PRINTED: 08/28/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345205	B. WING		C 07/31/2015	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 FLETCHER STREET	1 07/31/2013	
WESTWO	OD HILLS NURSING AND	REHABILITATION CENTER		WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 157 SS=G	consult with the reside known, notify the resident accident involving the injury and has the pot intervention; a signification physical, mental, or period deterioration in health status in either life thresting form of treatments or treatment; or a decision the resident from the §483.12(a).	iately inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a a, mental, or psychosocial seatening conditions or an ent due to alter treatment the discontinue an ment due to adverse commence a new form of ion to transfer or discharge facility as specified in	F 15		8/28/15	
ARODATORY	and, if known, the res or interested family m change in room or roo specified in §483.15( resident rights under regulations as specifications this section.  The facility must recount the address and phorn legal representative of the section.  This REQUIREMENT by:  Based on staff intervificatility failed to notify couldn't complete a the section of t	promptly notify the resident ident's legal representative ember when there is a sommate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of and periodically update the number of the resident's in interested family member.  The is not met as evidenced sews and record review the the physician when they norough assessment of a supplier representative's signature.		Westwood Hills Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	S (X6) DATE	

**Electronically Signed** 

08/21/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345205	B. WING _			C <b>07/31/</b> 2	2015
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	0773172	2013
				1016 FLETCHER STREET			
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER					
				WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED			(X5) DMPLETION DATE
F 157	Continued From page	e 1	F 1	57			
	resident was request sampled residents (F	•		and proposes this Plan the extent that the sum factually correct and in compliance with applica provisions of quality of o	mary of findings order to maintai able rules and care of residents	is n s.	
	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			The Plan of Correction written allegation of con Westwood Hills Nursing Rehabilitation Center as Statement of Deficienci denote agreement with Deficiencies nor does it admission that any defice Further, Nursing and Reserves the right to refedeficiencies on this State Deficiencies through Interesolution, formal appear or any other administrate proceeding.  F 157 Resident #24 was trans Hospital ER at 10:30pm her fractured hip. All residents will be ass	is submitted as inpliance. In and is response to this es does not the Statement of constitute an ciency is accurate an abilitation Cerute any of the tement of formal Dispute all procedure and tive or legal	a  is  of  tte.  nter  d/	
	An incident report da the night shift superv was found in the floo reluctant to move her ambulance, get me a report revealed the re bed. The night shift of the incident report the contacted at 3:20 AM			significant change in co an injury from a fall, for and or ER evaluation if 100% of all in house res assessed and reviewed change in condition, ind from a fall. These asses completed by the Admir staff, including the DON Nurse, SDC, RN Super Nurses and the MDS N assessments were com 19-24, 2015. Any area i significant change in co	notification of Mindicated. sidents were If or any significated in injury as ments were histrative nursing I, ADON, QI visors, Treatme urses. These hipleted August identified to be a	ant g nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345205	B. WING _				C / <b>31/2015</b>	
NAME OF P	ROVIDER OR SUPPLIER	<b>I</b>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	70172010	
					016 FLETCHER STREET			
WESTWO	OD HILLS NURSING	AND REHABILITATION CENTER			/ILKESBORO, NC 28697			
					,			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 157	Continued From p	age 2	F	157				
	· ·	practitioner was notified that			injury from a fall, was immediately calle	ad		
		having increased pain to right			to the MD/FNP or PA for that resident.	5u		
		as "drawn up." The resident			100% in-service initiated by the SDC,			
		en range of motion was			DON, or RN designee to all licensed a	nd		
		n-call practitioner ordered an			unlicensed staff in the nursing			
	x-ray.	can practice or acrea an			department. This in-service covered			
					notification of physician of any significa	ant		
	The radiology repo	ort dated 07/06/15 revealed			change in condition, including injury from			
	Resident #24 had a fracture of the right hip.				an accident, assessment of change in			
		•			condition, including injury from an			
	Resident #24 was	transported to the Emergency			accident, and reporting any changes to	)		
	Department on 07	/06/15 at 10:30 PM.			the appropriate staff at the nursing fac	lity.		
					This training will begin 8/20/2015 and			
		10 PM Nurse #1 was			be completed by 8/28/2015. This traini	-		
		xplained that he was orienting			will be given in orientation to all new hi			
		7/06/15 and that he normally			to the nursing department by the SDC			
		PM (day shift). He added that			beginning 8/25/2015.			
		ft if a resident fell and			All resident progress notes, and incide	nt		
		onset of pain he would contact			reports will be monitored daily by the			
		rse #1 reported that on			DON, ADON, and RN Supervisor to	4: _ <u>_</u>		
		notified that Resident #24 fell; responded to the resident and			ensure all significant changes in condi including injuries from an accident has			
		. He stated that he couldn't see			been assessed and the notification of			
		d felt it was safe to put her back			MD/FNP/PA has been notified. Any	.116		
		e stated that he assessed			concerns will immediately be addresse	h;		
		ore deciding to transfer her off			at that time.			
		unable to check range of motion			An audit tool will be utilized and monitor	ored		
		right leg. Nurse #1 explained			by the Administrator, DON, or ADON.			
		was in pain and when asked			tool will be completed by the QI Nurse			
		is located she patted her right			designee, 3x week x 4 weeks, then 2 >			
	hip, she was unab	le to verbalize a 1 to 10 pain			week x 4 weeks, then weekly x 4 week	ίS.		
	scale but the resid	lent showed facial grimacing			The Administrator and/or DON will rev	ew		
	_	er right side. The nurse stated			these audits as they are completed			
		t of pain after the fall was a			The Quarterly Quality Improvement			
	change in the resident's condition and he notified the night shift supervisor. He added that Resident			Committee will review the results of the	Э			
				audits and give recommendations for				
		ed" pain medication which he			follow up as needed or appropriate for			
		sident refused. Nurse #1 stated			continued compliance in this area and			
	that he did not not	ify the physician of Resident	1		determine the need for and or frequen	CV	1	

	OF DEFICIENCIES CORRECTION	` IDENTIFICATION NI IMBED: ` ´		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345205	B. WING _				31/2015	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		0.,,20.0	
				10	016 FLETCHER STREET			
WESTWO	OD HILLS NURSING AN	ID REHABILITATION CENTER			/ILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE A			(X5) COMPLETION DATE	
F 157	Continued From pag		F 1	57				
	leg after the fall becashift supervisor. Numot document his as On 07/31/15 at 9:00 was interviewed and Nurse #1 notified he complained of pain texcruciating but had The night shift superwas in bed when she supervisor reported the same length and Resident #24 was gridin't want to move reported that other thany injuries. The night she did not see physician since the medication. The night she did not contact texplanation why it wincident report that the On 07/31/15 at 9:30 was interviewed and notified on 07/06/15 but did not assess the medication aide	refused pain medication. visor stated Resident #24 e assessed the resident. The that Resident #24's legs were showed no deviation but that ripping her right knee and the leg. The supervisor han a skin tear she didn't see ght shift supervisor reported a need to contact the resident was refusing pain ht shift supervisor stated that he physician and offered no has documented on the he physician was contacted. AM the day shift supervisor reported that she was that Resident #24 had fallen jured. She explained that he resident until 11 AM when reported that Resident #24			of continued QI monitoring.			
	nurse practitioner an x-ray. The day shift when a resident fell physician should be direction.	at she contacted the on-call dreceived orders for an supervisor reported that and complained of pain the notified then for further						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345205	B. WING		C <b>07/31/2015</b>	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1016 FLETCHER STREET  WILKESBORO, NC 28697		07/31/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 157  F 224 SS=G	did not expect nurses after every fall. He en nurses to use clinical when to contact the pstated that if a fall occurred sudden onset of pain and no obvious injury a physician.  On 07/31/15 at 2:10 If was interviewed and change in a resident's onset of pain after a ficontact the physician 483.13(c) PROHIBIT MISTREATMENT/NE	lephone and reported that he to contact him immediately explained that he expected judgment to determine physician. The physician curred and there was a new not relieved with medication of then the nurse should notify.  PM the Director of Nursing reported that a significant is condition would be a new fall and the nurse should.  CGLECT/MISAPPROPRIATN elop and implement written res that prohibit it, and abuse of residents	F 15		8/28/15	
	by: Based on staff interviacility neglected to sa resident in pain who after she fell for 1 of 2 (Resident #24). The findings included Resident #24 was ad 01/09/15 with demen	·		F 224 Resident # 24 was assessed by the second shift supervisor on 7/6/2015, around 10:30pm. She sent the residenthe ER for evaluation and called the on-call physician, following her assessment. All residents will be assessed with a significant change in condition, including		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	ULTIPLE CONSTRUCTION			SURVEY PLETED
			A. BOILDI	NG _			С
		345205	B. WING			07/	31/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER		10	016 FLETCHER STREET		
				W	VILKESBORO, NC 28697		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD		E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 224	Continued From page	e 5	F	224			
		et (MDS) dated 06/25/15			an injury from a fall, for notification of N	/ID	
		t had short and long term			and or ER evaluation if indicated.		
	·	and moderately impaired			100% of all in house residents were		
		ily decision making but had			assessed and reviewed for any signific	ant	
	clear speech, was ab	•			change in condition, including an injury		
		illy understood others. The			from a fall. These assessments were		
	MDS also specified the				completed by the Administrative nursing	a	
		with activities of daily living,			staff, including the DON, ADON, QI	y	
		ain and had fallen twice			Nurse, SDC, RN Supervisors, and the		
	without injury.	alli allu ilau lalleli twice			MDS Nurses. These assessments wer	0	
	Review of Resident #						
					completed August 19-24, 2015. Any ar	<del>C</del> a	
		ntry made by the night shift			identified to be a significant change in		
		06/15 at 3:20 AM that read in			condition, including injury from a fall, w		
	I -	ound on the floor laying on			immediately called to the MD/FNP or F	Ά	
	_	ent clutched middle portion			for that resident.		
	_	ctant to move right leg."			100% in-service initiated by the SDC,	- al	
		ted 07/06/15 completed by			DON, or RN designee to all licensed a	10	
		isor specified Resident #24			unlicensed staff in the nursing		
		r clutching her thigh and was			department. This in-service covered		
		right leg asking "call an			notification of physician of any signification		
	_	n ambulance." The incident			change in condition, including injury fro	m	
		esident was placed back in			an accident, assessment of change in		
	bed.				condition, including injury from an		
		rs revealed on 07/06/15 at			accident, and reporting any changes to		
	· ·	ft supervisor obtained orders			the appropriate staff at the nursing faci	•	
	-	I's right hip and right knee			This training will begin 8/20/2015 and v		
	· ·	d physician order was			be completed by 8/28/2015. This traini	-	
		t 1:20 PM to administer			will be given in orientation to all new hi		
	· · ·	on) every 6 hours as needed			to the nursing department by the SDC.		
	for pain.				All resident progress notes, and incide	nt	
		medical record revealed a			reports will be monitored daily by the		
		7/06/15 at 1:20 PM the			DON, ADON, or RN Supervisor to ens	ure	
		24 was having increased			all significant changes in condition,		
		he leg was "drawn up."  The			including injuries from an accident has		
	resident would yell ou	ut when range of motion was			been assessed and the notification of t	he	
	performed. The on-c	all nurse practitioner was			MD/FNP/PA has been notified. Any		
		x-rays. Review of the			concerns will immediately be addresse	d	
		ation Record revealed			at that time. This will continue indefinite		
	Resident #24 receive				An audit tool will be utilized and monito	•	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI		<del></del>	، ا		
		345205	B. WING				31/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0112010	
14/50514/0				10	016 FLETCHER STREET			
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER		W	VILKESBORO, NC 28697			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 224	Continued From page	e 6	F	224				
		M after falling at 2:45 AM.			by the Administrator, DON, or ADON. 1	his		
		dated 07/06/15 at 5:39 PM			tool will be completed by the QI Nurse			
		4 had a fracture of the right			designee, 3x week x 4 weeks, then 2 x			
	hip.	·			week x 4 weeks, then weekly x 4 week			
	Resident #24 was tra	nsported to the Emergency			The Administrator and/or DON will revi	ew		
	Department on 07/06				these audits as they are completed.			
		PM nurse aide (NA) #1 was			The Quarterly Quality Improvement			
	•	rted that she was assigned			Committee will review the results of the	,		
		24 on 07/06/15. The NA			audits and give recommendations for			
	explained that when making rounds she found Resident #24 laying in the floor calling for help				follow up as needed or appropriate for continued compliance in this area and	to		
	and saying she was hurt. The NA added that she				determine the need for and or frequence			
	went immediately to				of continued QI monitoring.	'y		
		1 assessed Resident #24			or continued & morntoning.			
	and determined that i							
		The NA added that the						
	resident complained	of pain and appeared in pain						
	but remained in the b	ed the rest of the shift. NA						
		ecked on Resident #24						
		Resident #24 appeared to						
		mplaining of knee and hip						
		that she notified Nurse #1						
	•	1's complaint of pain. The						
	NA added that her sh On 07/30/15 at 4:10 F							
		ained that he was orienting						
		6/15 and that he normally						
	_	I (day shift). He added that						
	during the day shift if							
		et of pain he would contact						
	the physician. Nurse							
		fied that Resident #24 fell;						
	-	oonded to the resident and						
		e stated that he couldn't see						
	any red marks and felt it was safe to put her back							
		ated that he assessed						
		deciding to transfer her off						
		ble to check range of motion						
	uue to paili ili liei ligi	nt leg. Nurse #1 explained						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, BOILD	,.		، ا	2
		345205	B. WING				31/2015
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		01/2010
				1	016 FLETCHER STREET		
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER		V	VILKESBORO, NC 28697		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	115	
F 224	Continued From page	e 7	F	224			
	that Resident #24 wa	is in pain and when asked					
	where the pain was lo	ocated she patted her right					
	hip, she was unable t	to verbalize a 1 to 10 pain					
	scale but the resident	t showed facial grimacing					
	and was holding her	right side. The nurse stated					
	that the new onset of	pain after the fall was a					
	_	nt's condition and he notified					
		isor. He added that Resident					
		ed" pain medicine ordered					
	and he offered the re						
	but she refused. Nur						
		f Resident #24's complaint					
		move her leg after the fall					
		to the night shift supervisor.					
		AM the night shift supervisor					
		reported that on 07/06/15 rienting Nurse #1 to night					
		hree other halls. She					
	_	#1 notified her that Resident					
		ned of pain that did not					
		out had refused her PRN (as					
	needed) pain medica	•					
		e assessed the resident and					
	found the resident in						
	reported that Resider	nt #24's legs were the same					
		o deviation but that Resident					
	#24 was gripping her	right knee and didn't want to					
	move the leg. The su	upervisor reported that other					
	than a skin tear she of	didn't see any injuries. The					
		reported that she did not					
		t the physician since the				ſ	
	_	pain medication. The night				ĺ	
		ted that at 5 AM the day shift				ĺ	
	supervisor relieved he					ĺ	
		AM NA #3 was interviewed				ĺ	
		e worked with NA #2 on				ĺ	
		e recalled Resident #24				ĺ	
		e fall. She explained that				ĺ	
	she didn't provide dire	ect care for Resident #24				ĺ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345205	B. WING _				C 31/2015
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		1016 FLET	DDRESS, CITY, STATE, ZIP CODE TCHER STREET BORO, NC 28697	1 077	31/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 SS=E	NA #3 stated that Re of pain and looked li and kept holding her Attempts were made was unable to be read On 07/31/15 at 2:10 was interviewed and change in a resident onset of pain after a contact the physicial 483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an erenhances each residefull recognition of his This REQUIREMEN by:  Based on observation interviews, the facility must promanner and in an erenhances each residefull recognition of his this REQUIREMEN by:	the room and assisted NA #2. Esident #24 was complaining the she was in "a lot of pain" releg. It to contact NA#2 but she eached for an interview.  PM the Director of Nursing reported that a significant reported that a significant resolution would be a new fall and the nurse should have a new fall and the	F2	F24' Resid	dents #140, #6, #232, #104, and	#14	8/28/15
	in the secured unit. meal observations a #140, #232, #6 and  The finding included  1. Resident #140 w the facility on 05/07/ mental disorder, dep neoplasm of the hea dysphagia. His mos (MDS), a quarterly dep			expe to ea liquid food. delive seatii All re dining resid their own to	rience, to include assisting reside toff their own plates, drink their ods, and have access to their own. This is accomplished by meal ery schedule adjustment and resing in the dining room. Esidents will be provided a dignification own liquids, and have access to food. This is accomplished by mery schedule adjustment and resing in the dining room.	own ident ed ik their eal	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	c
		345205	B. WING				31/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP (		TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER	1016 FLETCHER STREET		016 FLETCHER STREET		
11201110	OD TILLO NOROINO AN	D REHABIEHATION GENTER		W	/ILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From pag up and supervision for Resident #6 was add 10/10/12 and had dia	or eating. nitted to the facility on	F:	241	100% in-service initiated by the SDC, DON, or RN designee to all licensed ar unlicensed staff in the nursing department. This in-service covered	nd	
	Alzheimer's disease, anxiety. Her most re 05/03/15 assessed h cognition, having phy	dementia, dysphagia, and cent quarterly MDS dated er with severely impaired vsical abusive behaviors and and requiring limited			dignity and respect of the individual resident during dining. Examples included, supervision at meal times to avoid residents attempting to take othe resident; s food, opening beverages, a offering all meal items. This training w begin 8/20/2015 and will be completed	nd vill	
	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				8/28/2015. This training will be given in orientation to all new hires to the nursir department by the SDC beginning 8/25/2015.  The schedule for the tray delivery as was the residents on each delivery has	ng	
					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.		
	Resident #140. Onc Resident #6 immedia cottage cheese from eat a small bite. Sta Resident #6 with her liquids. At 12:52 PM removed the cottage and gave it back to Feding anott reached over and so tried to eat any remn from which Resident PM, Resident #232 g	h her at her table adjacent to e seated, at 12:43 PM ately reached and took Resident #140 and began to ff immediately presented pureed meal and thickened an activity staff member cheese from Resident #6 Resident #140. As staff went her resident, Resident #6 rapped the empty plate and ants from the empty plate #140 had eaten. At 12:57 pathered the plate from ill had mashed potatoes and			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 week x 4 weeks, then 2x week x 4 week then weekly x 4 weeks. The Administra 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 determine the need for and or frequence.	: 3x ks, itor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345205	B. WING	B. WING			C <b>7/31/2015</b>	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 07	73 1/20 15	
				10	16 FLETCHER STREET			
WESTWO	OD HILLS NURSING	AND REHABILITATION CENTER		W	ILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 241	Continued From p	page 10	F 2	241				
	desert on it and to PM, Resident #23 empty plate and opotatoes. She the protector from Re #6's hand to keep Resident #140's pPM that Nurse Aid Resident #6 kept potatoes, she was potatoes to which 1:03 PM, Resident unthickened tea f#232 continued to Resident #140's cobserved to hit Re Once extra potatoes.	ook it to the counter. At 12:58 32 removed Resident #140's gave him his bowl of mashed en removed the clothing sident #6 and held Resident a Resident #6 from taking cotatoes. It was not until 1:01 de #3 staff intervened and as pointing to Resident 140's as asked if she wanted more the resident responded yes. At at #6 reached and began to drink from Resident #232. Resident at keep Resident #6 from taking dessert and Resident #6 was esident #232's hand away. bes arrived from the kitchen NA ent #6 who ate the mashed			of continued QI monitoring.			
	interviewed. She with the cottage of from it so she just On 07/30/15 at 3: management alwaides for the secuthe activity staff/n sharing food in the occurrence in this more if available of On 07/31/15 at 8: sometimes there oversee the diningesidents who at least 4 residents	10 PM, the activity staff was stated she saw Resident #6 sheese but did not see her eat a gave it back to Resident #140.  58 PM, Nurse # 2 stated that ays tried to schedule 3 nurse ared unit and in addition there is urse aide. He further stated that the dining room was a typical a unit. Management try to staff to oversee the residents.  44 AM NA #3 stated that are 2, 3 or even 6 staff to g. She was aware of several off others' trays, and named at including Residents #6. They try table but one resident needs to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345205	B. WING _			C 07/31/2015		
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 FLETCHER STREET WILKESBORO, NC 28697		1773 1720 13		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 241	Continued From page be fed and Resident fed.  On 07/31/15 at 10:4 separate residents to resident's food but it stated it was hard to with behaviors.  On 07/31/15 at 10:5 was interviewed. State happened frequently to having so many of who could not cognibelonged to them.  Interview with the Deat 2:58 PM revealed set up including all it placed in front of the were typically 2 to 3 the Sparks unit in action and nurse on the expected staff to pot to take from other's	·	F 2	DEFICIENCY)				
	residents who share stated the residents dementia and that s staff would not be a going on in the dinir that sharing has hap people including far 2. Resident #140 was the facility on 05/07 mental disorder, depneoplasm of the hea	e food and observe them. She were in different stages of taff should be watching but ble to catch all the activities and room. She further stated opened even with added						

		IDENTIFICATION NITIMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		<b>345205</b> B. WING				C 07/24/2045	
NAME OF P	ROVIDER OR SUPPLIER	0.10200	1	STREET ADDRESS, CITY, STATE, ZIP CC		)7/31/2015	
				1016 FLETCHER STREET			
WESTWO	OD HILLS NURSING AI	ND REHABILITATION CENTER		WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	Continued From pag	ge 12	F 2	241			
	(MDS) a quarterly d	ated 06/18/15 revealed he ed cognition, and required set					
	the first resident to be double portions. The coffee was left cove #140 had finished his continually scraped utensil, placing the deat more food but had a bowl of oatmet there to be eaten. #3 placed a clothing but did not move the him nor did she uncorrepeatedly tried to deat the remnants as he did not seem yogurt at the far side	41 AM, Resident #140 was be served and he received be tray was set up but the red. At 7:46 AM, Resident is plate of food and his empty plate with his utensil to his mouth trying to eaving none on his plate. He heal and a carton of yogurt still hat 7:47 AM Nurse Aide (NA) protector around his neck be coatmeal or yogurt closer to hover his coffee which he rink from throughout the o continued to scrape and try off his empty plate repeatedly to see he had oatmeal and be of his plate. This continued Nurse #2 sat with him, gave					
	him medications and the yogurt and oatm did not uncover the immediately began to continued to scrape repeatedly getting mat at 8:13 AM he be clothing protector with Assistant Director of Resident #140 the yofeed himself until he ADON did not uncover the ADON removed him with a fork. Whe coffee she stated it was in the ADON to the ADON removed him with a fork.	d water and Nurse #2 pushed eal closer to him. The nurse coffee. Resident #140 to eat. At 8:08 AM, he the remnants of his oatmeal hinuscule bits left in the bowl. gan scraping his pants and th his spoon. At 8:15 AM, the Nursing (ADON) offered ogurt which he proceeded to finished it at 8:18 AM. The ver the coffee. At 8:27 AM, the yogurt and his tray but left en asked about the covered was covered to stay warm. did not like coffee. Once the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345205	B. WING			C <b>07/31/2015</b>	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1016 FLETCHER STREET WILKESBORO, NC 28697	•	0113112013	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	gave him back his drink coffee and sput the fork in his something. This content of the fork in his staff offering him in Resident #140 sto. Throughout this man activity staff/nu floor nurse in and b. The lunch mea 07/30/15 at 12:34 aide/activity staff awere observed se PM Resident #140 pureed spaghetti pureed zucchini, abowl of pureed deimmediately starte he was scraping his empt in the room feedir passing teas. At cottage cheese are empty plate trying #5 removed the pzucchini and deseimmediately bega #140 was observed trying to feed hims This continued un room at 1:13 PM.  On 07/31/15 at 10 #140 has the behavior of the passing teas the process of the passing tead the process of the passing tead to passin	e had tried to drink it, ADON so coffee and he proceeded to crape the table with his fork and mouth as if he was eating continued until 8:43 AM, with no more to eat. At 8:43 AM, bod and left the dining room. heal, there were 2 nurse aides, urse aide, the ADON and the	F2	241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345205	B. WING _			C <b>07/31/2015</b>	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 FLETCHER STREET WILKESBORO, NC 28697		0770172010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 241	Continued From pa	ge 14	F 2	41			
	was interviewed. S Resident #140 was he had food in front repeatedly scraped  Interview with the D at 2:58 PM revealed set up including all i placed in front of the were typically 2 to 3 the Sparks unit in a aide and nurse on t residents were in di	rirector of Nursing on 07/31/15 If she expected each try to be tems taken from the tray and the resident. She stated there is staff to over see the dining in addition to the activity/nurse the unit. She stated the fferent stages of dementia					
	not be able to catch the dining room. 3. Resident #6 was	admitted to the facility on					
	anxiety. Her most r 05/03/15 assessed cognition, having ph other behaviors dail assistance with eati	e, dementia, dysphagia, and ecent quarterly MDS dated her with severely impaired hysical abusive behaviors and y and requiring limited ng. The care plan for resident needed assistance with eating.					
	07/30/15 at 12:34 P aide/activity staff ar were observed serv #6 was walking in a at the table. At 12:4 the thin ice tea from the activity staff/nur PM Resident #6 wa	wice was observed on M. 3 nurse aides, the nurse aid a part time activity assistant ring during this meal. Resident and out of the room not sitting 42 PM, Resident #6 grabbed a Resident #232, at which time se aide intervened. At 12:44 s the last to be served at the acceded to give her a bite of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345205	B. WING _		0.	C <b>07/31/2015</b>	
	ROVIDER OR SUPPLIER  OD HILLS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1016 FLETCHER STREET WILKESBORO, NC 28697		773 1720 13	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 241	table. Staff walked a #6 drank the thin liquid 1:00 PM she drank in unthickened tea. The of NA #5 who remove hand.  On 07/30/15 at 3:58 management always aides for the secured the activity staff/nurs sharing food in the discourrence in this unimore if available to on 07/31/15 at 8:44 sometimes there are oversee the dining. The residents who ate off least 4 residents inclided to serve table by table be fed and Resident fed. This morning, sinceded to be fed.  On 07/31/15 at 10:47 separate residents the resident's food but it stated it was hard to with behaviors.  On 07/31/15 at 10:54 was interviewed. She happened frequently to having so many contains the stated it was bard to with behaviors.	aged Resident #6 to sit at the way. At 12:58 PM, Resident id from Resident #232. At more of Resident #232's e surveyor got the attention ed the tea from Resident #6's PM, Nurse #2 stated that tries to schedule 3 nurse I unit and in addition there is e aide. He further stated that ning room was a typical it. Management tried to staff	F2	241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		345205	345205 B. WING		C		
	ROVIDER OR SUPPLIER  OD HILLS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD  1016 FLETCHER STREET  WILKESBORO, NC 28697	•	7/31/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 241	at 2:58 PM revealed set up including all placed in front of the were typically 2 to 3 the Sparks unit in a aide and nurse on the expected staff to post to take from other's sharing and they sharing and they sharing and they sharing and they sharing and the residents dementia and that sharing has hapeople including far 4. Resident #104 w 01/02/13 with diagn disease and demendisturbances. Her use to (MDS), a quarted with long and short moderately impaire required set up and Resident #14 was a 03/18/13 with diagn mental disorder and MDS dated 06/17/1 short term memory moderately impaire required set up and Resident #205 was 10/09/14 with diagn anxiety. Her quarter	director of Nursing on 07/31/15 d she expected each try to be items taken from the tray and e resident. She stated there is staff to over see the dining in addition to the activity/nurse he unit. She stated she isition the residents who tend tray in a way to reduce rould be aware of those is food and observe them. She is were in different stages of staff should be watching but ble to catch all the activities are room. She further stated ppened even with added millies.  The sa admitted to the facility on roses including Alzheimer's attain with behavioral most recent Minimum Data early dated 07/21/15 coded her term memory impairment and did decision making skills. She supervision with meals.  The same of those is a supervision with meals.  The supervision with meals.	F 2	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345205	B. WING			C <b>07/31/2015</b>	
	ROVIDER OR SUPPLIER  OD HILLS NURSING ANI	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1016 FLETCHER STREET WILKESBORO, NC 28697		07/31/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	supervision with mea 07/21/15 at 11:59 AM responsible party was date and was concern gaining weight. The resident was getting in The lunch meal service 07/30/15 at 12:34 PM nurse aide/activity states assistant were observed Residents #205, #14 table together. At 1:00 eaten her dessert and #14's dessert. No state Resident #205 moved dessert. Although the treatment of the room at this time, staff was feeding a reamounts consumed of another was just over On 07/30/15 at 3:58 Pm anagement always aides for the secured was the activity staff/stated that sharing for typical occurrence in staff more if available On 07/31/15 at 8:44 Pm sometimes there are oversee the dining. See residents who at off least 4 residents included the sometimes there are oversee the dining.	re and needing set up and ls. A nursing note dated larevealed that the sin care conference this need about the resident responsible party stated the into other residents' trays.  Three nurse aides, the aff and a part time activity and serving during this meal, and #104 were seated at a 3 PM Resident #205 had a proceeded to eat Resident aff intervened. At 1:06 PM, and on to eat Resident #104's here were at least 3 staff in no one intervened as one resident, one was marking on the tray tickets and reseeing from the doorway.  PM, Nurse #2 stated that tried to schedule 3 nurse unit and in addition there nurse aide. He further od in the dining room was a this unit. Management try to to oversee the residents.	F2	241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245205	B. WING		С		
NAME OF D	ROVIDER OR SUPPLIER	345205	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07	/31/2015	
NAIVIE OF PI	ROVIDER OR SUPPLIER			1016 FLETCHER STREET			
WESTWO	OD HILLS NURSING ANI	O REHABILITATION CENTER		WILKESBORO, NC 28697			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		ULD BE	(X5) COMPLETION DATE	
F 241	Continued From page	e 18	F 2	41			
	separate residents the resident's food but it of	AM, NA #4 stated they try to at tend to grab at other can be "a free for all." She supervise all the residents					
	staff was interviewed happened frequently	AM, nurse aide /activity  She stated sharing of food in the unit. She attributed it ps in front of each resident wely know which cup					
F 253 SS=E	at 2:58 PM revealed set up including all ite placed in front of the were typically 2 to 3 sthe Sparks unit in add aide and nurse on the expected staff to posito take from other's tr sharing and they shoresidents who share stated the residents vidementia and that stastaff would not be ablinging on in the dining that sharing has happ people including famil 483.15(h)(2) HOUSE	uld be aware of those food and observe them. She were in different stages of aff should be watching but the to catch all the activities froom. She further stated bened even with added lies.  KEEPING &	F 2	53		8/28/15	
	The facility must prov	ide housekeeping and s necessary to maintain a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			(X3) DATE SURVEY COMPLETED	
		345205	B. WING			С	
NAME OF D	20//050 00 01/00/150	343203	B. WING _	OTDEET ADDRESS OFFICE TIP OO	•	7/31/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
WESTWO	OD HILLS NURSING	AND REHABILITATION CENTER		1016 FLETCHER STREET			
				WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 253	Continued From p	age 19	F 2	53			
	· ·	ENT is not met as evidenced	'-				
	by:	in is not met as evidenced					
	,	ations and staff interviews, the		F 253			
		nintain walls in good repair		The wallpaper was repaired	in Rooms 403		
		ean commode bases and floors		and 411 on 8/11/2015. The	1111001110 100		
	on 2 of 6 hallways			walls/wallpaper were repaire	ed in Room		
		(,		503 on 8/12/2015. The wall			
	The finding include	ed:		in Room 505 on 8/20/2015.	The bathroom		
				adjoining 505 and 507 was r	epaired		
	Observations mad	e throughout the survey		8/12/2015 with replaced tiles	s and		
		lisrepair, soiled discolored		caulking. The walls in 508 w	as repaired		
	caulking around co	ommode bases and floors as		and the towel rack was repla	aced on		
	follows:			8/20/2015. The bathroom ad			
				and 508 was repaired with re	•		
		07/29/15 at 4:14 PM and on		and caulking 8/12/2015. Roo			
		M, approximately 2.5 feet by		repaired on 8/20/2015, the to			
		vallpaper under the sink was		reinstalled and the adjoining			
		seams and the wallpaper		has new tile and caulking. The			
	discolored making	nk area was yellowed and		for 511 has had the caulking the tiles replaced. The bathr			
	discolored making	it looked stailled.		and caulking in the shared b			
	h Room 411: On (	07/29/15 at 11:17 AM, on		516 and 518 was replaced 8			
		M and on 07/31/15 at 9:40 AM		A 100% audit of the conditio			
		es of ripped wallpaper, deeply		resident rooms and bathroor			
		ng over a 3 foot by 3 foot area		conducted on 8/13/2015 by			
		wallpaper that looked patched		Administrator, Maintenance			
		inch triangle that was not		the Housekeeping Superviso			
	covered back with	wallpaper by bed B.		needing repairs were identifi	ied. All repairs		
				will be completed by 8/28/20	)15.		
		07/30/15 at 12:09 PM and on		Repairs to resident rooms a	nd bathrooms		
		M the walls by bed A had 3		will be added to the Prevent			
	areas of peeled pa	aint with the wallboard showing.		Maintenance rounds. This w			
	<u></u>			completed on a monthly bas			
		07/28/15 at 1:20 PM, on		orders will continue to be co			
		PM, and on 07/31/15 at 9:44		the staff to notify the mainter			
		obly paint by the sink in the		department of issues as they			
		red bathroom shared with		housekeeping supervisor wil			
	KOOIII 507 NAG A V	very discolored floor.		monthly rounds to all resider			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
	345205	B. WING _	<del></del>		07/31/2015	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTWOOD HILLS NUDSING AND D	ELIADII ITATION CENTED		1016 FLETCHER STREET			
WESTWOOD HILLS NURSING AND R	WESTWOOD HILLS NURSING AND REHABILITATION CENTER		WILKESBORO, NC 28697			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
wall, and patched but un sink. In addition, the bat 506 had dark brown cau the commode.  f. Room 510: On 07/28/1 07/30/15 at 12:07 PM, a AM there were areas of unfinished patches cove 18 inches by 12 inches, the wallpaper measuring missing towel rack with the wall and the bathroom for brown caulking around the brown caulking around the seat extender in the Room 513.  h. Room 518: On 07/30/07/31/15 at 9:41 AM the shared with Room 516 he Interview with the house conducted on 07/31/15 at he cleaned the floor daily	ind on 07/31/15 at 9:43 into one end still on the offinished wall paper by the throom shared with Room alking around the base of the commode.  Is at 4:31 PM, on and on 07/31/15 at 9:41 missing wallpaper with the ring 2.5 feet by 8 inches, and a separating seam in 22 feet. There was a the metal clips still in the corthis room had dark the base of the commode.  Is at 4:28 PM, on and on 07/31/15 at 9:42 decaulking around the end dirt around the legs of bathroom shared with  It is at 12:02 PM and on and discolored flooring.  Except on the 500 hall, at 8:38 AM, revealed that y and sometimes twice thought the discolored floors was due to wax	F2	An in-service will be completed Administrator to the Maintenan Department and the Housekee Supervisor on 8/24/2015 to covaudit tool and requirements for Preventative Maintenance.  An audit tool ¿Condition of Res Rooms and Bathrooms¿ will be and monitored by the houseker supervisor, the QI nurse or destool will include torn, wallpaper the sheetrock, bathroom floor stoilet caulking. This tool will be by the QI nurse or designee we weeks, then monthly x 3. The Administrator and/or DON will these audits as they are compl. The Quarterly Quality Improver Committee will review the resu audits and give recommendation follow up as needed or approping continued compliance in this are determined the need for and or to of continued QI monitoring.	ce ping ver the new sident e utilized eping signee. This holes in stains, and completed eekly x 4 review eted. ment lts of the ons for riate for rea and to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345205	B. WING_			C <b>07/31/2015</b>	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1016 FLETCHER STREET WILKESBORO, NC 28697	•	7773 1720 13	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 253	had reported the to arrange for the to arrange for the On 07/31/15 at 1: rooms and bathro maintenance directory throughout the too worked under the described the prewhich did not inclustated he relied of those types of reported that he had a part walls but he was pand no longer pair rooms needing pair common (508 with not this surveyor identified director stated that painting/repairs in people. During the stated that he did daily and wanted the wall repairs. It caulking and the fold wax and rewalthere was a clean caused the wax to further stated that preventative thing mean something.	floors. He further stated he floors to his supervisor who was	F2	253			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	(X3) DATE SURVEY COMPLETED	
		345205	B. WING _		C 07/31/2015
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 FLETCHER STREET  WILKESBORO, NC 28697	07/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC' ( (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE COMPLETION
F 309 SS=G	bathrooms. She sta around the commod disinfectant they diswax. Her staff were but it was available twas something they of the housekeepersidentify the rooms alstripped and rewaxe 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessaror maintain the highmental, and psychos	re buffed monthly but not the ted the buffers did not fit es. She stated there was a covered that destroyed the not to use this disinfectant to other staff in case there needed to clean in absence s. She stated she did not cove as needing the floors d.  ARE/SERVICES FOR ING  receive and the facility must ry care and services to attain est practicable physical,	F 2		8/28/15
	by: Based on staff inter facility failed to seek they couldn't comple due to pain and the ambulance after falli sampled residents (I  The findings include  Resident #24 was a 01/09/15 with dement deficit, right hip fract The Minimum Data	·		F 309 Resident # 24 was assessed by th second shift supervisor on 7/6/201 around 10:30pm. She sent the res the ER for evaluation and called th on-call physician, following her assessment. All residents will be assessed with significant change in condition, inc an injury from a fall, for notification and or ER evaluation if indicated. 100% of all in house residents wer assessed and reviewed for any sig change in condition, including an in	5, ident to ne a cluding of MD re gnificant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345205	B. WING _	B. WING			/31/2015	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				10	016 FLETCHER STREET			
WESTWO	OD HILLS NURSING	AND REHABILITATION CENTER		W	/ILKESBORO, NC 28697			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 309	Continued From p	page 23	F	309				
	memory impairme	ent and moderately impaired			from a fall. These assessments were			
		daily decision making but had			completed by the Administrative nursing	ıg		
	clear speech, was	s able to make herself			staff, including the DON, ADON, QI			
	understood and usually understood others. The				Nurse, SDC, RN Supervisors, and the			
	MDS also specifie	ed the resident required			MDS Nurses. These assessments wer	е		
		nce with activities of daily living,			completed August 19-24, 2015. Any ar	ea		
	had no presence			identified to be a significant change in				
	without injury.				condition, including injury from a fall, w			
					immediately called to the MD/FNP or F	Ά		
		nt #24's medical record			for that resident.			
		s entry made by the night shift			100% in-service initiated by the SDC,	nd		
	l .	07/06/15 at 3:20 AM that read in as found on the floor laying on			DON, or RN designee to all licensed a unlicensed staff in the nursing	iu		
	her right side. Re			department. This in-service covered				
		reluctant to move right leg."			notification of physician of any signification	ant		
		oracia in to move right reg.			change in condition, including injury from			
	An incident report	dated 07/06/15 completed by			an accident, assessment of change in			
		ervisor specified Resident #24			condition, including injury from an			
	was found in the	floor clutching her thigh and was			accident, and reporting any changes to	)		
		her right leg asking "call an			the appropriate staff at the nursing faci			
		ne an ambulance." The incident			This training will begin 8/20/2015 and			
	· ·	e resident was placed back in			be completed by 8/28/2015. This traini	-		
	bed.				will be given in orientation to all new hi	res		
		07/00/45			to the nursing department by the SDC			
		rders revealed on 07/06/15 at			beginning 8/25/2015.	-4		
		shift supervisor obtained orders #24's right hip and right knee			All resident progress notes, and incide	nι		
		cond physician order was			reports will be monitored daily by the DON, ADON, and RN Supervisor to			
		15 at 1:20 PM to administer			ensure all significant changes in condi	tion		
		cation) every 6 hours as needed			including injuries from an accident has			
	for pain.	satistify exists a measure			been assessed and the notification of			
	1				MD/FNP/PA has been notified. This wi			
	Further review of	the medical record revealed a			continue indefinitely. Any concerns will			
	nurse's entry date	ed 07/06/15 at 1:20 PM the			immediately be addressed at that time			
	specified Resider	nt #24 was having increased			An audit tool will be utilized and monitor	ored		
		nd the leg was "drawn up." The			by the Administrator, DON, or ADON.			
		Il out when range of motion was			tool will be completed by the QI Nurse			
		on-call nurse practitioner was			designee, 3x week x 4 weeks, then 2 x			
	notified and order	ed x-rays. Review of the			week x 4 weeks, then weekly x 4 week	S.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SUR\ COMPLETE	
		345205	B. WING _			C <b>07/31/2</b>	015
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STA	TE, ZIP CODE	0170172	010
WESTWO	OD HILLS NUBSING	AND REHABILITATION CENTER		1016 FLETCHER STREET			
WESTWO	OD HILLS NUKSING A	AND REHABILITATION CENTER		WILKESBORO, NC 28697	7		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	_	(X5) MPLETION DATE
F 309	Continued From pa	age 24	F3	309			
F 309	Medication Administ Resident #24 receis medication at 1:20  The radiology reporevealed Resident hip.  Resident #24 was Department on 07/On 07/30/15 at 4:0 interviewed and restocare for Resident explained that whe Resident #24 layin and saying she was went immediately treported that Nurse and determined that resident back to be resident complained but remained in the #1 stated that she around 6:00 AM ar "really be hurting," pain. The NA state again of Resident #24 interviewed and extonight shift on 07/worked 7 AM to 3 Induring the day shift	stration Record revealed ved one dose of pain PM after falling at 2:45 AM.  Int dated 07/06/15 at 5:39 PM #24 had a fracture of the right wransported to the Emergency 06/15 at 10:30 PM.  O PM nurse aide (NA) #1 was ported that she was assigned at #24 on 07/06/15. The NA in making rounds she found g in the floor calling for help is hurt. The NA added that she is get Nurse #5. NA #1 is #5 assessed Resident #24 at it was okay to put the individual of pain and appeared in pain is bed the rest of the shift. NA in checked on Resident #24 and Resident #24 appeared to complaining of knee and hip is determined that she notified Nurse #5 in #24's complaint of pain. The shift ended.  O PM Nurse #5 was plained that he was orienting 106/15 and that he normally PM (day shift). He added that it if a resident fell and	F3	The Administrator ar these audits as they The Quarterly Qualit Committee will revie audits and give reco follow up as needed continued compliant determine the need of continued QI mon	are completed.  ty Improvement  w the results of the mmendations for or appropriate for ce in this area and for and or frequence		
	the physician. Nur 07/06/15 he was no he stated that he re	se #5 reported that on otified that Resident #24 fell; esponded to the resident and He stated that he couldn't see					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	_	(X3) DATE COMP	SURVEY LETED
		345205	B. WING				31/2015
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, S 1016 FLETCHER STREET WILKESBORO, NC 28	т	<u> </u>	5172013
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 309	to bed. The nurse str. Resident #24 before the floor but was una due to pain in her right that Resident #24 was where the pain was left hip, she was unable to scale but the resident and was holding her that the new onset of change in the resident the night shift superv #24 had an "as need and he offered the rebut she refused. Nur notify the physician of pain or inability to because he deferred.	It it was safe to put her back ated that he assessed deciding to transfer her off ble to check range of motion at leg. Nurse #5 explained in pain and when asked ocated she patted her right to verbalize a 1 to 10 pain at showed facial grimacing right side. The nurse stated pain after the fall was a nut's condition and he notified isor. He added that Resident and the pain medication is e #5 stated that he did not for Resident #24's complaint move her leg after the fall to the night shift supervisor.	F	309			
	she was very busy or shift and monitoring to explained that Nurse #24 fell and complain appear excruciating to needed) pain medical supervisor stated she found the resident in reported that Resider length and showed nowe the leg. The set than a skin tear she conight shift supervisor see a need to contact resident was refusing	assessed the resident and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	, ,	TE SURVEY MPLETED
		345205	B. WING _			C <b>97/31/2015</b>
	ROVIDER OR SUPPLIER  OD HILLS NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1016 FLETCHER STREET WILKESBORO, NC 28697	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	On 07/31/15 at 9:3 was interviewed a notified on 07/06/2 but did not appear she did not assess the medication aid was complaining of supervisor stated nurse practitioner x-ray. Then she an urse practitioner administer pain maccepted at 1:20 Freported that when of pain the physicifurther direction.  On 07/31/15 at 9:3 supervisor was into when she came of was notified that Fromplained of pair fracture. The second she was told that I pain medication at had been completed the results. She she first rounds between was asleep in bed explained that aro reported that the resident's legs we immediately called.	age 26 d her of her duties.  30 AM the day shift supervisor and reported that she was 15 that Resident #24 had fallen injured. She explained that is the resident until 11 AM when the reported that Resident #24 of pain. The day shift that she contacted the on-call and received orders for an and ded she contacted the on-call again and received orders to edication which the resident PM. The day shift supervisor in a resident fell and complained an should be notified then for a resident #24 had fallen, in but did not appear to have a cond shift supervisor added that Resident #24 had been given and she was aware that an x-ray red but they were still waiting on tated that when she made her ren 3:30 - 4:00 PM Resident #24. The second shift supervisor und 10:30 PM the nurse aides resident was crying in pain; she and to assess the resident, wers and saw that the retwo different lengths and to 9-1-1 and the resident was Emergency Department.	F	309		

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	345205	B. WING _		C 07/31/2015
	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 FLETCHER STREET  WILKESBORO, NC 28697	1 01.01.2010
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I	BE COMPLETION
On 07/31/15 at 11:00 and reported that she 07/06/15 and that she being in pain after the she didn't provide dire that day but was in the NA #6 stated that Resof pain and looked lik and kept holding her.  Attempts were made was unable to be read On 07/31/15 at 2:10 ff (DON) was interviewed significant change in be a new onset of pashould contact the photon that it took several he and results because and depending on the school company. She added resident showed significant for evalux-ray services.  483.25(a)(2) TREATM IMPROVE/MAINTAIN  A resident is given the services to maintain of specified in paragraph.  This REQUIREMENT by: Based on observation	AM NA #6 was interviewed worked with NA #2 on e recalled Resident #24 e fall. She explained that ect care for Resident #24 e room and assisted NA #2. sident #24 was complaining e she was in "a lot of pain" leg.  Ito contact NA#2 but she ched for an interview. PM the Director of Nursing ed and reported that a a resident's condition would in after a fall and the nurse expision. The DON reported expression to obtain x-ray services of the facility's location and redule of the mobile x-ray ed that if at any time a s of distress or obvious expect the nurse to obtain dent to the Emergency ation and not wait on mobile MENT/SERVICES TO I ADLS  The appropriate treatment and or improve his or her abilities the (a)(1) of this section.		11 F 311	8/28/15
interviews, the facility	ralled to provide services		Residents #140, #6, #232, #104, and	#14
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST. (EACH DEFICIENC REGULATORY OR I  Continued From page On 07/31/15 at 11:00 and reported that she being in pain after the she didn't provide dire that day but was in th NA #6 stated that Resof pain and looked lik and kept holding her  Attempts were made was unable to be read On 07/31/15 at 2:10 ff (DON) was interviewed significant change in be a new onset of pashould contact the photon that it took several holding and results because of depending on the school company. She added resident showed significant change in be an experience of the school company. She added resident showed significant change in the school company. She added resident showed significant change in the school company. The services to maintain of specified in paragraph.  This REQUIREMENT by:  Based on observation	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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.	ROVIDER OR SUPPLIER  DD HILLS NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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	A BUILDING  345205  345205  345205  345205  STREET ADDRESS, CITY, STATE, ZIP CODE  1016 F LETCHER STREET  WILKESBORD, N. C. 28897  SUMMARY STATEMENT OF DEPICIENCES  (EACH DEPICIENCY MUST BE PRECEDED BY PILL  REQUIATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 27  F 309  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 for an interview.  On 07/31/15 at 2:10 PM the Director of Nursing (DON) was interviewed 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.  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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345205	B. WING _			07/	31/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				101	16 FLETCHER STREET		
WESTWO	OD HILLS NURSING	AND REHABILITATION CENTER		WII	LKESBORO, NC 28697		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFII TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 311	Continued From p	page 28	F;	311			
	and supervision for	or 5 of 10 sampled residents			will be provided a dignified dining		
		parks dining room in order to			experience, to include assisting reside	nts	
		at off their own plates, drink			eat off their own plates, drink their own		
		and have access to their own			liquids, and have access to their own		
	•	#140, #6, #104, #14, and #205).			food. This is accomplished by meal		
	(	-, -, -, ,,			delivery schedule adjustment and resid	dent	
	The findings were	:			seating in the dining room.		
	J				All residents will be provided a dignifie	d	
	1. Resident #140	was admitted most recently to			dining experience, including to assist		
	the facility on 05/0	07/15. His diagnoses included			residents eat off their own plates, drink	(	
	mental disorder, o	depressive disorder, malignant			their own liquids, and have access to t	heir	
	neoplasm of the h	nead, face and neck, anxiety and			own food. This is accomplished by me	eal	
	dysphagia. His m	nost recent Minimum Data Set			delivery schedule adjustment and resid	dent	
	(MDS), a quarterly	y dated 06/18/15, revealed he			seating in the dining room.		
	had severely impa	aired cognition and required set			100% in-service initiated by the SDC,		
		n for eating. The care plan last			DON, or RN designee to all licensed a	nd	
		5 which addressed a history of			unlicensed staff in the nursing		
	_	ed the intervention for staff to			department. This in-service covered		
	set up and encou	rage meal consumption.			dignity and respect of the individual resident during dining and also to mair	ntain	
	a. On 07/30/15 at	7:41 AM, Resident #140 was			ADL¿s. Examples included, supervision		
	the first resident to	o be served and he received			meal times to avoid residents attemption		
	double portions. H	lis tray was set up except his			to take other resident; s food, opening		
	coffee was not un	covered. At 7:46 AM, Resident			beverages, and offering all meal items		
	#140 had finished	his plate of food and			This training will begin 8/20/2015 and	will	
	continually scrape	ed his empty plate with his			be completed by 8/28/2015. The training	ng	
	utensil, placing th	e utensil to his mouth trying to			will be given in orientation to all new hi		
		having none on his plate. He			to the nursing department by the SDC		
		meal and a carton of yogurt still			beginning 8/25/2015. The schedule for		
		At 7:47 AM Nurse Aide (NA)			the tray delivery as well as the residen		
	-	ng protector around his neck			on each delivery has been reviewed a	nd	
		the oatmeal or yogurt closer to			rearranged by a committee of the		
		s coffee. Resident #140 picked			Administrator, ADON, DON, Dietary		
		offee and attempted to drink it at			Manager, and the regular nursing	TI	
		1, 7:53 AM, 7:54 AM, 7:55 AM			assistants who work the SPARK unit.		
		Resident #140 continued to			meal delivery time schedule for the en	ııre	
		eat the remnants off his empty			facility was also reviewed at this time.	ام	
		as the oatmeal and yogurt sat at			An audit tool ¿Dining Room Dignity an		
	the far side of his	plate. This continued until 8:01			ADL Maintenance; will be utilized and		1

Facility ID: 923037

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		345205	B. WING			07/	/31/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER			016 FLETCHER STREET VILKESBORO, NC 28697		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 311	Continued From page	e 29	F;	311			
		at with him, gave him			monitored by the Administrator, DON,		
		er. Then Nurse #2 pushed			ADON, or designee. This tool will be		
		eal closer to him. Nurse #2			completed by the QI nurse or designee	3x	
	did not uncover his c	offee. Resident #140			week x 4 weeks, then 2x week x 4 wee	ks,	
		eat. At 8:08 AM, he			then weekly x 4 weeks. The Administra		
		he remnants of his oatmeal			and/or DON will review these audits as		
		nuscule bits left in the bowl.			they are completed.		
		an scraping his pants and hhis spoon. At 8:15 AM, the			The Quarterly Quality Improvement Committee will review the results of the		
	•	Nursing (ADON) offered			audits and give recommendations for	;	
		ogurt which he proceeded to			follow up as needed or appropriate for		
	,	finished it at 8:18 AM. ADON			continued compliance in this area and	to	
	did not uncover the c	offee. At 8:27 AM, the			determine the need for and or frequence		
	ADON removed the y	ogurt and his tray but he still			of continued QI monitoring.		
	had the fork in his ha						
	1	t the covered coffee and she					
		keep the coffee warm.					
		esident #140 did not like					
	_	ave him back his coffee and k coffee and scrape the table					
	1	the fork in his mouth as if he					
	-	g. This continued until 8:43					
		#140 stood and left the dining					
	room. Throughout th	is meal, there were 2 nurse					
	-	f/nurse aide, the ADON, and					
	the floor nurse in and	I out of the room.					
		rvice was observed on					
		1. Three nurse aides, the					
		aff and a part time activity					
		ved serving during this meal.  It #140 was served a double					
		aghetti and meat sauce, a					
		nini, a bowl of mashed					
		ureed desert and cottage					
		Itely started feeding himself.					
		scraping his empty plate and					
		y and began eating his					
		2:56 PM Resident #140 was					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTIO	N	(X3) DATE S	
		345205	B. WING _			07/3	31/2015
	ROVIDER OR SUPPLIER  OD HILLS NURSING AN	ID REHABILITATION CENTER		STREET ADDRES  1016 FLETCHER  WILKESBORO		1 0//3	51/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD I S-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	in the room feeding, passing trays. At 12 cottage cheese and empty plate trying to his mouth. NA #5 re and moved the zucc reach which he imm 1:08 PM, Resident # his empty bowls and his empty utensils. and left the dining room line to the series of the se	setting up more trays and setting and desert within his ediately began eating. At setting to feed himself with the set of the	F	311			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		345205	B. WING _			C 07/31/2015
	ROVIDER OR SUPPLIER  OD HILLS NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1016 FLETCHER STREET WILKESBORO, NC 28697		0770172010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 311	Continued From page	ge 31	F3	311		
	dementia and that s	were in different stages of staff should be watching but ble to catch all the activities ng room.				
	the facility on 05/07 mental disorder, de neoplasm of the hea dysphagia. His mos (MDS), a quarterly of had severely impair	vas admitted most recently to /15. His diagnoses included pressive disorder, malignant ad, face and neck, anxiety and st recent Minimum Data Set dated 06/18/15, revealed he ed cognition and required set for eating. The care plan last				
	reviewed 06/23/15 weight loss included	which addressed a history of the intervention for staff to ge meal consumption.				
	10/10/12 and had d Alzheimer's disease anxiety. Her most r 05/03/15 assessed cognition and requir	e, dementia, dysphagia, and ecent quarterly MDS dated her with severely impaired ring limited assistance with an for resident care indicated				
	07/21/15 with diagn and diabetes. Her N	admitted to the facility on oses of vascular dementia MDS had not been completed erview Resident #232 mpairment.				
	the Sparks secured aides and an activit trays. Trays were paincluded Resident #6 When Resident #6	88 PM meal service began on unit. There were 2 nurse y staff/nurse aide serving assed to a table which £232 and Resident #140. walked into the dining room, o was already served, assisted				

OLIVILIV	O I OIT MEDIO/ IITE A	WEDIO/ ND OLIVIOLO				CIVID ITC	<del>7. 0000 000 1</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		(	С
		345205	B. WING				31/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
WESTWO	OD HILLS NUBSING AN	D REHABILITATION CENTER		1	016 FLETCHER STREET		
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER		٧	VILKESBORO, NC 28697		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
1710		,			DEFICIENCY)		
F 311	Continued From page	e 32	F	311			
	Resident #6 to sit wit	h her at her table adjacent to					
		e seated at 12:43 PM,					
	Resident #6 immedia	itely reached and took					
		Resident #140 and began to					
	_	though Resident #232 tried					
	to discourage her. S	taff 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 R	Resident #140. As staff went					
	back to feeding anoth	ner resident, Resident #6					
	reached over and scr	rapped the empty plate and					
		ants from the empty plate					
	I .	#140 had eaten. At 12:57					
	_	athered the plate from					
	I .	ill had mashed potatoes and					
		it to the counter. At 12:58					
		emoved Resident #140's					
	1	repeatedly tried to scrape					
	_	nim his bowl of mashed					
	potatoes. She then r						
	I	ent #6 and held Resident					
		esident #6 from taking					
	-	toes. It was not until 1:01 NA) #3 staff intervened and					
		pointing to Resident 140's					
		sked if she wanted more					
	•	sident 6 responded yes. At					
		6 reached and began to drink					
	i '	Resident #232. Resident					
		ep Resident #6 from taking					
	I .	ert and Resident #6 was					
		lent #232's hand away.					
	I .	arrived from the kitchen NA					
		#6 who proceeded to eat the					
	mashed potatoes.	,					
	I .	PM, the activity staff was					
	i interviewed. Sne stat	ed she saw Resident #6 with					I

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		OATE SURVEY OMPLETED
		345205	B. WING _			C 07/31/2015
	DER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 FLETCHER STREET WILKESBORO, NC 28697	<b>I</b>	01/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
On ma aid the sha occur mo  On sor over res lead to she fed  On sep res sta with  On was hap to he who belong to he who he who belong to he who he who he who he who he who had the who had the who he who had the	or/30/15 at 3:58 nagement always es for the secure activity staff/nursering food in the courrence in this unre if available to or/31/15 at 8:44 netimes there are see the dining idents who ate or serve table by take fed and Residents.  Or/31/15 at 10:4 parate residents to be a t	but did not see her eat from it ack to Resident #140.  PM, Nurse # 2 stated that is tries to schedule 3 nurse dunit and in addition there is see aide. He further stated that dining room was a typical nit. Management try to staff oversee the residents.  AM NA #3 stated that e2, 3 or even 6 staff to She was aware of several if others' trays, and named at luding Resident #6. They try ble but one resident needs to a #6 sometimes needs to be a fact that the fact of the second for all." She is supervise all the residents  4 AM, nurse aide/activity staff is stated sharing of food a fact in the unit. She attributed it sups in front of each resident tively know which cup in the stated there is taff to over see the dining in	F	311		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		OATE SURVEY OMPLETED
		345205	B. WING _			C 07/31/2015
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1016 FLETCHER STREET WILKESBORO, NC 28697	DE	01/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 311	expected staff to po to take from other's sharing and they sh residents who share stated the residents dementia and that s staff would not be all going on in the dinir that sharing has hap people including fand.  3. Resident #6 was 10/10/12 and had did Alzheimer's disease anxiety. Her most in 05/03/15 assessed cognition, having phother behaviors dail assistance with eating care indicated she in The lunch meal service of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of the care indicated she in 107/30/15 beginning the nurse aide/active assistant were observed at the table of th	ne unit. She stated she sition the residents who tend tray in a way to reduce ould be aware of those of food and observe them. She were in different stages of taff should be watching but oble to catch all the activities of groom. She further stated opened even with added onlilies.  admitted to the facility on agnoses including of dementia, dysphagia, and ecent quarterly MDS dated her with severely impaired eysical abusive behaviors and yand requiring limited of many and requiring limited of the care plan for resident eleded assistance with eating.  Arice was observed on at 12:34 PM. 3 nurse aides, sity staff and a part time activity rived serving during this meal. Alking in and out of the room the le. At 12:42 PM, Resident #6 tea from Resident #232, at the staff/nurse aide intervened. The was the last to be of 4. Staff proceeded to give defend and encouraged Resident to Staff walked away. At #6 drank the thin liquid from the coop of the coo	F	311		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345205	B. WING _			C 07/31/2015
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1016 FLETCHER STREET WILKESBORO, NC 28697	E	07/31/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 311	management alway aides for the secure the activity staff/nur sharing food in the coccurrence in this u more if available to  On 07/31/15 at 8:44 sometimes there are oversee the dining, residents who ate o least 4 residents incompared to serve table by table fed and Residen fed. This morning, needed to be fed.  On 07/31/15 at 10:4 separate residents to resident's food but it stated it was hard to with behaviors.	ge 35  B PM, Nurse #2 stated that stries to schedule 3 nurse and unit and in addition there is see aide. He further stated that dining room was a typical nit. Management try to staff oversee the residents.  AM NA #3 stated that e 2, 3 or even 6 staff to She was aware of several ff others' trays, and named at studing Residents #6. They try ble but one resident needs to the staff stated 3 residents  AM, NA #4 stated they try to that tend to grab at other to can be "a free for all." She of supervise all the residents  AM, nurse aide /activity de. She stated sharing of food	F3	, , , , , , , , , , , , , , , , , , ,		
	to having so many of who could not cognibelonged to them.  Interview with the D at 2:58 PM revealed.	y in the unit. She attributed it cups in front of each resident itively know which cup irector of Nursing on 07/31/15 if she expected each try to be				
	placed in front of the were typically 2 to 3 the Sparks unit in a	tems taken from the tray and e resident. She stated there staff to over see the dining in ddition to the activity/nurse the unit. She stated she				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345205	B. WING _			C 07/31/2015		
	NAME OF PROVIDER OR SUPPLIER  WESTWOOD HILLS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1016 FLETCHER STREET WILKESBORO, NC 28697	•	0770172010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 311	to take from other's sharing and they sh residents who share stated the residents dementia and that staff would not be a going on in the dinir that sharing has halpeople including far 4. Resident #104 w 01/02/13 with diagn disease and demen disturbances. Her r Set (MDS), a quarte with long and short moderately impaired required set up and Resident #14 was a 03/18/13 with diagn mental disorder and MDS dated 06/17/1 short term memory moderately impaired required set up and Resident #205 was 10/09/14 with diagn anxiety. Her quarte coded her with seven having rejection of o supervision with me 07/21/15 at 11:59 A responsible party w date and was concegaining weight. The	sition the residents who tend tray in a way to reduce ould be aware of those of food and observe them. She were in different stages of staff should be watching but ble to catch all the activities and groom. She further stated opened even with added milies.  The sa admitted to the facility on oses including Alzheimer's tia with behavioral most recent Minimum Data orly dated 07/21/15 coded her term memory impairment and did decision making skills. She supervision with meals.  The schizophrenia. Her quarterly of coded her with long and deficits and having did decision making skills. She supervision with eating.  The supervision with eating and deficits and having did decision making skills. She supervision with eating.  The supervision with eating and deficits and having dementia and only MDS dated 07/15/15 or every impaired cognitive skills, care and needing set up and eats. A nursing note dated	F3	311				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X	(X3) DATE SURVEY COMPLETED		
		345205	B. WING _			C 07/31/2015		
	ROVIDER OR SUPPLIER  OD HILLS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1016 FLETCHER STREET  WILKESBORO, NC 28697		0.70 1120 10		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 311	the nurse aide/activit assistant were obser Residents #205, #14 table together. At 12 offered and gave Resident and gave Resident and when this was pointed Resident #205 had exproceeded to eat Resident #205 had exproceeded to eat Resident at 1:06 for to eat Resident #205 had exproceeded to eat Resident at 1:06 for to eat Resident #205 had exproceeded to eat Resident at 1:06 for to eat Resident #205 had exproceeded to eat Resident at 1:06 for to eat Resident #205 had exproceeded to eat Resident #205 had exproceeded to eat Resident #205 had exproceeded to expression the secure of the tray tickets and overseeing from the discontinuous sharing food in the discontinuous expression that the discontinuous expression in the discontinuous expression that the discontinuous expression is the discontinuous expression that the first expression is the first expression that the first expression expression is the first expression that the first expression is the first expression that the first expression is the first expression is the first expression that the first expression is the first expression is the first expression in the first expression in the first expression is the first expression in the first expression in the first expression is the first expression in the first expression in the first expression in the first expression is the first expression in the first expression in the first expression in the f	ce was observed on at 12:34 PM. 3 nurse aides, y staff and a part time activity ved serving during this meal. and #104 were sitting at a at:50 PM, Resident #104 sident #205 her tea to drink. stated would get more tea and out to staff. At 1:03 PM aten her desert and sident #14's desert. No staff PM, Resident #205 moved 104's desert. Although there in the room at this time, no se staff was feeding a tarking amounts consumed dianother was just doorway.  PM, Nurse #2 stated that tries to schedule 3 nurse I unit and in addition there is e aide. He further stated that trining room was a typical it. Management try to staff	F	311				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345205	B. WING _			C 07/31/2015	
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 FLETCHER STREET WILKESBORO, NC 28697	•	07/31/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 311	Continued From page		F3	311			
		can be "a free for all." She supervise all the residents					
	was interviewed. She happened frequently to having so many c	4 AM, nurse aide/activity staff ne stated sharing of food in the unit. She attributed it ups in front of each resident tively know which cup					
F 412 SS=D	at 2:58 PM revealed set up including all it placed in front of the were typically 2 to 3 the Sparks unit in ac aide and nurse on the expected staff to post to take from other's sharing and they sharing and they share stated the residents dementia and that staff would not be at going on in the dinin that sharing has hap people including fam	rector of Nursing on 07/31/15 she expected each try to be tems taken from the tray and resident. She stated there staff to over see the dining in Idition to the activity/nurse the unit. She stated she sition the residents who tend tray in a way to reduce build be aware of those food and observe them. She were in different stages of taff should be watching but ble to catch all the activities g room. She further stated the pened even with added filies.  WEMERGENCY DENTAL	F 4	.12		8/28/15	
	an outside resource §483.75(h) of this pa covered under the S dental services to m resident; must, if near	nust provide or obtain from in accordance with art, routine (to the extent tate plan); and emergency eet the needs of each cessary, assist the resident in s; and by arranging for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345205	B. WING _			C 7/31/2015	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	770172010	
			1016 FLETCHER STREET				
WESTWOOD HILLS NURSING AND REHABILITATION CENTER		ID REHABILITATION CENTER		WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 412	Continued From pag		F 4	12			
	must promptly refer damaged dentures to						
	by:	T is not met as evidenced		F412			
	facility failed to order and schedule followas a result of a denta residents reviewed for (Resident #54). The findings included Resident #54 was at 10/01/13 with diagnord dementia, anxiety, a of the quarterly Minimindicated Resident # the cognition evaluated assistance for most a including personal hywere identified. Resiming wear a dental partial Review of the medical #54 was seen for de again on 06/02/15. On was seen for a compact of the complaint of the mouth, and her the severe generalized in diagnosed with ramp generalized gingivitis Recommendations for included extractions	dmitted to the facility on oses that included Alzheimer's and cognitive deficits. Review mum Data Set dated 7/19/15 54 was unable to complete tion and required extensive activities of daily living ygiene. No dental issues dent #54 was revealed to in place of missing teeth. cal record revealed Resident and Pon 06/02/15 Resident #54 orehensive dental exam with pain. She received x-rays of eeth were cleaned. Resident and onflammation. She was		Resident #54¿s dental consul 4/28/2015 and 6/2/2015 was in the DON and the ADON on 7/7/27/2015, an order was obtated Chlorhex Glu Sol, rinse with seconds Q AM and Q PM. On an order was obtained to discidental treatments due to residental the RP and signed called the R	reviewed by '30/2015. On ined for 15ml. for 30 a 8/3/2015, continue dent's intal he not want the resident e in pain. seen on l clinic had e DON and fied that had nsed staff vas dental e nurses the or any new a 8/20/2015 b/2015. This ation to all urtment by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 BOILEST	_		С		
		345205	B. WING				31/2015	
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	31/2013	
					016 FLETCHER STREET			
WESTWO	OD HILLS NURSING AN	D REHABILITATION CENTER			VILKESBORO, NC 28697			
(VA) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 412	Continued From page	e 40	F.	412				
		commended to remove her			An audit tool "Dental Consult Services"	,		
		aning and disinfection, and			will be utilized and monitored by the DO			
		ste and periodontal rinse			ADON, or designee. This tool will be			
	were ordered.	·			completed by the QI nurse or designee	:		
	Further review of Res	sident #54's medical record			when the dental mobile is scheduled			
		ntation of orders for follow up			monthly x 6 months. It will include	ĺ		
		or orders for recommended			residents who were seen that day and			
		ollow up appointments were			orders for treatments, supplies, or follo			
		ental supplies were ordered.			up treatment. The visit for July 28th, 20	115		
	On 07/30/15 at 3:30 l	e #1. She stated when			has been reviewed and audited. No issues were identified from that audit.	ſho		
		om dental appointments, the			next visit is scheduled for August 25,	iie		
	nurse supervisor wou				2015. The DON, ADON or designee w	/ill		
	recommendations an				review the results for compliance.			
		the physician's orders in the			The Quarterly Quality Improvement			
		e #1 acknowledged she did			Committee will review the results of the	•		
	not see the follow up	orders for Resident #54.			audits and give recommendations for			
	On 07/30/15 at 4:20 I	PM an interview was			follow up as needed or appropriate for			
		ocial Worker (SW #1). She			continued compliance in this area and			
		be the person to get approval			determine the need for and or frequence	)y		
		Party (RP) for any consults			of continued QI monitoring.			
	•	SW #1 stated she could not						
		ence with Resident #54's RP 6/02/15 dental appointment				ĺ		
		ns. She indicated she thought				ĺ		
		onversation with the RP, but				ſ		
		y documentation and did not				ĺ		
	recall the outcome.	•				ſ		
	On 07/31/15 at 8:35	AM an interview was				ſ		
	conducted with the D	irector of Nursing (DON).				ſ		
		ss when a resident returned						
		involved the nurse writing						
		s in the medical record, and						
		ointments were scheduled.						
		ne process included the				ĺ		
		ns were placed on the						
		by the nurse supervisor and macy. The DON stated that						
	-	sistant Director of Nursing						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345205	B. WING		C <b>07/31/2015</b>
	ROVIDER OR SUPPLIER  OD HILLS NURSING AN	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 412	and Resident #54's were not completed. Resident #54's dent	ental log sheets from 06/02/15 recommendations and orders The DON acknowledged al orders and	F 41	2	
F 431 SS=D	know why. 483.60(b), (d), (e) D	ere missed and she did not RUG RECORDS, JGS & BIOLOGICALS	F 43	1	8/28/15
	a licensed pharmaci of records of receipt controlled drugs in s accurate reconciliati records are in order	ploy or obtain the services of st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically			
	labeled in accordance professional principle appropriate accessed	•			
	facility must store all locked compartment	State and Federal laws, the drugs and biologicals in sunder proper temperature only authorized personnel to seys.			
	permanently affixed controlled drugs lists Comprehensive Dru Control Act of 1976 abuse, except when	vide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit oution systems in which the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345205	B. WING _			C 07/31/2015	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		07/31/2013	
			1016 FLETCHER STREET				
WESTWOOD HILLS NURSING AND REHABILITATION CENTER		D REHABILITATION CENTER		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 COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	DATE	
F 431	Continued From page	e 42	F 4	31			
	quantity stored is min be readily detected.	imal and a missing dose can					
				F431 All expired medications in the scabinets in the drug room was and sent back to the pharmacy 7/31/2015. All stock drugs in the storage of the drug rooms were reviewed nurses on 7/31/2015 for expira 100% in-service initiated by the DON, or RN designee to all lice and all certified med aides in the department. This in-service comonitoring for expired stock drugining will begin 8/20/2015 and completed by 8/28/2015. This be given in orientation to all need the nursing department by the beginning 8/25/2015. The night aides will monitor the stock invitates will monitor the stock invitates will be utilized. An audit tool ¿Stock Med Drugincludes checking for expired rutilized. The tool will be completed. The tool will be completed these audits for continued completed these audits for continued completed will review the result and give recommendation.	boxed up y on  cabinets i by 2 ation date e SDC, ensed sta he nursing vered rugs. This had will be training w ew hires to SDC at shift me rentory re-orderin gs. Rotati gs. Which meds will eted by th x 4 week honthly x will revie holiance. ment ults of the	ns. aff g s vill o ed g on be ne es s 2.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345205	R WING	B. WING			0	
NAME OF D	DOVIDED OD CUIDDUED	345205				07/31/2015		
NAME OF PE	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
WESTWO	OD HILLS NURSING ANI	D REHABILITATION CENTER	1016 FLETCHER STREET					
			WILKESBORO, NC 2869		ILKESBORO, NC 28697			
(X4) ID PREFIX TAG			ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
	Continued From page storage room on third the stock medication checked, and she did medications were mis On 07/31/15 at 10:40 conducted with the D She stated the facility technician on third sh stocking and rotating from the pharmacy. T been nurse supervisor room checking for our stated she did not know medications were mis acknowledged it was stock medications were	e 43 I shift. Nurse #3 indicated was recently rotated and not know how the expired sed. AM an interview was irector of Nursing (DON). I had a medication ift that was responsible for medication as it arrived the DON revealed there had ors in the medications. She bow how the expired sed. The DON her expectation that the are rotated as they were attemedications would be	TAG	131	CROSS-REFERENCED TO THE APPROPRIA	to		