn, on resider of time to get out of bed and care per resident choice by Staff will not be allowed to reuntil education complete. 4. SSD and or DON will conresident interviews and residents interviews and residents exercise the Self Determination and Choiresident's choice for getting and nail care completed and residents choice. The SSD areport the results of the qualification to the QAPI committed will be reviewed by QAPI commonthly and Quality monitoring updated as indicated. 5. Date of Compliance 4/3/2	ading all shifts, at preference providing nail 3/21/2019. Seturn to work aduct five dent ek for 4 anths, to eir right to ce for out of bed provided per and DON will ity monitoring see. Findings mmittee ing (audit)		
	He stated his left thu thumb nail was obse	red long, clean and jagged. mb nail was painful. His left rved cracked down past the ven if he had clippers, he					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING				06/2019	
	ROVIDER OR SUPPLIER	L		6	STREET ADDRESS, CITY, STATE, ZIP CODE 125 ASHLAND STREET ARCHDALE, NC 27263	1 03/	00/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	Resident #30 stated hast time he received In an interview on 1/9 stated she was under Resident #30 was abishe would assist him In an observation on Resident #30 was eattrimmed and filed. He trimmed his finger nathrimmed his finger nathrimmed his posses concern and it was he assist Resident #30 m In an interview on 1/1 Administrator and Dir was their expectation nail care as needed of	seeing how to cut his nails. The could not remember the nail care. If 19 at 11:55 AM, NA #9 The impression that the to cut his own nails, but immediately. If 19/19 at 12:40 PM, thing his lunch. His nails were estated the nurse recently the sand they felt better. If 19/19 at 9:30 AM, the Nurse en if Resident #30 had sion, his vision would be a er expectation that the staff outinely with his nail care. If 19/19 at 2:30 PM, the ector of Nursing stated it that Resident #30 receive or requested.	F	561				
	1/2/14 and most rece with diagnoses that in disease, left foot drop The quarterly Minimu	admitted to the facility on ntly readmitted on 10/11/18 ncluded cerebrovascular or, and left-hand contracture. m Data Set (MDS) /9/18 indicated Resident						
		ully intact, and he had no						

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 561	Continued From pag	e 21	F 5	61		
	extensive assistance transfers, personal h toileting. Resident # with range of motion lower extremities. An interview was cor 1/7/19 at 4:40 PM. Hearly riser and prefer between 4:00 AM an required staff assistate Resident #32 reported this preference as he	d 5:00 AM. He stated he nce to get out of bed. ed that staff were aware of a had been a resident at the ars. He revealed that				
	consistently been ge preferred time. He s were 2 to 3 times per assisted out of bed un Resident #32 indicat not enough staff on t	tting him out of bed at his tated that on average there week that he was not ntil closer to 7:00 AM. ed he thought that there were he third shift which caused tter than he preferred.				
	Resident #32 on 1/10 #32 was seated in hi his Nursing Assistant	nterview were conducted of 0/19 at 6:00 AM. Resident s wheelchair. He stated that (NA) had gotten him out of go and he was satisfied with				
	stated that he was hi that he frequently wo reported he was very and was aware he lik AM and 5:00 AM. N	nducted with Nursing 1/9/19 at 3:58 PM. He red to work the third shift, but white other shifts as well. He red familiar with Resident #32 and to get up between 4:00 A #1 stated that third shift NAs for around 60-65				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 561	He indicated that re third shift had been had difficulty meetin when there were or shift. He further exprioritized and that #32 out of bed at hi to be accomplish be were prioritized before An interview was considered at the facilit normally worked the was familiar with Reliked to get up betw NA #2 stated that the NAs for around 60-on the census that recently the NA states been 2 NAs. She is meeting residents in only 2 NAs working explained that she I make sure the more completed first. NA prioritization caused as getting Resident to be pushed back amorning. An interview was considered first as getting Resident to be pushed back amorning. An interview was considered first as getting Resident to be pushed back amorning.	ending on the census that day. Incently the NA staffing for the 2 NAs. He explained that he righted residents' needs timely righted ly 2 NAs working on the third rolained that tasks were sometimes getting Resident as preferred time was not able recause more critical tasks	F 56			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	riple construction		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE	
F 561	census that day. She NA staffing for the this She revealed she had needs timely when the on the third shift. She prioritized to make so were completely first prioritization caused as getting Resident to be pushed back at morning. During an interview of 1/8/19 at 10:30 AM has the Administrator 2018. He revealed to obtaining and maintat three shifts since he When asked what his staffing was he state enough staff both in the to meet the needs of During an interview of 2018. She confirm interview related to the obtaining and maintat three shifts. She stanormally staffed with that one day recently as an NA on the 3rd who were on the schunable to find anyone.	nts total depending on the e indicated that recently the ord shift had been 2 NAs. It difficulty meeting residents' here were only 2 NAs working e stated that tasks had to be are the most important tasks. NA #3 revealed that this other non-critical tasks such £32 up at his preferred time and completed later in the with the Administrator on the stated he began working at this facility in June of the facility had difficulty ining enough NAs to staff all began as the Administrator. It is definition of sufficient the difficulty and quantity the residents. With the Director of Nursing the pool at the facility and quantity the residents. With the Director of Nursing the pool at the facility in June and the Administrator's the facility having difficulty ining enough NAs to staff all the that third shift was 2 or 3 NAs. She revealed the had to come in to work shift because 1 of the 2 NAs edule called off and she was	F	561			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCT		(X3) DATE COMP	SURVEY PLETED
		345450	B. WING				C 06/2019
	OVIDER OR SUPPLIER DD HEALTH AND REHA	BILITA		STREET ADDRE 625 ASHLAND ARCHDALE,		, 30.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(Ε <i>i</i>	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD I DSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	choices of residents t additionally indicated provide sufficient staf needs.	xpectation was for the o be honored. They their expectation was to fing to meet the residents'		561			
I	and participate in resi (i) The facility must progroup, if one exists, we reasonable steps, wit to make residents and upcoming meetings in (ii) Staff, visitors, or oresident group or family the respective group's (iii) The facility must preson who is approved group and the facility providing assistance requests that result from (iv) The facility must ore groups concerning is in the facility. (A) The facility must be response and rationa (B) This should not be facility must implement request of the resider.	ident has a right to organize ident groups in the facility. To rovide a resident or family with private space; and take the approval of the group, defamily members aware of the atimely manner. It ther guests may attend in a timely meetings only at a sinvitation. To rovide a designated staffered by the resident or family and who is responsible for and responding to written for group meetings. Consider the views of a sup and act promptly upon ecommendations of such sues of resident care and life to eable to demonstrate their lefor such response. The construed to mean that the int as recommended every int or family group.		565			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD HEALTH AND DEHA	DII ITA		S25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	ABILITA		ARCHDALE, NC 27263		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	D PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 565	Continued From pag		F 565			
	family member(s) or					
		et in the facility with the				
		epresentative(s) of other				
	residents in the facilit	-				
		T is not met as evidenced				
	by:	riew, and interviews with		F565- Resident/Family Group and		
		he facility failed to resolve		Response		
		eported during Resident		1. On 1/31/2019 the Regional Vice		
		4 of 4 consecutive months		President of Operations (RVPO)		
	_	not being answered timely.		re-educated the Executive Director (ED))	
		3 · · · · · · ,		and Activities Director (AD) on timely	′	
	The findings included	d:		response and filing of Grievances and/o	or	
				Concerns received during Resident		
	Review of the month	ly Resident Council meeting		Council and, ensure follow-up is reported	ed	
		8 indicated the residents		to Resident Council at the next schedul	ed	
		ern of call lights not being		meeting.		
	_	e Activities Director was				
	present at the meetir	ng.		2. The ED and SSD conducted a		
	D : (" "			Resident Council meeting to discuss		
		ly Resident Council meeting		prompt response to call lights, to ensure		
		/18 indicated a follow up of		residents are free to participate in Grou		
		s (9/19/18) concern of call vered timely. This follow up		Meeting and receive a prompt response on their grievance on 1/16/2019. Call	7	
	•	ere aware they needed to		lights were discussed at the meeting ar	nd	
		call light needs when a light		the Resident Council was informed of the		
		ites indicated that the issue		center □s steps taken to resolve the issu		
		time continued. The		A follow-up Resident Council meeting is		
		is present at the meeting.		scheduled for 02/11/19. Follow up base		
				on findings.		
	Review of the month	ly Resident Council meeting				
		/18 indicated a follow up of		3. The ED and RDCS will re-educate the	ne	
		s (10/17/18) concern of call		department managers on federal		
	, ,	vered timely. This follow up		regulations and guidelines for		
	stated that call light is			Resident/Family Grievance process and	d	
		ed it was improving. These		timely response and resolution of		
		at the issue of call light		grievances voiced in Resident Group		
	T	ot resolved and that the		meetings, specifically to promptly		
	issue stili needed imi	provement. The Activities		responding to call lights by 2/20/2019.		

IDENTIFICATION NUMBED:		LE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
345450	B. WING			C / 06/2019	
		STREET ADDRESS, CITY, STATE, ZIP CODE	03	100/2019	
		625 ASHLAND STREET			
ABILITA		ARCHDALE, NC 27263			
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
thly Resident Council meeting 9/18 indicated a follow up of 's (11/22/18) concern of call swered timely. This follow up issues continued to improve esolved. The Activities Director meeting. meeting was conducted on a feath and oriented residents in the facility's The residents reported that the esed repeatedly in the electings was the issue with the k for their call bells to be idents indicated this issue had not been resolved. When all to be response was to them at concern the group indicated the facility staff had been told to answer the call lights taff title. Inducted with the Activities at 2:25 PM following the residents had repeated call bells not being answered at the information provided in as issue had improved but had	F 56	Staff will not be allowed to return until education complete. 4. ED, RDCS and DCS will cond random resident interviews 3 time week for 4 weeks, then weekly for months, to ensure resident so gri including call light response are fup and timely. ED and DCS will Resident Group meetings (when to ensure timely follow-up and regrievances. Resident council meeting held every other week for 8 who continue with monthly. The DCS report on the results of the quality monitoring (audit) and report to the committee. Findings will be review QAPI committee monthly and Quimonitoring (audit) updated as indicated.	duct es per or 3 evances followed attend invited) sponse to etings will eeks then s will y ne QAPI ewed by licated.		
		A BUILDING 345450 B WING A BUILDING 345450 B WING A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING B WING PREFIX TAG B WING PREFIX TAG F 569 The Lest IDENTIFYING INFORMATION) The PREFIX TAG F 569 The Activities Director meeting The Prefix Tag The Prefix Tag The Prefix Tag F 569 The Activities Director meeting. The residents reported to the facility's presidents in the facility's presidents in the facility's presidents in the facility's presidents indicated this issue had not been resolved. When seed repeatedly in the meetings was the issue with the k for their call bells to be sidents indicated this issue had not been resolved. When seed the facility staff had been told to answer the call lights taff title. The Transport of the Activities at 2:25 PM following the meeting. She confirmed she residents had repeated of the information provided in the information provided in the sissue had improved but had the Administrator at this provided in the Reference of the Administrator at this provided in the Ad	A BUILDING 345450 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263 RICH CORRECTIVE ACTION SHA CROSS-REFERENCED TO THE APP DEFICIENCY) 109 226 Int at the meeting. Ithly Resident Council meeting 9/18 indicated a follow up of 1's (11/22/18) concern of call swered timely. This follow up tissues continued to improve seolved. The Activities Director meeting was conducted on in 6 alert and oriented residents indicipants in the facility's The residents reported that the seed repeatedly in the leetings was the issue with the k for their call bells to be idents indicated this issue had ido been resolved. When lifty 's response was to them at concern the group indicated the facility staff had been told to answer the call lights taff title. Deficiency Staff will not be allowed to return until education complete. 4. ED, RDCS and DCS will cond random resident interviews 3 tim week for 4 weeks, then weekly for months, to ensure resident□s gri including call light response are for up and timely. ED and DCS will. Resident Group meetings (when to ensure timely follow-up and res- grievances. Resident council mee to grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up and res- grievances. Resident council mee to ensure timely follow-up to ensure time	A BUILDING 345450 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263 STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) TO STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) F 565 Staff will not be allowed to return to work until education complete. 4. ED, RDCS and DCS will conduct random resident interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure resident!s grievances including call light response are followed up and timely. ED and DCS will attend Resident Group meetings (when invited) to ensure timely follow-up and response to grievances. Resident council meetings will be held every other week for 8 weeks then continue with monthly. The DCS will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019. The facility staff had been told to answer the call lights taff title. Conducted with the Activities at 2:25 PM following the neeting. She confirmed she residents had repeated call bells not being answered the information provided in s issue had improved but had Denducted with the 8/19 at 10:30 AM. He stated as the Administrator at this 18. He reported he was	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		X3) DATE COMP	
		345450	B. WING			03/) 06/2019
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		001	30/2013
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F 565	staff education was pregardless of disciplir call lights and assist tappropriate staff men was out of their scope. Administrator indicate improve on this concern and the Administrator both reported they ex in the Resident Coun investigated, and add in which they were disindicated they expect timely to meet the net Grievances CFR(s): 483.10(j)(1)-\$483.10(j) Grievance \$483.10(j) (1) The rest grievances to the facilitat hears grievances reprisal and without for reprisal. Such grievances reprisal and without for reprisal. Such grievances reprisal and without for residents, and other of facility stay. \$483.10(j)(2) The rest facility must make proresolve grievances the accordance with this	e facility and indicated that rovided to remind all staff he that they were to answer the resident if able or find an other to complete the task if it e of practice. The ed it was ongoing process to ern. With the Director of Nursing on 1/10/19 at 2:31 PM they pected concerns discussed cil to be reviewed, bressed after each meeting scussed. They additionally ed call bells to be answered eds of the residents. (4) S. ident has the right to voice lity or other agency or entity is without discrimination or ear of discrimination or ear of discrimination or ear of staff and of other concerns regarding their LTC dident has the right to and the compt efforts by the facility to e resident may have, in	F 5				4/3/19
	accordance with this	paragraph.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP COI 625 ASHLAND STREET ARCHDALE, NC 27263		0.00.2013	
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F 585	to the resident. §483.10(j)(4) The factories of all grievances regared contained in this paraprovider must give a to the resident. The grinclude: (i) Notifying resident it postings in prominent facility of the right to the (meaning spoken) or grievances anonymous of the grievance official can be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the confidering the review to obtain a written degrievance; and the confidering the review to obtain a written degrievance; and the confidering the review to obtain a written degrievance; and the confidering the review to obtain a written degrievance; and the confidering the responsible for oversing and state Loprogram or protection (ii) Identifying a Griev responsible for oversing and tracking conclusions; leading by the facility; maintain information associate example, the identity grievances submitted written grievance decorrelations.	ility must establish a asure the prompt resolution urding the residents' rights agraph. Upon request, the copy of the grievance policy rievance policy must a locations throughout the file grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone expected time frame for a of the grievance; the right cision regarding his or her ontact information of with whom grievances may ertinent State agency, Organization, State Survey ing-Term Care Ombudsman and advocacy system; arance Official who is seeing the grievance process, grievances through to their any necessary investigations ining the confidentiality of all ad with grievances, for of the resident for those anonymously, issuing disions to the resident; and e and federal agencies as	F 5	85			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345450	B. WING _			03/	06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263			
0(0)15	CLIMMADY C	FATEMENT OF DEFICIENCIES					(VE)	
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F 585	Continued From page 29		F:	585				
		king immediate action to						
	I .	itial violations of any resident						
	right while the allege	d violation is being						
	investigated;	1402 42(a)(4) immediataly						
		(483.12(c)(1), immediately						
		violations involving neglect,						
	abuse, including injui							
		ion of resident property, by						
	, ,	rvices on behalf of the						
	-	nistrator of the provider; and						
	as required by State	as required by State law; (v) Ensuring that all written grievance decisions						
	· ·							
	include the date the							
		of the resident's grievance,						
	I .	vestigate the grievance, a						
		nent findings or conclusions						
	-	nt's concerns(s), a statement						
		evance was confirmed or not						
		ctive action taken or to be						
	· ·	as a result of the grievance,						
		ten decision was issued; te corrective action in						
		te law if the alleged violation						
		ts is confirmed by the facility						
		having jurisdiction, such as						
	1	ency, Quality Improvement						
		Il law enforcement agency						
	_	or any of these residents'						
	rights within its area							
		ence demonstrating the						
		es for a period of no less than lance of the grievance						
	decision.	iance of the ghevalice						
		T is not mot as suideneed						
	· ·	T is not met as evidenced						
	by:	vious staff intervious resident			EEOE Criovenana			
		view, staff interview, resident			F585- Grievances			
	_	and family interview, and Department of Social			1. Resident #36 no longer resides at the			
		interview, the facility failed to			facility. The Regional Director of Clinic			
	provide a written sum	nmary for grievances			Services interviewed Resident #49 on			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345450	B. WING			03/	06/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD HEALTH AND REHA	BILITA			625 ASHLAND STREET		
				1	ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page	e 30	F	585	5		
		36) and failed to write and			3/12/19 to ensure any concerns with ca	are	
		ce that was reported verbally			are resolved and determine if any othe		
	to staff (Resident #49				grievances exist or require follow-up.		
	reviewed for grievand				Resident # 49 expressed their grievand	ces	
					were resolved and no additional		
	Findings included:				grievances were voiced.		
	1. Resident #36 was	admitted on 10/1/18 with the					
	diagnoses of neuropa	athy, diabetes, pressure			2. The SSD and or the RDCS complet	ed	
	ulcer of the right heel	unstageable, and need for			interviews of interviewable residents, a	nd	
	assistance with activi	ties of daily living.			the responsible party of un-interviewab	le	
					residents, to ensure residents are		
		ents care plan dated 10/1/18			provided care in a respectful and dignif		
	_	nterventions for pressure			manner, and grievances are resolved a	ind	
	ulcer prevention and	status.			follow up provided by 3/21/19. All		
	A ravious of the admic	ssion Minimum Data Set			grievances received were documented		
		revealed the resident had			with a written summary of resolution. No negative findings were identified in the	10	
	an intact cognition. T				interviews. Any future residents identif	ied	
		of 2 persons for transfer,			with grievances will follow re-established		
		ence care. The resident			grievance process.	,	
	required supervision				g p. cocco.		
					3. The RDCS and DON will provide the	,	
	A review of the signifi	icant change MDS dated			facility staff, including all shifts, part-tim		
	_	ss for worsening disease			and prn, re-education on the federal		
	process, meals were	now assistance of one staff,			regulations and guidelines related to th	е	
	and a swallowing dec	cline.			resident's right to ensure grievances ar	·e	
					resolved, followed up and a written		
		ent 's grievance report dated			summary by 3/21/19. Staff will not be		
		esident #36 's family filed a			allowed to return to work until educatio	n	
	_	sident had not had a bath in			complete.	ſ	
		sion other than the bath the			4 DDCC DON and an CCD will are dive	- 4	
		family informed the nurse at			4. RDCS, DON and or SSD will conduct five resident interviews 3 times per week		
		lack of bath. The grievance evealed: the resident had			five resident interviews 3 times per weef for 4 weeks, then weekly for 3 months,	2 <i>L</i>	
		it staff documentation and			including all shifts and some weekends	: to	
		completed and had been an			ensure resident's grievances are resolv		
		in-serviced. The resolution			and followed up. The SSD will report of		
		meeting with the family. The			the results of the quality monitoring (au		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345450	B. WING _				C / 06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA			62	REET ADDRESS, CITY, STATE, ZIP CODE 5 ASHLAND STREET RCHDALE, NC 27263	1 03	706/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 585	facility switched the resident 10/22/18 revealed the the resident had not led ressing had not been eeded to be offered Investigation: the resident had received incontinence care. A review of the resident 10/23/18 reported by family came to the fathe resident had received incontinence care. A review of the resident had received incontinence care. A review of the resident had received incontinence care. It is a reported by family came to the fathe resident had received incontinent incontinent incontinent incontinent incontinence. Investigation: the families resident incontinence. Investigation incontinence. Investigation incontinence. Investigation incontinence investigation incontinence investigation incontinence. Investigation incontinence investigation in the inves	ent's grievance report dated a family filed a grievance that had a bath, the foot wound in changed, and the resident incontinence care. Ident refused a shower three he plan was to meet with the educated on timely ent's grievance report dated the family revealed the cility at 7:45 pm to ensure ived his scheduled in arrival the family found the mand he was wet with urine ss. The nurse responded resing Assistants (NA) on the get to everyone in a timely your were short staffed. If you and administration staff confused because there that night. The NA in up and in-serviced on how to Plan was to change the more frequently. ent's grievance dated the family revealed that the oughly cleaned after bowel gation: Re-education was The results were not	F	585	and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monito (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	ring		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345450	B. WING			C 93/06/2019		
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F 585	resident refused on he the resident refused of daughter. The resident a different shift to ensure resident was unhapped showers. No written A review of the resident 11/23/18 reported by resident returned back outing and the family resident out of the cast family to assist the result of the daughter had to medical emergency of the resident out of the cast investigation: The number of the results were provided as the resident out of the resident out of the cast investigation: The number of the results were provided as the results wer	resident to another shift if the per shift. The plan was when to document and call the pent's shower was moved to gure compliance. The y with late (2nd shift) response was provided. The y with late (2nd shift) response was provided. The y with late (2nd shift) response was provided. The y with late (2nd shift) response was provided. The family revealed the sk to the facility after a family was unable to assist the r. NA #7 was asked by esident and stated he could tent back inside the facility. The fire department and service to help her get the r and back into the facility. The resident that the could not help the resident lity building was educated. Wided verbally. The resident dated that the r conditioner (PTAC) was not was replaced. There was no man interview was dent #36 who stated his formed the facility of his always received a response the facility of his always received a response fined. The resident stated not always answered timely, not accordingly changed.	F 58	35				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019		
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		30/00/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 585	who stated she filed bathing, wound care taken to respond to with transfer out of halso commented that multiple times that the resident's room family member state copy of the written gign three of them. It explained the facility written response or grievances. On 1/8/19 at 3:00 pr with the Director of Noresponsible for grievances. On 1/8/19 at 3:00 pr with the Director of Noresponsible for grievances. On 1/8/19 at 3:00 pr with the Director of Noresponsible for grievances. The provided a variety and provided a variety a	dent #36 's family member multiple grievances for experience in the call light, and assistance the call light, and assistance the call light, and assistance the car. The family member it she informed the staff the heat was not working in a before it was fixed. The state that she was not provided a rievances but was asked to the family member further or had not provided her with a written summary for her In an interview was conducted Nursing (DON) who was rance resolution. The DON #36 family 's grievance was provided to the family for off the occasions. The family written response to their DN stated she was not aware uired the facility to provide a the person who voiced or filed ought that having the family net the requirement.	F 5	85				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	NO _		، ا	3
		345450	B. WING			1	06/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	00/2010
WESTWO	OD HEALTH AND DELLA	ADILITA		6:	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	ABILITA		Α	ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From pagalways incontinent of		F	585			
	1/7/19 at 3:00 PM. In oriented with no improve asked if she had any stated that several with shift (3:00 PM to 11: and requested for state could urinate. So preferred to urinate in 2 staff members can them said the bed part of them said the bed part of the staff she hadn in the staff she had to urinate in recall the names of the unable to recall how care to be provided. Resident #49 stated incident to one of the name of the nurse) of Nursing (DON) was she had not seen eit again after she report that she had requesting the staff she had r	al Services (DSS) staff by 3:09 AM. She stated that ed to her several weeks ago ted staff to adjust her bed pan					
	of Nursing (DON) washe had not seen eit again after she report of Social phone on 1/9/19 at 8 Resident #49 report that she had request and they said somet the bed pan and told wanted to use the bed	as also aware. She indicated ther of the 2 staff members rted this incident to the nurse. as conducted with al Services (DSS) staff by 8:09 AM. She stated that ed to her several weeks ago					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345450	B. WING			C 03/06/2019		
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CO 625 ASHLAND STREET ARCHDALE, NC 27263		3373372013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 585	An interview was cor 1/9/19 at 2:30 PM. The ard one of the staff Resident #49 reporting the resident #49 reporting the resident to change he stated this was not a issue for a resident to brief. She indicated treated with dignity a she was unable to reheard this information unable to recall where revealed there was not included the stated that issues wo report of Resident #4 dignity and respect, where we was a grievance for the resident by the stated that issues wo report of Resident #4 dignity and respect, where we was a grievance for the resident by the stated that is the resident by the stated that is the resident by the stated that is an an interview was a grievance for the resident by the stated that is an an interview was a grievance for the information.	ducted with the DON on The DON revealed she had a say something about a staff member told ourinate because they were at that time. The DON ppropriate as it was a dignity of be told to urinate in their she expected residents to be and respect. The DON stated call what staff member she in from and she was also	F 5	35				
	her, assigning the gridepartment for investup on the grievance	ng grievances reported to evances to the appropriate tigation, and ensuring follow was completed. He revealed tentified the former SW had						

C 06/2019
00/2013
(X5) COMPLETION DATE
4/3/19

PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING				C	
NAME OF D	20/4050 00 01 1001 150	343430	B. WING_		TREET ADDRESS SITV STATE 7/D SODE	03	/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WESTWO	OD HEALTH AND RE	HABILITA			25 ASHLAND STREET			
				Α	ARCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From p	age 37	F	300				
	·	-		500		oilv		
		on with the outside podiatrist iting, resulting in worsening,			was provided to Resident #36's heel d starting 1/10/19 as ordered by the	ally		
		nd infection of the pressure			physician and his wound was assesse	Ч		
		36); neglected to provide daily			weekly for signs of improvement by the			
	•	und care as ordered, weekly			licensed nurse starting 1/23/19. Reside			
	·	ent/assessment and			#36 was followed by his physician star			
		sulting in a worsening pressure			on admission to facility on 10/1/2018, a			
); and neglected to provide			his care plan was updated on 1/29/19			
	•	er wound care as ordered and			the MDS nurse. Resident #36's wound	•		
	weekly wound me	asurement/assessment and			resolved on 2/8/2019 and he was			
			discharged 2/20/2019. Daily wound ca	are				
	reviewed; the facil	lity neglected to provide			was provided starting 1/10/19 following	j		
	,	sident #44) for 1 of 1 resident			physician's orders. Corporate Human			
		facility also neglected to			Resources and Regional staff worked	with		
	_	related to a request for			the Interim Executive Director to			
		(Resident #49) for 1 of 1			implement staff recruitment practices t	O		
	resident reviewed	•			ensure the center was appropriately			
	Immediate Iconor	dy bogon on 11/6/19 when stoff			staffed (center achieved appropriate	o.t		
		dy began on 11/6/18 when staff de pressure ulcer care with			staffing on 02/08/19). On 01/22/19 a ro cause analysis was completed by the	υί		
		for Resident #36. Immediate			Regional Vice President of Operations			
	_	noved on 3/6/19 when the			Regional Director of Clinical Services,			
		nd implemented an acceptable			Director of Nursing and the Divisional			
		of Immediate Jeopardy			Executive Director (acting administrate	or)		
	removal.	·			and determined that the Executive	,		
					Director failed to provide consistent			
	The facility will rer	main out of compliance at a			staffing to ensure treatments were			
		severity level to ensure			completed as ordered. Resident #1 wa	IS		
		ems are put in place and to			provided daily wound care beginning			
	complete employe	ee in-service training.			1/12/19 by licensed nurse. Resident #	1		
					and #44 wounds was measured and			
		so cited at a scope and severity			assessed weekly by licensed nurse			
	· •	that constitutes a pattern of			beginning 1-23-19. Resident #44 was			
		s not Immediate Jeopardy) for			provided daily wound care beginning	4.4		
	Example #2 (Resi				1-10-19 by licensed nurse. Resident #			
		ted at a scope and severity of G			had urinary catheter care provided by			
	·	ency of actual harm that is not rdy) for Example #3 (Resident			licensed nurse on 2-13-19. On 3/12/19 Resident #49 was interviewed by the	J		
	#49).	dy, for Example #3 (INESIDELL			Regional Director of Clinical Services t	·O		
	,,, , o j.		1		1 1 10glorial Director of Chillian Colvices (1	

Facility ID: 923156

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345450	B. WING		C 03/06/2019
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				625 ASHLAND STREET	
WESTWO	OD HEALTH AND REHA	ABILITA		ARCHDALE, NC 27263	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 600	Continued From pag		F 600	0	
	The facility was also	cited at a scope and severity		ensure call lights are answered time	ely and
	of E (a deficiency that	at constitutes a pattern of no		staff are verbally appropriate. No	
		otential for minimal harm that		concerns voiced at this time.	
		opardy) for Example #4			
	(Resident #44). Find	dings included:		2. On 2/15/2019 the Director of Nu	_
				completed a quality review of all cur	
		admitted to the facility on		resident treatment sheets, compare	d
		gnoses of Parkinson's,		them to the treatment orders and	
	ulcer of the right hee	s, and unstageable pressure		observed treatments to ensure that residents were provided wound care	
	uicei oi the fight fied	ii.		ordered. There are 3 current reside	
	Δ review of the resid	lent 's care plan dated		with pressure sores. Current reside	
		als and interventions for		with wounds are followed by wound	
	pressure ulcer preve			physician associated with the medic	
	p. 55554. 5 4.55. p. 5. 5			director's practice or a Vascular Sur	
	A review of the phys	ician order dated 10/1/18		Residents with wound care had the	
		t order for the right side of the		plans reviewed on 2/27/19-2/28/19	to
	heel that read "clear	nse with normal saline, pat		ensure that the facility addressed th	ie
	dry, apply antibiotic	ointment, and cover with dry		pressure sores comprehensively to	
	sterile dressing each	n day."		prevent worsening and promote hea	
				the pressure sores. Residents with	
		lent 's physician progress		pressure ulcers had their care plans	
		ated 10/1/18 revealed, a		reviewed on 2/28/19 by the Division	
		n, unstageable pressure		MDS nurse. Resident's wounds are	
	_	eral heel with a small area		observed and measured weekly by	
		rainage, but no erythema or		treatment nurse, beginning 1/23/19.	
	odor.			facility's treatment nurse coordinate outside services as needed and/or	
	Δ review of the admi	ission Minimum Data Set		ordered in collaboration with the	25
		3 revealed the resident had		physician. Current residents with we	nunds
	' '	The resident required			
		e of 2 persons for transfer,		associated with the Medical Directo	
		ence care. The resident had		practice, or a Vascular Surgeon. Th	
	_	essure ulcer on the side of the		physician notes are sent to the facil	
	right heel.			secure server email for the Director	-
				Nursing's review and then they are	filed in
	A review of the resid	lent 's October 2018		the medical record. Alert and orien	
	treatment administra	ation record (TAR) for		residents were interviewed 3/4/2019	9 if
	dressing change of t	the right heel pressure ulcer		they have ever felt neglected. No	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010	
				625 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETION DATE	
F 600	Continued From page	e 39	F 60	00			
		o documentation for wound 3-14, 10/17-18, 10/20-21,		negative responses were noted	i.		
	and 10/27-28.			3. Director of Nursing, Divisiona			
	A review of the reside	ent 's November 2018 TAR		Executive Director, and Region of Clinical Services provided ed			
		of the right heel pressure		all staff on abuse and neglect w			
		was no documentation for		emphasis that not providing car			
	wound care on 11/15	i-16, 11/23-25, and 11/20.		resident is neglect on 2/3/19, 2/			
				2/11/19, and 2/19/19 and re-ed			
		ent 's wound culture lab		3/3/19 and 3/4/19. New hires v			
		revealed an infection of taphylococcus aureus		provided training on neglect to providing care to the resident is			
	(MRSA) of the side of			Newly hired licensed nursing st	•		
	(iiii to) t) or are class of	. rigitt rioon		provided training and education			
	A review of the reside	ent 's physician progress		neglect including not providing			
		evealed an unstageable		resident as well as not providing			
	· ·	right heel which was present		care and treatment as being ne	-		
		positive MRSA culture.		facility employees a full time tre			
	(antibiotic) ordered 1	or Doxycycline 100 mg		unavailable, it will be communic			
	(antibiotio) ordered 1	1727 10 101 7 dayo.		licensed nurses by the Director			
	A review of the reside	ent ' s physician progress		to provide treatments as ordere			
		evealed the resident had a		physician. The licensed nurses			
		right later heel which was		capacity to complete their assig	ınments,		
	•	n. The resident was his own		including treatments within the	ula If tha		
	responsible party.			parameters of their work sched licensed nurse cannot complete			
	A review of the physi	cian 's progress note dated		treatment within the parameter			
		e resident was treated for		work schedule, the licensed nu			
		el. The resident finished his		report the issue to the Director			
		edication and contact		The Director of Nursing will gra	<u> </u>		
	precautions were no longer needed (healed). A review of the resident 's December 2018 TAR for dressing change of the right heel pressure to the licensed nurse to complete the task, delegate the responsibility to another nurse or assist with the task. The DON or MDS nurse will complete the assessment						
				1			
		was no documentation for		and measurements if the treatn			
		2, 12/5, 12/7, 12/15-17,		is unavailable. Corporate Hum			
	12/21-23, 12/25, and	12/28-31.		Resources and Regional staff v the Interim Executive Director to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING			1	C	
NAME OF D		343430	5: :::::0 _		TDEET ADDRESS CITY STATE ZID CODE	03/	06/2019	
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WESTWO	OD HEALTH AND REHA	ABILITA			25 ASHLAND STREET			
				Α	ARCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	ge 40	F 6	300				
	Physician progress	note dated 12/27/18 revealed			implement staff recruitment practices t	0		
		econdary to Parkinson ' s			ensure the center was appropriately			
		ent was followed by wound			staffed (center achieved appropriate			
		e Center outside the facility)			staffing on 02/08/19).The Regional Vic	e		
		ght heel pressure ulcer.			President of Operations and the Region			
					Director of Clinical Services will monitor	or		
	On 1/7/19 at 10:45 a	am an interview was			staffing levels to ensure adequate staf	fing		
	conducted with the	resident who stated his right			is maintained. On 2/7/19 the Regional			
	heel wound dressing was not always changed				Vice President of Operations and			
	every day.				Regional Director of Clinical Services			
					began monitoring daily staffing of direct			
	•	m an interview was conducted			care per resident per day using mornir	-		
		family member who stated			meeting and internal labor portal. Facil	ity		
	_	dressing was not being			leadership, including the Executive			
	-	as ordered and that she had the podiatrist to follow up.			Director, Director of Nursing and Interdisciplinary team provide direct			
		commented that the resident			oversight through rounding, observation	'n		
	•	essing was not always being			and resident/family communication to	'11		
		mily member looked at the			ensure neglect is not present and the			
	_	g and could see the date had			residents receive the care and service	S		
	passed by a couple	-			they need. Interdisciplinary team to			
	, , ,	•			include Social Worker, Activities Direct	tor,		
	On 1/8/19 at 3:00 pr	m an observation was done of			Medical Records Director, Dietary			
	the resident 's right	heel pressure ulcer wound			Manager, Housekeeping Manager, Re	hab		
		e treatment nurse (TN). The			Director, Business Office Manager, MI	OS		
		heel was dated 1/4/19 and			Coordinator and Human Resources			
	•	n with yellow purulent drainage			Director. Issues identified will be			
		macerated (wet, white, and			presented to the Executive Director an			
	peeling) around the	edges.			will follow the Abuse and Neglect proce	ess		
	A marriant of the colo	.m. 2040 TAD for day size			for investigation, resolution and/or			
		uary 2019 TAR for dressing			reporting.	20		
		neel pressure ulcer revealed			Regional Director of Clinical Service and or Director of Nursing will conduct			
the dressing was documented as being done on 1/1, 1/4 and 1/8.				and or Director of Nursing will conduct quality monitoring (audit) for neglect				
				including observation and interview of				
	On 1/8/19 at 10:25 a	am an interview was			resident treatments and documentation			
		TN who stated that she was			for 3 residents (rotating residents), 3			
					times per week for 4 weeks, then weel	κlv		
	responsible for all resident treatments but was frequently being re-assigned to work as a nursing				for 3 months. The Director of Nursing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25				С	
		345450	B. WING _			"	3/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	070072013	
					25 ASHLAND STREET			
WESTWO	OD HEALTH AND RE	HABILITA			RCHDALE, NC 27263			
040.15	CLIMMAD	Y STATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 600	Continued From p	age 41	F 6	300				
	assistant due to st	taff shortage. The TN stated			report on the results of the quality			
	when she was not	in the role of treatment nurse			monitoring (audit) and report to the QA	ŀΡΙ		
	the assigned floor	nurse was responsible to			committee. Findings will be reviewed	by		
		re for their residents. The			QAPI committee monthly and Quality			
	treatment nurse st	tated that she was responsible			monitoring (audit) updated as indicated			
		resident's wounds once a			The results of the quality monitoring w	ill		
		ne was assigned as a nursing			be brought to the Quality Assurance			
		nds were not measured or			Performance Improvement meeting by			
	_	treatment nurse stated she			Director of Nursing for review of on go	ing		
	assisted the wound care Nurse Practitioner once a week during weekly rounds except when she				wound care monthly. The Executive	the		
	_	a nursing assistant.			Director will provide data on staffing to QAPI committee for review of any staff			
	was assigned as a	a nursing assistant.			challenges. Quality Improvement	iiig		
	1/8/19 at 10:30 an	n an interview was conducted			monitoring schedule will be modified			
		ator who stated that there had			based on findings of monitoring			
		resignations as well as			The center Executive Director conveye	ed		
		emporarily resolve the nursing			an ADHOC Quality Assurance			
		e, licensed nurses have been			Performance Improvement meeting			
	assigned to the nu	ursing assistant role. The staff			02/22/19, including the Interim Executi	ve		
	informed the Admi	inistrator that they were			Director, Director of Nursing, the SDC	,		
	exhausted.				Director of Rehab, MDS Nurse, Housekeeping Manager, the Business			
	On 1/8/19 at 1:57	pm an interview was conducted			Office Manager, the Human Resource			
		stated that the resident had a			Coordinator, Medical Records, Central			
		nis right heel that was present			Supply Clerk, Admissions Director,			
		the dressing change was			Dietary Manager, Activity Director and	the		
		treatment nurse. Nurse #9 also			Environmental Services Director			
		as not responsible to change the			regarding the plan of removal of			
		#9 stated that she was			immediacy.			
	_	sident on 1/7-9/19, she had not						
	_	ent 's right heel dressing and			5. Date of Compliance 4/3/19			
		the resident had not received						
	, ,	ge by the treatment nurse. If						
		umentation in the resident 's care was not done.						
	record the would	care was not done.						
	On 1/8/19 at 2:21	pm an interview was conducted						
		tated the resident acquired an						
		ht heel pressure ulcer during						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(С
		345450	B. WING			03/	06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		625	EET ADDRESS, CITY, STATE, ZIP CODE ASHLAND STREET CHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	s pressure ulcer drean infection. The tright heel wound had completed his antible changed daily by be drainage and the dress was now moderate further commented resident to a podiation because they were being changed by the by what the resident saw the poperactitioner could note and when the wound increased drainage practitioner or wour not assessed the work of the date she placed dated 1/4/19. The the treatment admir was the last nurse to resident's right heel commented that if the signed/documented changed. The TN resident.	exp. Not changing the resident 'essing placed him at risk for eatment nurse stated that the di worsened after he iotic and the dressing was not ecoming larger with increased ainage that was scant serous creamy yellow. The TN that the family took the rist for the right heel wound aware the dressing was not ne date on the dressing and to stated. On the weeks the diatrist the wound care Nurse of treat the resident. The was not followed by the facility no weekly measurement done of the facility obtain the podiatry is dressing was not changed, and had gotten larger with the facility 's medical nurse and care nurse practitioner had bound. In an interview was conducted nurse (TN) who stated the pel pressure ulcer dressing had on the gauze from last week, TN stated she referred back to instration record (TAR) and o document/change the dressing on 1/4/18. The TN the TAR was not the dressing was not nurse stated that other than the rotes there were not facility	F	600			
	On 1/8/19 at 3:30 p	m an interview was conducted					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345450	B. WING		C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 600		ge 43 Nursing (DON) who stated taff to complete all treatments	F 60	00	
	conducted with the who stated she rou wound assessment treatment nurse. D was not available to the wounds and Reperiodically by the p Nurse Practitioners #36's right heel pr wound care today a was larger and had month (she had not was not infected. S resident had acquir right heel wound last that the dressing wountil now. The failur placed the resident wound infection and prior MRSA infection environment and a by dressing change MRSA to infect and wound drainage in the statement of the statemen	· ·			
	state that she asked podiatry notes and nor available in the She also stated tha nursing staff shorta care and measuren had brought her con	tree Practitioner went on to did the DON for the resident 's they were not provided to her resident 's medical record. It she was aware of the ge, made aware that wound nents were not completed, and incerns to the DON in the past The wound care Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		03/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	treat and measure the regular basis because the facility by a podiation of the pressure ulcer was a conducted with the facility of the pressure ulcer was a conducted to the failure and wound status of facility Nurse Practition usually followed the wound because he wound because he wound because he wound because he wound the wound to be a conducted with the facility notes in resident. The DON sobtain a copy from the conducted with the Ton formed by the DON as NA for 1/7, 1/8, are sponsible for facility treatments would be	at she could not evaluate, the resident's wound on a see he was being seen outside atrist (duplication of services). In an interview was acility medical Nurse that the resident's right wound was macerated and changed the wound care are to change the dressing thange and decline. The coner stated she had not right heel pressure ulcer was seen by an outside considered a duplication of the man interview was DON who stated there were the facility record for the stated she would attempt to the podiatry office.	F 6	, , , , , , , , , , , , , , , , , , ,		
	On 1/10/19 at 10:12 conducted with the E present. DON stated treatments were not	which included all wounds. am an interview was DON with Nurse #7 and TN d that she was aware that completed for Resident #36 and expected the TN nurse to ents on all the facility				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		1 00/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 600	duties. On 1/9/18 3:10 pm thaccompany the surveright heel dressing claws made aware that 1/4/19 and that the dechanged for 4 days, she was not aware the complete treatments her NA day shift on the stated that she was not treatments and had now a wound care on 1/7, and she agreed there was communication as to complete the resider also stated that the routside podiatrist and The Administrator and notified of Immediate pm. On 3/5/19 the facility credible allegation of removal: The center Executive of immediate jeopard. 1. The corrective a practice was accompon 1/8/2019 residen provided by a license.	ne DON and the TN to eyor to observe resident 's nange. The DON stated she at the dressing was dated ressing had not been. The TN nurse stated that nat she was responsible to including wound care after the three days. Nurse #7 not responsible for not completed the resident 's 1/8, and 1/9. The DON stated is a breakdown in who was responsible to int's treatments. The DON esident was seen by an discount would obtain the records. Indicate the following is provided the following is Immediate Jeopardy Director alleges abatement by on 03/05/19. Indicate the three three three degrees abatement by on 03/05/19. Indicate the three three three degrees abatement by on 03/05/19. Indicate the three three three three degrees abatement by on 03/05/19. Indicate three t	F 600			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 600	to Resident #36 's ordered by the physical assessed weekly for licensed nurse start was followed by his admission to facility plan was updated of Resident #36 's worked was provided starting orders. Corporate Human F worked with the Interior implement staff reciting the center was approachieved appropriation on 01/22/19 a root completed by the R Operations, Region Services, the Direct Divisional Executive administrator) and of Director failed to proensure treatments with alleged deficient proon 2/15/2019 the Dar quality review of a sheets, compared the and observed treatments were provided wourd 3 current residents with wour physician associated	B. Wound care was provided heel daily starting 1/10/19 as sician, and his wound was a right sign of improvement by the sing 1/23/19. Resident #36 physician starting on a no 10/1/2018, and his care on 1/29/19 by the MDS nurse. For any of the sing 1/20/2019 and 1/20/20/2019. Daily wound care on 1/20/19 following physician would be staffed (center the staffing on 02/08/19). Resources and Regional staffer for any of the staffing on 02/08/19). Cause analysis was begional vice President of all Director of Clinical for of Nursing and the experience of the staffing to were completed as ordered. The potential to be affected by the side of the staffing to were completed as ordered.	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· , ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP COI 625 ASHLAND STREET ARCHDALE, NC 27263		33/33/23 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 600	2/27/19-2/28/19 to en addressed the pressut to prevent worsening pressure sores. Resi had their care plans in Divisional MDS nurse observed and measu nurse, beginning 1/23 nurse coordinates ou and/or as ordered in ophysician. Current residents with wound physician asso Directors practice, or physician notes are sis server email for the review and then they record. Alert and oriented residents with a server esponses with the resident is neglect with emphasis the resident is neglect with emphasis the resident is neglect. Newly hired provided training and including not providing neglect. Newly hired provided in providing not provided training and including not provided provided training and including not provided provided provided training and including not provided prov	care plans reviewed on sure that the facility are sores comprehensively and promote healing of the dents with pressure ulcers eviewed on 2/28/19 by the series exiewed on 2/28/19 by the series exiewed by the treatment of 19. The facility 's treatment of 19. The facility 's treatment of 19. The facility 's treatment of 19. The facility is treatment of 19. The fac	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTR			DATE SURVEY COMPLETED	
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		345450	B. WING			03/	06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REI	HABILITA	•	625 ASHL	DDRESS, CITY, STATE, ZIP CODE AND STREET ALE, NC 27263			
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F 600	If the treatment nu communicated to to Director of Nursing ordered by the phy have the capacity including treatmentheir work schedult complete the treatmentheir work schedult the issue to the Dirof Nursing will granurse to complete responsibility to an task. The DON or assessment and murse is unavailab Resources and Rel Interim Executive I recruitment practic appropriately staffe staffing on 02/08/1. The Regional Vice the Regional Director monitor staffing levis maintained. On President of Opera Clinical Services by of direct care per meeting and intermeding and intermeding and intermeding and receive the care an receive the care an receive the care and received the care and receiv	rees a full time treatment nurse. rse is unavailable, it will be the licensed nurses by the g to provide treatments as rsician. The licensed nurses to complete their assignments, ts within the parameters of the. If the licensed nurse cannot ment within the parameter of the, the licensed nurse will report trector of Nursing. The Director and overtime to the licensed the task, delegate the tother nurse or assist with the MDS nurse will complete the the assurements if the treatment the. Corporate Human regional staff worked with the Director to implement staff these to ensure the center was the director of Operations and the of Clinical Services will the relations and Regional Director of the regan monitoring daily staffing the resident per day using morning	F	600				

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F 600	Dietary Manager, Ho Director, Business Or Coordinator and Hum Issues identified will I Executive Director ar Neglect process for in and/or reporting. Regional Director of Director of Nursing w (audit) for neglect in interview of resident documentation for 3 in residents), 3 times per weekly for 3 months. The results of (audit) and report to the Findings will be revied monthly and Quality indicated. The results be brought to the Quality and Improvement meeting for review of on going Executive Director with the QAPI committee challenges. Quality I schedule will be mode monitoring. The center Executive ADHOC Quality Assumprovement meeting Interim Executive Director of Housekeeping Manager, the Human Medical Records, Ce	edical Records Director, usekeeping Manager, Rehab fice Manager, MDS and Resources Director. Deepresented to the ad will follow the Abuse and avestigation, resolution Clinical Services and or a clilical Servic	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 3/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER	1 0.000		STREET ADDRESS, CITY, STATE, ZIP CODI		3/06/2019	
				625 ASHLAND STREET			
WESTWOOD HEALTH AND REHABILITA			ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 50	F 6	00			
		ronmental Services Director removal of immediacy.					
	immediacy plan via te	was made aware of the of elephone with the Executive ctor of Nursing on 3/1/19.					
		on of Immediate Jeopardy ed on 3/6/19 at 12:30 PM					
	were 17 new employ	cord review indicated there ees documented as starting ng assistant and licensed 19 and 2/27/19.					
	facility to home dated discharged to home of follow up with his phy were started, and me The first home visit s A review of Resident administration record 2019 revealed docum	#36 's discharge from the 12/20/19 revealed he was with family, was scheduled to visician, home care services edical supply was contacted. It is cheduled was for 2/25/19. #36 's treatment of January and February mentation that he received since the last survey.					
	2/15/19 and 3 curren that their wounds foll physician associated practice or a Vascula as ordered as eviden record. Wound care reviewed, and weekly measurements were	with the medical director's r Surgeon and wound care need by notes in their medical documentation was y observations and identified beginning 1/23/19. sign-in sheets for wound ect/exploitation were					

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F 600	3/4/2019 was review indicated that they have negative responses. Resident #36 was davailable for observ. On 3/6/19 at 11:55 conducted with the Services/Director of the facility was now mid-February 2019 provided across the facility staff were reeducation for abuse Staff morale has im reported grievances of the failures to proanswer, low morale preferences. Resid 2 weeks to address staff has been sustaff has been sustaffired contact inform. On 3/6/19 at 4:30 pmembers were constaff were required.	esident interviews dated wed and resident responses had ever felt neglected. No were noted. ischarged to home and not ation and interview. am an interview was Director of Clinical Nursing (DON) who stated fully staffed since and the new Administrator board raises for all staff. All quired to participate in a neglect, and exploitation. Proved and there are fewer and failure to meet resident ent council is now held every concerns. The increased sined. Surplus applicants not ation has been retained. In interviews of 5 random staff ducted which revealed that all	F 60	,			
	commented that "se assistants had start and the facility was grievances filed by had dropped by halmeeting in February and incontinence cathe satisfaction of the	everal newly employed nursing ed over the past 2 months fully staffed." The rate of residents and/or their family for the last resident council or 2019 identified that call lights are were addressed timely to be residents. An interview the Treatment Nurse (TN)					

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F 600	float to the nursing a available every day to weekends the nurse completed the treath the nurse assigned of a schedule book for at the nurses 'static Scheduling Coordination on 3/6/19 at 5:30 pm with the Corporate V who stated he conference Human Resources E staffing plans including recruitment and rete sufficient staffing. Obeen hired and receivance process of the staffing of th	was no longer required to ssistant position and was for treatments. On the assigned to the resident ments. In the TN's absence completed the treatments and who is responsible was kept on and managed by the ator and Director of Nursing. In an interview was conducted fice President of Operations renced with the Divisional Director and implemented in wage increases and intion plans to ensure in 2/7/19 sufficient staff had ived orientation prior to ment. Daily staffing meetings sure sufficient staffing	F6	500		
		admitted to the facility 10/3/18 noses of Cirrhosis and a in Thrombosis.				
	Data Set (MDS) date Cognitive Pattern as the Mood (Section D completed. She was with bed mobility, toi Resident #1 was coo	#1's admission Minimum ed 10/10/18 revealed that the sessment (Section C) and e) assessment was not s coded total staff assistance leting and personal hygiene. ded as non-ambulatory and er and bowel. She was coded				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 600	present on admission pressure reducing messure ulcer care.		F 6	00		
	dated 10/10/18 for p a Hospice resident a	#1's Care Area Assessment ressure ulcers read she was and she was admitted with a lependent of the staff for hering.				
	dated initiated 10/17 her left heel on 10/1 Resident #1's wound	#1's skin/wound care plan 7/18 read she had a SDTI to 7/18. The goal was for d was to show signs of s included the facility was to as ordered				
	read Resident #1 ha	e nursing note dated 10/8/18 Id a blister to her left heel lately 10 centimeter (cm). litten to apply Skin Prep to the t her heels.				
	read Resident #1 wa her left heel blister h orders dated 10/12/ was to be cleansed area patted dry and (two-sided wound co	eded (PRN) Hospice note as seen on 10/12/18 because and ruptured. There were new 18 which read her left heel with Normal Saline (NS), the the application of Mepitel ontact layer dressing), covering and wrap with a gauze				

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F 600	Continued From pag	ge 54	F 6	00			
		ing was ordered to be day and Thursday by the					
	Resident #1's left he hanging off her heel orders were written with NS, pat dry their cover with a non-adl and secure with a gachange was to be do	e note dated 10/22/18 read sel Mepitel dressing was but not on the wound. New to clean her left heel wound in apply a Vaseline gauze, herent dressing, pad the heel auze wrap. The dressing one every Monday and ospice Nurse would be t #1's wound care.					
	there was new order heel wound with Bet nonadherent dressir dressing daily. The i	e note dated 10/31/18 read rs for paint Resident #1's left tadine, cover the wound with a ng and wrap with a gauze note indicated the new wound scussed with the Treatment					
	Administration Reco documented evident treatment to her left 11/3/18,11/4/18, 11/	y November 2018 Treatment ord (TAR) revealed no ce of Resident #1's daily heel on 11/2/18, 10/18, 11/13/18, 11/24/18 and 11/26/18.					
	revealed no docume #1's daily treatment	y December 2018 TAR ented evidence of Resident to her left heel on 12/2/18, 2/19/18, 12/25/18, 12/28/18					

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F 600	Continued From page	ge 55	F 60	0		
	dated revised 1/3/19 was described as un for Resident #1's wo	#1's skin/wound care plan Peread her area to the left heel Instageable. The goal was round was to show signs of The sincluded the facility was to The sac ordered				
	no documented evid	y January 2019 TAR revealed dence of Resident #1's daily heel on 1/1/19, 1/2/19, 1/4/19				
	Treatment Nurse sta Treatment Nurse at 2017. She revealed around July of Augu having difficulty obta Nursing Assistants that time due to the normally assigned a	on 1/8/19 at 10:14 AM, the ated that she had been the the facility since October of that prior to sometime ast 2018, the facility began aining and maintaining (NA). She further explained at lack of NAs on staff, she was as an NA and the floor nurses omplete the treatments.				
	1/10/19 read Reside follow up to her left Resident #1's left he described as unstag 10% granulation, no serous drainage. N Thera-honey (dress grade honey) daily to	Practitioner (NP) note dated ent #1 was seen for wound heel. The NP assessed eel pressure ulcer was geable with 90% eschar with o odor with a small amount of ew orders were given for ing impregnated with medical to any granulated areas and etadine daily to the dark				

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F 600	Continued From page	e 56	F 6	00			
	the Treatment Nurse that treatments were	iew on 1/10/19 at 8:40 AM, revealed she had concerns not being provided as #1 by the floor nurses for					
	(DON) on 1/10/19 at expected the necessary provided to residents comprehensive care physician. She acknown care plan intervention	plan and as ordered by the owledged that Resident #1's as and physician's orders cer treatment had not been					
	1/10/19 at 2:31 PM, hecessary care and s residents as indicated	with the Administrator on the indicated he expected the services to be provided to d in their comprehensive ered by the physician.					
	revealed Resident #1	Weekly Wound Report did not appear on the report ntil the week of 1/23/19.					
	dated revised 1/30/19 was described as a s goal was for Residen	e1's skin/wound care plan of read her left heel wound tage 3 pressure ulcer. The t #1's wound was to show eventions included the facility nents as ordered.					

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	ROVIDER OR SUPPLIER	HABILITA		STREET ADDRESS, CITY, STATE, ZIP CO 625 ASHLAND STREET ARCHDALE, NC 27263	•	3/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	10:00 AM, the Tre Resident #1' press heel. There were in technique or infect heel appeared pall edges. There was bloody drainage and NS. The area was applied to the would approximately 3 con was covered with wrapped with gaustipain. She was lyin mattress and her in mattress surface. During an interview DON validated she 11/3/18 and 12/7/1 documented evides Resident #1's left unable to recall if and 12/7/18 but if didn't do. The DOI Resident #1's trea it would have been to do it due to limit responsible for mothat treatments we the DON stated she Medication Adminion one had been in During an interview #9 verified she would have unable to the world have been to do it would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she would have been to do it due to limit responsible for mothat treatments we the DON stated she had a limit to the DON stated she had a limit t	age 57 are observation on 3/6/19 at atment Nurse provided sure ulcer treatment to her left no observed concerns with her tion control. Resident #1's left e pink in color with white wound no odor and evidence of fter cleaning the wound with padded dry and Santyl was and bed which measured m by 2 cm by 0.5 cm. The area a nonadherent dressing and ze. Resident #1's voiced no g on a properly functioning air neels were floated above the w on 3/6/19 at 1:38 PM, the e worked with Resident #1 on 18 where there was no ence of pressure ulcer care to heel. She stated she was she did treatments on 11/3/18 she didn't document, she likely N stated if she did not complete tments on 11/3/18 and 12/7/18 in because she didn't have time ted staff. When asked who was onitoring the TARs to ensure ere administered as ordered, he had been monitoring the istration Records (MARs), but monitoring the TARs. w on 3/6/19 at 1:48 PM, Nurse are worked with Resident #1 on and 12/2/18. Nurse #9 stated are call if she completed tment to her left heel on the	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	2018 and December staffed, and communicated she was pulled and served as an aistated the Treatmer completing treatment and when that I responsible for communication and interview #8 verified she work 12/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/1/19, 1/28/18, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/2/19, 1/28/18, 1/28/18, 1/2/19, 1/28/18, 1/28	ge 58 It stated during November or 2018, the facility was short inication was bad. Nurse #9 Independent of the medication cart de on multiple occasions. She of the Nurse was also pulledfrom the and put on a medication mappened, each nurse was pleting their own treatments. In 3/6/19 at 1:52 PM, Nurse was pleting their own treatments. In 3/6/19 at 1:52 PM, Nurse was pleting their own treatments. In 3/6/19 at 1:52 PM, Nurse was plet to recall if she completed ment to her left heel on the stated during November was and January 2019, she of the medication cart to work work wort staffing. She stated the was usually pulled from the sand she was put on a worked as an aide too. Nurse treatment Nurse was pulled atments, the nurses were upleting their own treatments. In 3/6/19 at 2:00 PM, the was attended to the staffing she was a sing treatment and either was an aide up until	F 6				
	completing treatment responsible for compound an interview DON and Treatment was not on the Weet Pressure Ulcers price.	when she was pulled from hts, the nurses were pleting their own treatments. on 3/6/19 at 2:10 PM the t Nurse verified Resident #1 ekly Wound Report for or to the week of 1/23/19 is no evidence of the facility's					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	DED.	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
345450	B. WING		03/06/2019		
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F TAG REGULATORY OR LSC IDENTIFYING INFORMAT	FULL PREF		N SHOULD BE COMPLETION DATE		
Weekly assessment of her left heel pressure prior to 1/23/19. During a telephone interview on 3/6/19 at 2 PM, the Hospice Nurse stated there were occasions she knew Resident #1's treatmen were not getting done due to staffing. She she tried to discuss her concerns with the Treatment Nurse and the floor nurses, but the were not working as aides, so she did not knanagement was aware of her concerns. Thospice Nurse stated Resident #1's left her wound did worsen to the point it had to be debrided by the wound physician. During a telephone interview on 3/6/19 at 2 PM, the Nurse Practitioner (NP) stated she aware the facility had experienced staffing in and the nurses were working as aides. The also stated she was aware that the treatme Nurse was unable to perform her duties due having to work as an aide or on a medication. The NP stated the lack of staff contributed the worsening of Resident #1's left heel wound she could not say that staffing was the sole reason for the wound decline. During a telephone interview on 3/6/19 at 4 PM, the Medical Director stated it was expectation that the necessary care and se were provided to prevent the worsening of Resident #1's pressure ulcer. He stated Re #1 had several terminal comorbidies that contributed to the worsening of her pressure but not receiving her treatments as ordered have also contributed to the wound worsen. 3. Resident #49 was admitted to the facility 12/6/18 with diagnoses that included	e ulcer 2:25 Ints Stated Ithey Innow if The El 2:45 Was Sissues E NP Ent E to Don cart. Ito but 3:20 Ervices Sident The ulcer I would Ing.	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345450	B. WING		03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 600	disorder, adjustment mood, and anxiety di The admission Minim assessment dated 12 #49 's cognition was behaviors and no rejrequired the extensive mobility and toileting. She was frequently in always incontinent of The Care Area Assesurinary incontinence admission MDS indicand able to make deneeds. Resident #49 of incontinence and the sensation in her blad hold. The active care plan part, the following are Resident #49 had a (ADL) self-care performobility, Cerebrovas impaired balance. The part, assistance with adjusting clothes, an toilet use. Resident #49 had a related to CVA and cand wrist. Resident addifficulty holding her included, in part, bedients.	ase, major depressive disorder with depressed sorder. num Data Set (MDS) 2/13/18 indicated Resident fully intact. She had no ection of care. Resident #49 re assistance of 1 for bed and 2 or more for transfers. Incontinent of bladder and bowel. sement (CAA) related to for Resident #49 's 12/13/18 reated she was alert, oriented, cisions and communicate indicated she had a history hat she could feel a der, but it was difficult to for Resident #49 included, in reas: In Activities of Daily Living remance deficit related to cular Accident (CVA) and he interventions included, in tasks of washing hands, dicleaning self in relation to cultered bladder elimination contractures of the right hand repart with the interventions in pan, mechanical lift for rage communication of	F 60			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		1 33/33/23/3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	communicated by R Resources Coordina resident was concer waited for her call lig form had been revie assigned to the DOI An interview was co 1/9/19 at 11:30 AM. written by the HRC concern with how lo be answered was re She stated that in the pressed her call bel She indicated it tool to be answered. She brief during that time her urine. She reve was soaked with uri answered by the HF provided her with in A phone interview w Department of Socia phone on 1/9/19 at she spoke with Res and the resident tolo urine-soaked brief fi her call light for ass An interview was co 1/9/19 at 2:40 PM. report dated 1/8/19 reviewed with the H	Resident #49 to the Human ator (HRC) indicated that the rned about how long she ght to be answered. This ewed by the SW and was N for investigation. Inducted with Resident #49 on The grievance dated 1/8/19 that discussed the resident 's ang it took for her call light to eviewed with Resident #49. The early morning on 1/8/19 she I because she had to urinate. It is easily morning on 1/8/19 she I because she had to urinate. It is easily morning on 1/8/19 she I because she had to urinate. It is easily morning that the stated she urinated in her the as she had difficulty holding that all her stated she sat in her brief that the until her call bell was RC. She stated the DON then continent care. If all Services (DSS) staff by 8:09 AM. DSS staff stated ident #49 yesterday, 1/8/19, did her she sat in a cor over 2 hours after pressing istance. Inducted with the HRC on The complaint/grievance related to Resident #49 was RC. She stated she was	F 600			
	Resident #49 's cal room and asked the	1/8/19 when she saw I light on, so she entered the e resident if there was d help with. Resident #49				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE COMP	LETED	
		345450	B. WING		03/) 06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 33.	1 33/33/23 13	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	needed "cleaned up #49 reported that sl 4:45 AM. The HRO 7:10 AM when she the call light. She s odor of urine in the Resident #49 was when she spoke wit speaking to Resider and Administrator to An interview was co 1/9/19 at 2:30 PM. provided incontinen 1/8/19 after the HRO resident 's call light had been on for ove that Resident #49 h reported Resident # tearful when she pro-	ge 62 ad been waiting awhile and been waiting awhile been wait	F 60				
	DON confirmation of #2 and NA #1 were	the nursing schedule and on 1/9/19 at 2:45 PM, Nurse assigned to Resident #49 for 7/19 beginning at 11:00 PM 19 at 7:00 AM.					
	on 1/9/19 at 3:00 Pl assigned to Reside beginning 1/7/19 ar that 2 NAs were wo entire building and t Resident #49. Nurs Resident #49's cal	was conducted with Nurse #2 M. He confirmed he was Int #49 during the third shift Ind ending 1/8/19. He indicated Irking the third shift for the Ithat NA #1 was assigned to I light being on for an Itime during the early morning					

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		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA	6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 600	2 hours for Resident answered. He explain only 2 NAs working it answer call lights time meeting the resident. An interview was considered at 3:15 PM. He confined Resident #49 during 1/7/19 and ending 1/1/19 and ending en	#49's call light to be ined that when there were that was difficult for them to be inely which caused a delay in some of the third shift beginning 8/19. He stated he was at day beginning on the and working through the third He reported that he was 1 of our with that day and they be ident #49's call light being period of time during the early out revealed it was not a be explained that he had idents' needs timely when when only 2 NAs were shift. He stated that this had booths and it had not with the Administrator on the stated he began working at this facility in June of that he facility had difficulty saining enough NAs to staff all began as the Administrator. It is definition of sufficient did that sufficient staffing was terms of quality and quantity	F 600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345450	B. WING			C 03/06/2019
AND PLAN OF CORRECTION 345450			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	'	00/00/2010	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	During an interview (DON) on 1/9/19 at a began working as the of 2018. She confirmed interview related to a obtaining and maintakenes shifts. She stanormally staffed with that one day recentle as an NA on the 3rd who were on the solumable to find anyor. An interview was concerned as a conc	with the Director of Nursing 3:31 PM she stated she e DON at the facility in June med the Administrator 's the facility having difficulty aining enough NAs to staff all ated that third shift was a 2 or 3 NAs. She revealed by she had to come in to work shift because 1 of the 2 NAs medule called off and she was the else to fill in. Inducted with the with Resident #49 on 1/8/19 was reported by the HRC. He with Reported to him that she me for her call bell to be ininistrator indicated the	F 6	,		
	The care plan for Refocus area of skin/w continued presence to her sacrum that wadmission. This foc	esident #44 included the ound and identified the of a Stage 4 pressure ulcer as acquired prior to her us area was initiated on entions included, in part, ts as ordered.				

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		345450	B. WING _			03/	C 06/2019
	ROVIDER OR SUPPLIER	BILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 600	10/23/18 indicated Da (antimicrobial cleanse with normal saline an solution, gauze, and daily. The quarterly Minimulassessment dated 11 #44's cognition was behaviors and no rejerequired extensive as mobility, dressing, to No transfers had no clook back period. Recatheter and was free She had one Stage 4 present on admission pressure reducing de and she received pressure reducing de and she received pressure reducing de and she received pressure follow up visit for a character of the sacrum which will sacrum wh	or Resident #44 dated akin 's Half Strength er) cleanse sacral wound d pack with Dakin 's cover with dressing twice Im Data Set (MDS) /28/18 indicated Resident fully intact. She had no ection of care. Resident #44 esistance of 1 staff for bed leting, and personal hygiene. Occurred during the MDS sident #44 had an indwelling quently incontinent of bowel. pressure ulcer that was a. Resident #44 had a vice for her bed and chair ssure ulcer care. Ititioner (WNP) note dated sident #44 was seen for a pronic stage 4 pressure ulcer was being treated with Dakin gs. The wound was noted to ge healing secondary to the term of the supplementation per gry habits and lack of protein supplementation. The wound to make a repeat	F	600	NCY)		
	the wound healing.	ndicated Resident #44 was					

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		345450	B. WING _			1	C 06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRES 625 ASHLAND S ARCHDALE, N		1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	hospitalized for an un 12/12/18 through 12/ A WNP note dated 12/ #44 continued to have contamination of her hindrance to healing. be nonadherent with was also noted to be repositioning. The W Stage 4 sacral ulcer i improvement nor sign recommendation was colostomy. A review of Resident Administration Reconrelated to her Stage 4 treatment was not init nurse per the Physici days and shifts: 12/19 (1st shift), 12/22/28 (2 2nd shift), 12/29/18 (12/30/18 (1st and 2nd shift)). A WNP note dated 1/continued to have fed wound, nonadherence recommendations, and turning and reposition assessment of the work healing nor infection. was made for the sac daily to Anasept (antitidressings once daily was able to acquire the sact and the	related condition from 18/18. 2/26/18 indicated Resident e persistent fecal wound which was a The resident continued to diet recommendations. She nonadherent to turning and NPs assessment of the ndicated no signs of as of infection. A again made for a 444's hard copy Treatment d (TAR) for December 2018 as sacral ulcer revealed the tialed as administered by a san's orders on the following 20/18 (2nd shift), 12/21/18 (2nd shift), 12/28/18 (1st and 1st and 2nd shift), and d shift), and 12/31/18 (1st and 1st and 2nd shift), and 12/31/18 (1st and 1st and 2nd shift) in the e with diet and nonadherence with	F	600			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	COMPLETED
		345450	B. WING		C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 03/00/2013
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F 600	sacral ulcer treatmed cleanse sacral would pack with Dakin's with dressing twice wet to dry dressing facility was able to a pharmacy. A review of Resider January 2019 from to her Stage 4 sacra order for Anasept gwas added to the Total tread, "when An previous order for the continued until the Treatment Nurse's indicated that Anasefor the first time on Resident #44's Janthrough 1/8/19 reveinitialed as administ the Physician on the 1/1/19 (1st and 2nd shift), 1/3/19 (2nd shift), 1/7/19 (2nd shift), and interview was considered the admission of the resident was considered the review was considered the resident wa	ge 67 liscontinuation of the current ent (Dakin's Half Strength and with normal saline and solution, gauze, and cover daily) and initiation of Anasept daily and as needed if the acquire the gel from the at #44's hard copy TAR for 1/1/19 through 1/8/19 related al ulcer showed that the 1/3/19 el once daily and as needed AR on 1/3/19 with a notation asept comes in". The ne Dakin's twice daily was to ne Anasept came in. The documentation on the TAR ept was received and applied 1/9/19. Further review of nuary 2019 TAR from 1/1/19 aled the treatment was not thered by a nurse as ordered by a following dates and shifts: shift), 1/2/19 (1st and 2nd shift), 1/8/19 (1st and 2nd shift), nd 1/8/19 (1st and 2nd shift). Inducted with Resident #44 on the She reported she had a ger sacrum that developed on. She stated that her cluded the changing of her once during the first shift will and once during the PM to 11:00 PM). She stated as not always changed as ated that she believed it was	F 600		

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	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263			
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F 600	dressing as ordered. she was unsure if Not the dressing or if she shift and didn't get in the An interview was con Nurse on 1/8/19 at 1 she had been the Traince October 2017. June or July of 2018 role of Treatment Now WNP came to the facility had been have maintaining Nursing explained that due to was normally assign nurses were suppositreatments. An observation of wo by the Treatment Now sacral pressure ulce 11:14 AM. The Treatment Nurse on Treatment Nurse on Treatment Nurse on Treatment Nurse reverteatments were not Resident #44 by the month. She stated to occasions that she he changed Resident #44 and returned to work the same dressing of the same	tho had not changed her Resident #44 stated that arse #5 just forgot to change e ran out of time during her to it. Inducted with the Treatment 0:14 AM. She stated that eatment Nurse at the facility She revealed that since she was only working in the arse once weekly when the cility. She explained the ring difficulty obtaining and Assistants (NA). She further of the lack of NAs on staff, she ed as an NA and the floor ed to complete the Dund care that was provided arse for Resident #44 's ar was conducted on 1/9/19 at trent Nurse provided the red. Was conducted with the 1/10/19 at 8:40 AM. The realed she had concerns that being provided as ordered to floor nurses for over a that there were multiple and worked on a Friday, 44 's sacral ulcer dressing, at the following Monday to find an the sacral ulcer that she	F 6			
	Treatment Nurse rev treatments were not Resident #44 by the month. She stated to occasions that she he changed Resident # and returned to work the same dressing of put in place on Fridal dated each of her dreat	being provided as ordered to floor nurses for over a hat there were multiple ad worked on a Friday, 44's sacral ulcer dressing, at the following Monday to find				

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	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 600	revealed that she pro #44 's sacral ulcer of the first shift and that treatment to her sacrosame dressing from. This interview, conduction with the Treatment Nother that Resident #44 's contaminated by stood dressing changes coon the wound healing #44 's sacral ulcer's remained stable. She change to Resident #4 on 1/3/19 to disconting start Anasept wet to as needed. She indice several days to obtain they just received the reported that the Daks supposed to be continged to the contingent of Nursing (It treatment Nurse start Director of Nursing (It treatments not consist ordered. She was un informed the DON of A phone interview was on 1/10/19 at 10:17 A to Resident #44 on 9 shift, 12/28/19 2nd shift, 1/5/19 2nd shift, 1/5/1	when she provided the all ulcer today (1/9/19) the 1/7/19 was in place. Incted on 1/10/19 at 8:40 AM, are continued. She stated sacral ulcer was easily of and that inconsistent uld have a negative impact g. She stated that Resident is healing had stalled and in eindicated the WNP made a stated that 's sacral ulcer treatment in the Dakin's twice daily and dry dressings once daily and cated the Anasept took in pharmacy approval for and it medication on 1/9/19. She kin's twice daily was in ued until the Anasept was donot occurred. The ted that she informed the DON) of this issue with stently being provided as mable to recall when she first it this concern. The seconducted with Nurse #5 AM. Nurse #5 was assigned instances (12/22/19 2nd hift, 12/29/18 2nd shift, 1/4/19 2nd shift, 1/8/19 2nd shift	F 60	0	
	shift) when her sacra documented as provi that she was respons	Il ulcer treatment was not ided as ordered. She stated sible for providing treatments lents. She was asked if she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345450	B. WING _			C 03/06/201	19
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	<u>-</u> E	00/00/201	
			625 ASHLAND STREET			
WESTWOOD HEALTH AND REHABILIT	TA		ARCHDALE, NC 27263			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPL	K5) LETION ATE
F 600 Continued From page 70 provided wound care treat s sacral ulcer when she wastated that she normally wall wall on the second shift (3 and her wound care for the provided on the first shift. Changed the resident 's devening or if incontinent or Nurse #5 revealed she wall wall wall wall wall wall wall wal	vorked with Resident 8:00 PM to 11:00 PM) we sacral ulcer was She revealed that she be are was required. As unaware Resident to order for Dakin's was twice daily. She was unaware that the sacral ulcer was twice daily. She was unaware that the sacral unaware that the facility. See #3 was assigned to come the sacral unaware that sacral unaware that the sacral unaware that the facility in staff, but that for the sacral unaware that the facility in staff, but that for the sacral unaware that the facility in staff, but that for the sacral unaware that the facility in staff, but that for the sacral unaware that the facility in staff, but that for the sacral unaware that the facility in staff, but that for the sacral unaware that the facility in staff, but that for the sacral unaware that the	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2010
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F 600	An interview was considered and the dreatment order for Individual States and the dreatment of Resident pertinent that treatment or dreatment or dre	AM. She was unable to be view. Inducted with the WNP on She stated that she came to week for wound indicated that Resident #44 sacral ulcer that was present the facility. She reported that easily contaminated by stool and the resident 's bowel WNP indicated that Resident een stable, with no signs of o signs of infection. She at reported on Resident #44 'diet recommendations and grecommendations. She #44 's previous sacral ulcer Dakin's twice daily (initiated orted that Dakin's had a raning that if the Dakin's was 12 hours its effect was gone. Rected for treatments to be a she added that due to the #44's sacral ulcer, it was rents were provided as sessing was regularly changed infection. Inducted with the DON on She indicated she expected and services to be provided to red in their comprehensive dered by the physician. She Resident #44's care plan	F 600		
	pressure ulcer treate consistently follower	nysician 's orders related to ment had not been d. The DON was asked who monitoring the TARs to			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		345450	B. WING			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	<u> </u>	3370072013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	ordered. She reveal monitoring the Medic (MARs), but no one TARs. An interview was con Administrator on 1/1 indicated he expects services to be provide in their comprehensiby the physician. 4b. Resident #44 was facility on 8/21/18 aron 12/18/18 with dianeurogenic bladder, personal history of L (UTIs). The care plan for Res 8/31/18, included the altered bladder eliming bladder, suprapublic retention, and recurrincluded, in part, supordered by the physician 's order cleanse Resident #4 with normal saline, palginate and dressin. The quarterly Minimum assessment dated 1 #44 's cognition was behaviors and no reprequired extensive a mobility, dressing, to	atts were administered as ed that she had been cation Administration Records had been monitoring the additional monitoring the conducted with the conducted we care plan and as ordered as initially admitted to the conducted we care plan and as ordered conducted with the conducted conduct	F 60	00			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 03/0	0/2019	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
Continued From page	: 73	F 6	00			
back period. Resident catheter and was free catheter and was free catheter and was free catheter and was free Resident #44 's supranormal saline, pat dry and dressing once da order. A physician 's order of same order that was incleanse Resident #44 with normal saline, pat alginate and dressing. A review of Resident Administration Record was conducted and reforder related to clean catheter once daily (fit documented as provided following dates: 12/1/12/27/18, 12/28/18, 1	at #44 had an indwelling quently incontinent of bowel. For dated 8/30/18 to cleanse apubic catheter site with and apply silver alginate ily remained an active dated 12/27/18 repeated the nitiated on 8/30/18 to a suprapubic catheter site at dry, and apply silver once daily. #44 's hard copy Treatment do (TAR) and Medication do (MAR) for December 2018 evealed the physician 's sing of the suprapubic arst shift) was not ded as ordered on the 19/18, 12/20/18, 12/21/18, 2/30/18, and 12/31/18. #44 's hard copy TAR and appropriate from 1/1/19 through 1/8/19 evealed the physician 's sing of the suprapubic	F 6				
documented as provide through 1/8/19. An interview was condult/7/19 at 12:00 PM. Suprapubic catheter. treatment orders, includes	ded as ordered on 1/1/19 ducted with Resident #44 on She reported she had a She stated that her uding irrigation and					
	CORRECTION ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page back period. Resident catheter and was frequency The physician 's order of the seriod order. A physician 's order of the seriod order. A physician 's order of the same order that was in cleanse Resident #44 with normal saline, part alginate and dressing. A review of Resident #44 with normal saline, part alginate and dressing. A review of Resident #44 with normal saline, part alginate and dressing. A review of Resident in the seriod order related to cleanse catheter once daily (fit documented as provided following dates: 12/19, 12/27/18, 12/28/18, 1. A review of Resident in MAR for January 2019 was conducted and resorder related to cleanse catheter once daily (fit documented as provided through 1/8/19. An interview was conducted and resorder related to cleanse catheter once daily (fit documented as provided through 1/8/19. An interview was conducted and resorder related to cleanse catheter once daily (fit documented as provided through 1/8/19. An interview was conducted and resorder related to cleanse catheter once daily (fit documented as provided through 1/8/19.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. The physician's order dated 8/30/18 to cleanse Resident #44's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily remained an active order. A physician's order dated 12/27/18 repeated the same order that was initiated on 8/30/18 to cleanse Resident #44's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily. A review of Resident #44's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily. A review of Resident #44's hard copy Treatment Administration Record (TAR) and Medication Administration Record (MAR) for December 2018 was conducted and revealed the physician's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on the following dates: 12/19/18, 12/20/18, 12/21/18, 12/27/18, 12/28/18, 12/30/18, and 12/31/18. A review of Resident #44's hard copy TAR and MAR for January 2019 from 1/1/19 through 1/8/19 was conducted and revealed the physician's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on 1/1/19 through 1/8/19 was conducted and revealed the physician's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on 1/1/19	ROVIDER OR SUPPLIER DD HEALTH AND REHABILITA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. The physician 's order dated 8/30/18 to cleanse Resident #44 's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily remained an active order. A physician 's order dated 12/27/18 repeated the same order that was initiated on 8/30/18 to cleanse Resident #44 's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily. A review of Resident #44 's hard copy Treatment Administration Record (MAR) for December 2018 was conducted and revealed the physician 's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on the following dates: 12/19/18, 12/20/18, 12/21/18, 12/27/18, 12/28/18, 12/30/18, and 12/31/18. A review of Resident #44 's hard copy TAR and MAR for January 2019 from 1/1/19 through 1/8/19 was conducted and revealed the physician 's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on 1/1/19 through 1/8/19. An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a suprapubic catheter. She stated that her treatment orders, including irrigation and	ROVIDER OR SUPPLIER DD HEALTH AND REHABILITA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFY NO INFORMATION) Continued From page 73 Back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. The physician 's order dated 8/30/18 to cleanse Resident #44''s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily remained an active order. A physician 's order dated 12/27/18 repeated the same order that was initiated on 8/30/18 to cleanse Resident #44' 's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily. A review of Resident #44' s hard copy Treatment Administration Record (TAR) for December 2018 was conducted and revealed the physician 's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on the following dates: 12/19/18, 12/20/18, 12/21/18, 12/227/18, 12/28/18, 12/30/18, and 12/31/18. A review of Resident #44' s hard copy TAR and MAR for January 2019 from 1/1/19 through 1/8/19 was conducted and revealed the physician 's order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on 1/1/19 through 1/8/19. An interview was conducted with Resident #44 on 1/7/19 at 12.00 PM. She reported she had a suprapubic catheter once daily (first shift) was not documented as provided as ordered she had a suprapubic catheter. She stated that her treatment orders, including irrigation and	A BUILDING	

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		345450	345450 B. WING			
	ROVIDER OR SUPPLIER OD HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP COD 625 ASHLAND STREET ARCHDALE, NC 27263		33/06/2019
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	nurses just forgot to they ran out of time of get to it. She indicate sedimentation which be completed. An interview was cor 1/10/19 at 11:39 AM. Resident #44 on 8 in 12/31/18, 1/2/19, 1/3 1/8/19) when cleans in not documented as particularly was assigned to and MARs were revisitated that if she had treatment she would the TAR or the MAR revealed that someting of missed. She exployed worked as a Nurse a assigned as an NA dobtaining and maintathree shifts. Nurse # reason the order for both the December 2 the MAR for the 2nd been identified that the provided as ordered it down for both shifts by 1 of the 2 shifts. An interview was cor Practitioner (NP) on stated that Resident medical history. She	that she was unsure if the provide the treatments or if during the shifts and didn't ed that she often had a lot of required regular irrigation to aducted with Nurse #3 on Nurse #3 was assigned to stances (12/19/18, 12/27/18, /19, 1/4/19, 1/7/19, and and of the catheter site was provided as ordered. She responsible for providing ered to Resident #44 when her. Resident #44 's TARs ewed with Nurse #3. She completed Resident #44 's have marked it complete on (as applicable). She mes there were things that plained that some days she and sometimes she was ue to the facility 's difficulty ining enough NAs to staff all 3 also shared that the the catheter irrigation was on 2018 TAR for the 1st shift and shift was because it had the irrigation was not always for Resident #44 so they put is to ensure it was completed aducted with the Nurse 1/10/19 at 12:05 PM. She 1/10/19 at 12:05 PM.	F 6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019
	ROVIDER OR SUPPLIER	ABILITA	•	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	•	
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F 600	tendency to become that she expected he related to catheter caunaware that the ord implemented. The Nobelieved no negative Resident #44 related of her catheter care. An interview was conditional to the catheter care and residents as indicated care plan and as ord acknowledged that Finterventions and phurinary catheter care followed. The DON responsible for monithat treatments were she revealed that she Medication Administ no one had been modeled the expected services to be provided in their comprehensible the physician.	Resident #44 was for UTIs and that she had a septic rapidly. She stated are orders to be followed are and revealed she was ders were inconsistently NP expressed that she acconsequences occurred for dothe inconsistent provision orders. Inducted with the DON on She stated she expected the services to be provided to ad in their comprehensive dered by the physician. She Resident #44 's care plan ysician 's orders related to a had not been consistently N was asked who was toring the TARs to ensure administered as ordered. The had been monitoring the ration Records (MARs), but onitoring the TARs.	F 6	00		

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F 600	8/31/18, included the altered bladder elimbladder, suprapublic retention, and recursincluded, in part, subordered by the physical Resident on this date and the of a large amount of clear. The NP indicated resident on this date and the of a large amount of clear. The NP indicated resident on this date and the of a large amount of clear. The NP indicated resident or increased sedim. A physician 's ordered and the order for increased sedim at the company of the sediment of th	resident #44, initiated on the focus area of the risk for nination related neurogenic catheter, chronic urinary the rent UTIs. The interventions uprapubic catheter care as sician. For (NP) note dated 12/4/18 #44 had her catheter irrigated the nurse reported the presence of sediment that was flushed that a plan to flush the retwice weekly and as needed mentation. For dated 12/4/18 for Resident tion to suprapubic catheter day and Friday) and as	F 60		
	completed on the M 12/28/18. A phone interview w on 1/10/19 at 10:17 to Resident #44 on irrigation of the cath	vas conducted with Nurse #5 'AM. Nurse #5 was assigned 12/21/18 and 12/28/18 when neter was not documentation d. She was asked if she			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 600	provided catheter car she was assigned to she had not provided #44 as it was normall She then stated that catheter care if the fir to it. Nurse #5 was u irrigated Resident #44 that there were times "hectic" and she could An interview was con 1/10/19 at 2:31 PM. Increasing the provided acknowledged that R interventions and phy urinary catheter care followed. The DON responsible for monitor that treatments were She revealed that she Medication Administration one had been more An interview was con Administrator on 1/10 indicated he expected services to be provided.	e for Resident #44 when her. She initially stated that catheter care to Resident y provided by the first shift. She may have provided st shift staff had not gotten nable to recall if she had 4's catheter. She revealed that things got really dn't get to everything. ducted with the DON on She stated she expected the ervices to be provided to d in their comprehensive ered by the physician. She esident #44's care plan sician's orders related to had not been consistently was asked who was bring the TARs to ensure administered as ordered. It is the tation Records (MARs), but nitoring the TARs.	F 600		
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2)(i)(iii) sessment duct initially and periodically	F 630	5	4/3/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		0.	C 3/06/2019
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F 636	functional capacity. §483.20(b) Compres §483.20(b)(1) Resi A facility must make assessment of a resi goals, life history ar resident assessment by CMS. The asses the following: (i) Identification and (ii) Customary routin (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical functin (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xii) Activity pursuit (xiv) Medications. (xv) Special treatme (xvi) Discharge plar (xvii) Documentation regarding the addition the care areas to the Minimum Data so (xviii) Documentation assessment. The a include direct obser with the resident, as	chensive Assessments ident Assessment Instrument. e a comprehensive sident's needs, strengths, and preferences, using the instrument (RAI) specified ssment must include at least if demographic information ine. ins. vior patterns. vell-being. oning and structural problems. sis and health conditions. itional status.	F 63	36		
	the Minimum Data (xviii) Documentatic assessment. The a include direct obser with the resident, as	Set (MDS). on of participation in assessment process must rvation and communication s well as communication with ensed direct care staff				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		3/00/2019	
				625 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263			
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F 636	Continued From pag	e 79	F 6	36			
	§483.20(b)(2) When timeframes prescribed chapter, a facility mu assessment of a resistimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissic significant change in mental condition. (For "readmission" means following a temporary or therapeutic leave. (iii)Not less than once This REQUIREMENT by: Based on staff intervisacility failed to compassessment which in resident's Cognitive Mood (Section D) on (MDS) for 2 (Resider sampled residents reassessments. The fire	required. Subject to the ed in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ection. The timeframes 43(b) of this chapter do not r days after admission, ons in which there is no the resident's physical or or purposes of this section, as a return to the facility y absence for hospitalization) e every 12 months. T is not met as evidenced views and record review, the elete a comprehensive included a review of the Pattern (Section C) and the Minimum Data Set and Resident #4) of 20 eviewed for completed MDS andings included:		F636- Comprehensive Assess Timing 1. The Minimum Data Set (MD Coordinator completed, and tra quarterly assessment for Resid (1/8/19) and, Resident # 4 (on reflect the each resident's curr condition. 2. The DON and or Regional Coordinator completed quality (audits) of current residents' M	ansmitted a dent # 1 1/10/19) to ent MDS audit DS,		
	10/10/18 revealed th assessment (Section D) assessment was In an interview on 1/2 Coordinator stated si	10/19 at 11:40 AM, the MDS		Section C and D to determine by 3/1/2019. There were no a negative findings in the audit. 3. The Regional MDS Coording re-educated the MDS Coording Interdisciplinary Team on the putiming and completion of the Minclude section C and D on 3-	nator ator and proper IDS to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD HEALTH AND REHAI	BILITA		62	REET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	10/10/18 for Resident occurred at the time was worker (SW) resigner stated it was the resp complete Section C as stated the MDS consicompletion of Resident thought the MDS regulation of Resident thought the MDS regulation of Resident thought the MDS regulation of Resident thought the omission was idented as a sessment in the Sembolation of Resident #1's admission would have included assessment in the Sembolation of Resident #4 was an accumulative diagnose. Accident and dysphasion of Resident #10/8/18 revealed that assessment (Section D) assessment was multiple of Resident at the time when the proposition of Resident at the time when the proposition of Resident and D of the consultant assisted here.	t #1. She stated this when the previous Social d. The MDS Coordinator onsibility of the SW to and D of the MDS. She ultant assisted her with the nt #1's MDS and she ulations changed in October ould not be modified once ontified. 0/19 at 2:30 PM, the t was his expectation that ion MDS dated 10/10/18 a comprehensive ection C and Section D of the dmitted 10/1/18 with of Cerebral Vascular gia. 4's admission MDS dated the Cognitive Pattern C) and the Mood (Section not completed. 0/19 at 11:40 AM, the MDS are was aware of the MDS assessment dated #4. She stated this occurred previous Social Worker MDS Coordinator stated it of the SW to complete en MDS. She stated the MDS are with the completion of and she thought the MDS in October 2018 and	F	336	4. DON and or Regional MDS Coordinator will conduct audits of 5 residents of all sections, of 2 Admission MDS 3 times per week for 4 weeks, the weekly for 3 months, to ensure proper timing and completion of MDS. The Do will report on the results of the quality monitoring (audit) and report to the QA committee. Findings will be reviewed to QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	en ON Pl by	

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019	
	ROVIDER OR SUPPLIER DD HEALTH AND REHAL	BILITA	•	62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	Resident #4's admiss would have included assessment in the Se MDS.	o/19 at 2:30 PM, the t was his expectation that ion MDS dated 10/8/18 a comprehensive oction C and Section D of the		636			
F 641 SS=D	resident's status. This REQUIREMENT by: Based on observatio interviews, the facility complete the Minimulassessment in the are for 1 of 2 (Resident # accidents. Findings included: Resident #3 was adm 7/26/15 with diagnose bilat knees. Review of the quarter 10/2/18 revealed Resimpaired cognition. To non-ambulatory. Sectindicated the resident with 1 person for transitions.	of Assessments. t accurately reflect the is not met as evidenced ns, record review and staff failed to accurately m Data Set (MDS) ea of activities of daily living 3) residents reviewed for attention of the facility on es, in part, of contractures of ly MDS assessment dated ident #3 had severely ne resident was ion G (functional ability) required total assistance		641	F641- Accuracy of Assessments 1. On 1/9/2019 MDS Coordinator modification and transmitted Resident # 3 □ s MDS to reflect the resident □ s current condition 2. On 2/06/2019 the Divisional MDS Coordinator completed an MDS quality review of residents requiring assistance with transfers to ensure accuracy in the area of Activities of Daily Living (ADL) No additional negative findings were identified. 3. On 1/31/2019 the Divisional MDS provided re-education to the facility MD Coordinator on the proper completion of MDS in the area of ADL □ s to ensure accuracy. 4. DCS and or Regional MDS Coordinator will conduct random quality monitoring (audit) of MDS □ of patient	o e e e e : : : : : : : : : : : : : : :	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD HEALTH AND REHAL	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/	00/2013
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F 656 SS=E	the look back period of revealed Resident #3 with 2 people. Observation of Resid 1/9/19 at 11:44 AM resused to transfer resid wheelchair. An interview on 1/9/1 revealed she was new Resident #3 required from the Kardex and assistants. She reveat to transfer Resident #3 the resident 's safety. An interview on 1/9/1 nurse revealed she kellift for transfer, but co assessment. An interview on 1/9/1 revealed he was family knew she required a light that information was family the MDS be completed bevelop/Implement Completed to the MDS be completed bevelop/Implement Completed to the MDS be completed to the MDS to the M	es of daily living report for of 9/26/18 to 10/2/18 required total assistance ent #3 being transferred on evealed mechanical lift being ent back to bed from her 9 at 11:44 AM with NA #1 w to the facility but knew a mechanical lift to transfer report from other nursing alled she would never attempt to 3 without a lift for her and to 9 at 10:00 AM with the MDS new Resident #3 required a ded it wrong on the 9 at 12:03 PM with NA #2 liar with Resident #3 and mechanical lift. He stated	F 64	ADL□s to ensure accuracy, 3 times week for 4 weeks, then weekly for 3 months. The DCS will report on the results of the quality monitoring (auding and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality mor (audit) updated as indicated. 5. Date of Compliance 2/20/2019.	dit) nitoring	4/3/19
30 L	§483.21(b) Comprehe §483.21(b)(1) The fac	ensive Care Plans cility must develop and nensive person-centered				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 03/00/2013	
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F 656	Continued From pag	e 83	F 656			
	resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that or maintain the residential physical, mental, and required under §483 (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclustreatment under §48 (iii) Any specialized serenabilitative service provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wire resident's represental (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was assellocal contact agencie entities, for this purpor (C) Discharge plans plan, as appropriate, requirements set fort section.	ames to meet a resident's dimental and psychosocial fied in the comprehensive imprehensive care plan must grame to be furnished to attain ent's highest practicable if psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will for PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the attive(s)-lials for admission and reference and potential for collities must document is desire to return to the lessed and any referrals to the sand/or other appropriate				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3	3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	I ODE	03/00/2013
				625 ASHLAND STREET		
WESTWO	OD HEALTH AND RE	HABILITA		ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	staff interview, the care plan intervent care (Residents #3 catheter care (Residents.) The findings included the catheter that the catheter care (Residents.) The findings included the catheter that the catheter that the catheter care (Residents.)	review, resident interview, and facility failed to implement the cions related to pressure ulcer 36, #1, and #44), urinary ident #44), and antipsychotic ent #50) for 5 of 20 sampled ded: as admitted to the facility on agnoses of Parkinson's, tes, and unstageable pressure	F6		resides at the sing reviewed ts #1, #44 and ed the soutlined in ulcers, and urinary and the MDS an audit of all cers, urinary medications	
	Data Set (MDS) daresident had an inthad one unstagear of the right heel. A review of the rest 10/1/18 revealed a pressure ulcer care. A review of the phyrevealed a treatment of the phyrevealed at treatment of the phyrevealed at the second of the phyrevealed of the phyrevea	dident 's admission Minimum ated 10/8/18 revealed the sact cognition. The resident oble pressure ulcer on the side dident 's care plan dated in intervention to provide as ordered. Assician order dated 10/1/18 ent order for the right side of the anse with normal saline, pat		reflects current intervention Ulcers, urinary catheters an place. The Director of Nurs MDS Coordinator will obser Residents with Pressure Ulc catheters and antipsychotic Care Planned interventions This audit will be completed The results of this audit indi interventions were noted to per plan of care 3. The DON, RDCS or ED v	s for Pressure and Dialysis is in sing and the rve all cers, urinary to validate are in place. If by 3-25-19, icated all to be in place	
	dry, apply antibioti sterile dressing ea A review of the restreatment administ dressing change or revealed there was care on 10/6-8, 10 and 10/27-28.	c ointment, and cover with dry		all Nursing Staff including the on the weekends and as ne 3-27-19 related to following Care Plans for Pressure Ulcatheters and antipsychotic including completion and im of all care planned intervention DON will randomly observe and review their Care Plans weeks to validate care planfollowed and interventions of the plans and interventions.	nose working eeded by the Resident cers, urinary medications applementation tions. The 5 Residents s weekly for 12 s are being	

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLI						
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				62	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHAI	BILITA			RCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 85	F 6	656			
	ulcer revealed there wound care on 11/15. A review of the reside for dressing change of	of the right heel pressure was no documentation for -16, 11/23-25, and 11/20. ent 's December 2018 TAR of the right heel pressure			implemented for Pressure Ulcers, uring catheters and antipsychotic medication. Opportunities will be corrected daily by Director of Nursing as identified during these audits. 4. The DON will conduct quality	is.	
	wound care on 12/1-2 12/21-23, 12/25, and	vas no documentation for 2, 12/5, 12/7, 12/15-17, 12/28-31. ary 2019 TAR for dressing			monitoring (audit) and observe 5 Residents and review their Care Plans weekly for 12 weeks to validate care pl are being followed and interventions ar implemented for Pressure Ulcers, urina	ans e	
	change of the right he	eel pressure ulcer revealed umented as being done on			catheters and antipsychotic medication Opportunities will be corrected daily by Director of Nursing as identified during these audits. The DON will report on the	the	
	Nursing (DON) on 1/2 indicated she expected be consistently impled that Resident #36's concluded the resident related to following the pressure ulcer care homeometric implemented. The Domesponsible for monitor that treatments were she revealed that she medication Administration one had been more	_			results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monito (audit) updated as indicated. 5. Date of Compliance 4/3/2019.		
	services to be provide in their comprehensiv by the physician. 2. Resident #1 was a	d'19 at 2:31 PM. He d'the necessary care and ed to residents as indicated re care plan and as ordered dmitted to the facility 10/3/18 loses of Cirrhosis and a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) A. BUILDING		' '	(3) DATE SURVEY COMPLETED			
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F 656	Continued From pag	e 86	F 6	56		
	Data Set(MDS) dated Cognitive Pattern ass the Mood (Section D completed. She was with bed mobility, toil Resident #1 was cod incontinent of bladde for one stage 2 press Suspected Deep Tiss present on admission pressure reducing m pressure ulcer care.	#1's admission Minimum d 10/10/18 revealed that the sessment (Section C) and) assessment was not coded total staff assistance eting and personal hygiene. led as non-ambulatory and r and bowel. She was coded sure ulcer and one sue Injury (SDTI) both h. Interventions included a lattress to her bed and Resident #1 was coded for a n 6 months and for Hospice				
	dated 10/10/18 for pr a Hospice resident a	#1's Care Area Assessment ressure ulcers read she was and she was admitted with a rependent of the staff for her g.				
	dated initiated 10/17/ her left heel on 10/17/ Resident #1's wound	#1's skin/wound care plan '18 read she had a SDTI to '/18. The goal was for was to show signs of s included the facility was to s ordered.				
	there was new order heel wound with Beta nonadherent dressin dressing daily. The n	note dated 10/31/18 read s for paint Resident #1's left adine, cover the wound with a g and wrap with a gauze ote indicated the new wound ussed with the Treatment				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From pa	ge 87	F 650	5	
	Administration Reco documented eviden treatment to her left 11/3/18,11/4/18, 11/	y November 2018 Treatment ord (TAR) revealed no ace of Resident #1's daily heel on 11/2/18, 10/18, 11/13/18, 11/16/18, 11/24/18 and 11/26/18.			
	revealed no document #1's daily treatment	y December 2018 TAR ented evidence of Resident to her left heel on 12/2/18, 2/19/18, 12/25/18, 12/28/18			
	no documented evid	y January 2019 TAR revealed dence of Resident #1's daily heel on 1/1/19, 1/2/19, 1/4/19			
	Treatment Nurse st Treatment Nurse at 2017. She revealed around July of Augu having difficulty obtanursing Assistants that time due to the normally assigned a	on 1/8/19 at 10:14 AM, the ated that she had been the the facility since October d that prior to sometime ust 2018, the facility began aining and maintaining (NA). She further explained at lack of NAs on staff, she was as an NA and the floor nurses complete the treatments.			
	the Treatment Nurs that treatments wer	rview on 1/10/19 at 8:40 AM, e revealed she had concerns e not being provided as t #1 by the floor nurses for			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		COMPLETED	
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	ROVIDER OR SUPPLIER OD HEALTH AND REHAL	BILITA	•	STREET ADDRESS, CITY, STATE, ZIP CO 625 ASHLAND STREET ARCHDALE, NC 27263	DDE	, 00,00,20	
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F 656	Continued From page over a month.	e 88	F 6	556			
	(DON) on 1/10/19 at a expected care plan in consistently implement that Resident #1's car to following the physiculcer treatment had n followed. The DON was responsible for monitor that treatments were She revealed that she	nted. She acknowledged re plan interventions related cian's orders for pressure ot been consistently was asked who was oring the TARs to ensure administered as ordered. e had been monitoring the ation Records (MARs), but					
		with the Administrator on the indicated he expected that to be consistently					
	Director of Nursing (E with Resident #1 on 1 there was no docume ulcer care to Residen she was unable to red	n 3/6/19 at 1:38 PM, the OON) validated she worked 11/3/18 and 12/7/18 where ented evidence of pressure t #1's left heel. She stated call if she did treatments on but if she didn't document,					
	#9 verified she worke 11/4/18, 11/10/18 and she was unable to red	n 3/6/19 at 1:48 PM, Nurse d with Resident #1 on I 12/2/18. Nurse #9 stated call if she completed ent to her left heel on the					
	During an interview o	n 3/6/19 at 1:52 PM, Nurse					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	ATE SURVEY OMPLETED
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F 656	#8 verified she work 12/28/18, 1/1/19, 1/ stated she was una Resident #1's treatr days in question bu 2018, December 20	ked with Resident #1 on 2/19 and 1/8/19. Nurse #8 ble to recall if she completed ment to her left heel on the t stated during November 1/18 and January 2019, she m the medication cart to work	F 65	6		
	facility on 8/21/18 a on 12/18/18 with dia	as initially admitted to the nd most recently readmitted agnoses that included Multiple stage 4 pressure ulcer of				
	8/21/18, included the and identified the confidence of the confide	esident #44, initiated on e focus area of skin/wound ontinued presence of a Stage her sacrum that was acquired on. The interventions iminister treatments as				
	10/23/18 indicated I (antimicrobial clean with normal saline a	for Resident #44 dated Dakin's Half Strength ser) cleanse sacral wound and pack with Dakin's solution, ith dressing twice daily.				
	assessment dated #44's cognition was behaviors and no required extensive a	num Data Set (MDS) 11/28/18 indicated Resident fully intact. She had no ejection of care. Resident #44 assistance of 1 staff for bed oileting, and personal hygiene.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	(X5) COMPLETION DATE
F 656	Continued From page	e 90	F 6	556		
	look back period. Re catheter and was fred She had one Stage 4 present on admission pressure reducing de and she received pre					
	Administration Recorrelated to her Stage 4 treatment was not ad 12/19/18 (2nd shift), (2nd shift), 12/28/18 (2	#44's hard copy Treatment d (TAR) for December 2018 I sacral ulcer indicated the ministered as ordered on 12/21/18 (1st shift), 12/22/28 (1st and 2nd shift), 12/29/18 and 12/30/18 (1st and 2nd 1st shift).				
	indicated a discontinuulcer treatment (Daki sacral wound with no Dakin's solution, gautwice daily) and initial dressing daily and as able to acquire the ga	•				
	January 2019 from 1/2 to her Stage 4 sacral treatments had not be ordered. This TAR sl for Anasept gel once added to the TAR on read, "when Anasept order for the Dakin's continued until the Ar Treatment Nurse's do indicated that Anasept	een administered as nowed that the 1/3/19 order daily and as needed was 1/3/19 with a notation that comes in". The previous twice daily was to be				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	pressure ulcer treatn Resident #44 as orde shift), 1/2/19 (1st and shift), 1/4/19 (2nd sh	g dates and shifts the nent was not provided to ered: 1/1/19 (1st and 2nd d 2nd shift), 1/3/19 (2nd ift), 1/5/19 (1st and 2nd 2nd shift), 1/7/19 (2nd shift),	F6	556		
	1/7/19 at 12:00 PM. pressure ulcer on he prior to her admissio treatment orders includersing twice daily, (7:00 AM to 3:00 PM second shift (3:00 PM that her dressing was ordered. She indicate normally Nurse #5 with dressing as ordered. She was unsure if Nurse #5 with the state of the she was unsure if Nurse #5 with the state of the she was unsure if Nurse #5 with the state of the she was unsure if Nurse #5 with the state of the she was unsure if Nurse #5 with the state of the she was unsure if Nurse #5 with the she was unsure if Nurse with the she was unsure if Nurse with the she was with the she was unsure if Nurse with the was unsure if Nurse	she reported she had a resacrum that developed in. She stated that her uded the changing of her once during the first shift in and once during the without the tour that the same that she believed it was the had not changed her in the west of the				
	Nurse on 1/8/19 at 1 she had been the Trasince October 2017. June or July of 2018 role of Treatment Nu Wound Nurse Practif She explained the fa difficulty obtaining ar Assistants (NA). She to the lack of NAs on assigned as an NA a supposed to complete	nducted with the Treatment 0:14 AM. She stated that eatment Nurse at the facility She revealed that since she was only working in the rse once weekly when the cioner came to the facility. cility had been having at maintaining Nursing e further explained that due staff, she was normally nd the floor nurses were the treatments. The infirmed Resident #44's				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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				6	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	ABILITA		,	ARCHDALE, NC 27263		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 656	Continued From pag	ne 92	F	656			
	· -	atment for her sacral	'	000			
		not consistently provided as					
		ment Nurse revealed that					
		occasions that she had					
		changed Resident #44's					
		g, and returned to work the					
		find the same dressing on					
		she put in place on Friday.					
		she dated each of her					
	_	vas how she knew it was the					
	_	Treatment Nurse indicated					
		ractitioner (WNP) made a					
	_	#44's sacral ulcer treatment nue Dakin's twice daily and					
		dry dressings once daily and					
		icated the Anasept took					
		in pharmacy approval for and					
	_	e medication on 1/9/19. She					
	reported that the Da						
		inued until the Anasept was					
	received, but this ha						
	received, but this ha	a not occurred.					
	A phone interview w	as conducted with Nurse #5					
	on 1/10/19 at 10:17	AM. Nurse #5 was assigned					
	to Resident #44 on 9	instances when her sacral					
	ulcer treatment was	not provided as ordered.					
	She was asked if sh	e provided wound care					
	treatment to Resider	nt #44's sacral ulcer when					
	she was assigned to	her. Nurse #5 stated that					
	Resident #44's wour	nd care for the sacral ulcer					
	was normally provide	ed on the first shift. She				ĺ	
		anged the resident's dressing					
	if needed in the ever	ning or if incontinent care was					
		revealed she was unaware					
	T	ious treatment order for					
		ed to be provided twice daily.					
		ed that she was unaware that					
		for Dakin's was supposed to					
		asept gel from the 1/3/19				ſ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345450	B. WING			C 3/06/2019
	ROVIDER OR SUPPLIER	HABILITA		STREET ADDRESS, CITY, STATE, Z 625 ASHLAND STREET ARCHDALE, NC 27263		0/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 656	An interview was completed Resident #44 on 4 ulcer treatment was she stated that she wound care treatment was assigned to be facility had a Treatment was assigned to be facility had a Treatment was assigned to be facility had a Treatment was assigned to be facility had been assigned not been providing was in the facility. I reviewed with Nurshad completed Reswould have marked She revealed that that got missed. She worked as a Nassigned as an NA	age 93 Is received at the facility. Inducted with Nurse #3 on M. Nurse #3 was assigned to instances when her sacral is not provided as ordered. It was responsible for providing ent to Resident #44 when she er. She explained that the ment Nurse on staff, but that I months the Treatment Nurse I as an NA on the floor and had treatments unless the WNP Resident #44's TARs were see #3. She stated that if she is sident #44's treatment she did it on the TAR as completed. It is sometimes there were things the explained that some days urse and sometimes she was as She further explained that thic at times and she was	F	656		
	on 1/10/19 at 10:18 reached for interview An interview was c Nursing (DON) on indicated she expe be consistently imp that Resident #44's related to following	was attempted with Nurse #11 3 AM. She was unable to be ew. onducted with the Director of 1/10/19 at 2:31 PM. She cted care plan interventions to blemented. She acknowledged s care plan interventions the physician's orders for tment had not been				
	consistently followed was responsible for ensure that treatments	ed. The DON was asked who r monitoring the TARs to ents were administered as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345450	B. WING				C 06/2019
	ROVIDER OR SUPPLIER	BILITA		62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263	00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	(MARs), but no one had TARs. An interview was con Administrator on 1/10 indicated he expected be consistently imple. 3b. Resident #44 was facility on 8/21/18 and on 12/18/18 with diagneurogenic bladder, opersonal history of Uni(UTIs). A physician's order decleanse Resident #44 with normal saline, paralginate and dressing. The care plan for Res 8/31/18, included the altered bladder elimin bladder, suprapubic or retention, and recurre included, in part, suprordered by the physic. The quarterly Minimulassessment dated 11 #44's cognition was fibehaviors and no rejerequired extensive as mobility, dressing, toi No transfers had occiback period. Resider catheter and was free	ation Administration Records and been monitoring the ducted with the 0/19 at 2:31 PM. He dicare plan interventions to mented. Is initially admitted to the dimost recently readmitted phoses that included chronic urinary retention, and rinary Tract Infections ated 8/30/18 indicated at dry, and apply silver gionce daily. Isident #44, initiated on focus area of the risk for nation related neurogenic catheter, chronic urinary ent UTIs. The interventions rapubic catheter care as cian.	F	356			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	· /	E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND RI		1	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	, ,	310012010
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
twice weekly (Tue needed for increase physician's order Resident #44's so normal saline, pa and dressing oncorder. The care plan relessuprapubic cathe the intervention of need for increase. A physician's order same order that we cleanse Resident with normal saline alginate and dress. A review of Resident Administration Resident was conducted at order related to conder related to conder for irrigation the TAR for the 1 Fridays and also shift on Tuesdays irrigation of the condered on 12/21 A review of Resident MAR for January was conducted and so ordered on 12/21	gation to suprapubic catheter esday and Friday) and as ased sedimentation. The dated 8/30/18 to cleanse uprapubic catheter site with t dry, and apply silver alginate edaily remained an active ated to Resident #44's ater was updated on 12/4/18 with of irrigation twice weekly and as ed sedimentation. er dated 12/27/18 repeated the was initiated on 8/30/18 to at #44's suprapubic catheter site e, pat dry, and apply silver	F 65	56		

PREFIX (EACH DEFICIENCY MUS	345450 A ENT OF DEFICIENCIES BY BE PRECEDED BY FULL DENTIFYING INFORMATION)	B. WING ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/06/2019
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PREFIX (EACH DEFICIENCY MUS TAG REGULATORY OR LSC ID	ST BE PRECEDED BY FULL	PREFIX	DDOV/IDEDIO DI ANI OF CODDEC	
F 656 Continued From page 96			PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRIOR OF THE	JLD BE COMPLETION
catheter once daily (first s as ordered from 1/1/19 thr An interview was conducte 1/7/19 at 12:00 PM. She suprapubic catheter. She stated that her treatm irrigation and cleansing, was ordered. Resident #44 stated that so nurses just forgot to provid they ran out of time during get to it. She indicated the sedimentation which requibe completed. A phone interview was con on 1/10/19 at 10:17 AM. It to Resident #44 on 2 instate the catheter was not provided Resident #44 when she with She initially stated that she catheter care to Resident provided by the first shift. She may have provided cashift staff had not gotten to unable to recall if she had #44's catheter. She reveatimes that things got really couldn't get to everything. An interview was conducted 1/10/19 at 11:39 AM. Nur Resident #44 on 8 instance.	rough 1/8/19. ed with Resident #44 on reported she had a ment orders, including were not always provided she was unsure if the de the treatments or if go the shifts and didn't at she often had a lot of ired regular irrigation to muducted with Nurse #5 Nurse #5 was assigned ances when irrigation of ided as ordered. She is catheter care for was assigned to her. The had not provided #44 as it was normally she then stated that the atheter care if the first of it. Nurse #5 was irrigated Resident aled that there were y "hectic" and she ed with Nurse #3 on the see #3 was assigned to ed with Nurse #3 on the see #3 was assigned to ed with Nurse #3 on the see #3 was assigned to ed with Nurse #3 on the see #3 was assigned to	F 65	56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 656	she was assigned and MARs were restated that if she in treatment she would the TAR or the MAR revealed that soming the missed. She worked as a Nurse assigned as an Nurse assigned as an Nurse shifts. She for the catheter irricological part of the 2 shifts. An interview was on Nursing (DON) on indicated she experience it down for both ships 1 of the 2 shifts. An interview was on Nursing (DON) on indicated she experience in the consistently implementation of the catheter or should be consistently implementation of the consistently implementation of the Me (MARs), but no on TARs. An interview was on Administrator on 1	rdered to Resident #44 when to her. Resident #44's TARs eviewed with Nurse #3. She had completed Resident #44's had completed Resident #44's had have marked it complete on the complete on th	F	656		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2013
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F 656	Continued From pag	e 98	F 6	56		
		led to residents as indicated ve care plan and as ordered				
	12/11/18 with diagno	admitted to the facility on uses that included mood so, dementia with behavioral rchosis.				
	A physician's order of Seroquel (antipsycho milligrams (mg) once					
	assessment dated 1: #50's cognition was no behaviors and no #50 was administere	num Data Set (MDS) 2/18/18 indicated Resident severely impaired. She had rejection of care. Resident d antipsychotic medication g the MDS review period.				
	reviewed 12/27/18, in antipsychotic medica disorder and psycho- easily angered. The part, monitor behavior	orehensive care plan, last ndicated the focus area of ation for diagnoses of mood sis. She was noted to be interventions included, in oral symptoms and side antipsychotic medication.				
	Administration Reco	ember 2018 Medication rd (MAR) for Resident #50 ed Seroquel 100 mg once				
	Behavior/Intervention related to Resident # had no staff docume effect monitoring. It	cted of the December 2018 n Monthly Flow Record 50's Seroquel. The form ntation of behaviors or side was completely blank except n of Resident #50's name,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER OD HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03	/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 656	A review of the January through 1/8/19 indica administered Seroque. There was no Behavior Record for January 2 medical record. During an interview 1/9/19 at 11:30 AM interview was confor Resident. An interview was conformed at 12:05 PM. were completed on indicated that behavior monitoring related to were documented on Behavior/Intervention was kept in the same Nurse #3 confirmed 2018 Behavior/Intervention was kept in the same Nurse #3 confirmed 2018 Behavior/Intervention was kept in the same Nurse #3 confirmed 2019 Behavior/Intervention as it had been identificated that be	ary 2019 MAR from 1/1/19 ated Resident #50 was atel as ordered. vior/Intervention Monthly Flow 2019 for Resident #50 in the with Medical Records staff on the verified there was no vior/Intervention Monthly Flow #50. Inducted with Nurse #3 on She stated that all MARs hard copy forms. She iors and side effect to psychotropic medications	F 65	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2013	
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F 657 SS=D	end of each month a responsible for placiadditionally indicate administered medica responsible for ensuments. Monthly Flow Recorcompleted. Nurse # realized that this form in Resident #50's chastiff requested a co (1/9/19). She was un December 2018 form incomplete. An interview was conversed by an interview was conversed behavior monitoring to be doen between the december 2018 form incomplete. An interview was conversed behavior of monitoring to be doen behavior/Intervention Care Plan Timing and CFR(s): 483.21(b)(2) A combetion of the comprehensive (ii) Developed within the comprehensive (iii) Prepared by an inicludes but is not line (A) The attending phenomena (B) A registered nurse resident. (C) A nurse aide wit resident.	and they were also and the form in the chart. She at that all nursing staff who ations were ultimately uring the Behavior/Intervention at was in the chart and was a revealed she had not an for January 2019 was not art until Medical Records by of the form this morning able to explain why the an for Resident #50 was anducted with the Director of all 10/19 at 2:31 PM. She care plan interventions to be additionally stated that she anonitoring and side effect attemented on the and Revision and Revision by (i)-(iii) an ensive Care Plans apprehensive care plan must and days after completion of assessment. anterdisciplinary team, that anited to	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263			
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F 657	the resident and the An explanation mus medical record if the and their resident re not practicable for the resident's care plan. (F) Other appropriat disciplines as deterror as requested by the (iii)Reviewed and resteam after each assonated comprehensive and assessments. This REQUIREMENT by: Based on record restaff interview, the factorial Nursing Assistant in 1 of 4 residents review process (Resident #The findings included Resident #50 was a 12/11/18 with diagnormal transport of the sident #50 was a 12/11/18 with diagnormal record in the sident #50 was a 12/11/18 with diagnormal r	acticable, the participation of resident's representative(s). It be included in a resident's reparticipation of the resident presentative is determined the development of the resident. It is not met as evidenced view, resident interview, and acility failed to incorporate a the care planning process for ewed for the care planning resonance.	F 6	F657- Care Plan Timing and F 1. On 2/1/2019 Resident # 500 was audited by the MDS Coor updated with input from license and CNAs to ensure accuracy 2. On 2/1/2019 the DCS imple schedule to include Certified N Assistants (CNA)s assigned to the care planning of residents. 3. The Divisional MDS Nurse will provide re-education to	s care plan dinator and ed nurses emented a Jursing o resident in and or DCS		
	assessment dated 1 #50 's cognition wa A review of the care Resident #50 's initi conducted on 12/27 signature section for meeting. This meet	mum Data Set (MDS) 2/18/18 indicated Resident s severely impaired. conference record indicated fal care plan meeting was /18. This record had a r the staff who attended the ing was attended by the MDS r Manager, Social Worker,		Interdisciplinary Team on the in CNAs in care plan conference planning resident scare by 2. 4. DCS and or Regional MDS Coordinator will conduct randomonitoring (audit) of resident conferences to ensure direct caregivers participation, 3 time for 4 weeks, then weekly for 3	s in /6/2019. om quality care are es per week		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 657	Continued From page	e 102	F 6	557			
	and Activities Director. There was no Nursing Assistant in attendance at the meeting.				The DCS will report on the results of th quality monitoring (audit) and report to QAPI committee. Findings will be	the	
	she was responsible	at 3:30 PM. She reported			reviewed by QAPI committee monthly a Quality monitoring (audit) updated as indicated.	anu	
	facility utilized care pl and review the care pl indicated that care pla attended by herself, I Worker, Activities Dira Assistant who was fa stated that additional hospice, were include conference if appropri these care plan conference after admission, quar care plan conference indicated an NA had a admission care plan r	an conferences to develop plans for all residents. She can conferences were Dietary Manager, Social ector, and a Nursing miliar with the resident. She staff, such as therapy or			5. Date of Compliance 2/20/2019.		
	no NA present at this confirmed that an NA development of Residular alternative method. The revealed it was essent at the meeting becauthe staff that were mother esident. She addressed that the staff that were mother esident #50 had a vivial would have benefited development of her confirmed that are the resident #50 had a vivial have benefited development of her confirmed that are the staff that were mother than the staff that were mother tha	meeting. She additionally had not participated in the dent #50 's care plan by any The MDS Coordinator intial for an NA to be present se the NAs were normally est familiar with the needs of ditionally revealed that eariety of care needs that from an NAs input in the are plan such as being a grantipsychotic medication, vities of Daily Living					
		ted that the facility had been					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345450	B. WING _		03/06/2019
	ROVIDER OR SUPPLIER	ABILITA	•	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 33/05/23 13
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 677 SS=G	having difficulty obta staff. She stated that an NA not attending meeting as one was the meeting. An interview was concept Administrator and Don's 170/19 and 2:31 PM expected the regular to be followed. ADL Care Provided CFR(s): 483.24(a)(2) A residual control of the provided control of the	ining and maintaining NA at this probably contributed to Resident #50 's care plan not available at the time of available at the time of the ducted with the frector of Nursing (DON) on the Both indicated they be tions related to care planning for Dependent Residents (a) dent who is unable to carry living receives the necessary good nutrition, grooming, and regione; and regione; To is not met as evidenced aview, observation, and ent, family, Department of the staff, the facility failed to be care, showers, and/or pendent residents reviewed activity of daily living (ADL), #49 and #44). Resident #4 ary for staying soaked with lity staff responded to the call tinence care.	F 6		9 and 44 Intinence y are as a specific are, ene, ndings ation to prn, on

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBED:		LE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA XTREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263 (X5 (EACH CORRECTION SHOULD BE COMPLETED SHOU		345450	B. WING			_	
WESTWOOD HEALTH AND REHABILITA ARCHDALE, NC 27263 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	I DDE	03/06/2019	
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The admission Minimum Data Set (MDS) assessment dated 12/13/18 indicated Resident #49 's cognition was fully intact. She had no behaviors and no rejection of care. Resident #49 required the extensive assistance of 1 for bed mobility and tolleting and 2 or more for transfers. She was frequently incontinent of bladder and always incontinent of bowel. The Care Area Assessment (CAA) related to uninary incontinence for Resident #49 1 12/13/18 admission MDS indicated she was alert, oriented, and able to make decisions and communicate needs. Resident #49 indicated she had a history of incontinence and that she could feel a sensation in her bladder, but it was difficult to hold. The active care plan for Resident #49 included, in part, the following areas: Resident #49 had an Activities of Daily Living (ADL) self-care performance deficit related to mobility, Cerebrovascular Accident (CVAA) and impaired balance. The interventions included, in part, assistance with tasks of washing hands, adjusting clothes, and cleaning self in relation to tollet use. Resident #49 was noted to report difficulty holding her urine. The interventions included, in part, assistance with tolleting. A complaint/grievance report dated 1/8/19 communicated by Resident #49 to the Human	The admission Mir assessment dated #49 's cognition where behaviors and not required the exten mobility and toileting She was frequently always incontinent always incontinent admission MDS in and able to make the needs. Resident #40 fincontinence and sensation in her blook. The active care play part, the following - Resident #49 had (ADL) self-care per mobility, Cerebrov impaired balance. part, assistance where wadjusting clothes, toilet use. Resident #49 had related to CVA and and wrist. Resided difficulty holding he included, in part, but transfers, and enconeeds for assistant. A complaint/grieval.	nimum Data Set (MDS) 12/13/18 indicated Resident as fully intact. She had no rejection of care. Resident #49 sive assistance of 1 for bed ing and 2 or more for transfers. It incontinent of bladder and it of bowel. Sessment (CAA) related to the for Resident #49 's 12/13/18 dicated she was alert, oriented, decisions and communicate the indicated she had a history did that she could feel a adder, but it was difficult to an for Resident #49 included, in areas: did an Activities of Daily Living rformance deficit related to ascular Accident (CVA) and The interventions included, in that tasks of washing hands, and cleaning self in relation to did altered bladder elimination did contractures of the right hand in the year of the year of the year of the year in the year of the year of the year in the year i	F 67	incontinence care, bathing a personal hygiene, including 2/8/2019. Staff will not be a return to work until educatio 4. RDCS and or DON will c monitoring (audit) and observesidents receiving showers care and incontinent care, 3 week for 4 weeks, then wee months. The DON will reporesults of the quality monitor and report to the QAPI comprision of the personal report to the QAPI comprision will be reviewed by committee monthly and Qual (audit) updated as indicated	nail care by allowed to on complete. conduct quality rvation of 5 s/bathing, nail 3 times per ekly for 3 ort on the ring (audit) mittee. y QAPI ality monitoring i.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2010
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F 677	waited for her call lig form had been review assigned to the DON An interview was cor	ned about how long she ht to be answered. This wed by the SW and was I for investigation. nducted with Resident #49 on	F 6'	77	
	written by the HRC the concern with how lore be answered was resulted that in the pressed her call bell. She indicated it took to be answered. She brief during that time her urine. She reveatives soaked with uring the concern was soaked with uniter the concern with the concern	The grievance dated 1/8/19 nat discussed the resident 's ng it took for her call light to viewed with Resident #49. The early morning on 1/8/19 she because she had to urinate. The over 2 hours for her call bell to estated she urinated in her as she had difficulty holding alled she sat in her brief that the until her call bell was C. She stated the DON then continent care.			
	phone on 1/9/19 at 8 she spoke with Resident told	I Services (DSS) staff by :09 AM. DSS staff stated dent #49 yesterday, 1/8/19, her she sat in a r over 2 hours after pressing			
	1/9/19 at 2:40 PM. Treport dated 1/8/19 reviewed with the HF walking the halls on Resident #49's call room and asked the something she could informed her she had needed "cleaned up"	nducted with the HRC on The complaint/grievance elated to Resident #49 was RC. She stated she was 1/8/19 when she saw light on, so she entered the resident if there was help with. Resident #49 d been waiting awhile and to turned her call light on at			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		03/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	7:10 AM when she of the call light. She sodor of urine in the Resident #49 was when she spoke with speaking to Resider and Administrator to An interview was confully 19 at 2:30 PM. provided incontinen 1/8/19 after the HRC resident 's call light had been on for over that Resident #49 horeported Resident #49 horeported Resident #40 horeported	ge 106 C estimated it to be around entered the room to answer tated there was no obvious room. She indicated that isibly upset and was crying h her. She said that after nt #49 she went to the DON or report the information. Inducted with the DON on She reported she had to care to Resident #49 on C reported she answered the and the resident said her light er 2 hours. The DON stated ad urinated in her brief. She 49 was visibly upset and was ovided care. The DON steed call bells to be answered the nursing schedule and	F 6'	77		
	DON confirmation of #2 and NA #1 were the third shift on 1/7 and ending on 1/8/1 A phone interview won 1/9/19 at 3:00 Pl assigned to Resider beginning 1/7/19 and that 2 NAs were wo entire building and the Resident #49. Nurs Resident #49 's cal extended period of 1/8/19. He was 2 hours for Resident	n 1/9/19 at 2:45 PM, Nurse assigned to Resident #49 for /19 beginning at 11:00 PM				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CO 625 ASHLAND STREET ARCHDALE, NC 27263	DE	03/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 677	answer call lights tim meeting the resident An interview was cor at 3:15 PM. He conf Resident #49 during 1/7/19 and ending 1/ working a double that second shift 1/7/19 a shift ending 1/8/19. 2 NAs working the the each had about 30 rehad not recalled Reson for an extended promorning on 1/8/19, but surprise to him. He difficulty meeting resthere were only 2 NANA #1 reported that the past that it was diresidents ' needs tim	t was difficult for them to ely which caused a delay in	Fé	677		
	1/8/19 at 10:30 AM has the Administrator 2018. He revealed tobtaining and maintathree shifts since he When asked what histaffing was he state enough staff both in to meet the needs of During an interview of	with the Administrator on the stated he began working at this facility in June of that the facility had difficulty the stated has to staff all the began as the Administrator. The staffinition of sufficient that sufficient staffing was terms of quality and quantity				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 3/06/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	of 2018. She confirm interview related to the obtaining and maintal three shifts. She start normally staffed with that one day recently as an NA on the 3rd who were on the schunable to find anyone. An interview was con Administrator on 1/9/indicated he spoke wafter the grievance wistated that Resident had to wait a long time answered. The Adminivestigation into this beginning. He stated resident to wait over answered. 2. Resident #44 was facility on 8/21/18 and on 12/18/18 with diag Sclerosis (MS). The quarterly Minimulassessment dated 11/444 is cognition was behaviors and no rejerequired the extensive bed mobility, dressing hygiene. She was defined the start of the medical record in the start of	e DON at the facility in June ned the Administrator 's ne facility having difficulty ining enough NAs to staff all ted that third shift was 2 or 3 NAs. She revealed she had to come in to work shift because 1 of the 2 NAs edule called off and she was else to fill in. Inducted with the 19 at 10:20 AM. He with Resident #49 on 1/8/19 has reported by the HRC. He with Resident #49 on 1/8/19 has reported to him that she he for her call bell to be inistrator indicated the grievance was just at it was unacceptable for a 2 hours for a call bell to be initially admitted to the dimost recently readmitted gnoses that included Multiple	F 6	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING	B WING		C 03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REHAL	L	1	S1 62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263	<u> U3/</u>	06/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Wednesdays and Sathard copy shower/bathard copy shower/bathard conducted and revea - Saturday 12/1/18 shower/bath sheet was - Wednesday 12/15 shower/bath sheet for - Wednesday 12/15 discharged to the hose - Saturday 12/15/16 the hospital on 12/15/16 hospital on 12/15/16 shower/bath sheet was - Saturday 12/2/17 readmitted on 12/18/18 shower/bath sheet was - Saturday 12/22/18 shower/bath sheet for - Wednesday 12/2 was documented as was documented as was documented as was documented as was sheet Saturday 12/29/18 shower/bath sheet for - Wednesday 1/2/18 shower/bath sheet for - Wednesday 1/2/18 shower/bath sheet for - Wednesday 1/2/18 shower/bath sheet for - Wednesday 1/5/19: shower/bath sheet for - Saturday 1/5/19: shower/bathay 1/5/1	er/bathing schedule 44 's shower/bath days were furdays. A review of the th documentation from 9 for Resident #44 was led the following: 8: Resident #44 's as blank. 7/18: Resident #44 had no 12/8/18. 2/18: Resident #44 was spital on 12/12/18. 8: Resident #44 was 18 and the 12/19/18 as blank. 8: Resident #44 had no 12/22/18. 6/18: Resident #44 's hair washed on the shower/bath 8: Resident #44 had no 12/29/18. 19: Resident #44 had no 12/29/18. 19: Resident #44 had no 12/15/19. 6or Resident #44 had no 11/5/19. 6or Resident #44 indicated Activities of Daily Living 15. The interventions 16. Was dependent on 1 staff ning. 6ervation were conducted	F	677				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	1 00/	00/2010	
WESTWO	OD HEALTH AND DEHA	DILITA		625 ASHLAND STREET				
WESTWO	OD HEALTH AND REHA	BILLIA		ARCHDALE, NC 27263				
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F 677		appeared uncombed and	F 6	677				
	baths over showers at this preference. She concern with getting It that her hair was sup shower/bath days where Wednesdays ar her hair was not alware Wednesdays ar her hair was not alware scalp was itchy when twice per week. She hospital in the middle week and that she on since she returned from An interview was con Assistant (NA) #1 on stated that he was on third shift, but that he second shift as well. With Resident #44 and dependent on staff for needs. He indicated of bed and she prefer the stated that hair was provided for depended on their shower/bath the facility had difficul NA staff to fill all three	ducted with Nursing 1/9/19 at 3:58 PM. He iginally hired to work the frequently worked first and He reported he was familiar d he stated that she was r her bathing and grooming Resident #44 rarely got out rred to receive bed baths. ashing was supposed to be nt residents twice per week day. NA #1 revealed that ity obtaining and maintaining e shifts and that sometimes						
	another shift or anoth was not able to get al He explained that the be prioritized first and on the top of the prior	eshing were pushed to er day if the assigned NA I of their tasks completed. more critical tasks had to I that hair washing was not rity list. with the Administrator on						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG	· /	OMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		1 00:00:20:0	
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F 677	as the Administrator 2018. He revealed to obtaining and maintathree shifts since he When asked what hi staffing was he state enough staff both in to meet the needs of During an interview (DON) on 1/9/19 at 3 began working as the of 2018. She confirminterview related to the obtaining and maintathree shifts. She indowere asked to work work double shifts, had been going on for caused some of the acknowledged her anneeds had been miss. A follow up interview Director of Nursing of both indicated that the care needs to be metheir expectation was to meet the resident. 3. Resident #36 was diagnoses of neurop with activities of dail. A review of the residence and the review of the residence and the resident activities of dail.	ne stated he began working at this facility in June of that the facility had difficulty aining enough NAs to staff all began as the Administrator. It is definition of sufficient and that sufficient staffing was terms of quality and quantity of the residents. With the Director of Nursing 3:31 PM she stated she is a DON at the facility in June med the Administrator is the facility having difficulty aining enough NAs to staff all dicated that staff members additional shifts and/or to The DON indicated that this for several months and had staff to be exhausted. She wareness that essential care sed. With the Administrator and for 1/10/19 at 2:31 PM. They help expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They help expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and for 1/10/19 at 2:31 PM. They have expected residents in ADL at the Administrator and th	F6	77			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 677	bathing, grooming are care plan included the call out or whistle who addition to using the A review of the admit (MDS) dated 10/8/18 an intact cognition. extensive assistance bathing and inconting 3a. A review of Resident sheets from admission the resident did not reshowers per week. documented as havin November 30, 2018 18, 2018 on second On 1/7/19 at 10:30 a conducted with Resident received his two scheduled. The resident did not received his two scheduled. The resident at 1:00 and a conducted with a family who stated she was he had not received week in December 2 observed that the recurrently dirty, including member commented to have a bath herse On 1/8/19 at 10:25	Interventions were for and incontinence care. The last the resident would also be assistance was needed in call light. In a sion Minimum Data Set arevealed the resident had a resident required a of 2 persons for transfer, ence care. If #36 's documented shower on 10/1/8 to 1/10/19 revealed receive his scheduled two are sident was not not a second shift, December shift, and January 4, 2019. In an interview was dent #36 who stated he had showers per week as dent stated that he only had k and none the week before. If an interview was not not second shift, December shift, and January 4, 2019. In an interview was dent #36 who stated he had showers per week as dent stated that he only had k and none the week before. In an interview was not sident #36 informed by the resident that a shower during the last only. The family member sident 's hygiene was ling his hair. The family that she assisted her father lif.	F6	577			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 677	for an entire shift as staff shortages. It w assignment to include which included show that if there was not be rescheduled. The the resident 's show documented then the TN was aware that s received their showed. On 1/8/19 at 1:15 pr with Nursing Assistate cared for Resident # was currently a nurst facility. NA #8 stated assigned to her on the showed that Resident #36 has her. The resident was known. NA #8 stated document when the shower on the resider refused to let the nurcommented that if the	frequently being re-assigned a nursing assistant due to as not uncommon for an le 17 residents on day shift vers. The TN commented enough time showers would be treatment nurse stated if	F6	777			
	with Nurse #9, who is #36. Nurse #9 stated nursing assistants so her shift and was reassistant for an entire	n an interview was conducted regularly cared for Resident d there was a shortage of o she assisted them during assigned as a nursing e shift more than one day a s not aware that Resident #36					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 677	week and stated he 1/8/19 at 10:30 am a with the Administrate been several staff re To temporarily resolv shortage, licensed in the nursing assistan nursing assignment. over the past 3 mon expected residents to scheduled and if del on the next shift or in On 1/10/19 at 2:00 p conducted with the I who stated that she to provide showers to and if there was a re nurse for interventio that there was a nur and nurses where re DON stated that the important tasks such due to the shortage. the shower sheets w completed/documen provided to the resic 3b. On 1/7/19 at 10:30 a conducted with Resi not always received	an interview was conducted or who stated that there had esignations and terminations. We the nursing assistance curses have been assigned to trole, but not taken from a The shortage had been ths. The Administrator to receive showers as ayed to complete the shower next day. The man interview was Director of Nursing (DON) expected nursing assistants to the residents twice a week efusal to report this to the n. The DON further stated sing assistant staff shortage eassigned to assist. The re were times when lesser in as showers were postponed. The DON commented that if were not atted then the shower was not dent.	F 6	77		
	needed and had got to his bed on a few of when his family mer The resident comme	ten soaked through with urine occasions. The last time was onber assisted him with a bath. ented that at times he had to cond to his call light. The				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION	
F 677	Continued From pag	e 115	F 6	77		
	assistance because respond to the light.	ould call out or whistle for the staff did not always The resident stated one a e had to wait up to 45 ce.				
	informed by the residence time for staff to answer called out for staff as member had observed. December that the rehis undergarment and family member community member community time frame.	amily who stated she was dent he had to wait a long ver the call light and when he ssistance. The family				
	conducted of the res the TN who was ass duties today. The re soaked through with	im an observation was ident 's incontinence care by igned to nursing assistant sident 's undergarment was urine. The resident nad put his call light on for				
	with Nursing Assista cared for Resident # was currently a nurs NA #8 stated she ha her on two different I incontinence care was sometimes delayed. aware Resident #36 to summon staff for a	n an interview was conducted nt (NA) #8 who regularly 36. NA #8 stated that there ing shortage at the facility. d 17 residents assigned to nalls. NA #8 stated that as always completed but was NA #8 stated that she was used calling out or whistling assistance.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 677	the 2-hour schedule a also commented that or requested incontin- provide care	ON who stated she provide incontinence care on and as needed. The DON if the resident was observed ence care the staff should	F 67			
F 686 SS=K	S483.25(b) (1) Skin Integ §483.25(b) (1) Pressure Based on the compressional standard pressure ulcers and culcers unless the indidemonstrates that the (ii) A resident with prenecessary treatment with professional star promote healing, prevnew ulcers from deverthis REQUIREMENT by: Based on record revisional practitioner interview, daily pressure ulcer with the care Nurse Practitioner interview, daily pressure ulcer with the second care with the c	re ulcers. hensive assessment of a nust ensure that- s care, consistent with ls of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent loping. is not met as evidenced ew, observations, staff d family interview, wound er interview, and Nurse the facility failed to provide vound care as ordered,	F 68	F686- Treatment/Svcs to Prevent/ Pressure Ulcer 1. On 1/8/2019 resident #36 had w care provided by a licensed nurse. Resident #36 had a pressure reduce	ound	4/3/19
	documentation, and coutside podiatrist who in worsening, increas pressure ulcer (Residually pressure ulcer weekly wound measure	rement/assessment and communication with the b was also treating, resulting e in size and infection of the ent #36); failed to provide yound care as ordered, rement/assessment and ing in a worsening pressure		mattress and pad on bed and when 10/1/18. Resident #36's heels were floated and he was provided an off boot for therapy 10/11/18. Wound was provided to Resident #36's he starting 1/10/19 as ordered by the physician and his wound was asseweekly for signs of improvement by	e loading care el daily ssed	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
				62	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	BILITA		Α	RCHDALE, NC 27263		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 686	Continued From page		F	686			
	ulcer (Resident #1); a	and failed to provide daily			licensed nurse starting 1/23/19. Reside		
	•	d care as ordered and			#36 was followed by his physician star	-	
	·	urement/assessment and			on admission to facility on 10/1/2018, a		
	,	dent #44) for 3 of 4 sampled			his care plan was updated on 1/29/19	-	
	residents reviewed for	or wound care.			the MDS nurse. Resident #36's wound		
					resolved on 2/8/2019 and he was		
		began on 11/6/18 when staff			discharged 2/20/2019. Daily wound ca		
		sure ulcer care with resulting			was provided starting 1/10/19 following)	
		t #36. Immediate Jeopardy			doctors orders. Corporate Human	:41-	
		19 when the facility provided			Resources and Regional staff worked	with	
	and implemented an	•			the Interim Executive Director to	_	
	_	ate Jeopardy removal. The			implement staff recruitment practices to	5	
		t of compliance at a lower evel to ensure monitoring of			ensure the center was appropriately		
	systems are put in pla				staffed (center achieved appropriate staffing on 02/08/19).On 01/22/19 a roo	ot	
	employee in-service				cause analysis was completed by the	J.	
	ciripioyee iii service	training.			Regional Vice President of Operations		
	The facility was also	cited at a scope and			Regional Director of Clinical Services,		
		iciency that constitutes a			Director of Nursing and the Divisional	0	
		n that is not Immediate			Executive Director (acting administrato	r)	
	Jeopardy) for examp				and determined that the Executive	,	
		nt #44) was cited at a scope			Director failed to provide consistent		
	and severity of "E."	Findings included:			staffing to ensure treatments were		
					completed as ordered. Resident #1 w	as	
	1. Resident #36 was	admitted on 10/1/18 with the			provided daily wound care beginning		
	diagnoses of Parkins	on's, neuropathy, diabetes,			1/12/19 by licensed nurse. Resident #1		
		right heel unstageable, and			and #44 wounds was measured and		
	need for assistance v	with activities of daily living.			assessed weekly by licensed nurse		
					beginning 1-23-19. Resident #44 was		
		ent ' s care plan dated			provided daily wound care beginning		
	_	als and interventions for			1-10-19 by licensed nurse.		
	pressure ulcer prevei	ntion and status.			0 0 0 0/4 E/2040 # - D: 1 12 1		
	A rovious of the ad	naion Minimum Data Cat			2. On 2/15/2019 the Director of Nursin		
		ssion Minimum Data Set			completed a quality review of all currer	IL	
	•	revealed the resident had			resident treatment sheets, compared them to the treatment orders and		
	an intact cognition. T	of 2 persons for transfer,			observed treatments to ensure that		
		•					
		ence care. The resident had ssure ulcer on the side of the			residents were provided wound care as ordered. There are three current reside		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010	
				625 ASHLAND STREET		
WESTWO	OD HEALTH AND REH	ABILITA		ARCHDALE, NC 27263		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
F 686	Continued From pag	ge 118	F 686	3		
	right heel.			with pressure sores. Current residen	ts	
				with wounds are followed by wound		
		lent ' s physician progress		physician associated with the medica	I	
		lated 10/1/18 revealed the		director's practice or a Vascular Surg		
		eral heel had a small area		Residents with wound care had their		
	with yellow/brown di	rainage, no erythema or odor.		plans reviewed on 2/27/19-2/28/19 to		
	A	::::::::::::::::::::::::::::::::::::::		ensure that the facility addressed the		
		sician order dated 10/1/18 of the heel cleanse with		pressure sores comprehensively to	na of	
		ry, apply antibiotic ointment,		prevent worsening and promote heali the pressure sores. Residents with	rig oi	
		sterile dressing each day.		pressure ulcers had their care plans		
	and cover with dry s	nerile dressing each day.		reviewed on 2/28/19 by the divisional		
	A review of the resident 's October 2018			MDS nurse. Resident's wounds are		
		ation record (TAR) for		observed weekly starting 1/23/19 and	1	
		the right heel pressure ulcer		measured by the treatment nurse. Th		
	revealed there was	no documentation for wound		facility's treatment nurse coordinates		
	care dates 10/6-8, 1	0/13-14, 10/17-18, 10/20-21,		outside services as needed and/or as	;	
	and 10/27-28.			ordered with collaboration with the		
				physician. Current residents with wou	ınds	
		dent 's wound culture lab		are followed by the wound physician		
		led an infection of methicillin		associated with the Medical Directors		
		ccus aureus (MRSA) of the		practice, or a Vascular Surgeon. The	i a	
	side of right heel.			physician notes are sent to the facility secure server email for the Director		
	A review of the resid	dents November 2018 TAR for		Nursing's review and then they are file		
		the right heel pressure ulcer		the medical record. On 2/15/19 the	50 III	
		no documentation for wound		Director of Nursing began observing		
		, 11/23-25, and 11/20.		treatments on 3 pressure wounds and	d 2	
		,		non-pressure related wounds (3 resid		
	A review of the resid	lent ' s physician progress		per day, 3 days per week).On 2/15/20		
		revealed an unstageable		the Director of Nursing completed a		
	· · ·	e right heel which was present		quality review of all current resident		
		positive MRSA culture.		treatment sheets, compared them to		
	There was an order for Doxycycline 100 mg			treatment orders and observed treatment		
	(antibiotic) ordered.			to ensure that residents were provide		
				wound care as ordered. There are thr		
		dent 's physician progress		current residents with pressure sores		
		revealed the resident had a		Current residents with wounds are	tad	
	pressure uicer to his	right heel which was present		followed by wound physician associate	iea	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 3/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	•	3/00/2013	
				625 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION DATE	
F 686	Continued From page	e 119	F 68	86			
	on admission. The re	esident was his own		with the medical director's prac	ctice or a		
	responsible party.			Vascular Surgeon. Residents	with wound		
				care had their care plans review			
		cian 's progress note dated		2/27/19-2/28/19 to ensure that	the facility		
		e resident was treated for		addressed the pressure sores			
		el. The resident finished his		comprehensively to prevent wo			
		and contact precautions		and promote healing of the pre			
	were no longer need	ed (healed).		sores. Residents with pressure			
	A ravious of the regide	ent 's December 2018 TAR		had their care plans reviewed of			
		of the right heel pressure		by the divisional MDS nurse. R wounds are observed weekly s			
		was no documentation for		1/23/19 and measured by the t			
		/1-2, 12/5, 12/7, 12/15-17,		nurse. The facility's treatment r			
	12/21-23, 12/25, and			coordinates outside services as			
	, , , , , ,			and/or as ordered with collabor	ration with		
	Physician progress n	ote dated 12/27/18 revealed		the physician. Current resident	s with		
	a resident decline se	condary to Parkinson ' s		wounds are followed by the wo	und		
	disease. The resider	nt was followed by wound		physician associated with the N	√ledical		
	T	Center outside the facility)		Directors practice, or a Vascula			
	for the side of the rigi	ht heel pressure ulcer.		The physician notes are sent to	-		
				via secure server email for the			
	On 1/7/19 at 10:45 at			of Nursing's review and then th	ey are filed		
		esident who stated his right was not always changed		in the medical record.			
	every day.			3. The Director of Nursing and			
	0 4/0/40 14 57			Consulate Healthcare Executiv			
		an interview was conducted		and Director of Nursing provide			
		ated that the resident had a		re-education to facility licensed			
		nt side of heel that was n and the dressing change		including all shifts, part-time an providing treatments as ordere	•		
	was completed by the			physician and recording the tre	-		
				a TAR by 2/8/2019. The Division	onal Quality		
		an observation was done of		Educator provided education to			
	_	neel pressure ulcer wound		Director of Nursing and Treatm			
	-	t nurse (TN). The dressing		on treatment procedures begin	•		
		dated 1/4/18 and was yellow purulent drainage and		02/28/19 and on an on-going b Divisional Quality Educator pro			
	•	rated (wet, white, and		additional one on one training a			
	peeling) around the e	•		completed a clean dressing ch			

AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345450	B. WING		ı	C / 06/2019	
NAME OF PROVIDER OR SUPPLIER	0.0.00	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/06/2019	
NAME OF TROVIDER OR OUT FIER						
WESTWOOD HEALTH AND REHABIL	.ITA		625 ASHLAND STREET			
			ARCHDALE, NC 27263			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 686 Continued From page 1	20	F 68	66			
A review of the January change of the right heel the dressing was docum 1/1, 1/4 and 1/8. On 1/8/19 at 10:25 am a conducted with the TN versponsible for all reside frequently being re-assigned to staff shortage. The was not in the role of treassigned floor nurse was wound care for their reseast that she had been reass months and residents have wound care. On 1/8/19 at 3:10 pm are with the treatment nurse resident 's right heel protect the date she placed on the date of 1/4/18. The TN is the treatment administration was the last nurse to do resident's right heel drest commented that if the The signed/documented the changed which included back to October 2018. 1/8/19 at 10:30 am an in with the Administrator we been several staff resign terminations. To temporal assistance shortage, lice	2019 TAR for dressing pressure ulcer revealed nented as being done on an interview was who stated that she was genet treatments but was gned to nursing assistant the TN stated when she eatment nurse the s responsible to provide idents. The TN stated signed for the past four ad not received their daily in interview was conducted a (TN) who stated the essure ulcer dressing had the gauze from last week, tated she referred back to ation record (TAR) and cument/change the sing on 1/4/18. The TN AR was not dressing was not at this resident 's care		competency evaluation with the Nurse on 02/28/19. Licensed nurvere re educated by the DON an Regional Director of Clinical Servassessing status of wounds on a basis and with treatments and promote healing by 3/3/2019. Licensed nurses notify the physician if ther change to a wound, in collaboration the physician a referral may be methodologically the physician are ferral may be methodologically the physician are ferral may be methodologically preventative measures for prevere wounds, following care plan related devices and relieving pressure by of Nursing, Regional Director of Oservices and Divisional Executive by 3/3/19. Staff will not be allowed return to work until education con New hires will be provided the sattraining on hire prior to getting an assignment. The facility employed time treatment nurse. If the treated nurse is unavailable it will be communicated to the licensed nuthe Director of Nursing to provide treatments as ordered by the phy Licensed staff has the capacity to complete their assignments, inclustreatments within the parameters work schedule. If the licensed nucannot complete the treatment we parameter of their work schedule licensed nurse will report the issurbirector of Nursing. The Director Nursing will grant overtime to the	rses d vices on weekly oviding and censed e is a don with hade to de reporting , nting ed to y Director Clinical e Director ed to nplete. me a des a full ment drses by exician. Duding of their urse dithin the the to the of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
						С
		345450	B. WING			03/06/2019
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		
				625 ASHLAND STREET		
WESTWO	OD HEALTH AND RE	HABILITA		ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				DEFICIENCY	,	
F 686	Continued From page	age 121	F 68	36		
F 686	On 1/8/19 at 1:57 with Nurse #9 who pressure ulcer to hon admission and completed by the trace that she wadressing. Nurse assigned to the residuater learned that this dressing change there was no docurrecord the wound included prior mon 10/1/18. On 1/8/19 at 2:21 with the TN who stinfection of the rigit changing the residual placed him at risk nurse stated that the worsened by becondarinage and the cowas now moderate further commented resident to a podial because they were being changed by by what the resider resident saw the peractitioner could	pm an interview was conducted a stated that the resident had a his right heel that was present the dressing change was creatment nurse. Nurse #9 also is not responsible to change the #9 stated that she was sident on 1/7-9/19, she had not ent's right heel dressing and he resident had not received ge by the treatment nurse. If it mentation in the resident's care was not done which with back to his admission of the pm an interview was conducted fated the resident acquired an intelligent in the pressure ulcer. Not ent's pressure ulcer dressing for an infection. The treatment he right heel wound had ming larger with increased drainage that was scant serous the creamy yellow. The TN is that the family took the entire the right heel wound entire the date on the dressing was not the date on the dressing and int stated. On the weeks the odiatrist the wound care Nurse not treat the resident. The	F 68	responsibility to another nurse with the task. The Director of and/or Minimum Data Set Niccomplete the assessment are measurements if the treatments if the treatment completed. The Director of Niccompleted in the provide additional education dressing and competency sk beginning on 03/01/19. Lice not return to work until education in the treatment in the treatment in the treatment in the treatment in the procedures beginning on 02/08 decently in the procedures beginning on 02/08 decently in the procedures in the Director of Niccompleted in the Director of Niccompleted in the Director in the Director of Niccompleted additional training and completed additional training and completed additional training and completed a conference in the Procedures in the Regional Viceoperations and the Regional Clinical will monitor staffing in ensure adequate staffing is respectively.	of Nursing urse will and ent nurse is Nursing will viding k, to ensure tion are Jursing will on clean kills checklist ensed staff will ation is n Resources ith the Interimment staff ure the center achieved 8/19). The provided Nursing and or treatment 1/28/19 and on sional Quality I one on one expetency of Nurse on the President of I Director of evels to maintained.	
	because there was at the facility nor d notes, the resident and when the wou increased drainage	was not followed by the facility is no weekly measurement done id the facility obtain the podiatry it's dressing was not changed, and had gotten larger with the facility's medical nurse and care nurse practitioner had		On 2/7/19 the Regional Vice Operations and Regional Dir Clinical Services began mon staffing of direct care per resusing morning meeting and i portal. If a staffing challenge itself and the treatment nurse	rector of litoring daily sident per day internal labor e presents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345450	B. WING		C 03/06/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				625 ASHLAND STREET	
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F 686	Continued From pag	e 122	F 686	6	
	not assessed the wo	und.		cart, the Director of Clinical Services	will
				complete that day's treatments that a	re
		n an interview was conducted		ordered.	
		lursing (DON) who stated			
	that she expected sta	aff to complete all treatments		Regional Director of Clinical Service	
	as ordered.			and or Director of Nursing will condu	ct
	0 44040 4000			quality monitoring (audit) including	
	On 1/10/19 at 9:00 a			observation of resident treatments ar	
		ound care Nurse Practitioner ded on the residents for		documentation for 3 residents (rotating residents), 3 times per week for 4 week	_
		each week with the facility's		then weekly for 3 months. The Direct	
		e to staff shortage, the TN		Nursing will report on the results of the	
		not available to assist each week to measure		quality monitoring (audit) and report	
		ident #36 was being seen		QAPI committee. Findings will be	
		odiatrist. The wound care		reviewed by QAPI committee monthl	y and
	Nurse Practitioner st	ated she observed Resident		Quality monitoring (audit) updated as	;
	#36 's right heel pre	ssure ulcer during nursing		indicated. The results of the quality	
		nd assessed that the wound		monitoring will be brought to the Qua	-
	_	ncreased drainage than last		Assurance Performance Improvemen	
	•	measured the wound) but		meeting by the Director of Nursing fo	
		ne was aware that the		review of on going wound care month	
	•	d a MRSA infection of the		The Executive Director will provide d	
	_	month but was not aware		on staffing to the QAPI committee for review of any staffing challenges. Qu	
	_	s not changed as ordered e to change the dressing		Improvement monitoring schedule wi	-
		at high-risk to acquire a		modified based on findings of monito	
	· ·	would have contributed to his		The center Executive Director convergence	
	prior MRSA infection			an ADHOC Quality Assurance	, • •
	· .	ound that was not cared for		Performance Improvement meeting	
		was high-risk cause for		02/22/19, including the Interim Execu	ıtive
	MRSA to infect an or	pen wound with accumulating		Director, Director of Nursing, the SD0	Ͻ,
	wound drainage in th	ne dressing.		Director of Rehab, MDS Nurse,	
				Housekeeping Manager, the Busines	
		se Practitioner went on to		Office Manager, the Human Resource	
		the DON for the resident 's		Coordinator, Medical Records, Centr	al
		ney were not provided to her		Supply Clerk, Admissions Director,	
		esident 's medical record.		Dietary Manager, Activity Director an	d the
		she was aware of the		Environmental Services Director	
	nursing staff shortag	e, made aware that wound		regarding the plan of removal of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345450	B. WING			C		
NAME OF P	ROVIDER OR SUPPLIER	0.101.00		STREET ADDRESS, CITY, STATE, ZIP CODI		3/06/2019		
				625 ASHLAND STREET				
WESTWO	OD HEALTH AND REH	ABILITA		ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 686	Continued From pag	ge 123	F 68	6				
	care and measurem had brought her corcouple of months. The Practitioner stated the treat and measure the facility by a podi. On 1/10/19 at 9:30 a conducted with the facility by a podi. The Practitioner who state heel pressure ulcer around the edges an order due to the faile and wound status of facility Nurse Practitiusually followed the wound because her	ents were not completed, and ocerns to the DON in the past. The wound care Nurse nat she could not evaluate, the resident 's wound on a see he was being seen outside atrist (duplication of services).		immediacy. 5. Date of Compliance 4/3/20	19.			
	no podiatry notes in resident. The DON obtain a copy from the Conducted with the informed by the DO as NA for 1/7, 1/8, a responsible for facilit treatments would be each hall responsible required a treatment on 1/10/19 at 10:12 conducted with the line of the DO as NA for 1/7, 1/8, a responsible for facilities are the conducted with the line of the DO as NA for 1/10, 1/	OON who stated there were the facility record for the stated she would attempt to						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
			A. BOILDI			С	
		345450	B. WING			03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA	•	STREET ADDRESS, CITY, STATE, ZIP COD 625 ASHLAND STREET ARCHDALE, NC 27263	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 686	on 1/7, 1/8, and 1/9 complete the treatm residents in the after duties. On 1/9/18 the accompany the surright heel dressing of was made aware the 1/4/19 and that the changed for 4 days, she was not aware complete treatments her NA day shift on stated that she was treatments and had wound care on 1/7, she agreed there we complete the reside also stated that the outside podiatrist and the end of the surthere were no podiate provided by the facility credible allegation of removal: The center Executive of immediate jeopard 1. The corrective practice was accommon 1/8/2019 resider	and expected the TN nurse to ments on all the facility emoon after her NA day shift the DON allowed the TN to eveyor to observe resident 's change. The DON stated she at the dressing was dated dressing had not been. The TN nurse stated that that she was responsible to sincluding wound care after the three days. Nurse #7 not responsible for not completed the resident 's 1/8, and 1/9. The DON stated as a breakdown in o who was responsible to ent's treatments. The DON resident was seen by an and would obtain the records. Try on 1/10/19 at 5:00 pm atry records for the resident lity. Ind DON were notified of the y on 3/4/19 at 1:00 pm. Ty provided the following of Immediate Jeopardy The DON to the resident literature of the growth of t	F	686			

1. /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	COMPLETED		
		345450	B. WING			C 03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	<u> </u>	3370072013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 686	wheelchair 10/1/18. floated, and he was for therapy 10/11/18 to Resident #36 's hordered by the physiassessed weekly for licensed nurse starting was followed by his admission to facility plan was updated or Resident #36 's wou he was discharged 2 was provided starting orders. Corporate Human Reworked with the Intelement staff recrute center was approachieved appropriate. On 01/22/19 a root of completed by the Recompleted by t	attress and pad on bed and Resident #36's heels were provided an off loading boot Wound care was provided eel daily starting 1/10/19 as cian, and his wound was signs of improvement by the ng 1/23/19. Resident #36 ohysician starting on on 10/1/2018, and his care of 1/29/19 by the MDS nurse. Independent of 1/20/2019 and 1/20/2019. Daily wound care of 1/10/19 following doctor's resources and Regional staff from Executive Director to uitment practices to ensure extra printerly staffed (center extra printerly	F 68	36				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 686	three current resided Current residents wi wound physician as director 's practice of Residents with wour reviewed on 2/27/19 facility addressed the comprehensively to promote healing of the Residents with presiplans reviewed on 2 nurse. Resident 's with starting 1/23/19 and nurse. The facility 's outside services as with collaboration with collaboration with collaboration with wound physician as Directors practice, or physician notes are server email for the review and then the record. On 2/15/19 the Directors of Nurse and the pressure related the pressure related to the pressure related to the pressure of Nurse the pressure of Nurse the pressure provided restaff, including all shoroviding treatments.	th wounds are followed by sociated with the medical or a Vascular Surgeon. Indicate had their care plans 19-2/28/19 to ensure that the ele pressure sores prevent worsening and the pressure sores. Source ulcers had their care 1/28/19 by the divisional MDS wounds are observed weekly measured by the treatment of treatment nurse coordinates needed and/or as ordered with the physician. Ith wounds are followed by the sociated with the Medical or a Vascular Surgeon. The sent to the facility via secure to Director of Nursing 's y are filed in the medical of the sociated wounds (3 residents per sk).	F 686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345450	B. WING _		 	03/	06/2019		
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE				
MESTMO	OD UEALTH AND DEHAL	DIL ITA		625	S ASHLAND STREET				
WESTWO	OD HEALTH AND REHA	BILITA		AR	CHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
					DEFICIENCY)				
F 686	Continued From page	e 127	F 6	886					
	education to the Direct	ctor of Nursing and							
	Treatment Nurse on t	•							
		9 and on an on-going basis.							
	The Divisional Quality								
	additional one on one	training and completed a							
		e competency evaluation							
	with the Treatment No	urse on 02/28/19.							
		re reeducated by the DON							
	_	r of Clinical Services on							
	_	ounds on a weekly basis							
		and providing wound care to							
	improve wounds and								
		nurses notify the physician if							
	_	a wound, in collaboration							
		eferral may be made to the							
		ied Nurse Assistants will be							
		ing changes in resident skin							
		measures for preventing							
	_	re plan related to devices							
		e by Director of Nursing,							
	Regional Director of (
		Director by 3/3/19. Staff will							
		ırn to work until education							
		will be provided the same							
		o getting an assignment.							
		s a full-time treatment nurse.							
		e is unavailable it will be							
		licensed nurses by the							
	_	provide treatments as							
		cian. Licensed staff have the							
		their assignments, including parameters of their work				ĺ			
		•							
		sed nurse cannot complete				ĺ			
		he parameter of their work							
		d nurse will report the issue							
	to the Director of Nurs								
		ertime to the licensed nurse delegate the responsibility							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP 625 ASHLAND STREET ARCHDALE, NC 27263	CODE	00.	00.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 686	Director of Nursing an Nurse will complete the measurements if the unavailable. The Director of Nursing are completed. The Director of Nursing education on clean diskills checklist beginn staff will not return to completed. Corporate Human Resurred worked with the Interior of Nursing education on clean diskills checklist beginn staff will not return to completed.	ssist with the task. The nd/or Minimum Data Set ne assessment and	F	586			
	the center was approachieved appropriate Divisional Quality Edithe Director of Nursin regard to treatment p 02/28/19 and on an or Divisional Quality Editione on one training a evaluation with the Tr. The Regional Vice Pr. the Regional Director staffing levels to ensumaintained. On 2/7/19 President of Operation Clinical Services beg. of direct care per resimeeting and internal.	priately staffed (center staffing on 02/08/19). The ucator provided education to g and Treatment Nurse in rocedures beginning on n-going basis. The ucator provided additional nd completed a competency eatment Nurse on 02/28/19. esident of Operations and of Clinical will monitor are adequate staffing is 9 the Regional Vice ns and Regional Director of an monitoring daily staffing dent per day using morning labor portal.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 501251			(C	
		345450	B. WING			03/	06/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
WESTWO	OD HEALTH AND REHA	ABILITA			25 ASHLAND STREET			
				Α	RCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page treatments that are of Director of Nursing (audit) including obstreatments and dock (rotating residents), weeks, then weekly Nursing will report of monitoring (audit) are committee. Finding committee monthly a updated as indicated monitoring will be brown Assurance Performathe Director of Nursi wound care monthly provide data on staffor review of any s	ge 129 ordered. C Clinical Services and or will conduct quality monitoring servation of resident umentation for 3 residents 3 times per week for 4 for 3 months. The Director of n the results of the quality nd report to the QAPI swill be reviewed by QAPI and Quality monitoring (audit) d. The results of the quality rought to the Quality mance Improvement meeting by ang for review of ongoing of the Executive Director will fing to the QAPI committee offing challenges. Quality bring schedule will be indings of monitoring. The Executive Director will be indings of monitoring. The Director conveyed an an aurance Performance of 02/22/19, including the frector, Director of Nursing, and Rehab, MDS Nurse, ager, the Business Office on Resources Coordinator,		586				
		ector of Nursing on 3/1/19. ion of Immediate Jeopardy						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345450	B. WING			C 3/06/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C 625 ASHLAND STREET ARCHDALE, NC 27263					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 686	removal was validate which included: The 2/15/19 facility a confirmed 3 current region being followed by the with the medical direct Surgeon. Progress reach resident 's medical weekly observations, 1/23/19 for each resident. Documental weekly observations, 1/23/19 for each resident regarding care treatments in-serviewed and sign in provided. A review of Resident facility to home dated discharged to home of follow up with his phywere started, and medical treatments in the first visit schedul A review of Resident administration record 2019 revealed documents daily wound care. The resident was disavailable for observations of 1/25 are conducted with the Diservices/Director of 1/25 are conducted with the Diservices/Director of 1/25 are confident with the Diservi	udit was reviewed and esidents with wounds were wound physician associated ctor's practice or a Vascular notes were documented in dical record. Care plans ad been updated for each ation revealed there were measurements beginning dent, and wound care was d. the responsibility for wound ervice documentation was sheets for nursing was #36's discharge from the dical 2/20/19 revealed he was with family, was scheduled to visician, home care services edical supply was contacted. Ited was for 2/25/19. #36's treatment of January and February mentation that he received since the last survey. Charged to home and not tion and interview.	F 68	36				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDII		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP 625 ASHLAND STREET ARCHDALE, NC 27263	CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 686	dressing to prevent for resident was dischard home care services. completed daily the tot dedicated to wound cassigned staff nurse the wound care, and nurse was to inform to reassign. On 3/6/19 at 2:30 pm with the Treatment Nowas required to partice regarding abuse, neghow a failure to provice TN stated that if she can assigned staff nurse scheduler notified. Now education on how to wound measurement wounds. There has not the nursing assistant timeliness to provide improved now that the are now healing becaused in the past was fully staffed." The residents and/or their The last resident could 2019 identified that care were addressed the residents. All interested to the staff of the st	arther pressure. The ged to home with family and To ensure wound care was reatment nurse was are and if unavailable the was required to complete if unable the assigned staff the DON to complete care or an interview was conducted curse (TN) who stated she cipate in recent education lect, and exploitation and de care was related. The was unavailable to complete inform the DON and the would be assigned and the curses also received complete the treatments, and communication of new not been floating of nurses to	F	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP C 625 ASHLAND STREET ARCHDALE, NC 27263	ODE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 686	exploitation and how wound care) to meet related to neglect. On 3/6/19 at 5:30 pm with the Corporate Vi who stated he confer Human Resources D staffing plans includir recruitment and reter sufficient staffing. Or been hired and receivaccepting an assignm have occurred to enspatterns. 2. Resident #1 was a with cumulative diagrical history of a Deep Veil Review of Resident #Data Set (MDS) date Cognitive Pattern assigned the Mood (Section Dicompleted. She was with bed mobility, toil Resident #1 was cod incontinent of bladde for one stage 2 press Suspected Deep Tiss	not providing care (including the resident 's needs is an interview was conducted ace President of Operations enced with the Divisional irector and implemented and wage increases and antion plans to ensure a 2/7/19 sufficient staff had wed orientation prior to ment. Daily staffing meetings are sufficient staffing admitted to the facility 10/3/18 moses of Cirrhosis and a n Thrombosis. At 's admission Minimum and 10/10/18 revealed that the dessment (Section C) and and assessment was not a coded total staff assistance eting and personal hygiene. The ded as non-ambulatory and and bowel. She was coded sure ulcer and one sue Injury (SDTI) both	F	686					
	pressure reducing mapressure ulcer care. I prognosis of less that Services. Review of Resident #	n. Interventions included a attress to her bed and Resident #1 was coded for a n 6 months and for Hospice #1's Care Area Assessment ressure ulcers read she was							

PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING				06/2019	
	ROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET ARCHDALE, NC 27263	1 03/	00/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	SDTI and she was de activities of daily living. Review of Resident # dated initiated 10/17/her left heel on 10/17. Resident #1's wound healing. Interventions provide treatments as Review of a Hospice read Resident #1 had measuring approxima New orders were writ blister daily and float. Review of a Hospice changes in Resident #1 was her left heel blister had orders dated 10/12/18 was to be cleansed warea patted dry and the (two-sided wound corwith area with padding dressing. The dressing changed every Mondal Hospice nurse. Review of the Hospice through 10/22/18 rever provided Resident #1 Monday and Thursdal Review of a Hospice	and she was admitted with a appendent of the staff for her g. 1's skin/wound care plan 18 read she had a SDTI to 18. The goal was for was to show signs of included the facility was to cordered. Included the Hospice note cordered to be and the facility of the facility	F	686				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		STREET ADDRESS, CITY, STATE, ZIP COL 625 ASHLAND STREET ARCHDALE, NC 27263	•	00/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	hanging off her heel orders were written to with NS, pat dry ther cover with a non-adrand secure with a gachange was to be do Thursday and the Hocompleting Resident Review of the Hospithrough 10/31/18 review of the weekly dated 10/12/18, read area to her left heel. Review of a Hospice there was new order heel wound with Bet nonadherent dressing daily. The roare orders were dis Nurse at the facility. Review of the facility. Review of the facility. Review of the facility. Review of the facility. There was no evider treatment to her left 11/3/18, 11/4/18, 11/21/18, 11/22/18 1 There was no evider Evaluation Report for week of 11/16/18, 11/12/16/18. Review of the facility.	but not on the wound. New o clean her left heel wound in apply a Vaseline gauze, herent dressing, pad the heel auze wrap. The dressing one every Monday and ospice Nurse would be a #1's wound care. The notes from 10/22/18 wealed the Hospice Nurse of the Hospice Nurse of the Hospice Nurse of the Hospice Nurse of the Resident #1 an open of the Resident #1 an open of the Resident #1's left addine, cover the wound with a grand wrap with a gauze onto indicated the new wound cussed with the Treatment of (TAR) revealed no one of Resident #1's daily heel on 11/2/18, 10/18, 11/13/18, 11/16/18. The of a facility weekly Skin on the week of 11/09/18, the	F 6	86			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		03/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	#1's daily treatment to 12/7/18, 12/11/18 12/ and 12/29/18. Review of Resident # dated revised 1/3/19 was described as unsfor Resident #1's wou healing. Interventions provide treatments as Review of the facility no documented evide treatment to her left hand 1/8/19. During an interview of Treatment Nurse state Treatment Nurse at the 2017. She revealed to around July of August having difficulty obtain Nursing Assistants (Notat time due to the lanormally assigned as	o her left heel on 12/2/18, 19/18, 12/25/18, 12/28/18 1's skin/wound care plan read her area to the left heel stageable. The goal was and was to show signs of included the facility was to cordered January 2019 TAR revealed ance of Resident #1's daily eel on 1/1/19, 1/2/19, 1/4/19 In 1/8/19 at 10:14 AM, the ed that she had been the facility since October hat prior to sometime to 2018, the facility began	F6	DEFICIENCY)			
	1/10/19 read Resident follow up to her left her Resident #1's left her described as unstage 10% granulation, no descrous drainage. New Thera-honey (dressing grade honey) daily to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REH	IABILITA	6	STREET ADDRESS, CITY, STATE, ZIP CODE 525 ASHLAND STREET ARCHDALE, NC 27263	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 686	the Treatment Nurs that treatments wer ordered to Residen over a month. Review of the facilit revealed Resident of the facility revealed Resident of the facility was described as a goal was for Resides signs of healing. Into was to provide treat the facility of the	rview on 1/10/19 at 8:40 AM, se revealed she had concerns to not being provided as at #1 by the floor nurses for ty Weekly Wound Report #1 did not appear on the report until the week of 1/23/19. It #1's skin/wound care plan 19 read her left heel wound a stage 3 pressure ulcer. The ent #1's wound was to show terventions included the facility	F 686				
	Administrator stated Administrator of the recertification surve	on 3/6/19 at 12:20 PM, the dhe assumed the role of a facility shortly after the ey exit date of 1/10/19. He time he became aware of the					

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REH			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	ı	03/06/2019	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 686	was his expectation pressure ulcers recoordered. During an interview Director of Nursing with Resident #1 or there was no documulcer care to Reside she was unable to r 11/3/18 and 12/7/18 she likely didn't do. complete Resident and 12/7/18 it would didn't have time to to When asked who withe TARs to ensure administered as orce had been monitorin Administration Recomplete had been monitoring the During an interview #9 verified she work 11/4/18, 11/10/18 at she was unable to r Resident #1's treated days in question bu 2018 and December staffed, and communicated she was pulleand served as an air server in the condensation of the condensatio	ing all their ordered issues with staffing. He stated it at that all the residents with eive their treatments as on 3/6/19 at 1:38 PM, the (DON) validated she worked in 11/3/18 and 12/7/18 where mented evidence of pressure ent #1's left heel. She stated recall if she did treatments on 8 but if she didn't document, The DON stated if she did not #1's treatments on 11/3/18 in the did not with the didner of	F 68	36			
	completing treatment cart and when that responsible for complete.	nts and put on a medication happened, each nurse was pleting their own treatments. he did not have time to get					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			1	C 06/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2013	
				625	ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA			CHDALE, NC 27263			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWN)		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
F 686	Continued From page	e 138	F 6	886				
	her treatments done	on the days the Treatment						
	Nurse was pulled off	treatments, she would let						
	the DON know becau	se overtime would have to						
	be approved for her to	o stay over and complete						
		e #9 stated the DON would						
		mitted treatments, or the						
		the overtime for her to stay						
	over and complete th	em.						
	During an interview o	n 3/6/19 at 1:52 PM, Nurse						
	_	d with Resident #1 on						
	12/28/18, 1/1/19, 1/2/	19 and 1/8/19. Nurse #8						
	stated she was unabl	e to recall if she completed						
		ent to her left heel on the						
		stated during November						
		8 and January 2019, she						
		the medication cart to work						
		ort staffing. She stated the						
	Treatment Nurse was	s and she was put on a						
		rked as an aide too. Nurse						
		reatment Nurse was pulled						
		ments, the nurses were						
	responsible for comp	leting their own treatments.						
	Nurse #8 stated it wa	s very confusing and						
		I not know until the end of						
	_	n aide that her resident's						
		done. Nurse #8 stated she						
		N and it was up to her to						
		ertime to allow her to stay						
		eatments. Nurse #8 stated						
	she would either tell t	nts or the DON would tell						
		ete the missed treatments.						
	21 2112 11 22 II 20 II pi							
		n 3/6/19 at 2:00 PM, the						
		ed due to staffing she was						
		g treatment and either						
	worked on a medicati	on cart or as an aide up until						

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 33/33/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 686	recently. She stated completing treatment responsible for common The Treatment Nurseask the DON for approver and complete at there were other time complete the treatment ask for the overbecause she was we getting worse. She apperform her duties at During an interview DON and Treatment was not on the Weet Pressure Ulcers price therefore, there was weekly assessment prior to 1/23/19. During a telephone PM, the Hospice Nuoccasions she knew were not getting does she tried to discuss Treatment Nurse ar were not working as management was a Hospice Nurse state wound did worsen to debrided by the working as management was a Hospice Nurse state wound did worsen to debrided by the working as the procession of the	If when she was pulled from onts, the nurses were pleting their own treatments. See stated at times she would proval for overtime to stay any missed treatments and ones, she would stay over and onents to the worst wounds and ottime. She stated she did this forried about the wounds stated now she was able to as the Treatment Nurse. On 3/6/19 at 2:10 PM the to Nurse verified Resident #1 skly Wound Report for for to the week of 1/23/19 is no evidence of the facility's of her left heel pressure ulcer winterview on 3/6/19 at 2:25 are stated there were were we Resident #1's treatments one due to staffing. She stated her concerns with the ond the floor nurses, but they is aides, so she did not know if the ware of her concerns. The end Resident #1's left heel on the point it had to be und physician but there had the ment since the staffing	F 686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345450	B. WING		,	C 3/06/2019		
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 0	3/00/2019		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 686	Continued From pag	ge 140	F 68	36				
	Nurse was unable to having to work as ar The NP stated the la worsening of Reside she could not say th reason for the wound During a telephone in PM, the Medical Direct expectation that all the ordered. He stated Ferminal comorbidies worsening of her presents as a series of the stated of the sta	interview on 3/6/19 at 4:20 ector stated it was reatments were completed as Resident #1 had several is that contributed to the essure ulcer but not receiving redered would have also						
	facility on 8/21/18 ar on 12/18/18 with dia Sclerosis (MS) and s sacral region. A physician 's order 10/23/18 indicated E (antimicrobial cleans with normal saline a solution, gauze, and daily. The quarterly Minim assessment dated 1 #44 's cognition was behaviors and no re	s initially admitted to the and most recently readmitted agnoses that included Multiple stage 4 pressure ulcer of a for Resident #44 dated Dakin's Half Strength ser) cleanse sacral wound and pack with Dakin's cover with dressing twice a cover with dressing twice as fully intact. She had no jection of care. Resident #44 assistance of 1 staff for bed						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE : COMPI	SURVEY LETED
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	ROVIDER OR SUPPLIER OD HEALTH AND REHAL	BILITA	,	STREET ADDRESS, CITY, STATE, ZIP COL 625 ASHLAND STREET ARCHDALE, NC 27263	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 686	look back period. Recatheter and was free She had one Stage 4 present on admission pressure reducing de and she received present on admission pressure reducing de and she received present of the sacrum. Resid wet to dry dressings reported the wound healing secondary to supplementate facility food and consunhealthy fast food and consunhe	sident #44 had an indwelling quently incontinent of bowel. pressure ulcer that was. Resident #44 had a vice for her bed and chair ssure ulcer care. Ititioner (WNP) note dated sident #44 was seen for a pronic stage 4 pressure ulcer ent #44 was on Dakin's. The Treatment Nurse ealing had stalled. Resident anemic and refused iron agreeable to prenatal the resident also declined from the incomposition. She refused to eat the sumed large amounts of sewell as junk food such as sident #44's sacral ulcer provement. The WNP's addicated there was stool in the dressing upon observation. It to have stalled regarding anemia and poor protein Resident #44's dietary propriate iron and protein the wound showed no signs or another the persistent wound bool which was also hindering and indicated Resident #44 was related condition from	F6	186			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLETED				
		345450	B. WING			C / 06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 03/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	#44 continued to har contamination of her hinderance to healing be nonadherent with was also noted to be repositioning. The V Stage 4 sacral ulcer improvement nor signecommendation was colostomy. A review of Resident Administration Reconstated to her Stage treatment was not condered. A review of schedule was conducted to the December 20 nursing staff assigned dates and shifts that administered as ordered. It is shift - N 12/21/18 1st shift - N 12/22/18 2nd shift - N 12/28/18 2nd shift - N 12/28/18 2nd shift - N 12/29/18 2nd shift - N 12/30/18 1st shift - N 12/30/18 2nd shift - N 12/30/18 1st shift - N 12/30/18 1st shift - N 12/30/18 1st shift - N 12/31/18 1st shift - N 12/31/18 1st shift - N 12/31/18 1st shift - N A WNP note dated 1 continued to have fewound, nonadheren	2/26/18 indicated Resident we persistent fecal wound which was a g. The resident continued to diet recommendations. She enonadherent to turning and VNPs assessment of the indicated no signs of ins of infection. A s again made for a ##44 's hard copy Treatment rd (TAR) for December 2018 4 sacral ulcer indicated the consistently administered as f the facility 's nursing cted, and this was compared fa TAR to reveal the following fed to Resident #44 on the the treatment was not ered: Nurse #11 Jurse #12 Nurse #5 Jurse #3 Nurse #5 Jurse #3 Nurse #5 Jurse #3 /3/19 indicated Resident #44 cal contamination in the ce with diet nd nonadherence with	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CO 625 ASHLAND STREET ARCHDALE, NC 27263	DDE	30.00.20.10		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE		N	
F 686	healing nor infection. was made for the sac daily to Anasept (anti dressings once daily was able to acquire the A physician 's order of 1/3/19 indicated a dis sacral ulcer treatmen cleanse sacral wound pack with Dakin 's so with dressing twice do wet to dry dressing do facility was able to ac pharmacy. A review of Resident January 2019 from 1/1 to her Stage 4 sacral treatments had not be ordered. This TAR sl for Anasept gel once added to the TAR on read, "when Anasept order for the Dakin 's continued until the Ar Treatment Nurse 's co indicated that Anasep for the first time on 1/1 's nursing schedule w compared to the Janu following nursing staf	A treatment order change cral ulcer from Dakin's twice microbial gel) wet to dry and as needed if the facility ne gel from the pharmacy. For Resident #44 dated continuation of the current of (Dakin's Half Strength of with normal saline and plution, gauze, and cover faily) and initiation of Anisept faily and as needed if the require the gel from the cover the saline and plution of the current of the saline and plution of the current of the saline and plution, gauze, and cover faily and as needed if the require the gel from the cover the saline and the sal	F	586				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345450	B. WING			1	06/ 2019
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILIT	TA		62	REET ADDRESS, CITY, STATE, ZIP CODE 5 ASHLAND STREET RCHDALE, NC 27263	1 03/	00/2013
PREFIX (EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 Continued From page 144 1/2/19 2nd shift - Nurse # 1/3/19 2nd shift - Nurse # 1/5/19 1st shift - Nurse # 1/5/19 2nd shift - Nurse # 1/6/19 2nd shift - Nurse # 1/8/19 2nd shift - Nurse # 1/8/19 1st shift - Nurse # 3/8/19 2nd shift - Nurse # 3/8/19 2nd shift - Nurse # The active care plan for F the focus area of skin/woo continued presence of a S to her sacrum that was ac admission (8/21/18). The in part, administer treatme An interview was conduct 1/7/19 at 12:00 PM. She pressure ulcer on her sac prior to her admission. Sh treatment orders included dressing twice daily, once (7:00 AM to 3:00 PM) and second shift (3:00 PM to that her dressing was not ordered. She indicated th normally Nurse #5 who ha dressing as ordered. Res she was unsure if Nurse # the dressing or if she ran shift and didn't get to it. An interview was conduct Nurse on 1/8/19 at 10:14 she had been the Treatme	55 55 & Nurse #15 (split 55 & Nurse #15 (split 55 & Nurse #15 (split 56 & Nurse #15 (split 57 & Nurse #15 (split 58 & Nurse #15 (split 59 & Sesident #44 indicated and and identified the Stage 4 pressure ulcer equired prior to here interventions included, ents as ordered. The with Resident #44 on reported she had a srum that developed he stated that her is the changing of here and the changing of here and the change of the stated always changed as the she believed it was and not changed here sident #44 stated that #5 just forgot to change out of time during here and with the Treatment AM. She stated that	F	686			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345450	B. WING				06/ 2019
	ROVIDER OR SUPPLIER	BILITA	_ I	6	STREET ADDRESS, CITY, STATE, ZIP CODE 125 ASHLAND STREET ARCHDALE, NC 27263	03/	00/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 686	June or July of 2018 role of Treatment Nur WNP came to the fact facility had been having maintaining Nursing A explained that due to was normally assigned nurses were suppose treatments. An observation of wo by the Treatment Nursecral pressure ulcer 11:14 AM. The Treat wound care as ordered. A second interview worked on a Friday, of the sacral ulcer dressing, following Monday to fit the sacral ulcer that is She explained that she dressings and this was same dressing. She provided treatment to ulcer on 1/7/19 with E and that when she provided treatment to ulcer on 1/7/19 with E and that when she provided treatment to ulcer on 1/7/19 with E and that when she provided treatment to ulcer on 1/7/19 with E and that when she provided treatment to ulcer on 1/7/19 with E and that when she provided treatment to the provided treatment to ulcer on 1/7/19 with E and that when she provided treatment to the provide	She revealed that since she was only working in the se once weekly when the illity. She explained the ng difficulty obtaining and Assistants (NA). She further the lack of NAs on staff, she at as an NA and the floor and to complete the und care that was provided se for Resident #44 's was conducted on 1/9/19 at ment Nurse provided the add. as conducted with the 1/10/19 at 8:40 AM. The firmed Resident #44 's atment for her sacral of consistently provided as nally confirmed Resident as he was aware Nurse #5 provided the sacral ulcer when she was assigned to eatment Nurse revealed that coasions that she had changed Resident #44 's and returned to work the ind the same dressing on the put in place on Friday.	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	sacral ulcer was easi that inconsistent dres negative impact on the stated that Resident: healing had stalled an indicated the WNP m #44's sacral ulcer the discontinue Dakin's wet to dry dressings. She indicated the Ana obtain pharmacy appreceived the medicat that the Dakin's two continued until the Anad not occurred. The that she informed the of this issue with treat being provided as ord. A phone interview was on 1/10/19 at 10:17 At to Resident #44 on 9 ulcer treatment was a She was asked if she treatment to Resident #44's wou was normally provided revealed that she chadressing if needed in	e Treatment Nurse d that Resident #44 's ly contaminated by stool and using changes could have a ne wound healing. She #44 's sacral ulcer 's and remained stable. She ade a change to Resident eatment on 1/3/19 to twice daily and start Anasept once daily and as needed. asept took several days to roval for and they just ion on 1/9/19. She reported the daily was supposed to be the asept was received, but this the Treatment Nurse stated Director of Nursing (DON) treets not consistently dered. Is conducted with Nurse #5 th. Nurse #5 was assigned instances when her sacral not provided as ordered. In provided wound care the #44 's sacral ulcer when ther. She stated that and care for the sacral ulcer d on the first shift. She	F 6			
	order for Dakin 's wa twice daily. She add	4 's previous treatment s supposed to be provided tionally stated that she was tment order for Dakin 's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	,		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 686	from the 1/3/19 treather facility. An interview was considered that she would care treatment was assigned to he facility had a Treatre for the past several had been assigned not been providing was in the facility. Freviewed with Nurshad completed Reswould have marked She revealed that so that got missed. She worked as a Nuassigned as an NA things got very heccan had been assigned for interview on 1/10/19 at 10:18 reached for interview was considered for interview was conside	continue until the Anasept gell atment order was received at a conducted with Nurse #3 on M. Nurse #3 was assigned to instances when her sacral is not provided as ordered. It was responsible for providing ent to Resident #44 when she was responsible for providing ent to Resident #44 when she was an NA on the floor and had treatments unless the WNP Resident #44 's TARs were er #3. She stated that if she will still the target was an NA on the floor and had treatments unless the WNP Resident #44 's TARs were er #3. She stated that if she will ton the TAR as completed and sometimes there were things the explained that some days were and sometimes she was and sometimes she was as the further explained that the tic at times. Was attempted with Nurse #11 on AM. She was unable to be weed.	F 686	<u> </u>			
	the facility once per assessments. She had a large sacral upresent on her adm reported that the sa contaminated by ste	week for wound indicated that Resident #44 ulcer, Stage 4, that was nission to the facility. She					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
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		345450	B. WING			03/	06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	that she had recommoresident due to the diwound free of fecal coindicated that Reside stable, with no signs signs of infection. Shareported on resident recommendations and recommendations and recommendations. So sprevious sacral ulces twice daily (initiated that Dakin's had a 1 that if the Dakin's withours it's effect was about the 1/3/19 order Anasept once daily. Resident #44's wou wanted to try a change Anasept. She explain the Anasept was going pharmacy, so she included that the facility was not aware the Ar 1/9/19. The treatment inconsistent administ Resident #44's sacret the WNP. She stated treatments to be provided as ordered a regularly changed to The WNP stated that Resident #44's sacre (1/10/19).	contamination. She stated ended a colostomy for the fficulty with keeping the ontamination. The WNP nt #44's wound had been of improvement and no se verified her notes that #44's nonadherence to diet d turning/repositioning she discussed Resident #44' er treatment order for Dakin's 10/23/18). She reported 2-hour half-life, meaning as not reapplied every 12 gone. She then spoke er for a treatment change to She stated that because and was not healing she ge in treatment to the need that she was unsure if the good be approved by the licated that the Dakin's notinue until the Anasept was well as the was not received until not records that showed ration of the treatments for all ulcer was reviewed with that she expected for inded as ordered. She added on that treatments were and the dressing was reduce the risk of infection. she was going to assess	F	686			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				SURVEY PLETED
		345450	B. WING				C 06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA	•	62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET IRCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690 SS=E	she observed Reside completed an assess this assessment show improvement and she the Anasept. An interview was con Administrator and DC They both indicated the care treatments to be DON was asked who monitoring the TARs were administered as she had been monitor Administration Record been monitoring the Bowel/Bladder Incomplete (CFR(s): 483.25(e)(1) The fact resident who is continually admission receives a maintain continence of condition is or become not possible to maintain systems. See that (i) A resident who entindwelling catheter is resident's clinical concatheterization was not in A resident who entind in A resident who entinded	1:37 AM. She stated that an #44's sacral wound and sment. She revealed that wed the wound had some expected with the DN on 1/10/19 at 2:31 PM. That they expected wound exprovided as ordered. The was responsible for to ensure that treatments ordered. She revealed that ring the Medication ds (MARs), but no one had TARs. Thence, Catheter, UTI (-(3)) Ince. Cility must ensure that ment of bladder and bowel on ervices and assistance to unless his or her clinical mes such that continence is ain. Desident with urinary on the resident's sesment, the facility must ensure that the resident with urinary on the resident's sesment, the facility must ensure that the resident with urinary on the resident's sesment, the facility must ensure that the resident with urinary on the resident's sesment, the facility must ensure that the facility must ensure that the resident's sesment, the facility must ensure that the facility ensure that th		686			4/3/19

PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SUR COMPLETI	LETED	
		345450	B. WING _		03/06/2	2010	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/06/2	2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) DMPLETION DATE	
F 690	as possible unless the demonstrates that call and (iii) A resident who is receives appropriate prevent urinary tract continence to the extended of the extende	val of the catheter as soon he resident's clinical condition hitheterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. resident with fecal on the resident's ssment, the facility must hit who is incontinent of bowel treatment and services to mal bowel function as is not met as evidenced riew and interviews with the urse Practitioner, the facility any catheter care as ordered sidents (Resident #44) catheter care. d: tially admitted to the facility recently readmitted on ses that included neurogenic ary retention, and personal ct Infections (UTIs). dated 8/30/18 indicated 4's suprapubic catheter site at dry, and apply silver g once daily.	F 6	F690- Bowel/Bladder Incontinence Catheter, UTI 1. On 1/8/2019 Resident # 44 rece catheter care by a licensed nurse. 2. The Regional Director of Clinica Services completed a quality review (audit) of residents with catheters trensure treatment is provided as ore by on 3-14-19. All residents catheters received catheter care as ordered. 3. The DON will provide re-educat licensed nurses, including all shifts part-time and prn, on providing and documenting treatments to residen catheters by 3/21/19. No staff will allowed to work until education con	ived Il N O dered S with S ion to , Its with		
	The quarterly Minimu				nplete.		

Facility ID: 923156

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		ATE SURVEY MPLETED
		345450	B. WING			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 690	behaviors and no regrequired extensive a mobility, dressing, to No transfers had occoback period. Reside catheter and was free. A Nurse Practitioner indicated Resident # on this date and the of a large amount of clear. The NP indicated suprapubic catheter for increased sedime. A physician 's order #44 indicated irrigating twice weekly (Tuesdoneded for increase physician 's order dresident #44 's supnormal saline, pat dresident #44 's supnormal saline, pat dressing once doorder. A physician 's order dressing once doorder. A physician 's order same order that was cleanse Resident #4 with normal saline, pat dressing once doorder. A review of Resident #4 with normal saline, pat dressing once doorder. A review of Resident #4 with normal saline, pat dressing once doorder. A review of Resident #4 with normal saline, pat dressing once doorder.	s fully intact. She had no fection of care. Resident #44 ssistance of 1 staff for bed bileting, and personal hygiene. Curred during the MDS look ent #44 had an indwelling equently incontinent of bowel. (NP) note dated 12/4/18 each had her catheter irrigated nurse reported the presence sediment that was flushed ated a plan to flush the twice weekly and as needed entation. dated 12/4/18 for Resident on to suprapubic catheter ay and Friday) and as disedimentation. The ated 8/30/18 to cleanse trapubic catheter site with the sinitiated on 8/30/18 to each early and apply silver alginate ailly remained an active dated 12/27/18 repeated the sinitiated on 8/30/18 to each each dry, and apply silver given and material to each dry, and apply silver given each dry, and material each dry, and each dry,	F 69	monitoring (audit) including observe treatments and documentation for residents with catheters, 3 times per for 4 weeks, then weekly for 3 more. The DON will report on the results quality monitoring (audit) and report QAPI committee. Findings will be reviewed by QAPI committee monitoring (audit) updated indicated. 5. Date of Compliance 4/3/2019.	er week nths. of the rt to the thly and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	for the 1st shift staff and also was placed Tuesdays and Friday the catheter was also review of the facility conducted, and this of December 2018 TAF following nursing staron the dates and shift treatment was not provided for cleansing 12/20/18 1st shift - Norder for cleansing 12/21/18 1st shift - Norder for cleansing 12/21/18 1st shift - Norder for cleansing 12/21/18 1st shift - Norder for cleansing 12/27/18 1st shift - Norder for cleansing 12/28/18 1st shift - Norder for cleansing 12/28/18 1st shift - Norder for cleansing 12/28/18 1st shift - Norder for cleansing 12/30/18 1st shift - Norder for cleansing 12/31/18 1st shift - Norder for cleansing 12/3	ter was placed on the TAR on Tuesdays and Fridays on MAR for the 2nd shift on s. This order for irrigation of o not provided as ordered. A s nursing schedule was was compared to the & MAR to reveal the ff assigned to Resident #44 its that the catheter ovided as ordered: urse #3 failed to provide the urse #12 failed to provide and ovide the order for irrigation urse #3 failed to provide the urse #12 failed to provide the urse #12 failed to provide the ovide the order for irrigation urse #3 failed to provide the urse #12 failed to provide the urse #12 failed to provide the urse #12 failed to provide the urse #13 failed to provide the order for irrigation urse #13 failed to provide the order for irrigation urse #13 failed to provide the urse #144 's hard copy TAR and 19 from 1/1/19 through 1/8/19 evealed the physician 's nsing of the suprapubic first shift) was not provided	F6	90		
	12/30/18 1st shift - N the order for cleansir 12/31/18 1st shift - N order for cleansing A review of Resident MAR for January 20 was conducted and rorder related to clear catheter once daily (tas ordered. A review schedule was conducted was conducted as ordered.	urse #13 failed to provide ag urse #3 failed to provide the #44 's hard copy TAR and ag from 1/1/19 through 1/8/19 evealed the physician 's asing of the suprapubic				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345450	B. WING				06/ 2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET ARCHDALE, NC 27263	1 001	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	on the dates and shift treatment was not pro 1/1/19 1st shift - Nurs 1/2/19 1st shift - Nurs 1/3/19 1st shift - Nurs 1/4/19 1st shift - Nurs 1/5/19 1st shift - Nurs 1/6/19 1st shift - Nurs 1/6/19 1st shift - Nurs 1/8/19 1	f assigned to Resident #44 ts that the catheter ovided as ordered: se #12 se #3 se #3 se #15 se #15 se #15 se #3 se #3 se #15	F	690			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION _DING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			03/	06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP COD 625 ASHLAND STREET ARCHDALE, NC 27263	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 690	Resident #44 when so She initially stated that catheter care to Resiprovided by the first so she may have provided shift staff had not got unable to recall if she so catheter. She reverthat things got really get to everything. An interview was con 1/10/19 at 11:39 AM. Resident #44 on 8 instead that she would the catheter site was She stated that she would the TAR or the MAR revealed that someting got missed. She exp worked as a Nurse and assigned as an NA drobtaining and maintathree shifts. Nurse #3 the order for the cath the December 2018 MAR for the 2nd shift identified that the irrig provided as ordered fit down for both shifts by 1 of the 2 shifts. An interview was conditionally assigned as an NA conditionally and maintathree shifts. Nurse #3 the order for the cath the December 2018 MAR for the 2nd shift identified that the irrig provided as ordered fit down for both shifts by 1 of the 2 shifts.	wided catheter care for the was assigned to her. at she had not provided dent #44 as it was normally shift. She then stated that ed catheter care if the first ten to it. Nurse #5 was had irrigated Resident #44 aled that there were times thectic and she couldn't ducted with Nurse #3 on Nurse #3 was assigned to stances when cleansing of not provided as ordered. Was responsible for providing ared to Resident #44 when ther. Resident #44 when ther. Resident #44 when there were things that lained that some days she had sometimes she was use to the facility's difficulty ining enough NAs to staff all also shared that the reason eter irrigation was on both TAR for the 1st shift and the twas because it had been	F6	690				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		345450	B. WING		0:	C 3/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHAL	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 690 F 692 SS=D	reported she had suphistory of chronic UTI #44 was chronically phad a tendency to be stated that she expect followed related to cashe was unaware that inconsistently implement that she believed no roccurred for Resident inconsistent provision. An interview was con Administrator and DC They both indicated the care to be provided a asked who was responsible to the provided and been monitoring Administration Record been monitoring that the Nutrition/Hydration St CFR(s): 483.25(g) (1). §483.25(g) Assisted in (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident status, sidesirable body weight	licated medical history. She rapubic catheter and a long s. She indicated Resident positive for UTIs and that she come septic rapidly. She sted her orders to be theter care and revealed to the orders were lented. The NP expressed megative consequences to the first and the first and the first and		692		4/3/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	I	00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 692	§483.25(g)(2) Is offer maintain proper hydromaintain proper hydromaintain proper hydromaintain proper hydromaintain proper hydromaintain proper hydromaintain provider orders a the This REQUIREMENT by: Based on observation record review, the fact Physician ordered didunexpected weight to dependent resident wound with the sampled resident wound and the sampled resident wound and the sampled resident was additionally the sampled resident wound and physician ordered hydromaintain the sampled resident was additionally the sampled food, No thick liquids, divided spoon with narrow, so slide off easily for a resident work and the sampled food in the sample of	is is not possible or resident otherwise; red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. T is not met as evidenced ons, staff interviews and cility failed to provide a etary supplement to prevent loss and failed to assist a with eating for 1 (Resident idents reviewed for weight elude: nitted on 10/1/18 with sof Cerebral Vascular	F 6	F692- Nutrition/Hydration Status Maintenance 1. On 1/7/2019 the Dietary Mana DON audited Resident #4's diet tray ticket to ensure resident received as ordered. revealed the meal supplements received as ordered. Resident # provided assistance with meals 1/10/19. 2. The Dietary Manager, DON a completed a quality review (audidiet orders and compared to rescards on 2/18/2019 to ensure supplements was provided to recordered. The RDCS, DON and Director of Nursing (DDCS) comquality review of all residents by observation to ensure appropriate	ager and order to eived the The audit are being 4 was on and RDCS t) of all ident tray sidents as Divisional pleted a	
	(MDS) dated 10/8/18 Pattern assessment with exhibited physic care. He was coded eating. Resident #4 v	sion Minimum Data Set indicated the Cognitive (Section C) was incomplete al behaviors and rejection of for extensive assistance with was coded for no known gain, a mechanically		assistance provided during meal 3-27-19. No negative findings we identified. 3. The Dietary Manager re-educ dietary staff, including all shifts, prn and weekends, on providing supplements based on the tray of	ere cated part-time,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING			١,	C 03/06/2019
NAME OF P	ROVIDER OR SUPPLIER	0.0.00	<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	13/06/2019
NAME OF T	NOVIDER OR OUT FIER				ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	BILITA			CHDALE, NC 27263		
(X4) ID	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				PROVIDER'S PLAN OF CORRECTION		(X5)
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F 692	Continued From page	e 157	F 6	92			
	altered, therapeutic d pounds.	iet and a weight of 145			3/27/19. The DON, Divisional ED and RDCS will re-educate nursing staff, including all shifts, part-time and prn, o		
	Review of Resident #	4's undated			validating supplements on tray cards t		
		roblems care plan indicated			ensure the resident receives suppleme		
	interventions included Register Dietician (RI				as ordered and providing assistance v meals per plan of care by 3/27/2019.		
	assistance with eating				staff will be allowed to work until	NO	
					education complete.		
	Review of Resident # Communication Kard	4's undated Nurse Tech			4. The Dieton Money and as DON		
	dependent on staff fo				 The Dietary Manager and or DON conduct quality monitoring (audit) and 		
		•			observation of 5 tray cards and reside	ents	
		uisition Form dated 10/29/18			with feeding assistance 5 times a wee		
		s to be up in his wheelchair vas dependent on staff for			4 weeks, 2 times a week for 4 weeks t weekly for 8 weeks to ensure	nen	
		d plate and maroon spoon.			supplements are provided as ordered. The DON will report on the results of t		
		4's weight on 11/9/18 was			quality monitoring (audit) and report to		
	1	pounds on 12/5/18 (6%			QAPI committee. Findings will be	and	
	weight loss in one mo	mun).			reviewed by QAPI committee monthly Quality monitoring (audit) updated as	anu	
		4's weight for the week of			indicated.		
	12/16/18 through 12/2	22/18 was 143.6 pounds.			5 Date of Compliance 4/3/10		
	Review of a RD note	dated 12/21/18 read			5. Date of Compliance 4/3/19.		
	Resident #4 was see	n due to weight loss. The					
	I .	s spoon fed. The note read					
	double portions at bre	efit from magic cup and eakfast.					
	Review of a written P	hysician Order dated					
	I .	for Resident #4 to receive a					
	frozen nutritional sup tray and double portion	plement on lunch and dinner ons at breakfast.					
		4's medical record did not					
		tion Form for the frozen It at lunch and dinner or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, , ,	(X3) DATE SURVEY COMPLETED C		
		345450	B. WING_			03/06/2019	
	ROVIDER OR SUPPLIER	ABILITA	,	STREET ADDRESS, CITY, STATE, ZIP COD 625 ASHLAND STREET ARCHDALE, NC 27263		90,00,20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 692	Continued From pag		F 6	692			
	Physician Orders inc	#4's January 2019 monthly cluded orders for the frozen nt at lunch and dinner with reakfast.					
	main dining room, R reclining chair pushe allow him to feed hin was using a maroon Food was observed Nursing Assistant (N table assisting anoth NA #9 stated Reside	1/7/19 at 12:40 PM in the esident #4 was sitting in a ed up next to the table to inself using his right hand. He spoon and divided plate. On his shirt and on the table. IA) #9 was also sitting at the iter resident with her lunch. Ent #4 was able to feed aroon spoon and divided plate					
	main dining room, R reclining chair pushe allow him to feed hin was using a maroon There was no obsersupplement on his tricket, the nutritional ordered. NA #9 stated himself, but she NA #9 stated she was	esident #4 was sitting in a ed up next to the table to enself using his right hand. He spoon and divided plate. Wed the frozen nutritional ay and on review of his tray supplement was not listed as ed Resident #4 was able to e would intervene if needed. It is not aware that Resident #4 ritional supplement with lunch					
	Manage r(DM) review record and stated the Form completed on supplement was ord	8/19 at 12:15 PM, the Dietary wed Resident #4's medical ere was no Diet Requisition 12/21/18 when the nutritional ered. The DM stated if no m was completed, the kitchen					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHAE	BILITA	•	STREET ADDRESS, CITY, STATE, Z 625 ASHLAND STREET ARCHDALE, NC 27263	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED		
F 692	In an interview and of 12:30 in the main dini observed feeding Restray included a frozen his tray ticket also refi supplement and lunch stated Resident #4 wand had to be fed all In an interview on 1/9 of Nursing (DON) stat 1/4/19 was 145 pound In an interview on 1/9 stated it was her expereceive his nutritional dinner to prevent une stated the RD wrote the frozen nutritional supple took off the order did Requisition Form to be The DON stated it was RD to complete the Don stated she was nother facilities, the nuphysician order comperorm and forwarded is stated she would claric expectations. The RD expectation that Residence in the residence in t	the frozen nutritional red for lunch and dinner. Diservation on 1/9/19 at any room, Nurse #10 was sident #4. Observation of his nutritional supplement and dected the frozen nutritional and dinner. Nurse #10 as not able to feed himself meals. May at 1:45 PM, the Director red Resident #4's weight on dis. May at 3:10 PM, the DON extation that Resident #4 supplement for lunch and expected weight loss. She are order on 12/21/18 for the polement and the nurse who not complete the Diet reforwarded to the kitchen. The responsibility of the siet Requisition Form. Bew on 1/9/19 at 3:50 PM, the rese who took off the letted the Diet Requisition to the kitchen. The RD from the rest was her dent #4 receive the the tall unch and dinner and the sakfast to prevent	F	692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY	
		345450	B. WING _		1	C 03/06/2019	
	ROVIDER OR SUPPLIER DD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692 F 695 SS=D	was feeding Resident stated Resident #4 not eating. Observation of portions and double putray ticket. In an interview on 1/1 Practitioner stated it is Resident #4 receive a assistance with eating weight loss. In an interview on 1/1 Administrator stated is was not sure of who is completing the Diet Resident was his experience all supplementating to prevent une Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and The facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating to prevent unergine for the facility must ensure eating the facility ensurement e	1/10/19 at 8:30 AM, NA #1 t #4 his breakfast. NA #1 eeded staff assistance with of the tray revealed double cortions was indicated on the 10/19 at 9:30 AM, the Nurse was her expectation that all supplements and staff g to prevent unexpected 10/19 at 2:30 PM, the since he was not a nurse, he was responsible for Requisition Form when the attritional supplement and ordered on 12/21/18. He ectation that Resident #4 hts and staff assistance with expected weight loss. stomy Care and Suctioning		692			
	practice, the compreh care plan, the resider and 483.65 of this sui This REQUIREMENT by: Based on record rev	professional standards of nensive person-centered nts' goals and preferences, bpart. is not met as evidenced new, observation, staff and ne facility failed to have a		F695- Respiratory/Tracheostomy Ca and Suctioning	re		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						PLETED	
		345450	B. WING _			1	C (06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		62	REET ADDRESS, CITY, STATE, ZIP CODE 5 ASHLAND STREET RCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	physician order for ox (Resident #19) and fa nebulizer mask and daccordance with profepractice (Resident #2 residents reviewed for Findings included: 1. Resident #19 was diagnosis of chronic ordisease. A review of the resided Data Set dated 10/18 had an intact cognition of 1 staff for all activities meals and locomotion the resident received.	exygen administration diled to store a reuseable date nebeulizer tubing in dessional standards of) for 2 of 2 sampled or respiratory care. Admitted on 8/4/18 with the destructive pulmonary ent 's quarterly Minimum /18 revealed the resident on, required extensive assist dies of daily living except on. The MDS did not indicate oxygen treatments.	F6	695	1. On 1/9/2019 the DCS assessed Resident #□s 19 and 2, and an order vareceived for Resident #19 to receive oxygen; and Resident #2 was provided new tubing which was dated and stored. 2. On 1/18/2019 the DCS completed a quality review (audit) of residents using oxygen to ensure orders were in place and oxygen/nebulizer equipment is data and stored appropriately when not in using No negative findings were identified. 3. The DCS will provide re-education to direct care and licensed nurses, including all shifts, part-time and prn, on ensuring orders for oxygen are received and in place as well as proper storage of oxygen/nebulizer masks and tubing with not in use by 2/8/2019. Staff will not be	d. d. ded sed see. o ing ing	
	10/08/18 revealed resintervention for continuous pressure (CPAP) at mediused. A review of the residerevealed there was meresident to use oxygen. On 1/7/19 at 3:50 pm with the resident who oxygen by nasal cannows independent. The she did not use the positive airway pressure oxygen in the facility.	inuous positive airway ight and that the resident ent 's physician orders ot an order in place for the			4. RDCS and or DCS will conduct random quality monitoring (audit) of physician orders for oxygen and, oxyge and or nebulizer tubing is dated and stored when not in use, 3 times per we for 4 weeks, then weekly for 3 months. The DCS will report on the results of th quality monitoring (audit) and report to QAPI committee. Findings will be reviewed by QAPI committee monthly a Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019.	en ek le the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING _				C 06/2019
	ROVIDER OR SUPPLIER	BILITA		62	REET ADDRESS, CITY, STATE, ZIP CODE 5 ASHLAND STREET RCHDALE, NC 27263	1 03/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 162	F	895			
	at night instead of the short of breath.	e CPAP because she was					
	oxygen concentrator	an observation was of the that was in the resident 's for was observed to be next					
	12/8/18 to 01/08/19 re oxygen administration	ent 's nurses' notes from evealed no documentation of n. The resident had a pulse I of greater than 92% on January 2019.					
		ent 's physician progress revealed no mention of n.					
	note dated 1/7/19 rev room air with a 98%, oxygen concentrator resident reported the						
	that she was aware the at night since she was for a couple of month use the CPAP. The t	m an interview was eatment nurse who stated nat the resident used oxygen s no longer using the CPAP s. The resident refused to reatment nurse was not d not have an order for					
	with Nurse #9 who sta	an interview was conducted ated the she was aware that oxygen at night but was not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION G	COMPLETED		
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/06/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 695	On 1/9/19 at 9:55 an with the Director of N not aware that the refor oxygen but was a	an oxygen order in place y there was no order. n an interview was conducted Jursing who stated she was esident did not have an order aware that the resident was night instead of her CPAP.	F 69	5		
	9/23/18 with diagnost heart failure and chrodisease. A review of the facilit Change Schedule" rounder procedure, nedays along with equiname, date and roor. A review of a signific dated 10/1/18 reveal cognitively intact, recepted and no behaviors. A review of the phys 2018 revealed an ordinale contents of 1 shours for 7 days than	ant change in assessment				

C 345450 B. WING 03/06	6/2019
	0/2013
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695 Continued From page 164 nebulizer mask, tubing and machine on Resident #2's nightstand. The nebulizer mask and tubing was not bagged, labeled or dated. An observation on 1/8/19 at 8:30 AM revealed a nebulizer mask, tubing and machine on Resident #2's nightstand. The nebulizer mask and tubing was not bagged, labeled or dated. Two attempts to call the night shift nurse for Resident #2 on 1/9/19 and 1/10/19 were unsuccessful. An interview on 1/10/10 at 10:08 AM with the Director of Nursing revealed the night shift nurse on the hall was responsible for changing the nebulizer masks and making sure it was bagged, labeled and dated. She stated her expectation was that it be done weekly. She did not know why it had not been done for Resident #2. F 725 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) \$483.35(a) Sufficient Staff. The facility nursh have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). \$483.70(e).	4/3/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345450	B. WING _			1	06/2019
	ROVIDER OR SUPPLIER	BILITA		STREET ADDR 625 ASHLAND ARCHDALE,		1 00.	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	nursing care to all reresident care plans: (i) Except when waive this section, licensed (ii) Other nursing per limited to nurse aides §483.35(a)(2) Excep paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation interviews with reside of Social Services, and facility failed to provide ensure residents recorder, urinary cathete Activities of Daily Livicall bells. The facility sufficient nursing star preferences, treat rerespect, resolve individent grievances, and ensure involvement in the decomprehensive care sampled residents (F. #44, #47, #49, #50, aresident council). The sufficient staffing for Resident #36 resulte worsening and the decomprehensive and the decomprehensity and the decompreh	n a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not s. t when waived under section, the facility must nurse to serve as a charge f duty. I is not met as evidenced on, record review, and ent, family, staff, Department and Nurse Practitioners, the de sufficient nursing staff to eived pressure ulcer wound or care, assistance with ing (ADLs), and respond to y also failed to provide ff to honor resident sidents with dignity and vidual and resident council ure Nursing Assistant	F7	F725- S 1. Corpo Regiona Executive recruitme was app appropri Divisiona Vice Pre Director Director Senior Versource Cause A plan. The following LPN and Triad materials staff with hire Peres staff sch accurate	Sufficient Nursing Staff orate Human Resources and al staff worked with the Interim we Director to implement staff tent practices to ensure the cereoropriately staffed (center achievate staffing on 02/08/19). The al Executive Director, Regional esident of Operations, Regional of Clinical Services, Regional of Human Resources and the Vice President of Human ces conferred to discuss Root Analysis and develop an action he action plan included the grace Recruit, with incentives, CNA d RN staff from sister center in arket, Referral Bonus for existing himmediate pay out, Recruit and sonal Care Assistants, Retrain neduler and ensure schedule is e, Sign on bonus for CNA positical 2/19 a root cause analysis was	eved I I ng nd	
	Resident #36 develo	ped a MRSA infection in a ad worsened as a result of		complete	ed by the Regional Vice Presid ations, Regional Director of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				625 ASHLAND STREET	
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
F 725	Continued From pag	e 166	F 72	5	
		I failure to follow physician		Clinical Services, the Director of Nurs	ing
	orders for daily press	sure ulcer wound care, the		and the Divisional Executive Director	
	I -	omplete weekly wound		(acting administrator) and determined	
		ssments, and the failure to		the Executive Director failed to provide	
		the resident's external		consistent staffing to ensure treatmer	
		e Jeopardy was removed on		were completed as ordered. By 2/7/1	
	3/6/19 when the facil			sufficient staffs were provided to ensu	ıre
		eptable credible allegation of		residents receiving pressure ulcer	
		removal. The facility will		treatment, urinary catheter care, ADL	
		ance at a lower scope and		timely response of call bells and CNA	
		actual harm that is not		involvement in the development of the	=
		for Examples #1a and #1b. d #4 were cited at a scope		comprehensive care plan.	
		examples #5 and #6 were		2. On 1/22/2019 the ED, Regional Vi	CO
		everity of "E", and examples		President of Operations (RVPO),	CE
	-	l at a scope and severity of		Divisional Human Resources Director	· of
	"D".	at a coope and coverty of		Human Resources conferenced and	
				implemented staffing plans including	
				wage increases, recruitment and rete	ntion
	The findings included	d:		plans to ensure sufficient staffing. Or	
				2/7/19 sufficient staffs have been hire	
	This tag is cross-refe	erred to:		and have or are completing orientation	n.
		record review, observations,		3. The Executive Director will work wi	
		ent interview, family interview,		facility and corporate Human Resource	ces
		ractitioner interview, Nurse		staff to fulfill staffing needs through	
		, and Department of Social		appropriate recruitment and retention	
		ne facility neglected to		programs by 2/20/2019 and on-going	
	l · · · · ·	e ulcer wound care as		Executive Director will monitor staff	
	ordered, weekly wou			openings, recruitment, training and	4-9.
		sment and documentation,		scheduling of staff through review of o	_
		with the outside podiatrist		staffing levels at morning and evening	
		g, resulting in a worsening		meetings, review of open positions ar	ıu
	I -	nfection (Resident #36);		validation of staffing levels daily.	7.5
		daily pressure ulcer wound		Executive Director will monitor staffing times a week then 3 times a week for	
	care as ordered, wee	sment and documentation		weeks then 1 time a week for 8 week	
		ing pressure ulcer (Resident		ensure all resources are utilized. The	
		provide daily pressure ulcer		will report on the results of the quality	
		, provide daily pressure dicel	1	The standard of the results of the quality	1

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODI		75/00/2015	
				625 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION DATE	
F 725	Continued From page	e 167	F 72	25			
	wound care as ordere	ed and weekly wound		monitoring (audit) and report t	o the QAPI		
	measurement/assess	sment and documentation		committee. Findings will be re	eviewed by		
	(Resident #44) for 3 (of 4 residents reviewed; the		QAPI committee monthly and	Quality		
	facility neglected to p	rovide catheter care		monitoring (audit) updated as	indicated.		
	(Resident #44) for 1 of	of 1 resident reviewed; and		The Regional Vice President	of		
		cted to answer a call light		Operations and the Regional			
	related to a request f			Clinical Services will monitor s			
	(Resident #49) for 1 of	of 1 resident reviewed.		levels through internal portal a	•		
				visits to ensure adequate staff	•		
				maintained. The center Execu			
		record review, observations,		conveyed an ADHOC Quality			
		ent and family interview,		Performance Improvement me	-		
		ractitioner interview, and		03/06/19, including the Interim			
		terview, the facility failed to e ulcer wound care as		Director, Director of Nursing, I Rehab, MDS Nurse, Houseke			
	ordered, weekly wou			Manager, the Business Office			
		sment and documentation,		the Human Resources Coordi			
		with the outside podiatrist		Medical Records, Central Sup			
		g resulting in a worsening		Admissions Director, Dietary			
	-	fection (Resident #36); failed		Activity Director, the Environm	-		
	-	sure ulcer wound care as		Services Director, the Region			
	ordered, weekly wou	nd		President of Operations and F	Regional		
	measurement/assess	sment and documentation		Director of Clinical Services re	garding the		
		ing pressure ulcer (Resident		plan of removal of immediacy			
		vide daily pressure ulcer					
		ed and weekly wound		Executive Director will mor	-		
		sment and documentation		5 times a week then 3 times a			
	*	of 4 sampled residents		weeks then 1 time a week for			
	reviewed for wound o	care.		ensure all resources are utilize			
				will report on the results of the			
	_	vith the Administrator on		monitoring (audit) and report t			
		e stated he started as the		committee. Findings will be re	-		
		e of 2018. He revealed that		QAPI committee monthly and	-		
		having difficulty obtaining ugh NAs to staff all three		monitoring (audit) updated as The Regional Vice President of			
	_	. He reported that nurses		Operations and the Regional			
		o work as Nursing Assistants		Clinical Services will monitor s			
	_	os on the schedule. The		levels through internal portal a	•		
		that the Treatment Nurse		visits to ensure adequate staff	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	\ , ,	(X3) DATE SURVEY COMPLETED C	
		245450	B. WING				
		345450	B. WING _			3/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
WESTWO	OD HEALTH AND REHA	BILITA		625 ASHLAND STREET			
			ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	Continued From page	e 168	F 72	25			
F 725	was one of the nurse assigned as an NA. A follow up interview Administrator on 1/10 that sufficient staffing both in terms of quali needs of the resident awareness that sufficient facility. He stated currently working with develop employment maintain additional stresidents. An interview was con Nurse on 3/6/19 at 12 facility was insufficier of the residents. She staffing resulted in a sulcer care as ordered. An interview was con Nursing (DON) on 3/6 revealed the facility with meet the needs of the insufficient staffing repressure ulcer care as An interview was con Administrator on 3/6/10 reported he began will interim Administrator Regional Vice Presid the Corporate Human himself identified insucause of the facility's	was conducted with the 0/19 at 2:31 PM. He stated meant having enough staff ty and quantity to meet the se. He acknowledged his cient staffing was an issue at different that the facility was in the corporate office to incentives to obtain and taff to meet the needs of the ordered with the Treatment 2:04 PM. She indicated the needs the needs the needs of the ordered with the Director of 6/19 at 11:50 AM. She was insufficiently staffed to e residents. She stated this esulted in a failure to provide as ordered by the physician. Inducted with the Interim 19 at 12:20 PM. He orking at the facility as an on 1/18/19. He revealed the ent of Operations (RVPO), in Resources Director, and afficient staffing as the root failure to meet the needs of	F 72	maintained. The center Exection conveyed an ADHOC Quality Performance Improvement in 03/06/19, including the Interior Director, Director of Nursing, Rehab, MDS Nurse, Housek Manager, the Business Officithe Human Resources Coord Medical Records, Central Sundamissions Director, Dietary Activity Director, the Environ Services Director, the Region President of Operations and Director of Clinical Services plan of removal of immediaces. 5. Date of Compliance 4/3/2	y Assurance neeting im Executive , Director of deeping de Manager, dinator, dinply Clerk, Manager, mental nal Vice Regional regarding the y.		
	insufficient staffing repressure ulcer care a An interview was con Administrator on 3/6/reported he began work Interim Administrator Regional Vice Presid the Corporate Human himself identified insucause of the facility's the residents. He fur	esulted in a failure to provide as ordered by the physician. Inducted with the Interim 19 at 12:20 PM. He orking at the facility as an on 1/18/19. He revealed the ent of Operations (RVPO), in Resources Director, and afficient staffing as the root failure to meet the needs of ther revealed this insufficient failure to provide pressure					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						(c
		345450	B. WING			03/	06/2019
	NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA			62	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET RCHDALE, NC 27263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	3/6/19 at 1:34 PM. H Nurse's, DON's, and interviews that indicat insufficiently staffed to residents. He verified resulted in a failure to as ordered by the physical that previous Administ some difficulties with but he had not descrit difficulties. He reveal that residents' needs because the facility w RVPO stated that the failures was two-fold: 1. A lack of oversight 2. Insufficient staff The RVPO explained Administrator failed to processes and policie ensure residents were pressure ulcer care a and maintained sufficient provide necessary cannot file of the Immed 11:29 AM. On 3/6/19 at 5:17 PM following credible alled Jeopardy removal:	ducted with the RVPO on e confirmed the Treatment Interim Administrator's ited the facility had been o meet the needs of the d that this insufficient staffing o provide pressure ulcer care visician. The RVPO stated rator made him aware of the facility obtaining staff, bed the extent of these ed he had been unaware were unable to be met as insufficiently staffed. The root cause of the facility's that the facility's previous o provide oversight of es and effective leadership to e free from neglect, received s ordered by the physician, itent nursing staffing to re and services. ator, DON, and RVPO were tate Jeopardy on 3/6/19 at the facility provided the gation of Immediate	F	725	DEFICIENCY)		
	of immediate jeopard	Director alleges abatement y on 03/06/19.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	<u> </u>	03/00/2013	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 725	ensure residents recitreatment. A Root Cause Analys 01/22/2019 by the D Regional Vice Preside Director of Clinical S Human Resources and Human Resources investigative informat was the center wage wage analysis. The revealed that the cerlower end of the wage compared to other contributing fact issues: The Executive E guidance for keeping date. The recruitme real-time open positi (Indeed, Monster, et pulls resumes and a of applicants to the contribution of applicants to the con	provide sufficient staff to eived pressure ulcer sis was completed ivisional Executive Director, lent of Operations, Regional ervices, Regional Director of and the Senior Vice President is. The preliminary tion to determine root cause is scale and a competitive competitive wage analysis after needed to increase the ge scale for new hires as enters in the market. Orisidentified the following Director's failure to follow grecruitment software up to ant software provides ons to online job websites c.); additionally, the software poplications to ensure a flow tenter for interview. Director's failure to hire staff at	F 7				
	practice was accomp Corporate Human Roworked with the Interimplement staff recru	•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 725	Recruitment practice a. Update ICISMs so mentioned above) for (CNAs) and Persona b. Incentives for staff PRN (as needed) or c. Referral bonuses qualified applicants, d. Sign on bonuses for The Divisional Executary President of Operation Clinical Services, Recesources and the State Human Resources of discuss Root Cause action plan. The act following: - Recruit, with ince Practice Nursing (LP (RN) staff from sistent - Referral Bonus immediate pay out, - Recruit and hire - Retrain staff sch is accurate, - Sign on bonus for By 02/07/19 sufficier ensure residents are treatment. 2. Residents with the alleged deficient prace On 01/22/2019 the E of Operations, Division	e staffing on 02/07/19). Is include: Influde: I	F 7:	25			
	alleged deficient pra On 01/22/2019 the E of Operations, Divisi Director of Human R implemented staffing	ctice: :D, Regional Vice President onal Human Resources					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REH			STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/06/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 725	staff have been hire orientation. Sufficied determined by residindividual plans of conumber, acuity and resident population required facility assets. 3. Systemic Change The Executive Director or Corporate Human Resease through approximate the Executive Director or Tecruitment, training through review of dand evening meeting and validation of states at morning are of open positions are daily to ensure wouthe treatment nurse communicated to the Director of Nursing ordered by the physicapacity to complete treatments within the schedule. If the license to the Director of Nursing will grant of to complete the task	affing. On 02/07/19 sufficient d and have or are completing and staffing is measured as ent assessments and are and considering the diagnoses of the facility's in accordance with the essment. Ses: ctor will work with facility and esources staff to fulfill staffing opriate recruitment and Sufficient staffing was 19. will monitor staff openings, and scheduling of staff aily staffing levels at morning gs, review of open positions	F 72	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		03/00/2013	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	F 725 Continued From page 173 Director of Nursing and/or Minimum Data Set		F 7	25			
	Nurse will complete t measurements if the unavailable.	he assessment and					
	instructed to messag (scheduling software the Director of Nursir will assist the schedu	n there is a call out, is e all staff through OnShift that texts staff) and inform ng. The Director of Nursing aller in making calls and if n shift, the scheduler or fill fill the open shift					
	recruitment, training through review of dai and evening meeting	ill monitor staff openings, and scheduling of staff ly staffing levels at morning s, review of open positions alidation of staffing levels and staff interviews.					
	week then 3 times a time a week for 8 we are utilized. The ED the quality monitoring Quality Assurance ar Improvement (QAPI)	committee. Findings will be mmittee monthly and Quality					
	the Regional Director monitor staffing level weekly visits to ensu- maintained. Sufficie determined by reside individual plans of ca	resident of Operations and r of Clinical Services will s through internal portal and re adequate staffing is int staffing is measured as ent assessments and re and considering the liagnoses of the facility's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZI 625 ASHLAND STREET ARCHDALE, NC 27263	P CODE	33/33/2010	
(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 ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATI	(X5) COMPLETION DATE	
F 725	will inform the Executive Nursing when there as Executive Director wing Resource Director of update ICISMs (recrudirector of Nursing wischeduler to fill open delivered. The center Executive ADHOC Quality Assult Improvement meeting Interim Executive Director of Rehab, Ming Manager, the Busine Human Resources Cincert Records, Central Sup Director, Dietary Man Environmental Servic Vice President of Open Director of Clinical Seremoval of immediace The Medical Director immediacy plan via the Director and the Director and the Director and the Director the Executive Director and the Director and communication to sufficiently staffed. The credible allegation removal was validated.	a accordance with the assment. The staff scheduler rive Director and Director of are open positions. The all inform the Human open positions and to a positions and to a positions to ensure care is a positions and positions and positions and positions and positions and Regional positions are positions are positions and Regional positions are po	F7	725			

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345450 B. WING			03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP COD 625 ASHLAND STREET ARCHDALE, NC 27263	•	3/06/2019	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	Care Assistants, NA interviews verified re implemented and minimal. These staff in now felt equipped to An interview with the she was now able to as ordered by the prostaff. Interviews with Administrator, and Rether residents' needs facility was sufficient interview with the Me had been made award allegation action plant. 2. F550: Based on reresident interview, and failed to treat resident evidenced by inapprostatements (Resident answering a call ligh incontinence care (Resident #45 "humiliated" and "he failed to cover Resident and "he failed to cover Resident respect. 3. F561: Based on reinterview, observation interview, observation interview, and staff in consistently honor a out of bed at his pretare resident who required interview.	g a new scheduler, Personal s, and Nurses. Staff cruitment incentives were altiple new staff had been terviews revealed the staff meet the residents' needs. Treatment Nurse confirmed provide pressure ulcer care hysician due to the increase in a the scheduler, DON, Interimed by Policiated they all felt were being met and the sty staffed as of 2/7/19. An edical Director confirmed he re of the facility's credible in for F725 on 3/6/19. Decord review, observation, repartment of Social Services is staff interview, the facility into in a dignified manner as opriate staff to resident verbal at #32 and #49) and by not the related to a request for Resident #49). This failure	F 7	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	 	03/00/2013
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From pag	e 176	F 7	25		
	residents reviewed for nails were long, jagg	ils (Resident #30) for 2 of 2 or choices. Resident #30's ed, dirty and the left thumb cracked down past the nail				
	and interviews with r of Social Services, a provide incontinence bathing for 3 of 4 dep for the provision of a care (Residents #36, 49 was upset and tea	ecord review, observation, esident, family, Department and staff, the facility failed to care, showers, and/or bendent residents reviewed ctivity of daily living (ADL) #49 and #44). Resident # ary for staying soaked with ity staff responded to the call tinence care.				
	with residents and st resolve the repeat co Resident Council me	ecord review, and interviews aff, the facility failed to oncern reported during tetings for 4 of 4 consecutive Il lights not being answered				
	with the resident, sta the facility failed to p	ecord review and interviews ff, and Nurse Practitioner, rovide urinary catheter care sampled residents (Resident nary catheter care.				
	resident and family in Social Services (DSS failed to provide a win reported (Resident # investigate a grievant	ecord review, staff interview, nterview, and Department of S) staff interview, the facility ritten summary for grievances 36) and failed to write and ce that was reported verbally 9) for 2 of 2 residents ces.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA	6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 725	Continued From pa	ge 177	F 725				
	interview, and staff incorporate a Nursin planning process for	record review, resident interview, the facility failed to ng Assistant in the care or 1 of 4 residents reviewed for rocess (Resident #50).					
	1/8/19 at 10:30 AM Administrator in Jur the facility had beer and maintaining en- shifts since that tim had been assigned (NAs) to fill in the ga Administrator stated was one of the nurs assigned as an NA. During an interview PM he stated that h shift, but he frequer due to the facility's maintaining NA staf several times in the been asked to work in the NA schedule. about the third shift when only 2 NAs w he had difficulty ans timely, providing tim	with NA #1 on 1/9/19 at 3:58 e was hired to work the third ally worked other shifts as well difficulty obtaining and f. He revealed there were past few months that he had a double shift to fill in a gap NA #1 spoke specifically NA staffing and stated that here working on the third shift here working resident call bells hely incontinence care, and s choice to get out of bed					
	AM she stated she shift. NA #2 reveals months third shift w	with NA #2 on 1/10/19 at 6:20 normally worked the third ed that over the past several as staffed with 2 NAs. She only 2 NAs were working on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(>	(X3) DATE SURVEY COMPLETED		
		345450	B. WING_			C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA	1	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		0.00.2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACTION	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 725	Continued From page the third shift she had call bells timely, provicare, and honoring a of bed early in the mode of bed early incontinence of the service of bed early in the mode of the service o	e 178 I difficulty answering resident ding timely incontinence resident's choice to get out orning. With NA #3 on 1/10/19 at 6:25 he normally worked the third of that when only 2 NAs were shift she had difficulty hall bells timely, providing hare, and honoring a het out of bed early in the head the Administrator's report having difficulty obtaining high NAs to staff all three hed that staff members had hadditional shifts and/or to the revealed that this had	F 7	DEFICIENCY)			
	Administrator on 1/10 that sufficient staffing both in terms of qualineeds of the resident awareness that sufficient facility. He stated currently working with develop employment	was conducted with the 1/19 at 2:31 PM. He stated meant having enough staff ty and quantity to meet the s. He acknowledged his ient staffing was an issue at I that the facility was a the corporate office to incentives to obtain and aff to meet the needs of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	<u> </u>	0/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 756 SS=E	residents. An interview was cor Administrator on 3/6/reported he began w Interim Administrator Regional Vice Presid the Corporate Huma himself identified instrator ause of the facility's the residents. An interview was cor 3/6/19 at 1:34 PM. Hadministrator's interviad been insufficient of the residents. The Administrator made I difficulties with the fahad not described the He revealed he had Ineeds were unable to was insufficiently stathe root cause of the two-fold: 1. A lack of oversight 2. Insufficient staff The RVPO explained Administrator failed the processes and policiensure the facility hameet the needs of the Drug Regimen Revie CFR(s): 483.45(c)(1)	inducted with the Interim (19 at 12:20 PM. He orking at the facility as an on 1/18/19. He revealed the lent of Operations (RVPO), in Resources Director, and difficient staffing as the root failure to meet the needs of inducted with the RVPO on the confirmed the Interim view that indicated the facility ly staffed to meet the needs the RVPO stated the previous nim aware of some cility obtaining staff, but he the extent of these difficulties. The extent of these difficulties to be met because the facility ffed. The RVPO stated that facility's failures was that the facility's previous o provide oversight of the sand effective leadership to d sufficient nursing staff to the residents. The Report Irregular, Act On (2)(4)(5)	F 72			4/3/19
		imen Review. ug regimen of each resident least once a month by a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 756	Continued From page	e 180	F 75	56	
	licensed pharmacist.				
	§483.45(c)(2) This re of the resident's med	view must include a review ical chart.			
	irregularities to the at facility's medical direct and these reports mut (i) Irregularities including that meets the co (d) of this section for (ii) Any irregularities in during this review museparate, written report attending physician a director and director and director and the irregularity the (iii) The attending phyresident's medical recirregularity has been action has been take be no change in the resident and the irregularity that the irregularity has been action has been take be no change in the resident and the irregularity has been action the irregularity has been action the irregularity in the irregularity in the irregularity has been action the irregularity in the i	de, but are not limited to, any criteria set forth in paragraph an unnecessary drug. Noted by the pharmacist list be documented on a cort that is sent to the limited the facility's medical of nursing and lists, at a not's name, the relevant drug, he pharmacist identified. Sysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in			
	maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action This REQUIREMENT by:	cility must develop and procedures for the monthly that include, but are not s for the different steps in s the pharmacist must take ifies an irregularity that n to protect the resident.			
	Practitioner (NP) and	ns, staff, resident, Nurse Pharmacist Consultant I review, the Consultant		F756- Drug Regimen Review, Rep Irregular, Act On 1. The DON assessed Resident #3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			 ,	С	
		345450	B. WING			1	06/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00.2010	
WEOTING	OD 11541 TH AND DELIA	DU 174		62	25 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA		Α	RCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From page	e 181	F F	756				
		dentify the continued use of			received an order to discontinue as			
		n) medication that was not			needed (PRN) Ativan on 1/22/2019.			
		on for 1 (Resident #35) of 6			, ,			
		viewed for unnecessary			2. The DON completed a quality review	N		
	medications. The fine	dings included:			(audit) of current residents on PRN Ativ			
					to ensure a time limit is received on the			
		mitted 7/3/15 and readmitted			physician order on 2/19/19. No negative	е		
	Heart Failure, anxiety	ive diagnoses of Congestive			findings were identified. The Divisional Director of Clinical Services reviewed t	ho		
	Tieart Failule, allxiety	and Diabetes.			last 30 days of pharmacy consultant	iie		
	Review of Resident #	35's readmission Physician			report to ensure all residents were			
		indicated an order for			reviewed on 3/22/19.			
	Ativan 1 milligram (m	g) by mouth every 8 hours						
	as needed for anxiety	/.			3. Omnicare Pharmacy clinical manag	er		
					provided consultant pharmacist with			
		435's September 2018			re-education on the requirements and			
	mg by mouth every 8	icated an order to Ativan 1			expectations of F tag 756 to include monitoring all PRN psychotropic orders			
	anxiety.	Tiours as needed for			for appropriate indications and duration			
	anxioty.				as part of the monthly drug regimen	.0		
	Review of Resident #	35's Medication			review and irregularities will be			
	Administration Recor	d for September 2018			communicated to the facility and or			
		receive any doses of the			prescribers as part of the monthly			
	PRN Ativan.				consultation report on 3/22/19. The DC	·Ν		
	Daview of the Consul	Itarat Disawas sist Manthly			will provide re-education to licensed	لم		
		Itant Pharmacist Monthly Review dated 9/13/18			nurses, including all shifts, part-time ar prn to ensure time limited orders for PF			
		nted recommendations			Ativan are received on initial order by	VIN.		
	regarding the PRN At				2/8/2019. Staff will not be allowed to w	ork/		
					until education complete.			
	Review of Resident #	435's October 2018						
		icated an order to Ativan 1			4. RDCS and or DON will conduct qua	-		
	mg by mouth every 8	hours as needed for			monitoring (audit) of residents receiving	3		
	anxiety.				PRN Ativan to ensure time limits are			
	Review of Resident #	t35's Medication			ordered, 3 times per week for 4 weeks then weekly for 3 months. The DON w			
		d for October 2018 indicated			report on the results of the quality	III		
		N Ativan on 10/3/18, 10/5/18,			monitoring (audit) and report to the QA	PI		
		0/18/18 and 10/20/18 due to			committee. Findings will be reviewed by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	, ,	OATE SURVEY OMPLETED	
		345450	B. WING			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 756	Medication Regimen noted the PRN Ativar documented recomm PRN Ativan being tim Review of Resident Physician Orders inding by mouth every anxiety. Review of Resident Administration Recommended and Provided States of the Consument of the Consume	Itant Pharmacist Monthly Review dated 10/10/18 In prescribed but revealed no lendations regarding the limited in duration. Italians as needed for Italians Medication Italians and 11/10/18 due to Italians Pharmacist Monthly Review dated 11/15/18 Inted recommendations Italians Alexandrians Italians Alexand	F 75	QAPI committee monthly and omnitoring (audit) updated as it. 5. Date of Compliance 4/3/20	indicated.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 756	Continued From pag	ge 183	F 75	3		
	Physician Orders inc	#35's December 2018 dicated an order to Ativan 1 8 hours as needed for				
		#35's Medication rd for December 2018 t receive any doses of the				
	Medication Regimer	ultant Pharmacist Monthly n Review dated 12/5/18 ented recommendations ativan.				
	Orders indicated an	#35's January 2019 Physician order to Ativan 1 mg by as needed for anxiety.				
		#35's Medication rd for January 2019 to e did not receive any doses				
	at 3:15 PM, Resider PRN Ativan but repo months. She stated she has trouble brea	w and observation on 1/9/19 at #35 stated she received bred no anxiety in several when she becomes anxious, athing and had trouble dent #35 appeared clam, butty breathing.				
	of Nursing (DON) coreceived any documenthe Consultant Phar	9/19 at 4:24 PM, the Director on firmed the facility had not ented recommendations from macist about Resident #35's g time limited in duration.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	COME	
		345450	B. WING			C (06/2040
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	<u> U3</u>	/06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758 SS=E	stated it was her experience of the PRN Ativan be time lishe had not received Recommendation adderstand for the PRN Ativan. In a telephone interviethe Consultant Pharmexplain why he made regarding PRN Ativar duration. He stated heyet for January 2019 addressed it on his new the processed it on his new that is a state of the processed it on the processed it on the processed it on the processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreheresident, the facility medium states and the processed on a compreheresident, the facility medium states and the processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident, the facility medium states are processed on a compreheresident and the processed on a compreheresident are processed on a compreheresident and the processe	and he would have ext scheduled visit. 10/19 at 2:30 PM, the twas his expectation that Ativan order was time limited chotropic Meds/PRN Use (e)(1)-(5) In Drugs. In the service of a sessessment of a service of a sessessment of a service of a service assessment of a service of a service assessment of a service of a service assessment of a service of a s		758		4/3/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED	
		345450	B. WING _		0:	C 3/06/2019	
	ROVIDER OR SUPPLIER	BILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page	e 185	F 7	58			
		n is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral intervention	ents who use psychotropic il dose reductions, and ons, unless clinically n effort to discontinue these					
	unless that medication	ursuant to a PRN order on is necessary to treat a ondition that is documented					
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the Pl beyond 14 days, he of	RN order to be extended or she should document their ent's medical record and					
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT	rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. I is not met as evidenced					
	Practitioner and Phar and record review, th as needed (PRN) and was time limited in du failed to identify and	ons, staff, resident, Nurse rmacy Consultant interviews e facility failed to ensure an tianxiety (Ativan) medication uration (Resident #35) and monitor target behaviors for tions (Residents #35 and		F758- Free of Unnec Psychotro Med/PRN use 1. The DON assessed Resident received an order to discontinue Ativan on 1/22/2019. On 1/30/20 licensed nurse completed a Beh Monitoring Sheet for Resident #8	#35 and PRN 019 the avior		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345450	B. WING				C / 06/2019	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		,	00.2010	
MESTMO	OD 11541 TH AND DELIA	D.I. 174		625 ASHLAND STREET				
WESTWO	OD HEALTH AND REHA	BILITA		ARCHDALE, NC 27263				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 758	Continued From page	e 186	F 75	58				
	#50) for 2 of 6 sample	ed residents reviewed for						
	unnecessary medicat			2. The DON completed a qual	lity reviev	v of		
	The findings included	l:			current residents on PRN Ativan to ens a time limit is received on 2/19/19. The			
	1. Resident #35 was	admitted 7/3/15 and		residents receiving psychotrop				
		ith cumulative diagnoses of		medications to ensure monitor	•			
	Congestive Heart Fai	lure, anxiety and Diabetes.		target behaviors on 2-15-19. N findings were identified.	lo negati	ve		
	Review of Resident #	35's readmission Physician						
	Orders dated 8/13/18	indicated an order for		3. The DON will provide re-ed		0		
		g) by mouth every 8 hours		licensed nurses, including all s				
	as needed for anxiety	<i>/</i> .		part-time and prn, to ensure tir		d		
				orders for PRN Ativan are rece				
		35's September 2018		initial order and monitoring of t	-			
	mg by mouth every 8 anxiety.	icated an order to Ativan 1 hours as needed for		behaviors for psychotropic med 3/27/2019.	dications	by		
	anxiety.			4. RDCS and or DON will con-	duct qua	litv		
	Review of Resident #	35's Medication		monitoring (audit) of residents				
	Administration Recor	d for September 2018		PRN Ativan to ensure time limi	_	•		
		receive any doses of the		ordered and behavior monitori	ng sheet	s		
	PRN Ativan.			are in place, 3 times per week	for 4			
				weeks, then weekly for 3 mont	hs. The			
		35's September 2018		DON will report on the results	of the			
		Monthly Flow Record		quality monitoring (audit) and r		the		
		d targeted behaviors or any		QAPI committee. Findings will				
		mented behaviors. Review		reviewed by QAPI committee r	•	and		
		sing notes for September		Quality monitoring (audit) upda	ated as			
	2018 did not include	any documented behaviors.		indicated.				
		Itant Pharmacist Monthly		5. Date of Compliance 4/3/20	19.			
		Review dated 9/13/18 nted recommendations						
		ited recommendations tivan, targeted behaviors or						
	behaviors monitoring	. •						
	Review of Resident #	35's October 2018						
		icated an order to Ativan 1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345450	B. WING		03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	ABILITA	6	TREET ADDRESS, CITY, STATE, ZIP CODE 25 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 758	Continued From pag	ge 187	F 758			
	mg by mouth every anxiety.	8 hours as needed for				
	she received the PR	#35's Medication rd for October 2018 indicated N Ativan on 10/3/18, 10/5/18, 10/18/18 and 10/20/18 due to				
	indicated no identific evidence of any doc of Resident #35's nu	#35's October 2018 n Monthly Flow Record ed targeted behaviors or any umented behaviors. Review ursing notes for October 2018 documented behaviors.				
	Medication Regimer noted the PRN Ativa documented recomr PRN Ativan being tir	ultant Pharmacist Monthly n Review dated 10/10/18 n prescribed but revealed no mendations regarding the me limited in duration, or behaviors monitoring.				
	Physician Orders inc	#35's November 2018 dicated an order to Ativan 1 8 hours as needed for				
	indicated she receiv	#35's Medication ord for November 2018 ed the PRN Ativan 11/4/18, /8/18 and 11/10/18 due to				
	Behavior/Interventio indicated no identificated no identificated for any documents.	#35's November 2018 n Monthly Flow Record ed targeted behaviors or any umented behaviors. Review ursing notes for November				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	03/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 758	Review of the Cons Medication Regimer revealed no documer regarding the PRN / behaviors monitorin Resident #35 quarted dated 11/16/18 indicintact and exhibited assessment on the signs or symptoms coded as having recoded as having reconeded Ativan during Review of a Nurse For 11/20/18 revealed in Resident #35's PRN Review of Resident revised 11/29/18 incompared to the formula of the revised 11/29/18 incompared to the revised 11/29/18 incompar	ultant Pharmacist Monthly n Review dated 11/15/18 ented recommendations Ativan, targeted behaviors or g. erly Minimum Data Set (MDS) cated she was cognitively no behaviors. Her mood MDS did not indicated any of anxiety. Resident #35 was ceived one dose of the as g the 7 days look back period. Practitioner (NP) note dated o documentation regarding I Ativan or anxiety. #35's care plan dated last dicated she was receiving medication) as needed. ed monitoring for behaviors to anges, memory impairment, sedation and a gradual dose ly indicated. #35's December 2018 dicated an order to Ativan 1 8 hours as needed for	F 75			
	Review of Resident	#35's December 2018				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C		
		345450	B. WING		03/06/2019		
	ROVIDER OR SUPPLIER	ABILITA		1 00/00/2010			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 758	indicated no identified evidence of any doctor of Resident #35's not 2018 did not included. Review of a NP noted documentation regard. Ativan or anxiety. Review of the Consumedication Regimentation Regimentation Regimentation Regarding the PRN Abehaviors monitoring. Review of a Physicial	an Monthly Flow Record and targeted behaviors or any aumented behaviors. Review arsing notes for December any documented behaviors. a dated 12/4/18 revealed no arding Resident #35's PRN alltant Pharmacist Monthly a Review dated 12/5/18 anted recommendations activan, targeted behaviors or an note dated 12/10/18	F 75	58			
	#35's PRN Ativan or Review of a NP note documentation regard Ativan or anxiety. Review of Resident: Orders indicated an mouth every 8 hours. Review of Resident: Administration Recopresent indicated shof the PRN Ativan. Review of Resident: present Behavior/Int Record indicated no or any evidence of a Review of Resident:	#35's January 2019 Physician order to Ativan 1 mg by as needed for anxiety.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	OATE SURVEY COMPLETED
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER	ABILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263			33,733,2310
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	10:33 AM, Resident appeared calm and depression and voic or with the facility. In a second intervie at 3:15 PM, Resider PRN Ativan but report months. She stated she has trouble breat concentrating. Resider laxed with no difficult in an interview on 1 of Nursing (DON) correceived any docum the Consultant Phar PRN Ativan not bein DON stated there we Resident #35's target specific targeted befor the resident's used in an interview on 1 stated it was her ex PRN Ativan be time targeted behavior mot received any Pharmaddressing the cont Ativan. In a telephone interview in the second state of the resident was her expended to the control of the cont	observation on 1/7/19 at #35 reported no anxiety and relaxed. She reported no sed no concerns with her care when and observation on 1/9/19 at #35 stated she received orted no anxiety in several when she becomes anxious, athing and had trouble dent #35 appeared clam, culty breathing. /9/19 at 4:24 PM, the Director confirmed the facility had not mented recommendations from remacist about Resident #35's and the series of the end of the end of Ativan. /10/19 at 9:30 AM, the NP prectation that Resident #35's limited induration with nonitoring. She stated she had narmacy Recommendation inued order for the PRN view on 1/10/19 at 1:27 PM,	F 7	58		
	explain why he mad regarding PRN Ativa	macist stated he could not le no recommendations an with no time limited he had not been to the facility				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345450	B. WING		C 03/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 758	addressed it on his In an interview on 1 Administrator stated Resident #35's PRN in duration and that behaviors with ongo monitoring. 2. Resident #50 wa: 12/11/18 with diagn disorder, Alzheimer disturbance, and ps A physician 's orde Seroquel (antipsych milligrams (mg) ond The Admission Mini assessment dated ' #50 's cognition wa no behaviors and no #50 was administer on 7 of 7 days durin The Care Area Asse psychotropic medica 12/18/18 MDS indio Alzheimer 's, deme disorder. Resident confusion and disor Seroquel. This CAA (SW) was to refer R consultation. Resident #50 's con	9 and he would have next scheduled visit. 710/19 at 2:30 PM, the dit was his expectation that Nativan order was time limited the facility identify targeted bing documented behavior 8 admitted to the facility on oses that included mood 's, dementia with behavioral sychosis. 9 and 12/11/18 indicated mood ed aily at bedtime. 9 and 12/11/18 indicated mood 's, dementia with behavioral sychosis. 12/18/18 indicated Resident is severely impaired. She had to rejection of care. Resident ed antipsychotic medication in the MDS review period. 12/18/18 indicated to make a mood modern for Resident #50 's material states and mood with the modern for Resident with intentation daily. She was on A indicated that Social Work desident #50 for psychiatric imprehensive care plan, last	F 758			
	consultation. Resident #50 ' s correviewed 12/27/18,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3		ATE SURVEY DMPLETED
		345450	B. WING			C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	easily angered. The part, monitor behave effects related to the A review of the Decindicated she received aily as ordered. A review of the Decindicated she received aily as ordered. A review of the Decindicated to Resident target behaviors. To staff documentation monitoring. This for except for the documame, the month (Emedication (Seroque A review of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated serocompared to the service of the Januthrough 1/8/19 indicated s	personal section of the form additionally had no he form a	F 75	,		
	medical record. An observation was on 1/7/19 at 4:20 P and was seated in a signs or symptoms An observation was on 1/8/19 at 1:45 P was lying in bed. T symptoms of behave	s conducted of Resident #50 M. Resident #50 was alert and here were no signs or				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345450	B. WING _			C 3/06/2019	
	ROVIDER OR SUPPLIER OD HEALTH AND REHA	BILITA		STREET ADDRESS, CITY, STATE, ZIP COD 625 ASHLAND STREET ARCHDALE, NC 27263		3/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page 1/9/19 at 11:30 AM h	e 193 e verified there was no	F 7	58			
	January 2019 Behav Record for Resident	ior/Intervention Monthly Flow #50.					
	1/9/19 at 12:05 PM. were completed on h indicated that behavi	ors and side effect psychotropic medications					
	Behavior/Interventior was kept in the same Nurse #3 confirmed t	Monthly Flow Record that binder with the MARs. hat no target behaviors were					
	Behavior/Intervention no documentation wa	at #50 's December 2018 Monthly Flow Record and as completed related to or side effect monitoring.					
	Nurse #3 additionally January 2019 Behav Record for Resident	r confirmed there was not a ior/Intervention Monthly Flow #50. She revealed that f just brought out a "stack"					
	of blank Behavior/Into Record forms as it ha (1/9/19) that several	ervention Monthly Flow ad been identified today residents had not had this					
	asked who was responded asked	January 2019. She was onsible for ensuring the Monthly Flow Records were					
	that the third shift null changeover at the er	e completed. She indicated uses completed the monthly and of each month and they					
	· ·						
	Behavior/Interventior in the chart and was	n Monthly Flow Record was completed. Nurse #3 realized that this form for					
		ot in Resident #50 's chart s staff requested a copy of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345450	B. WING				0
NAME OF DE	ROVIDER OR SUPPLIER	343430	B. Willo	_	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	06/2019
NAME OF FR	COVIDER OR SUFFLIER				625 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	BILITA			ARCHDALE, NC 27263		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 758	Continued From page	· 194	F	758	3		
		(1/9/19). She was unable to	'	700	,		
	explain why the Dece						
	Resident #50 was inc						
	An interview was con-	ducted with Resident #50 's					
	Nurse Practitioner (N	P) on 1/10/19 at 12:05 PM.					
		expectation that target					
		fied and that behavior					
	completed for the use	effect monitoring were					
		isked why Resident #50 was					
		he NP indicated that the					
		quel at home prior to her					
		ad wanted to wait until a					
		on had been conducted sychotropic medication					
	changes.	yonotropio medication					
		ducted with the Social					
	` '	19 at 2:47 PM. She stated					
		d not seen the facility 's et. She reported that the					
		ctitioner came to the facility					
		ner most recent visit was on					
	·	ident #50 ' s admission					
	(12/11/18).						
	An interview was con-	ducted with the Director of					
	Nursing (DON) on 1/1	10/19 at 2:31 PM. She					
		ectation that target behaviors					
		at behavior monitoring, and					
		were completed for the use cations. She indicated this					
	monitoring was to be						
	_	Monthly Flow Record.					
F 812		ore/Prepare/Serve-Sanitary	F	812	2		
SS=E	CFR(s): 483.60(i)(1)(2	2)					
	§483.60(i) Food safet	y requirements.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		345450	B. WING		C 03/06/2019
	ROVIDER OR SUPPLIER OD HEALTH AND REH	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 812	approved or consident state or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision do from consuming for serve food in accordance for food serve food in the kitchen's dry expired food items a stored in 2 of 2 reaction 1/7/19 at 10:05	ure food from sources ered satisfactory by federal, rities. food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable elod-handling practices. Des not preclude residents elds not procured by the facility. Des, prepare, distribute and dance with professional	F 81	,	s to
	original wrapping w expiration date of 1: On 01/07/19 at 10:1 kitchen's two reach Dietary Manager re food items in both re	12 apple muffins not in their ith an expired hand-written 2/15/18. 15 am an observation of the in refrigerators with the wealed expired and undated each-in refrigerators. These d food items included: a		negative findings were identified. 3. On 2/6/19 the Dietary Contractor provided re-education to the DM in sa storage, preparation and serving of the dietary contractor will provide education to the dietary staff on safe storage, preparation and service of for by 2/13/2019. Staff will not be allowed.	oods.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION (X3 BUILDING		X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/06/2019	
WESTWO	OD HEALTH AND REHA	BILITA		625 ASHLAND STREET ARCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812	a hand-written expire container of chicken sexpired expiration date a hand written expire an opened pineapple no date, an opened of date, and an opened with no date. All item their container. On 1/7/19 at 10:20 are conducted with the Data the and the assignessible to check kitchen's dry storage and undated items are food and drink items items. The Dietary Manager state been done since the discarded the expired observed in the two monducted with the fill today to check the kit expired and undated he had not checked the for expired and undated on 1/10/19 at 2:00 preconducted with the Alexpected the kitchen.	mixed with mayonnaise with d expiration date of 1/2/19, a salad with a hand-written te of 1/3/19, a pork loin with d expiration date of 1/2/19, in a plastic container with container of juice with no container of tarter sauce as were half-full or more in m an interview was ietary Manager who stated ned cook for the day were kitchen refrigerators and the area each day for expired and to discard any expired and to discard open undated lanager stated that the open or re-wrapped food the discard date. The ed that this task had not previous Friday and then d and undated items each in refrigerators. In an interview was l-in Cook who was assigned then refrigerator units or food items. The cook stated he kitchen 's refrigerators ited food items today.	F 8	work until education complete. 4. ED will conduct quality moni (audit) of the kitchen area and ostorage facilities, 3 times per woweeks, then weekly for 3 month will report on the results of the committee. Findings will be revealed committee and committee monthly and committee monthly and committee of Compliance 2/20/20	dietary eek for 4 ns. The ED quality the QAPI viewed by Quality ndicated.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CX3) DATE SURVEY COMPLETED
		345450	B. WING		03/06/2019
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA (XA) ID PREFIX TAG (EACH DEFICIENCY MUST BE PECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 835 F 835 Continued From page 197 F 835 F 835 CFR(s): 483.70 \$483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interview, resident and family interview, and wound care Nurse Practitioner interview, the facility's Administrator failed to provide oversight of processes and policies and effective leadership to ensure residents were free from neglect as evidenced by not providing wound care for 3 of 4 residents with wounds (Resident #1, #36, and #44); not providing catheter care for 1 of 1 residents reviewed (Resident serviewed (Resident #49). The facility's administrator also failed to provide sufficient nursing staff to honor resident preferences, treat residents with dignity and respect, resolve individual and resident council grievances, and ensure Nursing Assistant involvement in the development of the comprehensive care plan. This affected 14 of 24 sampled residents (Residents #1, #30, #32, #36, President President President Executiv sampled residents (Residents #1, #30, #32, #36, President Presiden	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	1 33/06/2310			
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 835	Administration CFR(s): 483.70 §483.70 Administrati A facility must be adrenables it to use its refficiently to attain or practicable physical, well-being of each rethis REQUIREMENT by: Based on record revinterview, resident ar wound care Nurse Pfacility's Administration	on. ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced riew, observations, staff and family interview, and ractitioner interview, the tor failed to provide oversight		F835- Administration 1. On 1/18/19 effective leadership (a interim administrator Divisional Executive Director) was installed by Regional N	cutive /ice
	to ensure residents we evidenced by not prove residents with wound #44); not providing considents reviewed (I answering a call light incontinence care for (Resident #49). The failed to provide suffiresident preferences and respect, resolve council grievances, a involvement in the decomprehensive care sampled residents (F#44, #47, #49, #50, are sident council). The sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the decomposition of the sufficient staffing for Resident #36 resulted worsening and the sufficient staffing for Resident #36 resulted worsening and the sufficient staffing for Resident #36 resulted worsening and the sufficient staffing for Resident #36 resulted worsening and the sufficient staffing for Resident #36 resulted worsening #36 resulte	vere free from neglect as oviding wound care for 3 of 4 ds (Resident # 1, #36, and atheter care for 1 of 1 Resident #44); and by not a related to a request for 1 of 1 resident reviewed facility's administrator also cient nursing staff to honor, treat residents with dignity individual and resident and ensure Nursing Assistant evelopment of the plan. This affected 14 of 24 Residents #1, #30, #32, #36,		President of Operations to ensure predictions of the center including oversight of processes and policies are ensure resident were free from negles received pressure ulcer care as order and maintained sufficient nursing state to provide necessary care and service all residents of the center. Corporate Human Resources and Regional state worked with the Interim Executive Ditto implement staff recruitment practice ensure the center was appropriately staffed (center achieved appropriate staffing on 02/07/19). The Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources conferred 01/22/19 to dis Root Cause Analysis and develop are action plan. The action plan include following: Recruit, with incentives, CLPN and RN staff from sister center.	g the and to ect, ered affing ce for e ff irector ces to al ne scuss n d the NA,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG		,	C
		345450	B. WING			1	06/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				62	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	BILITA		Α	RCHDALE, NC 27263		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	e 198	F	835			
		began on 11/6/18 when due	•		Triad market, Referral Bonus for existir	na	
		and failed oversight, staff			staff with immediate pay out, Recruit a	-	
	_	pressure ulcer care resulting			hire Personal Care Assistants, Retrain	.~	
		d infection of Resident #36's			staff scheduler and ensure schedule is		
	wound. Immediate J	eopardy was removed on			accurate, Sign on bonus for CNA positi	on,	
	3/6/19 when the facili	· · · · ·			and that sufficient staff is provided to		
	implemented an acce	eptable credible allegation of			ensure that pressure sores care and		
	Immediate Jeopardy	removal.			treatment is done per physician orders		
					and that the residents are free from		
		n out of compliance at a			neglect. On 01/22/19 a root cause		
		erity level of "H" (actual harm			analysis was completed by the Regiona		
	that is not Immediate	· · · · · · · · · · · · · · · · · · ·			Vice President of Operations, Regional		
		s are put in place and to			Director of Clinical Services, the Direct		
	complete employee in	n-service training.			of Nursing and the Divisional Executive	;	
	Findings included:				Director (acting administrator) and determined that the former Executive		
	This tag is cross refe	renced to:			Director failed to provide consistent		
	This tag is cross rele	reflect to.			staffing to ensure treatments were		
	1a. Tag F-600: Based	d on record review.			completed as ordered, and failed to		
	_	terview, resident interview,			provide oversight to make sure that car	·e	
		nd care Nurse Practitioner			and services were delivered per physic		
		ctitioner interview, and			order. By 02/07/19 sufficient staff was		
		Services interview, the			provided to ensure residents receiving		
	facility neglected to p	rovide daily pressure ulcer			pressure ulcer treatment.		
	wound care as ordere	ed, weekly wound					
		sment and documentation,			2. On 01/22/2019 the Executive Director		
		vith the outside podiatrist			Regional Vice President of Operations		
		g resulting in a worsening			Divisional Human Resources conference		
		fection (Resident #36);			and implemented staffing plans includir	-	
		daily pressure ulcer wound			wage increases, recruitment and retent	ion	
	care as ordered, wee	Riy wound sment and documentation			plans to ensure sufficient staffing. On 02/07/19 sufficient staff was hired and		
		ing pressure ulcer (Resident			have completed orientation. The		
	_	provide daily pressure ulcer			Executive Director will provide oversight	nt of	
	wound care as order				the delivery of care and services of	11 01	
		sment and documentation			wounds to prevent neglect through rou	tine	
		of 4 residents reviewed; the			rounds, communication with Director of		
	facility neglected to p				Nursing and daily review of staffing leve		
		of 1 resident reviewed; and			3 -		

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(C
		345450	B. WING _				06/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				62	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REHA	BILITA		Α	RCHDALE, NC 27263		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	e 199	F	335			
		cted to answer a call light			3. On 01/18/19 the Regional Vice		
	related to a request for				President of Operations and the Regio	nal	
	· ·	of 1 resident reviewed.			Director of Human Resources began	iiai	
		or resident reviewed.			recruiting and interviewing qualified		
	b. Tag F-686: Based	on record review.			Administrators to fill the Executive		
	_	terview, resident and family			Director position at the center. The		
	interview, wound care				Executive Director worked with the fac	ility	
	interview, and Nurse	Practitioner interview, the			and corporate Human Resources staff	-	
	facility failed to provid	de daily pressure ulcer			fulfill staffing needs through appropriat	е	
	wound care as ordere	ed, weekly wound			recruitment and retention programs. T	he	
		sment and documentation,			facility achieved sufficient staffing on		
		vith the outside podiatrist			02/07/19. The Director of Nursing will		
		g resulting in a worsening			monitor daily staffing levels at morning		
	I -	fection (Resident #36); failed			and evening meetings, review of open		
	-	sure ulcer wound care as			positions and validation of staffing leve	IS	
	ordered, weekly woul				daily to ensure wound care will be		
		sment and documentation			completed. If the treatment nurse is	tho	
		ing pressure ulcer (Resident vide daily pressure ulcer			unavailable it will be communicated to licensed nurses by the Director of Nurs		
		ed and weekly wound			to provide treatments as ordered by the		
		sment and documentation			physician. Licensed staff has the capa		
		of 4 sampled residents			to complete their assignments, includir	-	
	reviewed for wound o				treatments within the parameters of the	-	
					work schedule. If the licensed nurse		
	c. Tag F-725: Based	on observation, record			cannot complete the treatment within t	ne	
	review, and interview	s with resident, family, staff,			parameter of their work schedule, the		
	Department of Social	Services, and Nurse			licensed nurse will report the issue to t	he	
	Practitioners, the faci	lity failed to provide sufficient			Director of Nursing. The Director of		
	nursing staff to ensur				Nursing will grant overtime to the licens		
	I -	d care, urinary catheter care,			nurse to complete the task, delegate the		
		ities of Daily Living (ADLs),			responsibility to another nurse or assis	t	
	,	ells. The facility also failed			with the task. The Director of Nursing		
	to provide sufficient n	-			and/or Minimum Data Set Nurse will		
		treat residents with dignity			complete the assessment and	_	
		individual and resident			measurements if the treatment nurse is	5	
	_	and ensure Nursing Assistant			unavailable. Executive Director will		
	involvement in the de				monitor staff openings, recruitment,	•	
		plan. This affected 13 of 24 desidents #1, #30, #32, #36,			training and scheduling of staff through review of daily staffing levels at morning		
	sampieu residents (R	.coidciilo # i, #JU, #JZ, #JU,			Toview of daily stailing levels at Intollin	9	

		SURVEY					
						(С
		345450	B. WING _			03/	06/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MECTIMO	OD LIE AL TIL AND DEL	IADU ITA		62	25 ASHLAND STREET		
WESTWO	OD HEALTH AND REF	IABILITA		Α	RCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	council). The repe sufficient staffing for Resident #36 resul worsening and the (Methicillin-resistar The Administrator a Immediate Jeopard On 3/6/19 the facilit credible allegation removal: The center Executi of immediate jeopard Deficient Practice The facility Administrator oversight of process leadership to ensuring lect, received pand maintained sufficient Practice The facility Administratory oversight of process leadership to ensuring lect, received pand maintained sufficient Practice The facility Administratory oversight of process leadership to ensuring lect, received pand maintained sufficient Practice The facility Administratory oversight of process leadership to ensuring	6 members of the resident ated failure to provide or pressure ulcer care to ted in his pressure ulcer development of MRSA at Staphylococcus) infection. and DON were notified of the dy on 3/6/19 11:29 am. ty provided the following of Immediate Jeopardy ve Director alleges abatement	F	835	and evening meetings, review of open positions and validation of staffing lever daily. Executive Director will monitor staffing and the delivery of wound care times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks ensure all resources are utilized. The Executive Director and Director of Nurs will report on the results of the quality monitoring (audit) and report to the QA committee. Findings will be reviewed QAPI committee monthly and Quality monitoring (audit) updated as indicated The Regional Vice President of Operations and the Regional Director Clinical Services will monitor staffing levels and the delivery of wound care through internal portal, communication with Executive Director/Director of Nursing and weekly visits to ensure adequate staffing is maintained. The center Executive Director conveyed an ADHOC Quality Assurance Performant Improvement meeting 03/06/19, include the Interim Executive Director, D	5 L to sing Pl Dy d. of	
	Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources. The preliminary investigative information to determine root cause was the center wage scale and a competitive wage analysis. The competitive wage analysis revealed that the center needed to increase the lower end of the wage scale for new hires as compared to other centers in the market. 1. The corrective action for the alleged deficient				Housekeeping Manager, the Business Office Manager, the Human Resource: Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Service regarding the plan of removal of immediacy.	5	
	practice was accor	-			4 Executive Director will monitor staffi	na	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			TE SURVEY MPLETED	
		345450	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343430	B: Willo _	STREET ADDRESS, CITY, STATE, ZIP C		03/06/2019	
NAME OF PI	ROVIDER OR SUPPLIER				JODE		
WESTWO	OD HEALTH AND REHA	BILITA		625 ASHLAND STREET			
				ARCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	Continued From page	e 201	F 8	35			
F 835	administrator Division installed by Regional Operations to ensure center including the composition of the center including the composition of the center and maintained sufficient of the center of th	vice President of proper Administration of the oversight of processes and expression and expression and service for all executive Director to item practices and Regional staff im Executive Director to item practices to ensure priately staffed (center staffing on 02/07/19). Analysis and develop an on plan included the incentives, Certified Nursing ensed Practical Nurse (LPN) are (RN) staff from sister the incentives, Care incentives, Certified Nursing ensed Practical Nurse (LPN) are (RN) staff from sister the incentives of expression and incentives and ensure are and treatment is done	F 8	and the delivery of wound of week then 3 times a week then 1 time a week for 8 we all resources are utilized. Director and Director of Nu on the results of the quality (audit) and report to the QAF Findings will be reviewed be committee monthly and Qu (audit) updated as indicate Regional Vice President of and the Regional Director of Services will monitor staffir the delivery of wound care internal portal, communicate Executive Director/Director weekly visits to ensure add is maintained. The center Edirector conveyed an ADH Assurance Performance Immeeting 03/06/19, including Executive Director, Director Director of Rehab, MDS Note Housekeeping Manager, the Human Coordinator, Medical Reconsupply Clerk, Admissions Idea Dietary Manager, Activity Editor of Coregarding the plan of removing mediacy. 5. Date of Compliance 4/	for 4 weeks eeks to ensure The Executive ursing will report of monitoring API committee. by QAPI uality monitoring d. The f Operations of Clinical ng levels and through tion with f of Nursing and equate staffing Executive OC Quality inprovement g the Interim or of Nursing, urse, ne Business in Resources ords, Central Director, Director, the f Operations linical Services val of		
	immediate pay out, Recruit and Assistants, Retrain staff schedule is accurate, Sign on bon That sufficie that pressure sores of	hire Personal Care scheduler and ensure us for CNA position, and int staff is provided to ensure		Regional Vice President of and Regional Director of C regarding the plan of remoinmediacy.	Operations linical Services val of		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	' '	DATE SURVEY COMPLETED
		345450	B. WING _			C 03/06/2019
	ROVIDER OR SUPPLIER	ABILITA	•	STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 835	Operations, Regional Services, the Director Divisional Executive administrator) and de Executive Director fastaffing to ensure tree ordered, and failed to sure that care and sephysician order. By 02/07/19 sufficient ensure residents reconsure residents reconsure residents reconsured treatment. 2. Residents with the alleged deficient practice on 01/22/2019 the EVice President of Operation of	rause analysis was regional Vice President of al Director of Clinical or of Nursing and the Director (acting retermined that the former railed to provide consistent atments were completed as or provide oversight to make revices were delivered per at staff was provided to reiving pressure ulcer the potential to be affected by rectice: receutive Director, Regional recations, Divisional Human reced and implemented staffing reincreases, recruitment and sure sufficient staffing. On reaff were hired and have rection. The Executive Director rection of the delivery of care and rection or prevent neglect through daily communication with and daily review of staffing reses.	F	335		
	Operations and the Resources began re	gional Vice President of Regional Director of Human cruiting and interviewing ors to fill the Executive the center.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ELE CONSTRUCTION		OMPLETED
		345450	B. WING			C 03/06/2019
	ROVIDER OR SUPPLIER	ABILITA		STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		03/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	Continued From pag	ge 203	F 83	35		
	and corporate Huma staffing needs throu	etor worked with the facility an Resources staff to fulfill gh appropriate recruitment ams. The facility achieved 02/07/19.				
	levels at morning ar of open positions ar daily to ensure wou the treatment nurse	sing will monitor daily staffing and evening meetings, review and validation of staffing levels and care will be completed. If is unavailable it will be a licensed nurses by the				
	Director of Nursing ordered by the physicapacity to complete treatments within the	to provide treatments as ician. Licensed staff have the their assignments, including a parameters of their work nsed nurse cannot complete				
	the treatment within schedule, the licens to the Director of Nu Nursing will grant ov	the parameter of their work ed nurse will report the issue ursing. The Director of vertime to the licensed nurse and delegate the responsibility				
	to another nurse or Director of Nursing a Nurse will complete measurements if the	assist with the task. The and/or Minimum Data Set the assessment and treatment nurse is				
		ort to the Executive Director.				
	scheduling of staff a review of daily staffi evening meetings, r	vill monitor staff openings, nd delivery of care through ng levels at morning and eview of open positions with ation of staffing levels daily staff interviews.				
	delivery of wound ca times a week for 4 v	vill monitor staffing and the are 5 times a week then 3 weeks then 1 time a week for all resources are utilized. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345450	B. WING _			C 03/06/2019		
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA				STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263	I	03/00/2013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 835	Executive Director are report on the results (audit) and report to Findings will be revie monthly and Quality indicated. The Regional Vice P the Regional Director monitor staffing level care through internal Executive Director/D visits to ensure adequative Director of Rehab, M Manager, the Busine Human Resources C Records, Central Su Director, Dietary Man Environmental Servic Vice President of Op Director of Clinical S removal of immediacy plan via the Director and the Director of Clinical S removal was validated which included:	and Director of Nursing will of the quality monitoring the QAPI committee. Ewed by QAPI committee monitoring (audit) updated as resident of Operations and of Clinical Services will so and the delivery of wound portal, communication with irector of Nursing and weekly uate staffing is maintained. Director conveyed an urance Performance go 3/06/19, including the rector, Director of Nursing, IDS Nurse, Housekeeping is Office Manager, the coordinator, Medical poly Clerk, Admissions nager, Activity Director, the ces Director, the Regional erations and Regional ervices regarding the plan of	F8	35				
	were 17 new employ	rees documented as starting ing assistant and licensed						

NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PAGE 125 ASHLAND STREET ARCHDALE, NC 27263 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	06/2019 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PAGE 125 ASHLAND STREET ARCHDALE, NC 27263 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
DEFICIENCY)	
Continued From page 205 nurse between 1/12/19 and 2/27/19. On 3/6/19 at 4:30 pm interviews of 5 random staff members were conducted which revealed that "several newly employed nursing assistants had started over the past 2 months and the facility was fully staffed." The rate of grievances filed by residents and/or their family had dropped by half. The last resident council meeting held February 2019 identified that call lights and incontinence care were addressed timely to the satisfaction of the residents. On 3/6/19 at 5:10 pm an interview was conducted with the Corporate Vice President of Operations who stated he conferenced with the Divisional Human Resources Director and implemented staffing plans including wage increases and recruitment and retention plans to ensure sufficient staffing. On 27/19 sufficient staff had been hired and had received orientation prior to accepting an assignment. Daily staffing meetings have occurred to ensure sufficient staffing patterns. The Corporate Vice President further commented that he was not aware of staffing to the significance level it had reached. He had communication from the facility Administrator who discussed recruitment of nursing assistants and that current nursing staff were covering shifts but not that care was not completed. The nursing assistant wage scale was higher for experience and the Administrator was informed to offer the higher wage scale to all staff. The Administrator did not follow the direction well. There was as lack	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345450	B. WING		C 03/06/2019	
NAME OF PROVIDER OR SUPPLIER WESTWOOD HEALTH AND REHABILITA				STREET ADDRESS, CITY, STATE, ZIP CODE 625 ASHLAND STREET ARCHDALE, NC 27263		
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F 867 SS=D	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	F867- QAPI/QAA Improvement Activit 1. The ED conducted a QAPI meeting discuss findings from annual survey ar audited an action plan to address the facilities failure to identify and monitor target behaviors for psychotropic medications on 1/25/2019. The ED informed the IDT team members (ED, DCS, SSD, MDS Coordinator, Busines Office Manager, Housekeeping Supervisor, Medical Records Coordina Activities Director, Rehab Manager, Dietary Manager, Human Resource Coordinator, CNA, Medical Director ar Division DCS) of the survey findings.	to nd for ss ator,	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345450	B. WING			C 03/06/2019		
NAME OF PROVIDER OR SUPPLIER			1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	06/2019	
					25 ASHLAND STREET			
WESTWO	OD HEALTH AND REHA	BILITA			RCHDALE, NC 27263			
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 867	the facility's inability the Assurance Program. This citation is cross F758 Based on obsection interviews and recordidentify and monitor for psychotropic medical #50) for 2 of 6 sample unnecessary medical monitor the side of use of pschotropic meaning the facility's 2 complaint survey the form to monitor the side of use of pschotropic meaning the residents refer to monitoring targeted by the facility of June 2018 and have improve other areas of focused on the Pharm	The findings included: referenced to: ervations, staff, resident, and Pharmacist Consultant of review, the facility failed to for target behaviors for the tions (Residents #35 and the edications reviewed for the tions. 15/18 recertification and facility was cited for failure feets and behaviors with the edications for 2 of 6 wiewed (Residents #40 & 10/19 at 2:30 PM, the lable to offer an explanation citation at F758 for behaviors associated with the medications. The he was new to the facility as dispersion behaviors for the nurses of the haviors for the use of	F	367	 On 3/26/2019 the RDCS completed quality review (audit) of QAPI meeting minutes and quality audit implemented ensure identifying and monitoring targe behaviors for psychotropic medications. The review (audit) revealed the meetin was held and the minutes were accura The RDCS will provide re-education QAPI Committee on the federal regulations and guidelines for QAPI/Q/procedures by 3/26/19. RDCS and or ED will conduct qualit monitoring (audit) of QAPI meetings to ensure QAPI Committee will meet a minimum of monthly to review areas of improvement per guidelines, monthly x monthly, and then quarterly for 2 quarte. The ED and DCS will report on the rest of the quality monitoring (audit) and rep to the QAPI committee. Findings will be reviewed by QAPI committee monthly a Quality monitoring (audit) updated as indicated. Date of Compliance 4/3/2019. 	et s. g tte. tto AA y 4 ers. ults port e		