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	345205	A. BUILDING _____ B. WING _____	06/16/2016

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WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label resident personal care equipment in 5 resident bathrooms on 3 of 6 resident hallways (Room #102, #106, #311, #403 and #406). The facility also failed to repair a wall bumper behind a resident's bed with metal edges exposed in 1 resident room (Room #202B) on 1 of 6 resident hallways, failed to repair torn wallpaper in 2 resident rooms (Room #202B and #514B) on 2 of 6 resident hallways, failed to repair baseboard that had pulled away from a wall in 1 resident room (Room #506B) on 1 of 6 resident hallways, failed to repair torn vinyl on a sofa in a resident lounge (300 hall), failed to repair torn vinyl on chairs in the television lounge of the locked unit on 2 of 6 resident halls and failed to repair stained flooring around the base of toilets in 7 resident bathrooms (Room #304, #309, #311, #316, #319, #403 and #406) on 2 of 6 resident hallways and failed to repair broken tile next to the base of a toilet in 1 of 7 resident bathrooms (Room #319) on 2 of 6 resident hallways. The findings included: 1. a. Observations in the bathroom of room #102 on 06/14/16 at 4:10 PM revealed a plastic urine hat used to collect and measure urine was sitting in a metal rack on the wall next to the toilet that	F 253	Westwood Hills Nursing and Rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehab's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Westwood Hills Nursing and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Personal care equipment, urine hats, urinals and bedpans in Rooms 102, 106, 311, 403 and 406 was collected and replaced (at no cost to the residents) on 6/16/2016. Every item replaced had the residents name applied and stored appropriately. A 100% audit of all personal care	7/14/16

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

Electronically Signed | 07/08/2016

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F 253	Continued From page 1 was not labeled with a resident's name. Observations in the bathroom of room #102 on 06/15/16 at 4:04 PM revealed a plastic urine hat used to collect and measure urine was sitting in a metal rack on the wall next to the toilet that was not labeled with a resident's name. Observations in the bathroom of room #102 on 06/16/16 at 9:15 AM revealed a plastic urine hat used to collect and measure urine was sitting in a metal rack on the wall next to the toilet that was not labeled with a resident's name. b. Observations in the bathroom of room #106 on 06/14/16 at 4:12 PM revealed a urinal was sitting on the floor next to the toilet that was not labeled with a resident's name. Observations in the bathroom of room #106 on 06/15/16 at 4:06 PM revealed a urinal was sitting on the floor next to the toilet that was not labeled with a resident's name. Observations in the bathroom of room #106 on 06/16/16 at 9:20 AM revealed a urinal was sitting on the floor next to the toilet that was not labeled with a resident's name. c. Observations in the bathroom of room #311 on 06/14/16 at 8:40 AM revealed a bedpan was sitting between the safety rail and the wall next to the toilet that was not labeled with a resident's name. Observations in the bathroom of room #311 on 06/15/16 at 4:14 PM revealed a bedpan was sitting between the safety rail and the wall next to the toilet that was not labeled with a resident's	F 253	equipment, such as urine hats, urinals and bedpans was performed on 6/16/2016, by the administrative nurses. Any item without proper labeling or storage was removed and replaced at that time. They were replaced with items that were properly labeled with the resident's names. Room # 202B will be repaired by 7/14/2016. The bumper pad will be replaced and the wallpaper will be repaired and replaced with new wall covering. Room # 514B will be repaired by 7/14/2016. The wallpaper will be removed and a new wall covering will be installed. The baseboard in Room 506B will be replaced by 7/14/2016. A 100% audit of bumper pads, baseboards and wallpaper condition was completed on 7/8/2016, by the Administrator and Housekeeping Supervisor. All areas in need of repair, will be repaired by July 14, 2016. The large sofa in the resident lounge on 300 Hall was removed on 6/24/2016 by the maintenance department. The 2 vinyl chairs were removed from the television lounge on the locked unit on 6/24/2016 by the maintenance department. A 100% audit for tears of all the chairs/sofas in the facility was completed on 7/8/2016. The administrator and housekeeping supervisor completed the audit. Any items with torn areas will be removed or replaced by 7/14/2016. The tiles in the bathrooms of rooms #304, #309, #311, #316, #319, #403 and #406 will all be replaced by 7/14/2016.	

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F 253	Continued From page 2 name. Observations in the bathroom of room #311 on 06/16/16 at 10:09 AM revealed bedpan was sitting between the safety rail and the wall next to the toilet that was not labeled with a resident's name. d. Observation in the bathroom of room #403 on 06/14/16 at 9:43 AM revealed a bedpan was hanging in a metal rack in the bathroom that was not labeled with a resident's name. Observations in the bathroom of room #403 on 06/15/16 at 4:19 PM revealed a bedpan was hanging in a metal rack in the bathroom that was not labeled with a resident's name. Observations in the bathroom of room #403 on 06/16/16 at 9:35 AM revealed a bedpan was hanging in a metal rack in the bathroom that was not labeled with a resident's name. e. Observation in the bathroom of room #406 on 06/14/16 at 11:23 AM revealed a bedpan was in a clear plastic bag and was hanging in a metal rack in the bathroom that was not labeled with a resident's name. Observations in the bathroom of room #406 on 06/15/16 at 4:21 PM revealed a bedpan was in a clear plastic bag and was hanging in a metal rack in the bathroom that was not labeled with a resident's name. Observations in the bathroom of room #406 on 06/16/16 at 9:38 AM revealed a bedpan was in a clear plastic bag and was hanging in a metal rack in the bathroom that was not labeled with a	F 253	A 100% audit of all bathroom tiles for stains or broken tile was completed on 7/8/2016, by the Administrator and Housekeeping Supervisor. Any areas in need of repair will be replaced by 7/14/2016. A retraining will be completed with 100% of the staff. This training will be completed by 7/14/2016. This training provided information on the importance of storing and labeling all personal care items. It also included work orders, in regards to where they are located, areas of concern to go on them, including torn furniture, torn wallpaper, loose or missing bumper pads, missing baseboards, broken tiles in bathrooms, and stains on tiles. This training will be provided by the Staff Facilitator or designee. Beginning the week of July 18, 2016, walking rounds on each unit to randomly audit for storage of and unlabeled personal care items will be completed by the QI or designee weekly x 4, then monthly. Any items found to be unlabeled or stored improperly will be replaced immediately with staff retraining. Beginning the week of July 18th, the administrator or designee and the housekeeping supervisor or designee will audit the facility for torn wallpaper, missing bumper pads, baseboards, torn furniture, bathroom tiles for stains and broken pieces. Any issues identified will be repaired at the time. These comprehensive audits will be continued x 4 weeks. After that time, these audits will be monthly. The Quarterly Quality Improvement	

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F 253	Continued From page 3 resident's name. During a tour and interview on 06/16/16 at 10:49 AM with the Assistant Director of Nursing she confirmed the resident care items stored in resident bathrooms in room #102, #106, #311, #403 and #406 were not labeled with resident names and the bathrooms were shared by residents. She explained she was not sure why the urine hat was stored in the bathroom of room #102 because usually it was used one time and then discarded. She stated urinals should not be left sitting on the floor in the bathroom and should be labeled with the resident's name. She further stated bedpans should be stored in bedpan covers the facility provided with the resident's name clearly visible on them because staff needed to know who the item belonged to so it was used for the correct resident and bedpans should not be stored in clear plastic bags. During an interview on 06/16/16 at 10:56 AM the Director of Nursing stated her expectation was for staff to place bedpans in the covers the facility provided and they should be labeled with resident name or room number. She further stated urinals should not be placed on the floor in the bathroom. 2. a. Observations in resident room #202B on 06/13/16 at 11:56 AM revealed a bracket was attached to the wall behind the headboard of the resident's bed on the left side and the metal was exposed with metal edges where the bed bumper pad was missing and there was torn wallpaper behind the head of the bed in 5 strips and 3 of the strips were approximately 2 inches long by 1 inch wide and 2 of the strips were approximately 4 inches long by 2 inches wide.	F 253	Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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Observations in resident room #202B on 06/14/16 at 8:31 AM revealed a bracket was attached to the wall behind the headboard of the resident's bed on the left side and the metal was exposed with metal edges where the bed bumper pad was missing and there was torn wallpaper behind the head of the bed in 5 strips and 3 of the strips were approximately 2 inches long by 1 inch wide and 2 of the strips were approximately 4 inches long by 2 inches wide.

Observations in resident room #202B on 06/15/16 at 8:29 AM revealed a bracket was attached to the wall behind the headboard of the resident's bed on the left side and the metal was exposed with metal edges where the bed bumper pad was missing and there was torn wallpaper behind the head of the bed in 5 strips and 3 of the strips were approximately 2 inches long by 1 inch wide and 2 of the strips were approximately 4 inches long by 2 inches wide.

b. Observations in resident room #514B on 06/14/16 at 9:50 AM revealed the wall by the left side of the resident's bed had a section of torn wallpaper with wallpaper missing with frayed edging approximately 12 inches long by 3 inches wide.

Observations on 06/16/16 at 8:18 AM in resident room #514B revealed the wall by the left side of the resident's bed had a section of torn wallpaper with wallpaper missing with frayed edging approximately 12 inches long by 3 inches wide.

Observations during a final tour with the Maintenance Director on 06/16/16 at 4:40 PM in resident room #514B revealed the wall by the left side of the resident's bed had a section of torn

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wallpaper with wallpaper missing with frayed edging approximately 12 inches long by 3 inches wide.

3. Observations in resident room #506B on 06/15/16 at 9:20 AM revealed the baseboard at the floor by the right side of the resident's bed was pulled away at the seam approximately one and a half inches from the wall.

Observations on 06/16/16 at 8:11 AM in resident room #506B revealed the baseboard at the floor by the right side of the resident's bed was pulled away at the seam approximately one and a half inches from the wall.

Observations during a final tour with the Maintenance Director on 06/16/16 at 4:40 PM in resident room #506B revealed the baseboard at the floor by the right side of the resident's bed was pulled away at the seam approximately one and a half inches from the wall.

4. a. Observation of a resident lounge on the 300 hall on 06/14/16 at 10:05 AM revealed a large sofa with damage to the vinyl on the front lower section of the sofa. There was a large circular hole approximately 5 inches in diameter in the vinyl with the under fabric exposed on the left lower front and there was a large tear approximately 3-4 inches in length in the vinyl on the right lower front of the sofa.

Observation of a resident lounge on the 300 hall on 06/15/16 at 4:50 PM revealed a large sofa with damage to the vinyl on the front lower section of the sofa. There was a large circular hole approximately 5 inches in diameter in the vinyl with the under fabric exposed on the left lower

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front and there was a large tear approximately 3-4 inches in length in the vinyl on the right lower front of the sofa.

Observation of a resident lounge on the 300 hall on 06/16/16 at 9:36 AM revealed a large sofa with damage to the vinyl on the front lower section of the sofa. There was a large circular hole approximately 5 inches in diameter in the vinyl with the under fabric exposed on the left lower front and there was a large tear approximately 3-4 inches in length in the vinyl on the right lower front of the sofa.

b. Observations on 06/13/16 at 12:30 PM of vinyl chairs in the television lounge in the locked unit revealed 2 of 3 chairs with vinyl arm rests with torn vinyl on the front edges of each arm rest. One of the torn chairs was observed with a large jagged tear approximately 8 inches long in the seat which puckered up and exposed the under fabric.

Observations on 06/15/16 at 8:23 AM of vinyl chairs in the television lounge in the locked unit revealed 2 of 3 chairs with vinyl arm rests with torn vinyl on the front edges of each arm rest. One of the torn chairs was observed with a large jagged tear approximately 8 inches long in the seat which puckered up and exposed the under fabric.

Observations on 06/16/16 at 8:18 AM of vinyl chairs in the television lounge in the locked unit revealed 2 of 3 chairs with vinyl arm rests with torn vinyl on the front edges of each arm rest. One of the torn chairs was observed with a large jagged tear approximately 8 inches long in the seat which puckered up and exposed the under

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fabric.

5. a. Observations in the bathroom of room #304 on 06/13/16 at 3:39 PM revealed dark brown stains on the floor around the base of the toilet and there was a strong odor of stale urine.

Observations in the bathroom of room #304 on 06/15/16 at 4:12 PM revealed dark brown stains on the floor around the base of the toilet and there was a strong odor of stale urine.

Observations in the bathroom of room #304 on 06/16/16 at 9:30 AM revealed dark brown stains on the floor around the base of the toilet and there was a strong odor of stale urine.

b. Observations in the bathroom of room #309 on 06/14/16 at 10:40 AM revealed dark brown stains on the floor around the base of the toilet.

Observations in the bathroom of room #309 on 06/15/16 at 4:13 PM revealed dark brown stains on the floor around the base of the toilet.

Observations in the bathroom of room #309 on 06/16/16 at 9:32 AM revealed dark brown stains on the floor around the base of the toilet.

c. Observations in the bathroom of room #311 on 06/14/16 at 8:40 AM revealed dark brown stains on the floor around the base of the toilet.

Observations in the bathroom of room #311 on 06/15/16 at 4:14 PM revealed dark brown stains on the floor around the base of the toilet.

Observations in the bathroom of room #311 on 06/16/16 at 10:09 AM revealed dark brown stains

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F 253	Continued From page 8 on the floor around the base of the toilet. d. Observations in the bathroom of room #316 on 06/14/16 at 9:37 AM revealed dark brown stains on the floor around the base of the toilet. Observations in the bathroom of room #316 on 06/15/16 at 4:15 PM revealed dark brown stains on the floor around the base of the toilet. Observations in the bathroom of room #316 on 06/16/16 at 9:34 AM revealed dark brown stains on the floor around the base of the toilet. e. Observations in the bathroom of room #319 on 06/14/16 at 9:43 AM revealed dark brown stains on the floor around the base of the toilet and broken tile on the floor next to the right side of the toilet base. Observations in the bathroom of room #319 on 06/15/16 at 4:16 PM revealed dark brown stains on the floor around the base of the toilet and broken tile on the floor next to the right side of the toilet base. Observations in the bathroom of room #319 on 06/16/16 at 9:35 AM revealed dark brown stains on the floor around the base of the toilet and broken tile on the floor next to the right side of the toilet base. f. Observations in the bathroom of room #403 on 06/14/16 at 11:23 AM revealed dark brown stains on the floor around the base of the toilet. Observations in the bathroom of room #403 on 06/15/16 at 4:20 PM revealed dark brown stains on the floor around the base of the toilet.	F 253		

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Observations in the bathroom of room #403 on 06/16/16 at 9:38 AM revealed dark brown stains on the floor around the base of the toilet.

g. Observations in the bathroom of room #406 on 06/14/16 at 10:47 AM revealed dark brown stains on the floor around the base of the toilet.

Observations in the bathroom of room #406 on 06/15/16 at 4:21 PM revealed dark brown stains on the floor around the base of the toilet.

Observations in the bathroom of room #406 on 06/16/16 at 9:39 AM revealed dark brown stains on the floor around the base of the toilet.

During an interview and tour on 06/16/16 which started at 4:27 PM with the Maintenance Director he explained the facility used work orders for repairs and staff was expected to fill them out when repairs needed to be made. He stated staff were trained in orientation to place the work orders in a box on the wall next to the mechanical/electrical room across from the nurse's station and he checked the box each time he walked by it. He explained he had projects planned but couldn't get to them because something always broke and had to be fixed. He stated he had a full time assistant who helped him and a painter worked 3 days a week and they tried to stay on schedule as much as they could. He explained he kept a list of repairs that needed to be made and he had a preventive maintenance schedule for major equipment but the administrative staff usually took care of furniture needs and repairs. He confirmed the bed bumper was missing in room #202B and he was unaware the metal bracket was exposed and no

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one had completed a work order to fix it. He also confirmed the tile was broken on the floor next to the toilet in room #319 and he was unaware of it and stated he expected housekeeping staff to clean the stains on the floors around the toilets but if the flooring needed to be repaired or replaced they needed to fill out work orders. He stated he had not noticed the torn vinyl on the sofa in the resident lounge on the 300 hall and did not recall it looked like that a week ago. He further stated he was unaware the baseboard in resident room #506 had pulled away from the wall and if he had known about it he would have glued it back in place and staff should complete work orders for torn wallpaper.

During an interview on 06/16/16 at 5:03 PM with the Supervisor of housekeeping, laundry and floor techs she explained the Nurses and Nurse Aides let her know when resident rooms and bathrooms were not cleaned or needed attention. She stated sometimes the resident's reported concerns to her when she made rounds on the resident hallways. She further stated she was aware some floors in resident bathrooms were stained around the base of toilets but the stains were old and were hard to remove. She explained even when her staff scrubbed and cleaned the floors around the toilets they were still stained and smelled of old urine. She stated she was not aware of the torn sofa in the resident lounge on the 300 hall and it looked like a wheelchair or other equipment had caught it and damaged it and someone should have reported it.

During an interview on 06/16/16 at 4:58 PM the Administrator stated she wanted staff to let her know when something was broken or needed to be fixed. She further stated the work order

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F 253	Continued From page 11 process was covered in orientation when staff was hired. She explained maintenance staff was on call 24 hours a day and she expected for staff to complete work orders for things like torn wallpaper, torn furniture, broken or stained tile. She stated she was unaware of the torn sofa in the resident lounge and the torn chairs in the locked unit and she expected staff to have filled out work orders for repairs or replacement of the furniture. She also stated in addition to work orders nursing staff did weekly checks on the resident halls and should have caught things that were damaged or broken.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		7/7/16

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	345205	A. BUILDING _____ B. WING _____	06/16/2016

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F 278	Continued From page 12 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to accurately code the Minimum Data Set assessment to reflect the resident received dialysis services for 1 of 1 residents (Resident #45). The findings included: Resident #45 was admitted to the facility on 03/23/16 and was readmitted on 05/08/16 and 05/22/16 with diagnoses which included: anxiety, diabetes, end stage renal disease, stage 5 kidney disease, diabetes, and dependence on renal dialysis. The Admission MDS dated 03/30/16 indicated Resident #45 was coded for receiving dialysis. The Admission MDS records dated 05/08/16 and 05/29/16 completed for readmission to the facility indicated Resident #45 was not coded for receiving dialysis. The MDS dated 05/29/16 further indicated Resident #45 was cognitively intact for daily decision making skills and required extensive assistance with activities of daily living (ADL). Review of the care plans initiated 05/13/16 and revised 05/24/16 revealed Resident #45 was care planned for End Stage Renal Disease and at risk for complications related to dialysis treatment which she received on Mondays, Wednesdays and Fridays.	F 278	The Minimum Data Set for Resident #45 was correctly coded for dialysis on 6/16/2016. A modification was completed and submitted on 6/16/2016. All other residents' MDS receiving dialysis were reviewed and found to be correctly coded on 6/16/2016. The Administrator reviewed the coding process for residents receiving dialysis with the MDS nurses and the QI Nurse on 7/7/2016. A random audit will be performed monthly x 3 by the QI Nurse or designee to check for accurate coding of dialysis residents. This will be completed quarterly thereafter x 3 quarters. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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F 278	Continued From page 13	F 278		

Review of the physician's progress notes dated 05/24/16 indicated Resident #45 had renal disease and was dependent on real dialysis.

The medical record revealed communications with the Dialysis center of services provided for Resident #45. The communications for Resident #45 included blood work results, weights, medication reviews, and vital sign monitoring during treatments received at the dialysis center.

An interview was conducted on 06/16/16 at 8:23 AM with Resident #45. Resident #45 revealed she received dialysis on Mondays, Wednesdays and Fridays at the dialysis center. Resident #45 further revealed the facility arranged and transported her to the dialysis center.

An interview was conducted on 06/16/16 at 8:34 AM with Nurse # 1. Nurse #1 stated Resident #45 received dialysis on Mondays, Wednesdays and Fridays

An interview was conducted on 06/16/16 at 8:59 AM with the MDS Coordinator. The MDS Coordinator verified Resident #45 was admitted to the facility and received dialysis treatments on Mondays, Wednesdays and Fridays. The MDS Coordinator further verified she coded Resident #45 for dialysis on her first admission MDS of 03/23/16 and the next 2 readmission MDS records were coded incorrectly. The MDS coordinator explained it was her error that the MDS record should have been marked for dialysis on 05//08/16 and 05/29/16.

An interview was conducted on 06/16/16 at 3:24 PM with the Administrator and the Director of

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F 278	Continued From page 14 Nursing (DON). The Administrator and the DON both verified the 2 Admission MDS records for Resident #45 were not coded correctly for dialysis. The Administrator and the DON both stated it was their expectation that the MDS records were to be coded accurately.	F 278		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to prepare foods to maintain nutritional value when hot water was added to pureed macaroni and cheese, regular macaroni and cheese and green peas during 1 of 1 meal preparation observation and the food was served to residents. The findings included: A review of a facility recipe titled Macaroni and Cheese revealed there were no instructions for thinning macaroni and cheese. An observation and interview during the meal preparation for lunch on 06/15/16 at 11:36 AM revealed Cook #1 removed the lid from a pan of pureed macaroni and cheese on the steam table on the tray line. She then picked up a one gallon clear plastic pitcher that was approximately two	F 364	To retain the proper nutrients, during thinning of foods on the steam table, that have thickened, the following liquids may be used, fruit juices for fruit, vegetable juice or buttered water for vegetables, gravy, au jus, or beef or chicken broth/stock for meats, starches such as macaroni and cheese may be thinned with warm milk and melted margarine. Food will continue to be properly thinned on the steam table with appropriate liquids to maintain proper nutrients. 100% of the dietary staff will be retrained by the Clinical Dietary Manager and the Dietary Supervisor on the proper thinning of foods on the steam table. This will be completed by 7/14/2016. The Clinical Dietary Manager or designee will monitor consistency of food on the steam table daily x 1 week, then 2x week	7/14/16

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F 364	Continued From page 15 thirds full of clear liquid and without measuring it poured approximately one third of the liquid into the pan of pureed macaroni and cheese and stirred it. She then picked up the pitcher again and poured more of the clear liquid into the pureed macaroni and cheese and stirred it again. Cook #1 confirmed the liquid in the one gallon pitcher was hot water. She explained the macaroni noodles had thickened up while it sat on the steam table and she had to add hot water to thin it so she could serve it. She stated it was her routine practice to add hot water to foods when they thickened up on the steam table before she served them. She then removed the lids off a pan of regular macaroni and cheese and green peas and picked up the clear pitcher and without measuring poured hot water into the regular macaroni and cheese and stirred it and then poured hot water into the green peas and stirred it and then began plating food to be served to residents. During interviews on 06/16/16 at 9:47 AM in the Dietary Manager's office in the kitchen the Dietary Manager, the Clinical Dietician and the Dietary Consultant were present. The Dietary Manager stated she had worked in the facility since February 2016 and was unaware Cook #1 was using hot water to thin foods. She stated she expected for cooks to use milk, butter, broth, gravies or vegetable broths to thin foods to preserve the nutritional content of the foods. During an interview on 06/16/16 at 9:49 AM the Dietary Consultant stated it was her expectation Cook #1 should have used heated milk or should have added extra cheese sauce to thin the pureed macaroni and cheese and regular macaroni and cheese. She explained Cook #1	F 364	x 2 weeks, at random meals for proper thinning of food on the steam table if needed. Any issues will be addressed at the time with retraining. Thereafter, a monthly random audit will be completed by the Clinical Dietary manager or designee to monitor for continued compliance. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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F 364	Continued From page 16 could have put both the milk and cheese sauce together in the macaroni and cheese to thin them. She further stated cooks could use vegetable broth or add butter to vegetables to thin them in order to preserve the nutrients in the foods. During an interview on 06/16/16 at 9:52 AM the Clinical Dietician stated she was not aware Cook #1 had been adding hot water to thin foods. She stated she had taken into consideration the water that was used to cook the foods when she calculated the calorie content of the food for residents but since she did not know hot water had been added to thin the foods she had not taken that into consideration and the hot water did not add any nutrients to the foods. During a follow up interview on 06/16/16 at 10:30 AM the Dietary Consultant stated she had called the corporate office and confirmed they did not have a policy and procedure for staff to follow to thin foods.	F 364		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		7/14/16

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F 514	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document the events leading up to a hospital transfer for 1 of 3 residents sampled for hospitalizations (Resident #212). The findings included: Resident #212 was admitted to the facility on 03/18/16. Her diagnoses included pneumonia, anemia, coronary heart disease, heart failure, hypertension, diabetes and gastroesophageal reflux disease. The admission Minimum Data Set dated 03/25/16 coded her with intact cognition, having no behaviors, and requiring limited assistance with most activities of daily living skills. Review of the Nursing Progress notes included the following entries: *04/06/16 stated the Nurse practitioner was aware of laboratory results and left no new orders; *04/10/16 at 9:53 PM At 5 pm the resident's blood sugar was 370 mg/dL and given sliding scale insulin. She ate 25 to 30 percent of dinner and was noted at 9 pm clammy and lethargic with a blood sugar at 31 mg/dL. Glucose gel administered per standing order which raised blood sugar to 42 mg/dL. The on call physician was contacted and ordered Glucagon injection which raised the blood sugar to 82 mg/dL. A request was made to have physician possibly modify sliding scale insulin and have glucose gel and glucose injectable available as needed.	F 514	On 04/16/2016, Resident #212 was assessed by the Nurse #3 for rectal bleeding. He called the supervisor, who in turn called the on-call physician. An order was obtained to send the resident to the ER for evaluation. She was admitted for Hematochezia. All residents will have appropriate documentation in the medical record, leading up to a hospital transfer. This will include symptoms and reason for transfer. 100% of licensed staff will be re trained on proper documentation in the medical records progress notes for acute episodes leading to transfer to ER for evaluation. This retraining will be completed by the DON or designee. The re-training will be completed by 7/14/2016. All resident progress notes will be reviewed daily by the DON, ADON, or designee to ensure proper documentation is in place for all residents who are transferred to the ER. This is will be completed daily x 30 days. Thereafter, the QI nurse or designee will audit documentation monthly. Any issues with this documentation will be reviewed and retrained with the nursing staff involved when it is audited. The Administrator and DON will review the findings of these audits. The Quarterly Quality Improvement Committee will review the results of the audits and give recommendations for follow up as needed or appropriate for	

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F 514	Continued From page 18 *04/11/16 at 3:36 PM Resident was continuously complaining of nonproductive cough. Resident had been started on Mucinex on 04/04/16 for 10 days. The responsible party was requesting medication to help with cough. A note was prepared to make the physician aware. *04/14/16 at 11:37 AM Resident stated she was having some feelings of anxiousness at times. She was on Zoloft daily. She would like something to help her at times with her anxiety. Note prepared and placed in on call book for physician to review. *04/15/16 at 4:58 PM Resident had cold sore on lower lip and was requesting a topical medication to treat it. The physician was notified. *04/15/16 at 7:06 PM New orders received for Ativan as needed for anxiety. *04/16/16 at 5:37 PM Resident was transferred to Emergency Room for evaluation of gastrointestinal bleed and dizziness. *04/16/16 at 8:14 Resident was admitted with Hematochezia (the passage of red blood through the rectum). Review of the medical record revealed no other notes related to any observations or assessment of Resident #212 other than vital signs. The vital signs taken on 04/16/16 were as follows: *at 2:11 AM blood pressure 136/66; temperature 98.8 Fahrenheit (F); pulse 69 beats per minute regular; respiration were 16; *at 11:17 AM blood pressure 146/70 lying; 98.2 F; pulse 58 beats per minute regular; respiration were 18; *at 5:57 PM blood pressure 108/50 lying; at 6:40 PM pulse was 70 beats per minute and regular; at 6:03 PM respiration was 16; *at 6:00 AM blood sugar was 128.0 mg/dL and at 11:51 AM blood sugar was 208.0 mg/dL;	F 514	continued compliance in this area and to determine the need for and or frequency of continued QI monitoring.	

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*at 2:11 AM her oxygen saturation level was 95% on room air and at 11:17 AM they were 96% on room air.

A phone interview on 06/16/16 at 3:14 PM was conducted with Nurse #2 who wrote the notes of 04/16/16 at 5:37 PM and of 04/16/16 at 8:14 PM. Nurse 2 stated she was the supervisor on the hall and recalled either Nurse #2 or a nurse aide reported to her that Resident #212 had used the bathroom and had visible blood. Nurse #2 stated she was aware of the resident having a history of hemorrhoids so she was going to observe her. Nurse #2 stated that when Resident #212 was going to the hair dresser she complained of dizziness. Nurse #2 then called the physician who gave orders to send her out to the hospital for an evaluation. Nurse #2 stated Resident #212's vital signs were stable. She further stated that she would have "absolutely expected" the nurse on duty, Nurse #3, to document his assessment of the resident describing the problem.

An attempt to call Nurse #3 via phone was unsuccessful.

Interview with the Director of Nursing (DON) on 06/16/16 at 4:08 PM revealed she expected nurses to document what they find involving a resident and any change in condition, to call the physician and to document the physician notification. The DON stated that she did not know what happened with Resident #212 on 04/16/16 and would have expected a full assessment of the resident to describe her condition and any bleeding observed. She further stated that staff must have seen something to determine she had possible gastrointestinal

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F 514	Continued From page 20 bleeding.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2015. This was for one recited deficiency	F 520	On 7/8/2016, the facility QI Committee held a meeting. The Regional Vice President, the Administrator, DON, ADON, QI nurse, MDS nurses, Staff Facilitator, Maintenance Director, Social Worker, Medical Records, the Activity	7/14/16

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F 520	Continued From page 21 which was originally cited July of 2015 on a Recertification survey and subsequently recited in June of 2016 on the current recertification survey. The deficiency was in the area of Housekeeping and maintenance. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 253 House Keeping and Maintenance: Based on observations and staff interviews the facility failed to label resident personal care equipment in 5 resident bathrooms on 3 of 6 resident hallways (Room #102, #106, #311, #403 and #406). The facility also failed to repair a wall bumper behind a resident's bed with metal edges exposed in 1 resident room (Room #202B) on 1 of 6 resident hallways, failed to repair torn wallpaper in 2 resident rooms (Room #202B and #514B) on 2 of 6 resident hallways, failed to repair baseboard that had pulled away from a wall in 1 resident room (Room #506B) on 1 of 6 resident hallways, failed to repair torn vinyl on a sofa in a resident lounge (300 hall), failed to repair torn vinyl on chairs in the television lounge of the locked unit on 2 of 6 resident halls and failed to repair stained flooring around the base of toilets in 7 resident bathrooms (Room #304, #309, #311, #316, #319, #403 and #406) on 2 of 6 resident hallways and failed to repair broken tile next to the base of a toilet in 1 of 7 resident bathrooms (Room #319) on 2 of 6 resident hallways During the recertification survey in July 31, 2015 the facility was cited for failure to maintain wells in good repair and/or maintain clean commode bases and floors for 2 of 6 hallways. On the current recertification survey the facility was cited again for failure to label resident personal care	F 520	Director Assistant, Dietary Manager and Housekeeping Supervisor was in attendance. These Department Heads will attend monthly QI Committee meetings on an ongoing basis and will assign additional team members as appropriate. On 07/08/2016 the Regional Vice President in-serviced the facility QI Committee, consisting of, the Administrator, DON, ADON, MDS nurses, Maintenance Director, Dietary Manager, Social Worker, Medical Records, and Housekeeping Supervisor on the appropriate functioning of the QI Committee and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F253. As of 7/8/2016, after the Regional Vice President in-serviced, the monthly QI Committee will begin identifying other areas of quality concern through the QA review process, for example: review of rounds tools and review of work orders, and any resident concerns. The Quarterly Executive QA Committee, to include the Medical Director, will meet at a minimum of quarterly. The quarterly Executive QA Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion, to	

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WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 22 equipment in 5 resident bathrooms on 3 of 6 resident hallways (Room #102, #106, #311, #403 and #406). The facility also failed to repair a wall bumper behind a resident's bed with metal edges exposed in 1 resident room (Room #202B) on 1 of 6 resident hallways, failed to repair torn wallpaper in 2 resident rooms (Room #202B and #514B) on 2 of 6 resident hallways, failed to repair baseboard that had pulled away from a wall in 1 resident room (Room #506B) on 1 of 6 resident hallways, failed to repair torn vinyl on a sofa in a resident lounge (300 hall), failed to repair torn vinyl on chairs in the television lounge of the locked unit on 2 of 6 resident halls and failed to repair stained flooring around the base of toilets in 7 resident bathrooms (Room #304, #309, #311, #316, #319, #403 and #406) on 2 of 6 resident hallways and failed to repair broken tile next to the base of a toilet in 1 of 7 resident bathrooms (Room #319) on 2 of 6 resident hallways. An interview with Administrator on 06/16/16 at 5:53 PM revealed that the as a result of the July 2015 citation they have been putting up a special board behind the residents bed so when the bed is raised and lowered it does not make holes in the walls, the Administrator stated that they educated the entire staff to not place the bed right up to the walls and to be very carefully when raising and lowering the bed, which is a work in progress. The Administrator stated that the building is old and they just can't keep patching the floors, she believes that they are going to have to do something different like go with a special heat sealed floor so liquid does not get under the floor and cause odors or stains and she belives that will be successful in fixing the problem with the floors.	F 520	include F 353. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The quarterly Executive QA Committee meeting agenda, resulting plans of corrections, and audit results will be documented in the meeting minutes. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled quarterly meeting.	