STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to notify the physician when they couldn't complete a thorough assessment of a	F 157	Westwood Hills Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	8/28/15

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

Electronically Signed | 08/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 resident in pain after falling out of bed and the resident was requesting an ambulance for 1 of 2 sampled residents (Resident #24). The findings included: Resident #24 was admitted to the facility on 01/09/15 with dementia, cognitive communication deficit, right hip fracture (07/06/15) and others. The Minimum Data Set (MDS) dated 06/25/15 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making but had clear speech, was able to make herself understood and usually understood others. The MDS also specified the resident required extensive assistance with activities of daily living, had no presence of pain and had fallen twice without injury. Review of Resident #24's medical record revealed a nurse's entry made by the night shift supervisor dated 07/06/15 at 3:20 AM that read in part, "Resident was found on the floor laying on her right side. Resident clutched middle portion of thigh and was reluctant to move right leg." An incident report dated 07/06/15 completed by the night shift supervisor specified Resident #24 was found in the floor clutching her thigh and was reluctant to move her right leg asking "call an ambulance, get me an ambulance." The incident report revealed the resident was placed back in bed. The night shift supervisor documented on the incident report that the physician was contacted at 3:20 AM. Further review of the medical record revealed a nurse's entry dated 07/06/15 at 1:20 PM specified	F 157	and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehabilitation Center¿s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F 157 Resident #24 was transferred to the local Hospital ER at 10:30pm for evaluation of her fractured hip. All residents will be assessed with a significant change in condition, including an injury from a fall, for notification of MD and or ER evaluation if indicated. 100% of all in house residents were assessed and reviewed for any significant change in condition, including an injury from a fall. These assessments were completed by the Administrative nursing staff, including the DON, ADON, QI Nurse, SDC, RN Supervisors, Treatment Nurses and the MDS Nurses. These assessments were completed August 19-24, 2015. Any area identified to be a significant change in condition, including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 the on-call nurse practitioner was notified that Resident #24 was having increased pain to right leg and the leg was "drawn up." The resident would yell out when range of motion was performed. The on-call practitioner ordered an x-ray. The radiology report dated 07/06/15 revealed Resident #24 had a fracture of the right hip. Resident #24 was transported to the Emergency Department on 07/06/15 at 10:30 PM. On 07/06/15 at 4:10 PM Nurse #1 was interviewed and explained that he was orienting to night shift on 07/06/15 and that he normally worked 7 AM to 3 PM (day shift). He added that during the day shift if a resident fell and developed a new onset of pain he would contact the physician. Nurse #1 reported that on 07/06/15 he was notified that Resident #24 fell; he stated that he responded to the resident and "checked" her out. He stated that he couldn't see any red marks and felt it was safe to put her back to bed. The nurse stated that he assessed Resident #24 before deciding to transfer her off the floor but was unable to check range of motion due to pain in her right leg. Nurse #1 explained that Resident #24 was in pain and when asked where the pain was located she patted her right hip, she was unable to verbalize a 1 to 10 pain scale but the resident showed facial grimacing and was holding her right side. The nurse stated that the new onset of pain after the fall was a change in the resident's condition and he notified the night shift supervisor. He added that Resident #24 had "as needed" pain medication which he offered but the resident refused. Nurse #1 stated that he did not notify the physician of Resident	F 157	injury from a fall, was immediately called to the MD/FNP or PA for that resident. 100% in-service initiated by the SDC, DON, or RN designee to all licensed and unlicensed staff in the nursing department. This in-service covered notification of physician of any significant change in condition, including injury from an accident, assessment of change in condition, including injury from an accident, and reporting any changes to the appropriate staff at the nursing facility. This training will begin 8/20/2015 and will be completed by 8/28/2015. This training will be given in orientation to all new hires to the nursing department by the SDC beginning 8/25/2015. All resident progress notes, and incident reports will be monitored daily by the DON, ADON, and RN Supervisor to ensure all significant changes in condition, including injuries from an accident has been assessed and the notification of the MD/FNP/PA has been notified. Any concerns will immediately be addressed at that time. An audit tool will be utilized and monitored by the Administrator, DON, or ADON. This tool will be completed by the QI Nurse or designee, 3x week x 4 weeks, then 2 x week x 4 weeks, then weekly x 4 weeks. The Administrator and/or DON will review these audits as they are completed The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 #24's complaint of pain or inability to move her leg after the fall because he deferred to the night shift supervisor. Nurse #1 also stated that he did not document his assessment of Resident #24. On 07/31/15 at 9:00 AM the night shift supervisor was interviewed and reported that on 07/06/15 Nurse #1 notified her that Resident #24 fell and complained of pain that did not appear excruciating but had refused pain medication. The night shift supervisor stated Resident #24 was in bed when she assessed the resident. The supervisor reported that Resident #24's legs were the same length and showed no deviation but that Resident #24 was gripping her right knee and didn't want to move the leg. The supervisor reported that other than a skin tear she didn't see any injuries. The night shift supervisor reported that she did not see a need to contact the physician since the resident was refusing pain medication. The night shift supervisor stated that she did not contact the physician and offered no explanation why it was documented on the incident report that the physician was contacted. On 07/31/15 at 9:30 AM the day shift supervisor was interviewed and reported that she was notified on 07/06/15 that Resident #24 had fallen but did not appear injured. She explained that she did not assess the resident until 11 AM when the medication aide reported that Resident #24 was complaining of pain. The day shift supervisor stated that she contacted the on-call nurse practitioner and received orders for an x-ray. The day shift supervisor reported that when a resident fell and complained of pain the physician should be notified then for further direction. On 07/31/15 at 10:55 AM the physician was	F 157	of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 interviewed on the telephone and reported that he did not expect nurses to contact him immediately after every fall. He explained that he expected nurses to use clinical judgment to determine when to contact the physician. The physician stated that if a fall occurred and there was a new sudden onset of pain not relieved with medication and no obvious injury then the nurse should notify a physician. On 07/31/15 at 2:10 PM the Director of Nursing was interviewed and reported that a significant change in a resident's condition would be a new onset of pain after a fall and the nurse should contact the physician.	F 157		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility neglected to seek medical intervention for a resident in pain who requested an ambulance after she fell for 1 of 2 sampled residents (Resident #24). The findings included: Resident #24 was admitted to the facility on 01/09/15 with dementia, cognitive communication deficit, right hip fracture (07/06/15) and others.	F 224	F 224 Resident # 24 was assessed by the second shift supervisor on 7/6/2015, around 10:30pm. She sent the resident to the ER for evaluation and called the on-call physician, following her assessment. All residents will be assessed with a significant change in condition, including	8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 5 The Minimum Data Set (MDS) dated 06/25/15 specified the resident had short and long term memory impairment and moderately impaired cognitive skills for daily decision making but had clear speech, was able to make herself understood and usually understood others. The MDS also specified the resident required extensive assistance with activities of daily living, had no presence of pain and had fallen twice without injury. Review of Resident #24's medical record revealed a nurse's entry made by the night shift supervisor dated 07/06/15 at 3:20 AM that read in part, "Resident was found on the floor laying on her right side. Resident clutched middle portion of thigh and was reluctant to move right leg." An incident report dated 07/06/15 completed by the night shift supervisor specified Resident #24 was found in the floor clutching her thigh and was reluctant to move her right leg asking "call an ambulance, get me an ambulance." The incident report revealed the resident was placed back in bed. The physician's orders revealed on 07/06/15 at 11:00 AM the day shift supervisor obtained orders to x-ray Resident #24's right hip and right knee due to pain. A second physician order was written on 07/06/15 at 1:20 PM to administer Norco (pain medication) every 6 hours as needed for pain. Further review of the medical record revealed a nurse's entry dated 07/06/15 at 1:20 PM the specified Resident #24 was having increased pain to right leg and the leg was "drawn up." The resident would yell out when range of motion was performed. The on-call nurse practitioner was notified and ordered x-rays. Review of the Medication Administration Record revealed Resident #24 received one dose of pain	F 224	an injury from a fall, for notification of MD and or ER evaluation if indicated. 100% of all in house residents were assessed and reviewed for any significant change in condition, including an injury from a fall. These assessments were completed by the Administrative nursing staff, including the DON, ADON, QI Nurse, SDC, RN Supervisors, and the MDS Nurses. These assessments were completed August 19-24, 2015. Any area identified to be a significant change in condition, including injury from a fall, was immediately called to the MD/FNP or PA for that resident. 100% in-service initiated by the SDC, DON, or RN designee to all licensed and unlicensed staff in the nursing department. This in-service covered notification of physician of any significant change in condition, including injury from an accident, assessment of change in condition, including injury from an accident, and reporting any changes to the appropriate staff at the nursing facility. This training will begin 8/20/2015 and will be completed by 8/28/2015. This training will be given in orientation to all new hires to the nursing department by the SDC. All resident progress notes, and incident reports will be monitored daily by the DON, ADON, or RN Supervisor to ensure all significant changes in condition, including injuries from an accident has been assessed and the notification of the MD/FNP/PA has been notified. Any concerns will immediately be addressed at that time. This will continue indefinitely. An audit tool will be utilized and monitored	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 6 medication at 1:20 PM after falling at 2:45 AM. The radiology report dated 07/06/15 at 5:39 PM revealed Resident #24 had a fracture of the right hip. Resident #24 was transported to the Emergency Department on 07/06/15 at 10:30 PM. On 07/30/15 at 4:00 PM nurse aide (NA) #1 was interviewed and reported that she was assigned to care for Resident #24 on 07/06/15. The NA explained that when making rounds she found Resident #24 laying in the floor calling for help and saying she was hurt. The NA added that she went immediately to get Nurse #1. NA #1 reported that Nurse #1 assessed Resident #24 and determined that it was okay to put the resident back to bed. The NA added that the resident complained of pain and appeared in pain but remained in the bed the rest of the shift. NA #1 stated that she checked on Resident #24 around 6:00 AM and Resident #24 appeared to "really be hurting," complaining of knee and hip pain. The NA stated that she notified Nurse #1 again of Resident #24's complaint of pain. The NA added that her shift ended. On 07/30/15 at 4:10 PM Nurse #1 was interviewed and explained that he was orienting to night shift on 07/06/15 and that he normally worked 7 AM to 3 PM (day shift). He added that during the day shift if a resident fell and developed a new onset of pain he would contact the physician. Nurse #1 reported that on 07/06/15 he was notified that Resident #24 fell; he stated that he responded to the resident and "checked" her out. He stated that he couldn't see any red marks and felt it was safe to put her back to bed. The nurse stated that he assessed Resident #24 before deciding to transfer her off the floor but was unable to check range of motion due to pain in her right leg. Nurse #1 explained	F 224	by the Administrator, DON, or ADON. This tool will be completed by the QI Nurse or designee, 3x week x 4 weeks, then 2 x week x 4 weeks, then weekly x 4 weeks. The Administrator and/or DON will review these audits as they are completed. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 7	F 224		

that Resident #24 was in pain and when asked where the pain was located she patted her right hip, she was unable to verbalize a 1 to 10 pain scale but the resident showed facial grimacing and was holding her right side. The nurse stated that the new onset of pain after the fall was a change in the resident's condition and he notified the night shift supervisor. He added that Resident #24 had an "as needed" pain medicine ordered and he offered the resident the pain medication but she refused. Nurse #1 stated that he did not notify the physician of Resident #24's complaint of pain or inability to move her leg after the fall because he deferred to the night shift supervisor.
On 07/31/15 at 9:00 AM the night shift supervisor was interviewed and reported that on 07/06/15 she was very busy orienting Nurse #1 to night shift and monitoring three other halls. She explained that Nurse #1 notified her that Resident #24 fell and complained of pain that did not appear excruciating but had refused her PRN (as needed) pain medication. The night shift supervisor stated she assessed the resident and found the resident in bed. The supervisor reported that Resident #24's legs were the same length and showed no deviation but that Resident #24 was gripping her right knee and didn't want to move the leg. The supervisor reported that other than a skin tear she didn't see any injuries. The night shift supervisor reported that she did not see a need to contact the physician since the resident was refusing pain medication. The night shift supervisor reported that at 5 AM the day shift supervisor relieved her of her duties.
On 07/31/15 at 11:00 AM NA #3 was interviewed and reported that she worked with NA #2 on 07/06/15 and that she recalled Resident #24 being in pain after the fall. She explained that she didn't provide direct care for Resident #24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 8 that day but was in the room and assisted NA #2. NA #3 stated that Resident #24 was complaining of pain and looked like she was in "a lot of pain" and kept holding her leg. Attempts were made to contact NA#2 but she was unable to be reached for an interview. On 07/31/15 at 2:10 PM the Director of Nursing was interviewed and reported that a significant change in a resident's condition would be a new onset of pain after a fall and the nurse should contact the physician.	F 224		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide a dignified dining experience for 5 of 10 sampled residents in the secured unit. This occurred during 3 of 3 meal observations and affected Residents #104, #140, #232, #6 and #14. The finding included: 1. Resident #140 was admitted most recently to the facility on 05/07/15. His diagnoses included mental disorder, depressive disorder, malignant neoplasm of the head, face and neck, anxiety and dysphagia. His most recent Minimum Data Set (MDS), a quarterly dated 06/18/15, revealed he had severely impaired cognition and required set	F 241	F241 Residents #140, #6, #232, #104, and #14 will be provided a dignified dining experience, to include assisting residents to eat off their own plates, drink their own liquids, and have access to their own food. This is accomplished by meal delivery schedule adjustment and resident seating in the dining room. All residents will be provided a dignified dining experience, including to assist residents eat off their own plates, drink their own liquids, and have access to their own food. This is accomplished by meal delivery schedule adjustment and resident seating in the dining room.	8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 9 up and supervision for eating. Resident #6 was admitted to the facility on 10/10/12 and had diagnoses including Alzheimer's disease, dementia, dysphagia, and anxiety. Her most recent quarterly MDS dated 05/03/15 assessed her with severely impaired cognition, having physical abusive behaviors and other behaviors daily and requiring limited assistance with eating. Resident #232 was admitted to the facility on 07/21/15 with diagnoses of vascular dementia and diabetes. Her MDS had not been completed yet. Attempts to interview Resident #232 revealed cognitive impairment. On 07/28/15 at 12:38 PM meal service began on the Sparks secured unit. There were 2 nurse aides and an activity staff/nurse aide serving trays. Trays were passed to a table which included Resident #232 and Resident #140. When Resident #6 walked into the dining room, Resident #232, who was already served, assisted Resident #6 to sit with her at her table adjacent to Resident #140. Once seated, at 12:43 PM Resident #6 immediately reached and took cottage cheese from Resident #140 and began to eat a small bite. Staff immediately presented Resident #6 with her pureed meal and thickened liquids. At 12:52 PM an activity staff member removed the cottage cheese from Resident #6 and gave it back to Resident #140. As staff went back to feeding another resident, Resident #6 reached over and scrapped the empty plate and tried to eat any remnants from the empty plate from which Resident #140 had eaten. At 12:57 PM, Resident #232 gathered the plate from Resident #6 which still had mashed potatoes and	F 241	100% in-service initiated by the SDC, DON, or RN designee to all licensed and unlicensed staff in the nursing department. This in-service covered dignity and respect of the individual resident during dining. Examples included, supervision at meal times to avoid residents attempting to take other resident¿s food, opening beverages, and offering all meal items. . This training will begin 8/20/2015 and will be completed by 8/28/2015. This training will be given in orientation to all new hires to the nursing department by the SDC beginning 8/25/2015. The schedule for the tray delivery as well as the residents on each delivery has been reviewed and rearranged by a committee of the Administrator, ADON, DON, Dietary Manager, and the regular nursing assistants who work the SPARK unit. The meal delivery time schedule for the entire facility was also reviewed at this time. An audit tool ¿Dining Room Dignity and ADL Maintenance¿ will be utilized and monitored by the Administrator, DON, ADON, or designee. This tool will be completed by the QI nurse or designee 3x week x 4 weeks, then 2x week x 4 weeks, then weekly x 4 weeks. The Administrator and/or DON will review these audits as they are completed. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 10 desert on it and took it to the counter. At 12:58 PM, Resident #232 removed Resident #140's empty plate and gave him his bowl of mashed potatoes. She then removed the clothing protector from Resident #6 and held Resident #6's hand to keep Resident #6 from taking Resident #140's potatoes. It was not until 1:01 PM that Nurse Aide #3 staff intervened and as Resident #6 kept pointing to Resident 140's potatoes, she was asked if she wanted more potatoes to which the resident responded yes. At 1:03 PM, Resident #6 reached and began to drink unthickened tea from Resident #232. Resident #232 continued to keep Resident #6 from taking Resident #140's dessert and Resident #6 was observed to hit Resident #232's hand away. Once extra potatoes arrived from the kitchen NA #3 sat with Resident #6 who ate the mashed potatoes. On 07/28/15 at 4:10 PM, the activity staff was interviewed. She stated she saw Resident #6 with the cottage cheese but did not see her eat from it so she just gave it back to Resident #140. On 07/30/15 at 3:58 PM, Nurse # 2 stated that management always tried to schedule 3 nurse aides for the secured unit and in addition there is the activity staff/nurse aide. He further stated that sharing food in the dining room was a typical occurrence in this unit. Management try to staff more if available to oversee the residents. On 07/31/15 at 8:44 AM NA #3 stated that sometimes there are 2, 3 or even 6 staff to oversee the dining. She was aware of several residents who ate off others' trays, and named at least 4 residents including Residents #6. They try to serve table by table but one resident needs to	F 241	of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 11	F 241		

be fed and Resident #6 sometimes needed to be fed.

On 07/31/15 at 10:47 AM, NA #4 stated they try to separate residents that tend to grab at other resident's food but it can be "a free for all." She stated it was hard to supervise all the residents with behaviors.

On 07/31/15 at 10:54 AM, nurse aide/activity staff was interviewed. She stated sharing of food happened frequently in the unit. She attributed it to having so many cups in front of each resident who could not cognitively know which cup belonged to them.

Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She stated she expected staff to position the residents who tend to take from other's tray in a way to reduce sharing and they should be aware of those residents who share food and observe them. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room. She further stated that sharing has happened even with added people including families.

2. Resident #140 was admitted most recently to the facility on 05/07/15. His diagnoses included mental disorder, depressive disorder, malignant neoplasm of the head, face and neck, anxiety and dysphagia. His most recent Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 12	F 241		

(MDS) a quarterly dated 06/18/15 revealed he had severely impaired cognition, and required set up and supervision for eating.

a. On 07/30/15 at 7:41 AM, Resident #140 was the first resident to be served and he received double portions. The tray was set up but the coffee was left covered. At 7:46 AM, Resident #140 had finished his plate of food and continually scraped his empty plate with his utensil, placing the utensil to his mouth trying to eat more food but having none on his plate. He had a bowl of oatmeal and a carton of yogurt still there to be eaten. At 7:47 AM Nurse Aide (NA) #3 placed a clothing protector around his neck but did not move the oatmeal or yogurt closer to him nor did she uncover his coffee which he repeatedly tried to drink from throughout the meal. Resident #140 continued to scrape and try to eat the remnants off his empty plate repeatedly as he did not seem to see he had oatmeal and yogurt at the far side of his plate. This continued until 8:01 AM when Nurse #2 sat with him, gave him medications and water and Nurse #2 pushed the yogurt and oatmeal closer to him. The nurse did not uncover the coffee. Resident #140 immediately began to eat. At 8:08 AM, he continued to scrape the remnants of his oatmeal repeatedly getting minuscule bits left in the bowl. At at 8:13 AM he began scraping his pants and clothing protector with his spoon. At 8:15 AM, the Assistant Director of Nursing (ADON) offered Resident #140 the yogurt which he proceeded to feed himself until he finished it at 8:18 AM. The ADON did not uncover the coffee. At 8:27 AM, the ADON removed the yogurt and his tray but left him with a fork. When asked about the covered coffee she stated it was covered to stay warm. NA# 3 then said he did not like coffee. Once the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 13	F 241		

surveyor stated he had tried to drink it, ADON gave him back his coffee and he proceeded to drink coffee and scrape the table with his fork and put the fork in his mouth as if he was eating something. This continued until 8:43 AM, with no staff offering him more to eat. At 8:43 AM, Resident #140 stood and left the dining room. Throughout this meal, there were 2 nurse aides, an activity staff/nurse aide, the ADON and the floor nurse in and out of the room.

b. The lunch meal service was observed on 07/30/15 at 12:34 PM. 3 nurse aides, the nurse aide/activity staff and a part time activity assistant were observed serving during this meal. At 12:42 PM Resident #140 was served a larger portion of pureed spaghetti and meat sauce, a bowl of pureed zucchini, a bowl of mashed potatoes, a bowl of pureed desert and cottage cheese. He immediately started feeding himself. At 12:54 PM he was scraping his empty plate and pushed zucchini away and began eating his cottage cheese. At 12:56 PM Resident #140 was scraping his empty plate. 3 staff were observed in the room feeding, setting up more trays and passing teas. At 12:59 PM he has finished his cottage cheese and was continually scraping his empty plate trying to spoon food in his mouth. NA #5 removed the plate at 1:01 PM and moved the zucchini and desert within his reach which he immediately began eating. At 1:08 PM, Resident #140 was observed scraping his empty bowls and trying to feed himself with his empty utensils. This continued until he got up and left the dining room at 1:13 PM.

On 07/31/15 at 10:47 AM, NA #4 stated Resident #140 has the behaviors of repeatedly scraping and trying to eat from his empty plate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 14	F 241		

On 07/31/15 at 10:54 AM, nurse aide/activity staff was interviewed. She stated she was not sure if Resident #140 was cognizant enough to know if he had food in front of him or not when he repeatedly scraped an empty plate.

Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room.

3. Resident #6 was admitted to the facility on 10/10/12 and had diagnoses including Alzheimer's disease, dementia, dysphagia, and anxiety. Her most recent quarterly MDS dated 05/03/15 assessed her with severely impaired cognition, having physical abusive behaviors and other behaviors daily and requiring limited assistance with eating. The care plan for resident care indicated she needed assistance with eating.

The lunch meal service was observed on 07/30/15 at 12:34 PM. 3 nurse aides, the nurse aide/activity staff and a part time activity assistant were observed serving during this meal. Resident #6 was walking in and out of the room not sitting at the table. At 12:42 PM, Resident #6 grabbed the thin ice tea from Resident #232, at which time the activity staff/nurse aide intervened. At 12:44 PM Resident #6 was the last to be served at the table of 4. Staff proceeded to give her a bite of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 15	F 241		

her food and encouraged Resident #6 to sit at the table. Staff walked away. At 12:58 PM, Resident #6 drank the thin liquid from Resident #232. At 1:00 PM she drank more of Resident #232's unthickened tea. The surveyor got the attention of NA #5 who removed the tea from Resident #6's hand.

On 07/30/15 at 3:58 PM, Nurse #2 stated that management always tries to schedule 3 nurse aides for the secured unit and in addition there is the activity staff/nurse aide. He further stated that sharing food in the dining room was a typical occurrence in this unit. Management tried to staff more if available to oversee the residents.

On 07/31/15 at 8:44 AM NA #3 stated that sometimes there are 2, 3 or even 6 staff to oversee the dining. She was aware of several residents who ate off others' trays, and named at least 4 residents including Residents #6. They try to serve table by table but one resident needs to be fed and Resident #6 sometimes needs to be fed. This morning, staff stated 3 residents needed to be fed.

On 07/31/15 at 10:47 AM, NA #4 stated they try to separate residents that tend to grab at other resident's food but it can be "a free for all." She stated it was hard to supervise all the residents with behaviors.

On 07/31/15 at 10:54 AM, nurse aide/activity staff was interviewed. She stated sharing of food happened frequently in the unit. She attributed it to having so many cups in front of each resident who could not cognitively know which cup belonged to them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 16	F 241		

Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She stated she expected staff to position the residents who tend to take from other's tray in a way to reduce sharing and they should be aware of those residents who share food and observe them. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room. She further stated that sharing has happened even with added people including families.

4. Resident #104 was admitted to the facility on 01/02/13 with diagnoses including Alzheimer's disease and dementia with behavioral disturbances. Her most recent Minimum Data Set (MDS), a quarterly dated 07/21/15 coded her with long and short term memory impairment and moderately impaired decision making skills. She required set up and supervision with meals.

Resident #14 was admitted to the facility on 03/18/13 with diagnoses including persistent mental disorder and schizophrenia. Her quarterly MDS dated 06/17/15 coded her with long and short term memory deficits and having moderately impaired decision making skills. She required set up and supervision with eating.

Resident #205 was admitted to the facility on 10/09/14 with diagnoses including dementia and anxiety. Her quarterly MDS dated 07/15/15 coded her with severely impaired cognitive skills,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 17	F 241		

having rejection of care and needing set up and supervision with meals. A nursing note dated 07/21/15 at 11:59 AM revealed that the responsible party was in care conference this date and was concerned about the resident gaining weight. The responsible party stated the resident was getting into other residents' trays.

The lunch meal service was observed on 07/30/15 at 12:34 PM. Three nurse aides, the nurse aide/activity staff and a part time activity assistant were observed serving during this meal. Residents #205, #14 and #104 were seated at a table together. At 1:03 PM Resident #205 had eaten her dessert and proceeded to eat Resident #14's dessert. No staff intervened. At 1:06 PM, Resident #205 moved on to eat Resident #104's dessert. Although there were at least 3 staff in the room at this time, no one intervened as one staff was feeding a resident, one was marking amounts consumed on the tray tickets and another was just overseeing from the doorway.

On 07/30/15 at 3:58 PM, Nurse #2 stated that management always tried to schedule 3 nurse aides for the secured unit and in addition there was the activity staff/nurse aide. He further stated that sharing food in the dining room was a typical occurrence in this unit. Management try to staff more if available to oversee the residents.

On 07/31/15 at 8:44 AM NA #3 stated that sometimes there are 2, 3 or even 6 staff to oversee the dining. She was aware of several residents who ate off others' trays, and named at least 4 residents including Resident #104. They try to serve table by table but one resident needs to be fed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 18 On 07/31/15 at 10:47 AM, NA #4 stated they try to separate residents that tend to grab at other resident's food but it can be "a free for all." She stated it was hard to supervise all the residents with behaviors. On 07/31/15 at 10:54 AM, nurse aide /activity staff was interviewed. She stated sharing of food happened frequently in the unit. She attributed it to having so many cups in front of each resident who could not cognitively know which cup belonged to who. Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She stated she expected staff to position the residents who tend to take from other's tray in a way to reduce sharing and they should be aware of those residents who share food and observe them. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room. She further stated that sharing has happened even with added people including families.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain walls in good repair and/or maintain clean commode bases and floors on 2 of 6 hallways (400 and 500). The finding included: Observations made throughout the survey revealed walls in disrepair, soiled discolored caulking around commode bases and floors as follows: a. Room 403: On 07/29/15 at 4:14 PM and on 07/31/15 at 8:32 AM, approximately 2.5 feet by 2.5 inches of the wallpaper under the sink was pulled away at the seams and the wallpaper surrounding the sink area was yellowed and discolored making it looked stained. b. Room 411: On 07/29/15 at 11:17 AM, on 07/30/15 at 5:27 PM and on 07/31/15 at 9:40 AM there were 2 places of ripped wallpaper, deeply gauged and peeling over a 3 foot by 3 foot area behind bed A and wallpaper that looked patched in a 3 inches by 5 inch triangle that was not covered back with wallpaper by bed B. c. Room 503: On 07/30/15 at 12:09 PM and on 07/31/15 at 9:43 AM the walls by bed A had 3 areas of peeled paint with the wallboard showing. d. Room 505: On 07/28/15 at 1:20 PM, on 07/30/15 at 12:10 PM, and on 07/31/15 at 9:44 AM, there was bubbly paint by the sink in the room and the shared bathroom shared with Room 507 had a very discolored floor.	F 253	F 253 The wallpaper was repaired in Rooms 403 and 411 on 8/11/2015. The walls/wallpaper were repaired in Room 503 on 8/12/2015. The wall was repaired in Room 505 on 8/20/2015. The bathroom adjoining 505 and 507 was repaired 8/12/2015 with replaced tiles and caulking. The walls in 508 was repaired and the towel rack was replaced on 8/20/2015. The bathroom adjoining 506 and 508 was repaired with replaced tiles and caulking 8/12/2015. Room 510 was repaired on 8/20/2015, the towel rack was reinstalled and the adjoining bathroom has new tile and caulking. The bathroom for 511 has had the caulking repaired and the tiles replaced. The bathroom flooring and caulking in the shared bathroom of 516 and 518 was replaced 8/20/2015. A 100% audit of the condition of the resident rooms and bathrooms were conducted on 8/13/2015 by the Administrator, Maintenance Director and the Housekeeping Supervisor. Any areas needing repairs were identified. All repairs will be completed by 8/28/2015. Repairs to resident rooms and bathrooms will be added to the Preventative Maintenance rounds. This will be completed on a monthly basis. Work orders will continue to be completed by the staff to notify the maintenance department of issues as they arise. The housekeeping supervisor will also make monthly rounds to all resident rooms and bathrooms. This will continue indefinitely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 20 e. Room 508: On 07/28/15 at 12:02 PM, on 07/30/15 at 12:09 PM, and on 07/31/15 at 9:43 AM the wall had at least 11 holes from removed nails, discolored bubbly areas on the wall by the sink, a missing towel rack with one end still on the wall, and patched but unfinished wall paper by the sink. In addition, the bathroom shared with Room 506 had dark brown caulking around the base of the commode. f. Room 510: On 07/28/15 at 4:31 PM, on 07/30/15 at 12:07 PM, and on 07/31/15 at 9:41 AM there were areas of missing wallpaper with unfinished patches covering 2.5 feet by 8 inches, 18 inches by 12 inches, and a separating seam in the wallpaper measuring 2 feet. There was a missing towel rack with the metal clips still in the wall and the bathroom for this room had dark brown caulking around the base of the commode. g. Room 511: On 07/28/15 at 4:28 PM, on 07/30/15 at 12:06 PM, and on 07/31/15 at 9:42 AM there was blackened caulking around the base of the commode and dirt around the legs of the seat extender in the bathroom shared with Room 513. h. Room 518: On 07/30/15 at 12:02 PM and on 07/31/15 at 9:41 AM the floor in the bathroom shared with Room 516 had discolored flooring. Interview with the housekeeper on the 500 hall, conducted on 07/31/15 at 8:38 AM, revealed that he cleaned the floor daily and sometimes twice depending on the condition. He stated that things in need of repair were reported to maintenance. Housekeeper stated he thought the discolored flooring in the bathroom floors was due to wax build up and wear and tear as he had scrubbed	F 253	An in-service will be completed by the Administrator to the Maintenance Department and the Housekeeping Supervisor on 8/24/2015 to cover the new audit tool and requirements for Preventative Maintenance. An audit tool ¿Condition of Resident Rooms and Bathrooms¿ will be utilized and monitored by the housekeeping supervisor, the QI nurse or designee. This tool will include torn, wallpaper, holes in the sheetrock, bathroom floor stains, and toilet caulking. This tool will be completed by the QI nurse or designee weekly x 4 weeks, then monthly x 3. The Administrator and/or DON will review these audits as they are completed. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 21	F 253		

and scrubbed the floors. He further stated he had reported the floors to his supervisor who was to arrange for the floor tech to fix it.

On 07/31/15 at 1:48 PM a tour of the resident rooms and bathrooms was conducted with the maintenance director and he was interviewed throughout the tour. He stated the floor techs worked under the housekeeping supervisor. He described the preventative maintenance program which did not include checking for wall repair. He stated he relied on staff to fill out a work order for those types of repairs. The work orders were checked multiple times during the day. He stated that he had a part time person to paint and repair walls but he was promoted a couple of weeks ago and no longer painted. He stated he had a list of rooms needing paint/repair. Review of this list included 6 rooms on the 500 hall with only one room (508 with no specific repairs identified) that this surveyor identified above. The maintenance director stated that it was hard to keep up with the painting/repairs in a building this size with only 2 people. During the tour, the maintenance director stated that he did not routinely check the walls daily and wanted staff to fill out work orders for the wall repairs. He stated the toilets needed new caulking and the floors needed to be stripped of old wax and rewaxed. He further stated that there was a cleaner staff sometimes used that caused the wax to discolor and wear off. He further stated that he could make a list of preventative things to check for, but it would mean something else was not checked.

On 07/31/15 at 2:23 PM the housekeeping supervisor was interviewed and toured the bathrooms on the 500 hall. She stated that at least once a year the floors were stripped and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 22 rewaxed. Floors were buffed monthly but not the bathrooms. She stated the buffers did not fit around the commodes. She stated there was a disinfectant they discovered that destroyed the wax. Her staff were not to use this disinfectant but it was available to other staff in case there was something they needed to clean in absence of the housekeepers. She stated she did not identify the rooms above as needing the floors stripped and rewaxed.	F 253		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to seek medical intervention when they couldn't complete a thorough assessment due to pain and the resident requested an ambulance after falling out of bed for 1 of 2 sampled residents (Resident #24). The findings included: Resident #24 was admitted to the facility on 01/09/15 with dementia, cognitive communication deficit, right hip fracture (07/06/15) and others. The Minimum Data Set (MDS) dated 06/25/15 specified the resident had short and long term	F 309	F 309 Resident # 24 was assessed by the second shift supervisor on 7/6/2015, around 10:30pm. She sent the resident to the ER for evaluation and called the on-call physician, following her assessment. All residents will be assessed with a significant change in condition, including an injury from a fall, for notification of MD and or ER evaluation if indicated. 100% of all in house residents were assessed and reviewed for any significant change in condition, including an injury	8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23	F 309		

memory impairment and moderately impaired cognitive skills for daily decision making but had clear speech, was able to make herself understood and usually understood others. The MDS also specified the resident required extensive assistance with activities of daily living, had no presence of pain and had fallen twice without injury.

Review of Resident #24's medical record revealed a nurse's entry made by the night shift supervisor dated 07/06/15 at 3:20 AM that read in part, "Resident was found on the floor laying on her right side. Resident clutched middle portion of thigh and was reluctant to move right leg."

An incident report dated 07/06/15 completed by the night shift supervisor specified Resident #24 was found in the floor clutching her thigh and was reluctant to move her right leg asking "call an ambulance, get me an ambulance." The incident report revealed the resident was placed back in bed.

The physician's orders revealed on 07/06/15 at 11:00 AM the day shift supervisor obtained orders to x-ray Resident #24's right hip and right knee due to pain. A second physician order was written on 07/06/15 at 1:20 PM to administer Norco (pain medication) every 6 hours as needed for pain.

Further review of the medical record revealed a nurse's entry dated 07/06/15 at 1:20 PM the specified Resident #24 was having increased pain to right leg and the leg was "drawn up." The resident would yell out when range of motion was performed. The on-call nurse practitioner was notified and ordered x-rays. Review of the

from a fall. These assessments were completed by the Administrative nursing staff, including the DON, ADON, QI Nurse, SDC, RN Supervisors, and the MDS Nurses. These assessments were completed August 19-24, 2015. Any area identified to be a significant change in condition, including injury from a fall, was immediately called to the MD/FNP or PA for that resident.
100% in-service initiated by the SDC, DON, or RN designee to all licensed and unlicensed staff in the nursing department. This in-service covered notification of physician of any significant change in condition, including injury from an accident, assessment of change in condition, including injury from an accident, and reporting any changes to the appropriate staff at the nursing facility. This training will begin 8/20/2015 and will be completed by 8/28/2015. This training will be given in orientation to all new hires to the nursing department by the SDC beginning 8/25/2015.
All resident progress notes, and incident reports will be monitored daily by the DON, ADON, and RN Supervisor to ensure all significant changes in condition, including injuries from an accident has been assessed and the notification of the MD/FNP/PA has been notified. This will continue indefinitely. Any concerns will immediately be addressed at that time.
An audit tool will be utilized and monitored by the Administrator, DON, or ADON. This tool will be completed by the QI Nurse or designee, 3x week x 4 weeks, then 2 x week x 4 weeks, then weekly x 4 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24 Medication Administration Record revealed Resident #24 received one dose of pain medication at 1:20 PM after falling at 2:45 AM. The radiology report dated 07/06/15 at 5:39 PM revealed Resident #24 had a fracture of the right hip. Resident #24 was transported to the Emergency Department on 07/06/15 at 10:30 PM. On 07/30/15 at 4:00 PM nurse aide (NA) #1 was interviewed and reported that she was assigned to care for Resident #24 on 07/06/15. The NA explained that when making rounds she found Resident #24 laying in the floor calling for help and saying she was hurt. The NA added that she went immediately to get Nurse #5. NA #1 reported that Nurse #5 assessed Resident #24 and determined that it was okay to put the resident back to bed. The NA added that the resident complained of pain and appeared in pain but remained in the bed the rest of the shift. NA #1 stated that she checked on Resident #24 around 6:00 AM and Resident #24 appeared to "really be hurting," complaining of knee and hip pain. The NA stated that she notified Nurse #5 again of Resident #24's complaint of pain. The NA added that her shift ended. On 07/30/15 at 4:10 PM Nurse #5 was interviewed and explained that he was orienting to night shift on 07/06/15 and that he normally worked 7 AM to 3 PM (day shift). He added that during the day shift if a resident fell and developed a new onset of pain he would contact the physician. Nurse #5 reported that on 07/06/15 he was notified that Resident #24 fell; he stated that he responded to the resident and "checked" her out. He stated that he couldn't see	F 309	The Administrator and/or DON will review these audits as they are completed. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25	F 309		

any red marks and felt it was safe to put her back to bed. The nurse stated that he assessed Resident #24 before deciding to transfer her off the floor but was unable to check range of motion due to pain in her right leg. Nurse #5 explained that Resident #24 was in pain and when asked where the pain was located she patted her right hip, she was unable to verbalize a 1 to 10 pain scale but the resident showed facial grimacing and was holding her right side. The nurse stated that the new onset of pain after the fall was a change in the resident's condition and he notified the night shift supervisor. He added that Resident #24 had an "as needed" pain medicine ordered and he offered the resident the pain medication but she refused. Nurse #5 stated that he did not notify the physician of Resident #24's complaint of pain or inability to move her leg after the fall because he deferred to the night shift supervisor.

On 07/31/15 at 9:00 AM the night shift supervisor was interviewed and reported that on 07/06/15 she was very busy orienting Nurse #1 to night shift and monitoring three other halls. She explained that Nurse #5 notified her that Resident #24 fell and complained of pain that did not appear excruciating but had refused her PRN (as needed) pain medication. The night shift supervisor stated she assessed the resident and found the resident in bed. The supervisor reported that Resident #24's legs were the same length and showed no deviation but that Resident #24 was gripping her right knee and didn't want to move the leg. The supervisor reported that other than a skin tear she didn't see any injuries. The night shift supervisor reported that she did not see a need to contact the physician since the resident was refusing pain medication. The night shift supervisor reported that at 5 AM the day shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26	F 309		

supervisor relieved her of her duties.

On 07/31/15 at 9:30 AM the day shift supervisor was interviewed and reported that she was notified on 07/06/15 that Resident #24 had fallen but did not appear injured. She explained that she did not assess the resident until 11 AM when the medication aide reported that Resident #24 was complaining of pain. The day shift supervisor stated that she contacted the on-call nurse practitioner and received orders for an x-ray. Then she added she contacted the on-call nurse practitioner again and received orders to administer pain medication which the resident accepted at 1:20 PM. The day shift supervisor reported that when a resident fell and complained of pain the physician should be notified then for further direction.

On 07/31/15 at 9:52 AM the second shift supervisor was interviewed and reported that when she came on duty on 07/06/15 at 3 PM she was notified that Resident #24 had fallen, complained of pain but did not appear to have a fracture. The second shift supervisor added that she was told that Resident #24 had been given pain medication and she was aware that an x-ray had been completed but they were still waiting on the results. She stated that when she made her first rounds between 3:30 - 4:00 PM Resident #24 was asleep in bed. The second shift supervisor explained that around 10:30 PM the nurse aides reported that the resident was crying in pain; she stated that she went to assess the resident, pulled back the covers and saw that the resident's legs were two different lengths and immediately called 9-1-1 and the resident was transported to the Emergency Department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 27 On 07/31/15 at 11:00 AM NA #6 was interviewed and reported that she worked with NA #2 on 07/06/15 and that she recalled Resident #24 being in pain after the fall. She explained that she didn't provide direct care for Resident #24 that day but was in the room and assisted NA #2. NA #6 stated that Resident #24 was complaining of pain and looked like she was in "a lot of pain" and kept holding her leg. Attempts were made to contact NA#2 but she was unable to be reached for an interview. On 07/31/15 at 2:10 PM the Director of Nursing (DON) was interviewed and reported that a significant change in a resident's condition would be a new onset of pain after a fall and the nurse should contact the physician. The DON reported that it took several hours to obtain x-ray services and results because of the facility's location and depending on the schedule of the mobile x-ray company. She added that if at any time a resident showed signs of distress or obvious injury then she would expect the nurse to obtain orders to send a resident to the Emergency Department for evaluation and not wait on mobile x-ray services.	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide services	F 311	F 311 Residents #140, #6, #232, #104, and #14	8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 28	F 311		

and supervision for 5 of 10 sampled residents observed in the Sparks dining room in order to assist residents eat off their own plates, drink their own liquids and have access to their own food. (Residents #140, #6, #104, #14, and #205).

The findings were:

1. Resident #140 was admitted most recently to the facility on 05/07/15. His diagnoses included mental disorder, depressive disorder, malignant neoplasm of the head, face and neck, anxiety and dysphagia. His most recent Minimum Data Set (MDS), a quarterly dated 06/18/15, revealed he had severely impaired cognition and required set up and supervision for eating. The care plan last reviewed 06/23/15 which addressed a history of weight loss included the intervention for staff to set up and encourage meal consumption.

a. On 07/30/15 at 7:41 AM, Resident #140 was the first resident to be served and he received double portions. His tray was set up except his coffee was not uncovered. At 7:46 AM, Resident #140 had finished his plate of food and continually scraped his empty plate with his utensil, placing the utensil to his mouth trying to eat more food but having none on his plate. He had a bowl of oatmeal and a carton of yogurt still there to be eaten. At 7:47 AM Nurse Aide (NA) #3 placed a clothing protector around his neck but did not move the oatmeal or yogurt closer to him or uncover his coffee. Resident #140 picked up the covered coffee and attempted to drink it at 7:47 AM, 7:51 AM, 7:53 AM, 7:54 AM, 7:55 AM and at 7:59 AM. Resident #140 continued to scrape and try to eat the remnants off his empty plate repeatedly as the oatmeal and yogurt sat at the far side of his plate. This continued until 8:01

will be provided a dignified dining experience, to include assisting residents eat off their own plates, drink their own liquids, and have access to their own food. This is accomplished by meal delivery schedule adjustment and resident seating in the dining room.
All residents will be provided a dignified dining experience, including to assist residents eat off their own plates, drink their own liquids, and have access to their own food. This is accomplished by meal delivery schedule adjustment and resident seating in the dining room.
100% in-service initiated by the SDC, DON, or RN designee to all licensed and unlicensed staff in the nursing department. This in-service covered dignity and respect of the individual resident during dining and also to maintain ADL¿s. Examples included, supervision at meal times to avoid residents attempting to take other resident¿s food, opening beverages, and offering all meal items. This training will begin 8/20/2015 and will be completed by 8/28/2015. The training will be given in orientation to all new hires to the nursing department by the SDC beginning 8/25/2015. The schedule for the tray delivery as well as the residents on each delivery has been reviewed and rearranged by a committee of the Administrator, ADON, DON, Dietary Manager, and the regular nursing assistants who work the SPARK unit. The meal delivery time schedule for the entire facility was also reviewed at this time.
An audit tool ¿Dining Room Dignity and ADL Maintenance¿ will be utilized and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 29 AM when Nurse #2 sat with him, gave him medications and water. Then Nurse #2 pushed the yogurt and oatmeal closer to him. Nurse #2 did not uncover his coffee. Resident #140 immediately began to eat. At 8:08 AM, he continued to scrape the remnants of his oatmeal repeatedly getting minuscule bits left in the bowl. At at 8:13 AM he began scraping his pants and clothing protector with his spoon. At 8:15 AM, the Assistant Director of Nursing (ADON) offered Resident #140 the yogurt which he proceeded to feed himself until he finished it at 8:18 AM. ADON did not uncover the coffee. At 8:27 AM, the ADON removed the yogurt and his tray but he still had the fork in his hand. At that time, the surveyor asked about the covered coffee and she said the cover was to keep the coffee warm. Then NA #3 stated Resident #140 did not like coffee. The ADON gave him back his coffee and he proceeded to drink coffee and scrape the table with his fork and put the fork in his mouth as if he was eating something. This continued until 8:43 AM, when Resident #140 stood and left the dining room. Throughout this meal, there were 2 nurse aides, an activity staff/nurse aide, the ADON, and the floor nurse in and out of the room. b. The lunch meal service was observed on 07/30/15 at 12:34 PM. Three nurse aides, the nurse aide/activity staff and a part time activity assistant were observed serving during this meal. At 12:42 PM Resident #140 was served a double portion of pureed spaghetti and meat sauce, a bowl of pureed zucchini, a bowl of mashed potatoes, a bowl of pureed desert and cottage cheese. He immediately started feeding himself. At 12:54 PM he was scraping his empty plate and pushed zucchini away and began eating his cottage cheese. At 12:56 PM Resident #140 was	F 311	monitored by the Administrator, DON, ADON, or designee. This tool will be completed by the QI nurse or designee 3x week x 4 weeks, then 2x week x 4 weeks, then weekly x 4 weeks. The Administrator and/or DON will review these audits as they are completed. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 30	F 311		

scraping his empty plate. 3 staff were observed in the room feeding, setting up more trays and passing trays. At 12:59 PM he has finished his cottage cheese and was continually scraping his empty plate trying to spoon nonexistent food in his mouth. NA #5 removed the plate at 1:01 PM and moved the zucchini and desert within his reach which he immediately began eating. At 1:08 PM, Resident #140 was observed scraping his empty bowls and trying to feed himself with his empty utensils. This continued until he got up and left the dining room at 1:13 PM.

Interview with NA #3 and NA #4 on 07/30/15 at 8:30 AM revealed neither could recall who set up Resident #140's tray.

On 07/31/15 at 8:44 AM, NA #3 stated tray set up included uncovering all the food items.

On 07/31/15 at 10:47 AM, NA #4 stated it was hard to supervise all the residents with behaviors. She further stated Resident #140 has the behaviors of repeatedly scraping and trying to eat from his empty plate.

On 07/31/15 at 10:54 AM, nurse aide/activity staff was interviewed. She stated she was not sure if Resident #140 was cognizant enough to know if he had food in front of him or not when he repeatedly scraped an empty plate.

Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each tray to be set up including all items taken from the tray, uncovered and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 31	F 311		

stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room.

2. Resident #140 was admitted most recently to the facility on 05/07/15. His diagnoses included mental disorder, depressive disorder, malignant neoplasm of the head, face and neck, anxiety and dysphagia. His most recent Minimum Data Set (MDS), a quarterly dated 06/18/15, revealed he had severely impaired cognition and required set up and supervision for eating. The care plan last reviewed 06/23/15 which addressed a history of weight loss included the intervention for staff to set up and encourage meal consumption.

Resident #6 was admitted to the facility on 10/10/12 and had diagnoses including Alzheimer's disease, dementia, dysphagia, and anxiety. Her most recent quarterly MDS dated 05/03/15 assessed her with severely impaired cognition and requiring limited assistance with eating. The care plan for resident care indicated she needed assistance with eating.

Resident #232 was admitted to the facility on 07/21/15 with diagnoses of vascular dementia and diabetes. Her MDS had not been completed yet. Attempts to interview Resident #232 revealed cognitive impairment.

On 07/28/15 at 12:38 PM meal service began on the Sparks secured unit. There were 2 nurse aides and an activity staff/nurse aide serving trays. Trays were passed to a table which included Resident #232 and Resident #140. When Resident #6 walked into the dining room, Resident #232, who was already served, assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 32	F 311		

Resident #6 to sit with her at her table adjacent to Resident #140. Once seated at 12:43 PM, Resident #6 immediately reached and took cottage cheese from Resident #140 and began to eat a small bite, even though Resident #232 tried to discourage her. Staff immediately presented Resident #6 with her pureed meal and thickened liquids. At 12:52 PM an activity staff member removed the cottage cheese from Resident #6 and gave it back to Resident #140. As staff went back to feeding another resident, Resident #6 reached over and scrapped the empty plate and tried to eat any remnants from the empty plate from which Resident #140 had eaten. At 12:57 PM, Resident #232 gathered the plate from Resident #6 which still had mashed potatoes and desert on it and took it to the counter. At 12:58 PM, Resident #232 removed Resident #140's empty plate which he repeatedly tried to scrape food from and gave him his bowl of mashed potatoes. She then removed the clothing protector from Resident #6 and held Resident #6's hand to keep Resident #6 from taking Resident #140's potatoes. It was not until 1:01 PM that Nurse Aide (NA) #3 staff intervened and as Resident #6 kept pointing to Resident 140's potatoes, she was asked if she wanted more potatoes to which Resident 6 responded yes. At 1:03 PM, Resident #6 reached and began to drink unthickened tea from Resident #232. Resident #232 continued to keep Resident #6 from taking Resident #140's desert and Resident #6 was observed to hit Resident #232's hand away. Once extra potatoes arrived from the kitchen NA #3 sat with Resident #6 who proceeded to eat the mashed potatoes.

On 07/28/15 at 4:10 PM, the activity staff was interviewed. She stated she saw Resident #6 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 33	F 311		

the cottage cheese but did not see her eat from it so she just gave it back to Resident #140.

On 07/30/15 at 3:58 PM, Nurse # 2 stated that management always tries to schedule 3 nurse aides for the secured unit and in addition there is the activity staff/nurse aide. He further stated that sharing food in the dining room was a typical occurrence in this unit. Management try to staff more if available to oversee the residents.

On 07/31/15 at 8:44 AM NA #3 stated that sometimes there are 2, 3 or even 6 staff to oversee the dining. She was aware of several residents who ate off others' trays, and named at least 4 residents including Resident #6. They try to serve table by table but one resident needs to be fed and Resident #6 sometimes needs to be fed.

On 07/31/15 at 10:47 AM, NA #4 stated they try to separate residents that tend to grab at other resident's food but it can be "a free for all." She stated it was hard to supervise all the residents with behaviors.

On 07/31/15 at 10:54 AM, nurse aide/activity staff was interviewed. She stated sharing of food happened frequently in the unit. She attributed it to having so many cups in front of each resident who could not cognitively know which cup belonged to them.

Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 34	F 311		

aide and nurse on the unit. She stated she expected staff to position the residents who tend to take from other's tray in a way to reduce sharing and they should be aware of those residents who share food and observe them. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room. She further stated that sharing has happened even with added people including families.

3. Resident #6 was admitted to the facility on 10/10/12 and had diagnoses including Alzheimer's disease, dementia, dysphagia, and anxiety. Her most recent quarterly MDS dated 05/03/15 assessed her with severely impaired cognition, having physical abusive behaviors and other behaviors daily and requiring limited assistance with eating. The care plan for resident care indicated she needed assistance with eating.

The lunch meal service was observed on 07/30/15 beginning at 12:34 PM. 3 nurse aides, the nurse aide/activity staff and a part time activity assistant were observed serving during this meal. Resident #6 was walking in and out of the room not sitting at the table. At 12:42 PM, Resident #6 grabbed the thin ice tea from Resident #232, at which time the activity staff/nurse aide intervened. At 12:44 PM Resident #6 was the last to be served at the table of 4. Staff proceeded to give her a bite of her food and encouraged Resident #6 to sit at the table. Staff walked away. At 12:58 PM, Resident #6 drank the thin liquid from Resident #232. At 1:00 PM she drank more of Resident #232's unthickened tea. The surveyor got the attention of NA #5 who removed the tea from Resident #6's hand.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 35	F 311		

On 07/30/15 at 3:58 PM, Nurse #2 stated that management always tries to schedule 3 nurse aides for the secured unit and in addition there is the activity staff/nurse aide. He further stated that sharing food in the dining room was a typical occurrence in this unit. Management try to staff more if available to oversee the residents.

On 07/31/15 at 8:44 AM NA #3 stated that sometimes there are 2, 3 or even 6 staff to oversee the dining. She was aware of several residents who ate off others' trays, and named at least 4 residents including Residents #6. They try to serve table by table but one resident needs to be fed and Resident #6 sometimes needs to be fed. This morning, staff stated 3 residents needed to be fed.

On 07/31/15 at 10:47 AM, NA #4 stated they try to separate residents that tend to grab at other resident's food but it can be "a free for all." She stated it was hard to supervise all the residents with behaviors.

On 07/31/15 at 10:54 AM, nurse aide /activity staff was interviewed. She stated sharing of food happened frequently in the unit. She attributed it to having so many cups in front of each resident who could not cognitively know which cup belonged to them.

Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 36	F 311		

expected staff to position the residents who tend to take from other's tray in a way to reduce sharing and they should be aware of those residents who share food and observe them. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room. She further stated that sharing has happened even with added people including families.

4. Resident #104 was admitted to the facility on 01/02/13 with diagnoses including Alzheimer's disease and dementia with behavioral disturbances. Her most recent Minimum Data Set (MDS), a quarterly dated 07/21/15 coded her with long and short term memory impairment and moderately impaired decision making skills. She required set up and supervision with meals.

Resident #14 was admitted to the facility on 03/18/13 with diagnoses including persistent mental disorder and schizophrenia. Her quarterly MDS dated 06/17/15 coded her with long and short term memory deficits and having moderately impaired decision making skills. She required set up and supervision with eating.

Resident #205 was admitted to the facility on 10/09/14 with diagnoses including dementia and anxiety. Her quarterly MDS dated 07/15/15 coded her with severely impaired cognitive skills, having rejection of care and needing set up and supervision with meals. A nursing note dated 07/21/15 at 11:59 AM revealed that the responsible party was in care conference this date and was concerned about the resident gaining weight. The responsible party stated the resident was getting into other residents' trays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 37	F 311		

The lunch meal service was observed on 07/30/15 beginning at 12:34 PM. 3 nurse aides, the nurse aide/activity staff and a part time activity assistant were observed serving during this meal. Residents #205, #14 and #104 were sitting at a table together. At 12:50 PM, Resident #104 offered and gave Resident #205 her tea to drink. Staff intervened and stated would get more tea when this was pointed out to staff. At 1:03 PM Resident #205 had eaten her desert and proceeded to eat Resident #14's desert. No staff intervened. At 1:06 PM, Resident #205 moved on to eat Resident #104's desert. Although there were at least 3 staff in the room at this time, no one intervened as one staff was feeding a resident, one was marking amounts consumed on the tray tickets and another was just overseeing from the doorway.

On 07/30/15 at 3:58 PM, Nurse #2 stated that management always tries to schedule 3 nurse aides for the secured unit and in addition there is the activity staff/nurse aide. He further stated that sharing food in the dining room was a typical occurrence in this unit. Management try to staff more if available to oversee the residents.

On 07/31/15 at 8:44 AM NA #3 stated that sometimes there are 2, 3 or even 6 staff to oversee the dining. She was aware of several residents who ate off others' trays, and named at least 4 residents including Resident #104. They try to serve table by table but at least one resident routinely needed to be fed and sometimes others needed to be fed.

On 07/31/15 at 10:47 AM, NA #4 stated they try to separate residents that tend to grab at other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 38 resident's food but it can be "a free for all." She stated it was hard to supervise all the residents with behaviors. On 07/31/15 at 10:54 AM, nurse aide/activity staff was interviewed. She stated sharing of food happened frequently in the unit. She attributed it to having so many cups in front of each resident who could not cognitively know which cup belonged to them. Interview with the Director of Nursing on 07/31/15 at 2:58 PM revealed she expected each try to be set up including all items taken from the tray and placed in front of the resident. She stated there were typically 2 to 3 staff to over see the dining in the Sparks unit in addition to the activity/nurse aide and nurse on the unit. She stated she expected staff to position the residents who tend to take from other's tray in a way to reduce sharing and they should be aware of those residents who share food and observe them. She stated the residents were in different stages of dementia and that staff should be watching but staff would not be able to catch all the activities going on in the dining room. She further stated that sharing has happened even with added people including families.	F 311		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for	F 412		8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 39 transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to order requested dental supplies and schedule follow-up treatments recommended as a result of a dental examination for 1 of 3 residents reviewed for dental status and services (Resident #54). The findings included: Resident #54 was admitted to the facility on 10/01/13 with diagnoses that included Alzheimer's dementia, anxiety, and cognitive deficits. Review of the quarterly Minimum Data Set dated 7/19/15 indicated Resident #54 was unable to complete the cognition evaluation and required extensive assistance for most activities of daily living including personal hygiene. No dental issues were identified. Resident #54 was revealed to wear a dental partial in place of missing teeth. Review of the medical record revealed Resident #54 was seen for dental referrals on 04/28/15 and again on 06/02/15. On 06/02/15 Resident #54 was seen for a comprehensive dental exam with a chief complaint of pain. She received x-rays of her mouth, and her teeth were cleaned. Resident #54 was indicated to have poor oral hygiene and severe generalized inflammation. She was diagnosed with rampant decay, severe generalized gingivitis, and moderate bone loss. Recommendations for follow-up treatment included extractions of teeth #6, #7, #10, #11, and #14. Multiple fillings were recommended which included teeth #3, #20, #22, #23, #24, #25, and #27; as well as further cleaning.	F 412	F412 Resident #54¿s dental consult from 4/28/2015 and 6/2/2015 was reviewed by the DON and the ADON on 7/30/2015. On 7/27/2015, an order was obtained for Chlorhex Glu Sol, rinse with 15ml. for 30 seconds Q AM and Q PM. On 8/3/2015, an order was obtained to discontinue dental treatments due to resident's refusal. On 8/18/2015, the dental designee called the RP and she reconfirmed that the RP does not want any dental work done unless the resident has an abscess or an increase in pain. All other residents who were seen on 6/2/2015 by the mobile dental clinic had their consults reviewed by the DON and ADON. No orders were identified that had not been transcribed. Re-training of the nursing licensed staff and nursing unlicensed staff was conducted which included, all dental consults will be reviewed by 2 nurses the day of the consult to review for any new orders. THis training will begin 8/20/2015 and will be completed by 8/28/2015. This training will be given in orientation to all new hires to the nursing department by the SDC beginning 8/25/2015. The dental designee will return all consults directly to the supervisor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 40 Resident #54 was recommended to remove her partial at night for cleaning and disinfection, and high fluoride toothpaste and periodontal rinse were ordered. Further review of Resident #54's medical record revealed no documentation of orders for follow up dental appointments or orders for recommended dental supplies. No follow up appointments were scheduled and no dental supplies were ordered. On 07/30/15 at 3:30 PM an interview was conducted with Nurse #1. She stated when residents returned from dental appointments, the nurse supervisor would take the recommendations and prescriptions and transcribe them into the physician's orders in the medical record. Nurse #1 acknowledged she did not see the follow up orders for Resident #54. On 07/30/15 at 4:20 PM an interview was conducted with the Social Worker (SW #1). She revealed she would be the person to get approval from the Responsible Party (RP) for any consults outside of the facility. SW #1 stated she could not find any correspondence with Resident #54's RP as it related to the 06/02/15 dental appointment and recommendations. She indicated she thought she remembered a conversation with the RP, but she could not find any documentation and did not recall the outcome. On 07/31/15 at 8:35 AM an interview was conducted with the Director of Nursing (DON). She stated the process when a resident returned from a dental consult involved the nurse writing the recommendations in the medical record, and making sure the appointments were scheduled. The DON revealed the process included the orders for medications were placed on the doctor's order sheet by the nurse supervisor and was sent to the pharmacy. The DON stated that both she and the Assistant Director of Nursing	F 412	An audit tool "Dental Consult Services" will be utilized and monitored by the DON, ADON, or designee. This tool will be completed by the QI nurse or designee when the dental mobile is scheduled monthly x 6 months. It will include residents who were seen that day and any orders for treatments, supplies, or follow up treatment. The visit for July 28th, 2015 has been reviewed and audited. No issues were identified from that audit. The next visit is scheduled for August 25, 2015. The DON, ADON or designee will review the results for compliance. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 41 had reviewed the dental log sheets from 06/02/15 and Resident #54's recommendations and orders were not completed. The DON acknowledged Resident #54's dental orders and recommendations were missed and she did not know why.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		8/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 42 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to remove expired stock medications from 1 of 3 medication storage rooms. The findings included: On 07/31/15 at 9:45 AM an observation of the storage cabinets in the medication storage room on Halls 100-400 revealed six bottles of Ibuprofen 200mg. tablets with 100 tablets in each bottle had an expiration date of 04/2015. Two bottles of Vite vitamins with 100 tablets in each bottle had an expiration date of 05/2014. Two bottles of Vite vitamins with 100 tablets in each bottle had an expiration date of 06/2015. One bottle of Vitamin C 500mg with 100 tablets in the bottle had an expiration date of 04/2015. On 07/31/15 at 10:15 AM an interview was conducted with Nurse #4. She stated stock medications were gotten from the pharmacy and put up in the cabinets on third shift. She stated when stock medications were put in cabinets, it was the responsibility of the person stocking the medications to rotate the stock and remove out of date medications. Nurse #4 indicated all the nurses on the medication carts were responsible for checking medications and keeping a check on the expiration dates of medications in the storage room. She states each shift the nurse supervisor is responsible for the medication room. On 07/31/15 at 10:30 AM an interview was conducted with Nurse #3 who was the nurse supervisor for that shift. She stated stock medication is put in cabinets in the medication	F 431	F431 All expired medications in the storage cabinets in the drug room was boxed up and sent back to the pharmacy on 7/31/2015. All stock drugs in the storage cabinets in the drug rooms were reviewed by 2 nurses on 7/31/2015 for expiration dates. 100% in-service initiated by the SDC, DON, or RN designee to all licensed staff and all certified med aides in the nursing department. This in-service covered monitoring for expired stock drugs. This training will begin 8/20/2015 and will be completed by 8/28/2015. This training will be given in orientation to all new hires to the nursing department by the SDC beginning 8/25/2015. The night shift med aides will monitor the stock inventory weekly for expired drugs with re-ordering and sending back expired drugs. Rotation of stock will be utilized. An audit tool ¿Stock Med Drugs¿ which includes checking for expired meds will be utilized. The tool will be completed by the QI nurse or designee 2x week x 4 weeks, then weekly x 4 weeks, then monthly x 2. The DON, ADON, or designee will review these audits for continued compliance. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 07/31/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 43 storage room on third shift. Nurse #3 indicated the stock medication was recently rotated and checked, and she did not know how the expired medications were missed. On 07/31/15 at 10:40 AM an interview was conducted with the Director of Nursing (DON). She stated the facility had a medication technician on third shift that was responsible for stocking and rotating medication as it arrived from the pharmacy. The DON revealed there had been nurse supervisors in the medication storage room checking for out of date medications. She stated she did not know how the expired medications were missed. The DON acknowledged it was her expectation that the stock medications were rotated as they were stocked, and out of date medications would be removed and returned to the pharmacy.	F 431	follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	