	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · ·	ATE SURVEY DMPLETED
		345216	B. WING			03/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		03/22/2010
				3100 TRAMWAY ROAD		
WESTFIEI	D REHABILITATION AN	ID HEALTH CENTER		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 583 SS=D	Personal Privacy/Co CFR(s): 483.10(h)(1)	nfidentiality of Records)-(3)(i)(ii)	F 5	83		4/19/18
		nd Confidentiality. ght to personal privacy and or her personal and medical				
	telephone communic and meetings of fam	edical treatment, written and ations, personal care, visits, ily and resident groups, but the facility to provide a				
	residents right to per right to privacy in his written, and electron the right to send and mail and other letters materials delivered to	cility must respect the sonal privacy, including the or her oral (that is, spoken), ic communications, including promptly receive unopened s, packages and other o the facility for the resident, ered through a means other				
	and confidential pers (i) The resident has to of personal and med provided at §483.70(federal or state laws (ii) The facility must a Office of the State Lo to examine a residen administrative record	esident has a right to secure conal and medical records. the right to refuse the release ical records except as i)(2) or other applicable allow representatives of the ong-Term Care Ombudsman it's medical, social, and ls in accordance with State				
	by: Based on record rev	T is not met as evidenced riew, observation and staff failed to provide privacy		F583 Personal Privacy/ The plan for correcting the	•	

Electronically Signed

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.

04/06/2018

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO (X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMP	
		345216	B. WING		03/2	22/2018
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 583	Continued From page	91	F 58	33		
	(Resident # 27). Find Resident #27 was ad 7/27/17 with multiple hypertension and aph Minimum Data Set (M 2/2/18 indicated that cognitive impairment On 3/21/18 at 10:00 A observed during the r was observed to pull his covers down expo and his disposable br medications via Gast #27's bed was near th entrance door was wi curtain was not pulled On 3/21/18 at 10:10 A	mitted to the facility on diagnoses including hasia. The quarterly IDS) assessment dated Resident #27 had severe and had a feeding tube. AM, Resident #27 was medication pass. Nurse #7 the resident's shirt up and bsing his abdominal area ief prior to administering the rostomy (G) tube. Resident the entrance door. The de open and the privacy d.		deficiency and the process alleged deficiency: On 3/21/18 the Director of re-educated Nurse#7 on r related to the provision of resident care and medica administration with return of Nurse#7 practice obse Director of Nurses. Procedure for implementi acceptable plan of correct specific deficiency cited: On 3/26/18, the Director of re-education, with observ demonstration, of all full the and per-diem nurses. Ed focused on the provision nurses during medication or resident care. All full the per-diem nurses will be re- observation by the Director 4/19/18	of Nurses facility policy f privacy during ation demonstration rved by the ting the ction for the of Nursing began vation by return time, part time ducation will be of privacy by all administration me, part time and e-educated with	
	provided privacy by c medication administra On 3/22/18 at 11:40 A (DON) was interviewe she expected the stat the medication admin	losing the door during the		The monitoring procedure the plan of correction is e specific deficiency cited r and or in compliance with requirements: The Director of Nurses w observe nurse practice for the provision of privacy d administration and reside be done on all shifts inclu The Director of Nurses w Quality Assurance audit t adherence to facility polic weekly x4 then monthly x of Nursing will present rep Administrator weekly,that shared with the Quality A	effective and that emains corrected in the regulatory ill randomly or adherence to uring medication ent care. This will uding weekends. ill complete the ool for cy and process c3. The Director ports to the t in turn will be	

Facility ID: 923117

If continuation sheet Page 2 of 42

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		COMPLETED
		345216	B. WING		03/22/2018
	ROVIDER OR SUPPLIER	D HEALTH CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 100 TRAMWAY ROAD ANFORD, NC 27330	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 583 F 607		e 2 Abuse/Neglect Policies	F 583	Committee to ensure that corrective action for any identified trends or on concerns are initiated and monitored appropriate. The Director of Nursing Minimum Data Set Coordinator, Sup Nurse, Therapy Manager, Health Information Manager, Dietary Manag Administrator and Medical Director a the weekly Quality Assurance Meetin Deficiencies that are identified during monitoring process will be addresse through the Quality Assurance proce The title of the person responsible for implementing the acceptable plan of correction is The Director of Nurses.	d as poport ger, attend ng. g the d ess. or
SS=D	§483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establi to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on resident an record review, the fac written policy and pro- reporting of an injury	ay must develop and licies and procedures that: it and prevent abuse, tion of residents and esident property, sh policies and procedures ch allegations, and e training as required at T is not met as evidenced and staff interviews and cility failed to implement their procedure for investigating and of unknown origin (UKO) for 1 sampled resident reviewed		F607 Develop/Implement Abuse/Ne Policies On 3/22/18 the Director of Nurses assessed 100% of all current resider with any injuries of unknown origins including: bruises,skin tears, abrasic	nts

Event ID: XIKH11

Facility ID: 923117

If continuation sheet Page 3 of 42

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345216	B. WING		03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 607	Continued From page	e 3	F 60	7	
	Review of the facility Prohibition" dated las read as follows: The J will investigate of any on the areas of conce Any injuries of UKO r Health Care Personn and 5-day report. Resident #224 was a cumulative diagnoses history of a fall with le Resident #224 was c increased risk for fall problems. There was fall. Resident #224 admis (MDS) dated 02/03/1 cognitive impairment coded for extensive a and transfers. Review of Resident # indicated he was out the Orthopedic office on 02/15/18 at the Ur Review of the Situatio Appearance, Review dated 02/15/18 at 4:0 #224 was experiencin was ordered. Review of a nursing r	policy titled "Abuse at revised November 2017 Administrator or designee y areas of concern. Included erns was injuries of UKO. must be reported to the el Registry via the 24-hour dmitted 01/27/18 with s of osteoporosis and a eff hip fracture. are planned 01/29/18 for related to gait and balance no care plan for an actual esion Minimum Data Set 8 indicated moderate with no behaviors. He was assistance with bed mobility e224's medical record of the facility on 02/14/18 at and out of the facility again rologist office.		and wounds. No other concerns v identified that met reporting requi to Department of Health and Hun Services, Division of Health Servi Regulation. Procedure for implementing the acceptable plan of correction: On the Nurse Consultant re-educated facility Administrator and Director Nurses on facility policy related to investigation and reporting of inju unknown origin. The re-education on the investigation process and regulations required for injuries o unknown origin. Inservice education began on 3/2 the Director of Nursing for all RNs Medication Aides, and Nursing As Full time, Part Time, and Per-dier employees related to facility abuse/neglect policies. The inser topics included: Abuse & Neglect reporting requirements. The Direc Nursing will ensure that all above employees will receive this trainin 4/19/18. The title of the person responsible for implementing the acceptable plan of correction is th Administrator.	rements han ice 3/22/18 d the of o ries of h focused reporting f 26/18 by s, LPNs, ssistants, m vice , and ctor of required ng by

Facility ID: 923117

If continuation sheet Page 4 of 42

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 04/19/2018 FORM APPROVED //B NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		3) DATE SURVEY COMPLETED
		345216	B. WING				03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
WESTFIE	D REHABILITATION AN	D HEALTH CENTER		-	00 TRAMWAY ROAD		
				S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 607	Continued From page	e 4	F	607			
	AM read Resident #2 dislocated left hip. Or Resident #224 to the There was no evident completed for Reside to the facility on 01/27 the hospital on 02/16/ Resident #224 was re 02/19/18 with a diagn left hip. Resident #224 readm indicated he sustaine In an interview on 03/ Resident #224 stated facility. He confirmed physician visits by the service but could not	ce of an incident report ant #224 from his admission 7/18 to his readmission to /18. eadmitted to the facility on hosis of a closed dislocated hission MDS dated 02/26/18 d no falls.					
	Director of Nursing (E #224 experienced no of his left hip. She sta felt his hip must have was out at one of his stated there was no in completed. In an interview on 03/ Administrator stated s an investigation or a 2 submitted to the Heal	20/18 at 5:20 PM, the DON) confirmed Resident falls prior to the dislocation ated she and management gotten dislocated while he follow-up appointments. She nvestigation or reporting 21/18 at 2:43 PM, the she did not have evidence of 24-hour or 5-day report th Care Personnel Registry 24's left hip dislocation.					

						10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			TE SURVEY MPLETED
		345216	B. WING		0	3/22/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	E	
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		0 TRAMWAY ROAD NFORD, NC 27330		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From page	e 5	F 607			
F 656 SS=D	Administrator stated s #224's left hip dislocation therefore she did not stated it was her expo UKO be investigated the facility policy. Develop/Implement C	on 03/21/18 at 4:45 PM, the she did not think Resident ation as an injury of UKO investigate or report it. She ectation that all injuries of and reported as stated in Comprehensive Care Plan	F 656			4/19/18
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The cor describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the re- under §483.10, include treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its				

Facility ID: 923117

If continuation sheet Page 6 of 42

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345216	B. WING		03/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CC	DDE
WEATELE				3100 TRAMWAY ROAD	
WESTFIEI	LD REHABILITATION AN	ID HEALTH CENTER		SANFORD, NC 27330	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETI TE APPROPRIATE DATE
F 656	Continued From page	e 6	F 65	6	
			1 00	0	
	resident's representa	als for admission and			
	desired outcomes.				
		eference and potential for			
		cilities must document			
	whether the resident'	's desire to return to the			
	community was asse	essed and any referrals to			
	-	es and/or other appropriate			
	entities, for this purpo				
		in the comprehensive care			
		in accordance with the			
		h in paragraph (c) of this			
	section.	T is not met as evidenced			
	by:	i is not met as evidenced			
	-	view, observation, and staff		The plan for correcting the	specific
		failed to implement the		deficiency and the process t	•
	-	plan for hydration/fluid		alleged deficiency: Resident	
	restriction and interve			February 2018 MAR reveale	
	document the intake	and output for Resident #26.		was on the medication Rem	eron for
	The facility also failed	d to develop a care plan for		diagnosis of Depression tha	t was
		edications for Resident #228		prescribed for her on 2/9/18	
		This was for 3 of 14 sampled		no active care plan for the a	
		or care plan development		medication. The care plan h	
	and implementation.			revised on 3/6/18 and on 3/ prescribed Zoloft, an antider	
	Findings include:			medication. None of the two	
				had been added to the care	
	1. Resident #26 was	admitted to the facility from		had been reviewed on 3/10/	
	the hospital on 8/12/			Resident #26 had an order f	
				restriction for 1500cc per da	y. 720cc from
	Physician order date	d 8/25/17 revealed fluid		dietary and 780cc from nurs	
		c centimeters (cc) per day		from day shift nursing and 3	
		and 780 ccs from nursing		night shift). There was not a	
	(390 ccs day shift an	d 390 ccs on night shift).		communication between the	
				nursing assistants working v	
		Im Data Set dated 2/1/18		resident as to how much flui	-
		26 had adequate hearing and		each provide for the residen	
	was understood and	understands. The resident		document accurately the an	

Facility ID: 923117

If continuation sheet Page 7 of 42

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345216	B. WING			03/22/2018
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	E	
				3100 TRAMWAY ROAD		
VESTFIE	LD REHABILITATION AN	ID HEALTH CENTER		SANFORD, NC 27330		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 7	F 6	56		
		red cognition. The resident	1.00	the resident had consumed. T	his included	
		limited assistance for		how much the resident consumed.		
		g and set up for meals. The		medication pass and any fluid	-	
		were obstructive uropathy,		any time during each sift with		
		Izheimer's dementia, and		documentation.		
		ertrophy with bladder neck		Procedure for Implementing th	ne	
	obstruction.			acceptable plan of correction		
				specific deficiency cited:		
	A review of Resident	#26 ' s care plan dated		The MDS Coordinator added	he new	
	2/23/18 revealed the	resident had goals and		medications to the care plan for	or the two	
		ential dehydration related to		residents on 3/20/18 when the		
		fluid restriction of 1500 ccs		alerted her on the care plan u		
		as to comply with the fluid		The MDS Consultant re-educa		
		vention was for a 1500 cc		MDS nurses on reviewing all r		
		ay and for staff to monitor		physician orders and updating		
	and document intake	and output.		plans as indicated. All new ord		
	0 0/00/40 -+ 40-05			printed out and given to the M		
	On 3/20/18 at 10:35			daily during clinical meetings.		
		e #7. Nurse #7 stated she		nurse will review them and up		
	•	ident #26. Nurse #7 read		care plans as indicated on the The Director of Nursing re-edu		
		nd stated that the resident of 1500 cc per day, 720 ccs		nurses and the nursing assista		
		ccs from nursing. Nurse #7		accurately identifying all the re		
		ot document how much fluid		are on fluid-restriction, how m		
	the resident drank, w			restriction they are on, how to		
		Irse #7 stated that she		measure each amount the res		
		assistant charted the intake		consumed and communicate		
		7 asked NA #7 where the		information to the nurses. The		
		nd NA #7 was not sure		document on the designated r		
	where, but in the pas	t an option opened on the		The monitoring procedure to e	•	
	kiosk screen if the do	ocumentation was required.		the plan of correction is effecti specific deficiency cited remai		
	On 3/20/18 at 10:40	am an interview was		and/or in compliance with the	regulatory	
	conducted with NA #	7 and indicated she was not		requirements: The Director of	-	
		had a fluid restriction. NA #7		and MDS Nurses will review 3		
		ated that the resident ' s		using the QA audit tool for car		
	-	nt charting did not have an		revision and update weekly x		
		ntake and output. NA #7		monthly x 3. Reports will be pr		
	opened the kiosk ele	ctronic charting and stated		the Administrator weekly that i	n turn will	

Facility ID: 923117

If continuation sheet Page 8 of 42

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		NO. 0938-039 TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		ĆCO	MPLETED	
		345216	B. WING)3/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTFIEI	D REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 656	 would not know how in NA #7 stated she did the bedside cup held On 3/20/18 at 10:50 at conducted with the Di Manager stated that Prestriction of 1500 cc with nursing. Dietary on each of three trays meals in his room and document the fluid int On 3/20/18 at 1:45 pr conducted with Nurse the facility- provided, #26 was measured at nursing assistant filled on day and evening s On 3/21/18 at 4:00 pr conducted with the Di The DON stated that implement the compress Accident (CVA), apha hemiplegia. Resident #228's adm 	 document the intake and much the resident drank. not know how much fluid when full. am an interview was ietary Manager. The Dietary Resident #26 was on a fluid per day and that was split provided 8 ounces/240 ccs is each day. The resident ate d nursing was required to take. m an interview was e #7. Nurse #7 stated that covered cup for Resident and held 960 ccs. The d the cup with ice and water whifts each day. m an interview was irector of Nursing (DON). she expected the staff to ehensive care plan. s admitted on 02/05/18 with a of Cerebral Vascular usia, dementia and right-side ission Minimum Data Set 8 indicated she had severe 	F 65	6 be shared with the weekly QA by the Director of Nurse to ens corrective action for trends or concerns is initiated as approp weekly QA meeting is attended DON, MDS Coordinator, Supp Therapy Manager, Health Info Manager, Dietary Manager, Ad and Medical Director. Deficien are identified during the monito process will be addressed thro facility QA process. The title of the person respons implementing the acceptable p correction: MDS Nurse and Director of Nu	sure ongoing priate. The d by the port Nurse, rmation dministrator cies that oring bugh the sible for plan of		
	Review of Resident #	228's March 2018 physician					

If continuation sheet Page 9 of 42

						0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP		
		345216	B. WING		03/2	22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIOI DATE	
F 656	Continued From page	e 9	F 65	6			
		was started on Ativan for and she was started on Zoloft 15/18.					
		planned read it was last There was no care plan for ⁄.					
	stated she was on va through March 16, 20 was covering for her stated all physician o	3 at 4:52 PM, the MDS Nurse cation March 12, 2018 018 and the MDS Assistant that week. The MDS Nurse rders were reviewed in their care planned accordingly.					
	Assistant stated she of Nurse the week of Ma 16, 2018. She stated (DON) brought all new meetings for review. S any mention of new n #228. The MDS Assis missed the newly pre						
		8 at 5:13 PM, the MDS Nurse re plan the antianxiety ent #228.					
	she took all new order for review. She stated orders for an antidepu- medication for Reside her expectation that a	B at 5:20 PM, the DON stated ers to the morning meetings d she did not recall the new ressant and an antianxiety ent #228. She stated it was anytime a new psychotropic cribed, it should be care					

If continuation sheet Page 10 of 42

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
		345216	B. WING			3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
WESTFIEI	LD REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD		
				SANFORD, NC 27330		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From page	e 10	F 65	6		
	planned.					
		s admitted 01/27/18 with s of osteoporosis and a eft hip fracture.				
		ission Minimum Data Set 8 indicated moderate with no behaviors.				
		¢224's February 2018 cated he was prescribed pressant on 02/09/18.				
		e plan read it was last revised vas no care plan for the use				
	stated she did not ca prescribed for Reside MDS Nurse stated al	8 at 5:13 PM, the MDS Nurse re plan the antidepressant ent #224 on 02/09/18. The I physician orders were ning meeting and care				
	she took all new order for review. She stated orders for an antidep She stated it was her	B at 5:20 PM, the DON stated ers to the morning meetings d she did not recall the new ressant for Resident #224. • expectation that anytime a edication was prescribed, it ed.				
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)	d Revision	F 65	7		4/19/18
	§483.21(b) Compreh §483.21(b)(2) A com	ensive Care Plans prehensive care plan must				

Facility ID: 923117

If continuation sheet Page 11 of 42

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/20 FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345216	B. WING		03/22/2018
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIEI	LD REHABILITATION AN	D HEALTH CENTER		100 TRAMWAY ROAD	
_	-		S	ANFORD, NC 27330	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 657	Continued From page	e 11	F 657		
	be-				
	(i) Developed within	7 days after completion of			
	the comprehensive a				
		terdisciplinary team, that			
	includes but is not lin				
	(A) The attending phy	ysician. e with responsibility for the			
	resident.	e with responsibility for the			
	(C) A nurse aide with	responsibility for the			
	resident.				
	(D) A member of food	and nutrition services staff.			
		cticable, the participation of			
		resident's representative(s).			
		be included in a resident's			
		participation of the resident presentative is determined			
	not practicable for the				
	resident's care plan.				
		staff or professionals in			
		ined by the resident's needs			
	or as requested by th				
		ised by the interdisciplinary			
		ssment, including both the			
	comprehensive and o assessments.	quarterly review			
		Γ is not met as evidenced			
	by:				
		iew and staff interview, the		The plan for correcting the specific	
	facility failed to review	w and revise the		deficiency and the process that lead	to the
		plan for dehydration when		alleged deficiency:	
		on was discontinued for 1 of		Resident #31 had been care planned	
	14 sampled residents	s (Resident #31).		at risk for dehydration related to use	
	Findings include:			diuretic medication. The physician or dated 1/21/18 revealed that the diure	
	The resident was adr	mitted on 10/5/13		(Lasix 40mg) was discontinued. The	
				resident's care plan dated 2/14/18 wa	as
	The significant-chang	ge Minimum Data Set dated		still showing the diuretic medication a	
		resident had adequate		dehydration showing on the care plan	
	hearing, was underst	ood and understands. The		The focus problem should have beer	

Event ID: XIKH11

Facility ID: 923117

If continuation sheet Page 12 of 42

IP CODE OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY) (X3) DATE SURVEY COMPLETS (X3) DATE SURVEY COMPLETE (X3) DATE SURVEY (X5) (X5) (X5) (X5) (X5) (X5) (X5) (X5)
OF CORRECTION (X5) ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
OF CORRECTION (X5) ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
blan since it has
was no longer
nator resolved the
tion/diuretic use)
n. All the residents
focus for risk for
medication use
DS nurses on revised and
irrent physicians
menting the
ction for the : On 3/21/18 the
e-educated the
e plan revision and ice and on as
rders are to be
the MDS nurses
tings. The MDS and update the
on the orders.
re to ensure that
effective and that
remains corrected
th the regulatory
and MDS nurses
sing the QA audit
n and update v x3. Reports will
ninistrator which
th the weekly QA
tor of Nursing to
s for trends or
iated as
QA Meeting is
IDS Coordinator, Director, Health

Event ID: XIKH11

Facility ID: 923117

If continuation sheet Page 13 of 42

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/20 FORM APPROVE OMB NO: 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345216	B. WING		03/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIEI	D REHABILITATION AN	D HEALTH CENTER		100 TRAMWAY ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 657	Continued From page	e 13	F 657	Administrator and Medical Director Deficiencies that are identified duri monitoring process will be address through the facility QA process. The title of the person responsible implementing the acceptable plan correction: The Director of Nursing	ng the ed for
F 658 SS=D	CFR(s): 483.21(b)(3) §483.21(b)(3) Compr The services provider as outlined by the com must- (i) Meet professional This REQUIREMENT	ehensive Care Plans d or arranged by the facility, mprehensive care plan,	F 658		4/19/18
	record review, the fac administration time for allergies) (Resident # medications by leavin room (Resident #65) observed. The finding 1. Resident #231 was was admitted with ord in each nostril one tim Observation of Resid	s admitted on 03/03/18. She ders for Flonase two sprays		The statements made on this Plar Correction are not an admission to not constitute an agreement with th alleged deficiencies. To remain in compliance with all Federal and St Regulations, the facility has taken take the actions set forth in this Pla Correction. The Plan of Correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic F658 Services Provided Meet Professional Standards Based on observation, staff intervier record review, the facility failed to of	and do ne ate or will an of of l be cated. ews and
	Administration Record #231's Flonase was s	2018 electronic Medication d (MAR) populated Resident scheduled to be AM. Nurse #1 did not		the administration time for Flonase to treat allergies) (Resident #231) a failed to secure medications by lea medications in resident's room (Re	and ving

Facility ID: 923117

If continuation sheet Page 14 of 42

		MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,			PLETED
		345216	B. WING		03	8/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 658	Continued From page	e 14	F 65	8		
	administer the Flonas would call the physici time her Flonase was the order read it was bedtime. Review of the March Resident #231 had be 9:00 AM rather than a Review of the physici Resident #231's Flon administered at 9:00 Interview with on 03/2 stated when she enter Flonase orders, she r administration time as PM. Interview on 03/22/18 Nursing (DON) stated Resident #231 receiv bedtime or 9:00 PM.	se but rather stated she an for clarification of the s to be administered since to be administered at 2018 MAR indicated een receiving her Flonase at at bedtime as ordered. an clarification order for ase indicated it was to be PM. 21/18 at 12:45 PM, Nurse #6		 #65) for 2 of 2 sampled if The plan for correcting the deficiency and the proceed alleged deficiency: On 3/21/18 The Director re-educated Nurse#1 and policies related to clarific medication orders and mentry. Nurse#6 was as we by the Director of Nurses related to securing medicated to securing medicated. On 3/26/18, the Director re-education with observed demonstration of all full to and per-diem nurses. Explose on facility policy securing medications, clarmedication orders and mentry. All full time, part the nurses will be re-educated observation by return de the Director of Nurses by the	he specific ess that led to the of Nurses d #6 on facility cation of nedication order vell re-educated s on facility policy cations for menting the ction for the of Nursing began vation by return time, part time ducation was related to arification of nedication order me and per diem ed with emonstration by	
	(MDS) assessment d Resident #65's cognit	erly Minimum Data Set ated 2/28/18 indicated that tion was intact.		The monitoring procedur the plan of correction is a specific deficiency cited and/or in compliance wit requirements:	effective and that remains corrected h the regulatory	
		-		The Director of Nurses w observe nurse practice for the securing of medication of medication orders and order entry. All full time,	or adherence to ons, clarification d medication part time and per	
		M, Resident #65 was Ichair in her room. There vith 5 tablets of medications		diem nurses will be re-ed observation by return de the Director of Nurses by	monstration by	

Facility ID: 923117

If continuation sheet Page 15 of 42

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		
		345216	B. WING		03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIEL	D REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 658	Continued From page	e 15	F 65	8	
	nurse observed in the cart. On 3/21/18 at 9:55 A interviewed. She sta assigned to Resident she could leave med resident was alert an acknowledged that sl medications of Resid indicated that she wa it. On 3/22/18 at 11:40 A (DON) was interview	ted that she was the nurse ; #65. Nurse #6 stated that ications in the room if a		The monitoring procedure to ensu- the plan of correction is effective specific deficiency cited remains and/or in compliance with the reg- requirements: The Director of Nurses will rando observe nurse practice for adhered the securing of medications, med order entry and medication order clarification process. This will be all shifts including weekends. The of Nurses will complete the Quali Assurance audit tool for adherence facility policy and process weekly monthly x 3. The Director of Nurse present reports to the Administrat weekly, that in turn will be shared Quality Assurance Committee to that corrective action for any iden trends or ongoing concerns are ir and monitored as appropriate. The Director of Nursing, Minimum Dat Coordinator, Support Nurse, Thei Manager, Health Information Mar Dietary Manager, Administrator a Medical Director attend the week Assurance Meeting. Deficiencies identified during the monitoring pr will be addressed through the Qu Assurance process. The title of the person responsible implementing the acceptable plar correction:	and that corrected gulatory mly ence to dications done on e Director ity ce to 7 x 4 then ses will tor d with the ensure htified hitiated he ta Set rapy hager, and ly Quality that are rocess iality e for
F 675 SS=D	Quality of Life CFR(s): 483.24		F 67	The Director of Nursing.	4/19/18

Facility ID: 923117

If continuation sheet Page 16 of 42

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIPI	LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
		345216	B. WING		0;	3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WESTFIEI	LD REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 675		e 16 damental principle that	F 67	5		
	applies to all care and residents. Each residents. Each residents facility must provide to necessary care and so the highest practicable psychosocial well-being	d services provided to facility dent must receive and the				
	by:	Γ is not met as evidenced ons, resident, staff, Nurse		The statements made on this P	an of	
	review, the facility fail assessment and inter a left hip dislocation f	sician interviews and record led to provide timely rventions for a resident with for 1 (Resident #224) of 1 iewed for well-being. The		Correction are not an admission not constitute an agreement with alleged deficiencies. To remain compliance with all Federal and Regulations, the facility has take take the actions set forth in this Correction. The Plan of Correcti	n the n State n or will Plan of	
		dmitted 01/27/18 with s of osteoporosis and a eft hip fracture.		constitutes the facility's allegatio compliance such that all alleged deficiencies cited have been or corrected by the date or dates in	n of will be	
	increased risk for fall	are planned 01/29/18 for related to gait and balance no care plan for an actual		F675 Quality of Life Based on observations, resident Nurse Practitioner and Physicial interviews and record review, the failed to provide timely assessm	n e facility	
	(MDS) dated 02/03/1 cognitive impairment	ssion Minimum Data Set 8 indicated moderate with no behaviors. He was assistance with bed mobility		interventions for a resident with dislocation for 1 of 1 sampled re reviewed for well being. Resident#224 The plan for correcting the spec deficiency and the process that	sidents	
		of the facility on 02/14/18 at and out of the facility again		alleged deficiency: On 3/21/18 the Director of Nurse re-educated Nurse #1 and #2 or policy related to change in resid condition and timely initiation an	es i facility ent	

Facility ID: 923117

If continuation sheet Page 17 of 42

	OF DEFICIENCIES			E CONSTRUCTION	(X3) DATE	0.0938-03
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	LETED
		345216	B. WING		03/	22/2018
NAME OF PI	ROVIDER OR SUPPLIER		· 1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WESTFIEI	D REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 675	Continued From page	e 17	F 67	5		
F 0/3	Review of an occupat 02/15/18 read the the #224's left foot interna reposition his foot res the Rehabilitation Ma of Resident #224 left Review of a physical read Resident #224 p rotation of left hip and therapist was unable Review of the Situatio Appearance, Review dated 02/15/18 at 4:0 #224 was experiencin was ordered. Review of the x-ray e	tional therapy noted dated brapist noticed Resident ally rotated. An attempt to sulted in pain. The note read nager and nurse were aware hip concerns. therapy note dated 02/15/18 bresented with internal d complaints of pain. The to realign correctly.	F 673	through of stat physician orders 3/17/18 through 3/21/18. 100% residents were reviewed with 10 meeting compliance for timely assessment of change in conditi review of stat orders and new or diagnostic test revealed complia The procedure for implementing acceptable plan of correction for specific deficiency cited: On 3/26/18, the Director of Nurs re-education of all full time, part per-diem nurses. Education will focused on facility policy related in resident condition and timely i and follow through of stat physic orders. All full time, part time and per-diem nurses will be re-educa the Director of Nurses by 4/19/1.	of 0% on. 100% ders for nce. the the the es began time and be to change nitiation cian d ated by 8. sure that	
	AM read Resident #2 movement and the let Waiting for an x-ray of Review of the x-ray re completed 3:56 AM a reported to the facility Review of a nursing r AM read Resident #2 completed at 4:00 AM dislocation. The phys obtained to send Res	note dated 02/16/18 at 1:49 24 complained of pain with ft hip appeared swollen. If the left hip to be done. eport indicated the x-ray was nd results were read and or at 5:09 AM. note dated 02/16/18 at 6:39 24's left hip x-ray was A and indicated a left hip ician was notified and orders ident #224 to the hospital.		 the plan of correction is effective specific deficiency cited remains and/or in compliance with the representation of the Director of Nurses will moni adherence to resident change in and the initiation and follow through physician orders. The Director of will complete the Quality Assurat took for adherence to facility pol process weekly x4 and then mont The Director of Nursing will press reports to the Administrator wee turn will be shared with the Quality Assurance Committee to ensure corrective action for any identifier or ongoing concerns are initiated 	corrected gulatory tor for condition ugh of stat f Nurses nce audit icy and nthly x3. ent kly, that in ity that cd trends	

Facility ID: 923117

If continuation sheet Page 18 of 42

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPLETED
		345216	B. WING		03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETI
F 675	Continued From page	e 18	F 67	5	
	left hip.			Nursing, Minimum Data Set Coord	dinator,
	indicated he sustaine			Support Nurse, Therapy Manager Information Manager, Dietary Man and Administrator will attend the v Quality Assurance Meeting. Defic	r, Health nager veekly iencies
	facility. He confirmed physician visits by the	/20/18 at 12:15 PM, he had no falls while at the he had been taken to two facility transportation state how or when he left		that are identified during the moni process will be addressed through facility Quality Assurance process The title of the person responsible implementing the acceptable plan correction:	h the 5. e for
	Rehabilitation Manag therapist talking abou Resident 224's left leg	1/18 at 11:30 AM, the er stated she recalled a it a significant change in g with a change in the t. Her directive was to let his		The Director of Nursing	
	occupational therapy physical therapy assist #224 was fine the day Orthopedist. The PT	21/18 at 11:50 AM, the assistant (OTA) and the stant (PTA) stated Resident y before he went out to the A stated she spoke with er observed concerns with oot.			
	stated his nursing as				
	Nurse Practitioner (N by phone between the PM Monday through after lunch, Nurse #1	21/18 at 12:47 PM, the P) stated she was available e hours of 8:00 AM and 5:00 Friday. She stated sometime contacted her about nternal rotation of Resident			

If continuation sheet Page 19 of 42

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		345216	B. WING		0:	3/22/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COD	E	
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		100 TRAMWAY ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 675	· · · · · · · · · · · · · · · · ·		F 675			
	STAT (Immediate) x-r the turn-around tine v was a few hours. She obtained until 3:56 Al nurses did not follow	stated she gave orders for a ray. The NP stated normally with a mobile x-ray provider e stated if the x-ray was not M on 02/16/18 and the up on why the x-ray location, that would be				
	the x-ray provider sta x-ray was ordered an 4:15 PM. She stated was STAT. She state arrived at 3:56 AM at were called into the fa	ew on 03/21/18 at 12:54 PM, ted the order for a left hip d called in to their agency at the order did not indicate it ed the x-ray technician the facility and resulted acility at 5:09 AM. She stated ent #224 had a left hip was				
	Assistant (NA) #1 sta Resident #224 on 02/ double shift that day to NA #1 stated Resider Orthopedic office and She stated she assist she told his nurse. Sh provide incontinence second shift because and did not requested #1 stated she only ch him on second shift of 02/15/18 when Resid appointment with his complaining of pain a	21/18 at 1:49 PM, Nursing ted she was assigned /14/18 and she worked at from 7:00 AM till 11:00 PM. It #224 came back from the complained of left hip pain. ted him to bed and thought the stated she did not have to care to Resident #224 on the had a urinary catheter d to go to the bathroom. NA necked him and repositioned on 02/14/18. She stated on ent #224 returned from an Urologist, he was again and his left leg "looked ie told Nurse #1 and she				

If continuation sheet Page 20 of 42

					D. 0938-039
	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
	345216	B. WING		03	/22/2018
OVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
OREHABILITATION AN	D HEALTH CENTER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO DATE
recalled it was early a she became aware of #224's left leg. She si and noted internal rot stated she contact the STAT x-ray. Nurse #1 provider and told ther the STAT x-ray. She si miscommunication be provider because it w Nurse #1 stated when #2 at 7:00 PM, she to been done. She state AM on 02/16/18, Nurse #224 to the hospital. In an interview on 03/ #1 stated he and the Resident #224 began pain. He stated his ex- contacted at 4:00 PM end of Nurse #1's twe there should have be before leaving or by N He stated 12 hours w STAT x-ray and he wo Resident #224 directl waiting to send him o In a telephone intervin Nurse #2 stated Nurse	Afternoon on 02/15/18 when f a problem with Resident tated assessed his left leg tation and swelling. She e NP and she ordered a stated she contact the x-ray m verbally about the need for stated there must have been etween her and the x-ray ras to be done on 02/15/18. In she reported off to Nurse old her the x-ray still had not ed when she came in at 7:00 se #2 was sending Resident /21/18 at 3:05 PM, Physician NP were notified when in complaining about left hip spectation that if x-ray was and did not arrived by the elve-hour shift at 7:00 PM, en follow up by Nurse #1 but Nurse #2 when she came on. ras too long to wait for a build have opted to send y to the hospital rather than in 02/16/18. ew on 03/21/18 at 3:42 PM, we #1 reported to her that	F 675			
	DVIDER OR SUPPLIER DREHABILITATION AN SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page recalled it was early a she became aware o #224's left leg. She si and noted internal rot stated she contact the STAT x-ray. Nurse #1 provider and told ther the STAT x-ray. Nurse #1 provider because it w Nurse #1 stated when #2 at 7:00 PM, she to been done. She stated AM on 02/16/18, Nurse #2 at 7:00 PM, she to been done. She stated AM on 02/16/18, Nurse #2 at 7:00 PM, she to been done. She stated AM on 02/16/18, Nurse #2 at 7:00 PM, she to been done. She stated AM on 02/16/18, Nurse #224 to the hospital. In an interview on 03, #1 stated he and the Resident #224 began pain. He stated his ep contacted at 4:00 PM end of Nurse #1's twe there should have be before leaving or by N He stated 12 hours w STAT x-ray and he wa Resident #224 directli waiting to send him o In a telephone intervii Nurse #2 stated Nurse	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345216 OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 recalled it was early afternoon on 02/15/18 when she became aware of a problem with Resident #224's left leg. She stated assessed his left leg and noted internal rotation and swelling. She stated she contact the NP and she ordered a STAT x-ray. Nurse #1 stated she contact the x-ray provider and told them verbally about the need for the STAT x-ray. She stated there must have been miscommunication between her and the x-ray provider because it was to be done on 02/15/18. Nurse #1 stated when she reported off to Nurse #2 at 7:00 PM, she told her the x-ray still had not been done. She stated when she came in at 7:00 AM on 02/16/18, Nurse #2 was sending Resident	EDEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CA SORRECTION IDENTIFICATION NUMBER: A BUILDING 345216 B. WING DVIDER OR SUPPLIER STI DERHABILITATION AND HEALTH CENTER STI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 20 F 675 recalled it was early afternoon on 02/15/18 when she became aware of a problem with Resident #224's left leg. She stated assessed his left leg and noted internal rotation and swelling. She stated she contact the NP and she ordered a STAT x-ray. Nurse #1 stated she contact the x-ray provider because it was to be done on 02/15/18. Nurse #1 stated when she reported off to Nurse #2 at 7:00 PM, she told her the x-ray still had not been done. She stated when she came in at 7:00 AM on 02/16/18, Nurse #2 was sending Resident #224 to the hospital. In an interview on 03/21/18 at 3:05 PM, Physician #1 stated he and the NP were notified when Resident #224 began complaining about left hip pain. He stated his expectation that if x-ray was contacted at 4:00 PM and did not arrived by the end of Nurse #1's twelve-hour shift at 7:00 PM, there should have been follow up by Nurse #1 but before leaving or by Nurse #2 when she came on. He stated 12 hours was too long to wait for a STAT x-ray and he would have opted to send Resident #224 directly to the hospital rather than waiting to send him on 02/16/18. In a telephone interview on 03/21/18 at 3:42 PM, Nurse #2 stated N	Image: Contract of the second seco	DEFICIENCIES DORRECTION (X1) PROVIDERSUPPLIENCLA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATL COM 345216 STREET ADDRESS, CITY, STATE, ZIP CODE 03 SVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) POONDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) POONDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 20 F 675 Continued From page 20 F 675 Continued From page 20 F 675 STAT x-ray. Nurse #1 stated she contact the x-ray provider and told them verbally about the need for the STAT x-ray. Nurse #1 stated she contact the x-ray provider and told them verbally about the need for the STAT x-ray. She stated there must have been miscommunication between her and the x-ray provider and told them verbally about the need for the STAT x-ray. She stated when she came in at 7:00 AM on 02/16/18, Nurse #2 was sending Resident #224 to the hospital. In an interview on 03/21/18 at 3:05 PM, Physician #1 stated he can the NP were notified when Resident #224 began complaining about left hip pain. He stated this expectation that if x-ray was contacted at 4:00 PM and did not arrived by the end of Nurse #1 studewere the septed to her that Fort X-ray and he would have opted to send Resident #224 directly to the hospital rather than waiting to send him on 02/16/18. In a telephone inte

If continuation sheet Page 21 of 42

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	D. 0938-03
nd plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMF	PLETED
		345216	B. WING		03	/22/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
WESTFIE	LD REHABILITATION A	ND HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 675	Continued From pag	e 21	F 675			
		She stated toward the end				
	-	provider called and reported				
		hip was dislocated. She I the physician and received				
	orders to send him to					
		3/21/18 at 4:00 PM, Nurse #8 4 was transported to both of				
		ment on 02/14/18 and				
	02/15/18 using the fa	acility contacted				
	-	e. She stated no incidents				
	were reported by Re transporter.	sident #224 of the				
	stated she worked se Resident #224 did ne	3/21/18 at 4:05 PM, NA #2 econd shift on 02/15/18 and ot complain of left hip pain different" and Nurse #1 was				
	Director of Nursing (#224 experienced no	8/20/18 at 5:20 PM, the DON) confirmed Resident o falls prior to the dislocation				
	that when there is a any resident, it be re	ated it was her expectation change on the condition on ported the physician timely. as her expectation that if				
	there is an order for not arrived within two be follow-up with the	a STAT x-ray and they had b-three hours, there should x-ray provider to determine arrival or the physician be				
		ding the resident out to the				
F 675	emergency room for					4/40/10
F 677 SS=D	ADL Care Provided CFR(s): 483.24(a)(2	for Dependent Residents)	F 677			4/19/18
	§483.24(a)(2) A resi	dent who is unable to carry				

If continuation sheet Page 22 of 42

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,	3		MPLETED
		345216	B. WING			03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
()(4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	STENET OF DELIVITOR DELIVITOR	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TU DEFICIENCY	ON SHOULD BE TE APPROPRIATE	COMPLETIO
F 677	Continued From page	e 22	F 67	7		
		good nutrition, grooming, and				
	personal and oral hyp					
	This REQUIREMENT	is not met as evidenced				
	by:					
		ns, responsible party,		F677 ADL Care Provided for	or Dependent	
		erviews and record review,		Residents Based on observation, reco	rd roviow, and	
		ovide showers as scheduled and Resident #224) of 4		staff, responsible party, resi		
		viewed for activities of daily		interviews the facility failed		
	living (ADLs). The fin			showers as scheduled for tw	•	
				residents sampled.		
	1. Resident #228 wa	s admitted on 02/05/18with		The plan for correcting the s	specific	
	cumulative diagnoses	s of Cerebral Vascular		deficiency and the process	that led to the	
		asia, dementia and right-side		alleged deficiency:		
	hemiplegia.			On 3/22/18 the Director of N		
				all residents to ensure show		
		ission Minimum Data Set		given as scheduled or refus	als were	
		8 indicated she had severe swith no behaviors. She		documented. On 3/22/18 The Director of	Nurses and	
		ng total assistance with		Support Nurse developed a		
	personal hygiene and	-		assure that each resident re	•	
		2 Saumig.		shower as scheduled or refu		
	Resident #228 was c	are planned on 02/06/18 for		documented. A process was		
	activities of daily living	g (ADLs) assistance due to		assure that any newly admi	tted or	
		no care plan for the refusal		re-admitted residents will ha		
	of her ADLs.			as scheduled unless contra	indicated by	
				physician order.		
	Review of the facility			On 3/22/18 the Director of N		
		ted she was to receive a sday and Saturday on first		re-educated NA#5 and NA# policy related to showers.	in on raciiity	
	shift.	outy and Catalogy of first		The procedure for implement	nting the	
				acceptable plan of correctio		
	Review of Resident #	228's personal care records		specific deficiency cited:		
		d one shower from 02/05/18		On 3/26 /2018, the Director	of Nursing	
	to 03/20/18. She was	showered on 03/10/18.		began re-education of all fu		
				time, per-diem nurses and r	-	
	Interview on 03/21/18			assistants. Education will be		
		ted she had never known		showering residents per the		
	Resident #228 to refu	use any of her ADLs to		unless contraindicated by p	hysician order	

Facility ID: 923117

If continuation sheet Page 23 of 42

		MEDICAID SERVICES			OMB NO. 09	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345216	B. WING		03/22/2	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WESTFIE	LD REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE CC	(X5) DMPLETIO DATE
F 677	Continued From page	e 23	F 67	77		
	include showers.			and documenting any ref	usals.	
				As of 4/19/18 all full time,		
		3 at 1:49 PM, NA #1 stated		per diem nurses and nurs	sing assistants	
		Resident #228 to refuse		will be educated by the D		
	any ADLs to include s	showers.		on showering residents p		
	Interview on 03/21/18	3 at 1:49 PM, NA #6 stated		unless contraindicated by and documenting any ref		
		Resident #228 to refuse		The monitoring procedure		
	any ADLs to include s			the plan of correction is e		
				specific deficiency cited r		
	Interview on 03/21/18	3 at 4:20 PM, Resident		and/or in compliance with	the regulatory	
	-	Party (RP) stated she was		requirements:		
		lent #228 was not receiving		The Director of Nurses or		
	-	ated she had not inquired rs were given to Resident		randomly observe nursing documentation for adhere	-	
	#228.	is were given to Resident		schedule. This will be dor		
	1220.			including weekends. The		
	Interview on 03/22/18	3 at 9:35 AM, the		Nurses or delegate will co		
	Rehabilitation Manag	er stated occupation therapy		Quality Assurance audit t	ool for	
	was working on spon			adherence to facility polic		
		apy never assisted with		weekly x 4 then monthly x		
	showering Resident #	#228.		of Nursing will present re		
	Interview on 03/22/18	3 at 10:20 AM, NA #5 and NA		Administrator weekly, tha shared with the Quality A		
	#1 stated on the reha			Committee to ensure that		
		taying, each room has a		action for any identified tr		
	personal shower. NA	#5 stated she thought		concerns are initiated and		
	-	unsafe to shower Resident		appropriate. The Directo	-	
		her room. NA #5 stated		Minimum Data Set Coord		
	-	ake Resident #228 to the		Nurse, Minimum Data Se		
		n the long-term care hall. NA there was no directive not to		Therapy Manager, Health Manager, Dietary Manager		
		o the main shower room for		and Medical Director atte		
	a shower.			Quality Assurance Meetir	2	
				that are identified during	-	
		3 at 11:30 AM the Director of		process will be addressed	C	
	- · ·	d it was her expectation that		facility Quality Assurance	process.	
		their showers as requested			an an aible fan	
	or scheduled. The DC	ON stated the aides should		The title of the person res	sponsible for	

Facility ID: 923117

If continuation sheet Page 24 of 42

						10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	· · ·	FE SURVEY MPLETED
		345216	B. WING		0	3/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	Continued From page	e 24	F 67	7		
		#228 to the main shower n care hall for her showers.		implementing the acceptable plan correction:	n of	
		s admitted 01/27/18 with s of osteoporosis and a eft hip fracture.		The Director of Nursing		
	activities of daily livin	are planned 01/29/18 for g (ADLs) assistance. There any refusal of his ADLs.				
	(MDS) dated 02/03/1 cognitive impairment coded for limited ass	sion Minimum Data Set 8 indicated moderate with no behaviors. He was istance with personal assistance required with				
	indicated he was see	224's medical record an at the Orthopedic office on surgical staples removed.				
		224's medical record t to the hospital on 02/16/18 facility on 02/19/18.				
		t224's hospital discharge e required no additional to his left hip.				
		shower schedule for ted he was to receive a ay and Friday on second				
		224's personal care records one shower from 02/19/18				

If continuation sheet Page 25 of 42

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/19/2018 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345216	B. WING			0	3/22/2018
	ROVIDER OR SUPPLIER	D HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODI 3100 TRAMWAY ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	ANFORD, NC 27330 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	#224 was sitting up in confirmed his surgica his left hip. Resident remember the last tim He stated a shower v Interview on 03/21/18 Assistant (NA) #5 sta Resident #224 to refu include showers. Interview on 03/21/18 she had never known any ADLs to include s Interview on 03/21/18 she had never known any ADLs to include s Interview on 03/21/18 she had never known any ADLs to include s Interview on 03/21/18 she had never known any ADLs to include s Interview on 03/22/18 Rehabilitation Manag was working on spon Resident #224. Thera showering Resident # Interview on 03/22/18 #1 stated on the reha Resident #224 was s personal shower. NA therapy stated it was #224 in the shower in would have to take R shower room on the l	 at 12:15 PM, Resident a his wheelchair. He al staples were no longer on #224 stated he could and he was given a shower. would "be nice." B at 8:05 AM, Nursing at 8:05 AM, Nursing at 8:05 AM, Nursing at 9:37 AM, NA #4 stated b at 9:37 AM, NA #4 stated c Resident #224 to refuse showers. B at 1:49 PM, NA #1 stated a Resident #224 to refuse showers. B at 4:05 PM, NA #2 stated a Resident #224 to refuse showers. B at 9:35 AM, the a ter stated occupation therapy ge bathing only with apy never assisted with #224. B at 10:20 AM, NA #5 and NA 	F	677			

Facility ID: 923117

If continuation sheet Page 26 of 42

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345216	B. WING		00/00/00 40
	ROVIDER OR SUPPLIER	545210		TREET ADDRESS, CITY, STATE, ZIP CODE	03/22/2018
	NOVIDER OR OUT FLER			100 TRAMWAY ROAD	
WESTFIEL	LD REHABILITATION AN	ID HEALTH CENTER		ANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 677	a shower. NA #1 statt any resident with sur- reminded his surgica 02/14/18. NA #1 state been given a shower Interview on 03/22/18 Nursing (DON) state all residents receiver or scheduled. The DO have taken Resident room on the long-terr after his staples were Quality of Care CFR(s): 483.25 § 483.25 Quality of c Quality of care is a fu applies to all treatme facility residents. Bas assessment of a resi that residents receive accordance with prof practice, the comprel care plan, and the re This REQUIREMENT by: Based on record rev interview, the facility document the ordere	o the main shower room for red they could not shower gical staples. NA #1 was I staples were removed ed Resident #224 could have r any time after 02/14/18. B at 11:30 AM the Director of d it was her expectation that their showers as requested ON stated the aides should #224 to the main shower m care hall for his showers e removed on 02/14/18. are indamental principle that nt and care provided to sed on the comprehensive dent, the facility must ensure e treatment and care in ressional standards of hensive person-centered sidents' choices. Γ is not met as evidenced riew, observation, and staff failed to implement and d hydration/fluid restriction of ers each day for 1 of 2	F 677	F684 Quality of Care Based on observation, record review, a staff interview the facility failed to implement and document the ordered hydration/fluid restriction of 1500 cubic centimeters each day for 1 of 2 sample	
	Findings include:			residents reviewed for hydration. The plan for correcting the specific deficiency and the process that led to t alleged deficiency:	

Event ID: XIKH11

Facility ID: 923117

If continuation sheet Page 27 of 42

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRI	JCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			· /	PLETED
		345216	B. WING			03	/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD REHABILITATION AN	ID HEALTH CENTER			WAY ROAD 0, NC 27330		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	2N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	C	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETIO DATE
F 684	Continued From page	e 27	F 68	4			
	1. Resident #26 was	admitted to the facility from		On 3/2	20/18 the Director of Nurses		
	the hospital on 8/12/2				cated Nurse #7 and Nursing		
				ant #8 on facility policy related	l to		
		d 8/25/17 revealed fluid			of the resident's kardex and	:	
		bic centimeters (cc) per day			nentation of fluid intake for res rders for restricted amounts of		
		and 780 ccs from nursing 390 cc on night shift).		fluids.	Iders for restricted amounts of		
		soo ce on night shirt).			21/18 the Director of Nurses		
	The quarterly Minimu	Im Data Set dated 2/1/18			ved all residents with fluid rest	riction	
		26 had adequate hearing and		orders	and documentation of the ord	dered	
		understands. The resident			nt of restricted fluids. No other		
		red cognition. The resident			encies were found.		
		limited assistance for			rocedure for implementing the		
		g and set up for meals. The were obstructive uropathy,			table plan of correction for the ic deficiency cited:		
	-	Izheimer's dementia, and			26 /2018, the Director of Nurs	ina	
		ertrophy with bladder neck			re-education of all full time, p		
	obstruction.			time, p	per-diem nurses, and nursing		
					ants. Education will be focuse		
		#26's care plan dated			nentation of fluid intake for res		
		resident had goals and			rdered fluid restrictions and re		
		ential dehydration related to			dent kardex prior to the initiati	on of	
		fluid restriction of 1500 ccs as to comply with the fluid		Care.	4/19/18 all full time, part time a	and	
		ion was for a 1500 cc fluid			em nurses, medications aides		
		Id for staff to monitor and			g assistants will be educated		
	document intake and				or of Nurses.		
					nonitoring procedure to ensure		
		of Resident #26's electronic			an of correction is effective and		
	and paper record rev				ic deficiency cited remains cor		
	documentation could	not de identified.			r in compliance with the regula	погу	
	On 3/20/18 at 9:30 at	m an observation was done			ements: irector of Nurses or designee	will	
		acility-provided, covered full			mly audit practice for adheren		
		with a straw was on the			policy on fluid restrictions and		
	bedside table.				nentation of restricted fluids		
					nts This will be done on all sh		
	On 3/20/18 at 10:30 a				ing weekends. The Director of	:	
	conducted with nursi	ng assistant (NA) #8. NA #8		Nurse	s will complete the Quality		

Facility ID: 923117

If continuation sheet Page 28 of 42

TATEMENT OF DEFICIE		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF CORRECT	ON	IDENTIFICATION NUMBER:	l` '	B	COMPLETED
		345216	B. WING		03/22/2018
NAME OF PROVIDER O	R SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	·
WESTFIELD REHAI	BILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330	
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
stated a restriction facility-p with ice know he did not on day On 3/20 conduct was ass the phy had a fl from die stated t the resi medicat thought and out intake v where, kiosk so On 3/20 conduct aware F stated a kiosk nu option t opened there w would n NA #7 s the bed	on. NA #8 sta provided, cova and water. Now much fluid ecord how m shift. /18 at 10:35 ed with Nurse igned to Res sician order a uid restriction tary and 780 nat she did no dent drank, w ion pass. Nu the nursing a but. Nurse # ras charted a but in the pas reen if the do /18 at 10:40 ed with NA # Resident #26 nd demonstra- trising assista o document in the kiosk ele as no place to ot know how tated she did side cup held /18 at 10:50 ed with the D	ware of Resident #26 ' s fluid ated she filled the resident ' s ered bedside cup each day NA #8 stated she did not was in the bedside cup and buch fluid the resident drank am an interview was e #7. Nurse #7 stated she ident #26. Nurse #7 read and stated that the resident of 1500 cc per day, 720 ccs ccs from nursing. Nurse #7 bt document how much fluid thich included during arse #7 stated that she assistant charted the intake 7 asked NA #7 where the nd NA #7 was not sure t an option opened on the boumentation was required. am an interview was 7 and indicated she was not had a fluid restriction. NA #7 ated that the resident ' s nt charting did not have an ntake and output. NA #7 ctronic charting and stated to document the intake and much the resident drank. not know how much fluid	F 68	Assurance audit tool for adhere facility policy and process week monthly x 3. The Director of Nu present reports to the Administr weekly, that in turn will be share Quality Assurance Committee to that corrective action for any ide trends or ongoing concerns are and monitored as appropriate. Director of Nursing, Minimum E Coordinator, Support Nurse, Mi Data Set RN, Therapy Manage Information Manager, Dietary M Administrator and Medical Dire the Monthly Quality Assurance Deficiencies that are identified of monitoring process will be addr through the facility Quality Assu- process. The title of the person responsi implementing the acceptable pl correction: The Director of Nursing	kly x 4 then ursing will rator ed with the to ensure entified a initiated The Data Set inimum er, Health Manager, ctor attend Meeting. during the ressed urance ble for

If continuation sheet Page 29 of 42

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/19/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345216	B. WING		03/22/2018
	ROVIDER OR SUPPLIER	D HEALTH CENTER	3100	EET ADDRESS, CITY, STATE, ZIP CC) TRAMWAY ROAD IFORD, NC 27330	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION TE APPROPRIATE DATE
F 684	on each of three trays ate meals in his room to document the fluid On 3/20/18 at 1:45 pr conducted with Nurse the facility- provided, #26 was measured a nursing assistant fille on day and evening s On 3/21/18 at 4:00 pr conducted with the D The DON stated that follow the physician of document the intake. Bowel/Bladder Incont CFR(s): 483.25(e)(1) §483.25(e) Incontinent §483.25(e)(1) The fact resident who is contin admission receives s maintain continence condition is or becom not possible to mainta §483.25(e)(2)For a re- incontinence, based comprehensive asses ensure that- (i) A resident who ent indwelling catheter is resident's clinical con catheterization was n (ii) A resident who ent	r provided 8 ounces/240 ccs s, each day. The resident a and nursing was required intake. m an interview was e #7. Nurse #7 stated that covered cup for Resident and held 960 ccs. The d the cup with ice and water shifts each day. m an interview was irector of Nursing (DON). she expected the staff to order for fluid restriction and tinence, Catheter, UTI -(3) mce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical tes such that continence is ain. esident with urinary on the resident's assment, the facility must ers the facility without an not catheterized unless the dition demonstrates that	F 684		4/19/18

Facility ID: 923117

If continuation sheet Page 30 of 42

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	. ,	MPLETED	
		345216	B. WING		-	03/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
WESTFIEI	D REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE	
F 690	Continued From page	e 30	F 69	90			
		val of the catheter as soon					
	as possible unless the resident's clinical condition						
		theterization is necessary;					
	and						
		incontinent of bladder					
		treatment and services to					
	continence to the exte	infections and to restore					
	§483.25(e)(3) For a r	esident with fecal					
	incontinence, based of						
	comprehensive asses	ssment, the facility must					
		t who is incontinent of bowel					
	receives appropriate restore as much norn possible.	treatment and services to nal bowel function as					
		is not met as evidenced					
	by:						
	Based on observatio	ons, staff interviews and		The statements ma	•		
		cility failed to assess a			n admission to and do		
		tion site for injury and failed		not constitute an ag			
		heter care as ordered for		alleged deficiencies			
		acility also failed to secure a event tension for Resident			ance with all federal is the facility has taken		
		of 3 sampled residents		or will take the action			
		catheters. The findings			The plan of correction		
	included:	<u> </u>		constitutes the facil	-		
				compliance such th	at all alleged		
		s admitted 01/27/18 with		deficiencies cited ha			
	-	s of a left hip fracture and		corrected by the da			
	retention.	ertrophy (BPN) with urinary		The statements ma	de on this plan of n admission to and do		
				not constitute an ag			
	Resident #224 was c	are planned 01/29/18 for an		alleged deficiencies			
		heter. Interventions included		-	ance with all federal		
	catheter care every s	hift.		and state regulation	is the facility has taken		
				or will take the action			
		224's admission orders			The plan of correction		
	dated 01/27/18 read a	as follows: Catheter care		constitutes the facili	tv⊔s allegation of		

Facility ID: 923117

If continuation sheet Page 31 of 42

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0 (X3) DATE SUI	
	CORRECTION	IDENTIFICATION NUMBER:	· /	3	COMPLET	
		345216	B. WING		03/22/	2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
WESTFIE	LD REHABILITATION AN	ID HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330			
(VA) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE C TO THE APPROPRIATE	OMPLETIO DATE
F 690	Continued From page	e 31	F 69	90		
	every shift.			compliance such that all	l alleged	
				deficiencies cited have b	u	
	Review of Resident #	•		corrected by the dates in		
		ation Record (TAR) indicated		The statements made o		
		catheter care on first shift		correction are not an ad		
		second shift (3:00 PM-11:00 t (11:00 PM-7:00 AM).		not constitute an agreen alleged deficiencies.	nent with the	
		(11.00 F M-7.00 AW).		To remain in compliance	e with all federal	
	Resident #224 admis	sion Minimum Data Set		and state regulations the		
	(MDS) dated 02/03/1	8 indicated moderate		or will take the actions s	-	
		with no behaviors. He was		plan of correction. The p		
	coded for an indwellir	ng urinary catheter.		constitutes the facility	-	
				compliance such that all	u	
		note dated 02/16/18 at 6:39 the hospital for a dislocated		deficiencies cited have t corrected by the dates in		
	left hip.	the hospital for a dislocated		F690 Bowel/Bladder Inc		
				Catheter, UTI		
	Resident #224 was re	eadmitted to the facility on		Based on observation, r	ecord review, and	
		nosis of a closed dislocated		staff interviews the facili		
	left hip.			a urinary catheter insert	• •	
				and failed to provide uri	-	
		224's February 2018 TAR		as ordered for resident #		
		providing catheter care on 00 PM), second shift (3:00		also failed to secure a u prevent tension for resid	-	
		n third shift (11:00 PM-7:00		was for two of three san		
		ed when Resident #224 was		reviewed for urinary catl	-	
	sent to the hospital or			The plan for correcting t		
				deficiency and the proce	ess that led to the	
		224's readmission orders		alleged deficiency:		
		as follows: Provide catheter		On 3/20/18 the Director		
	care daily every day	51111.		the catheter order to inc securing of the catheters		
	Review of Resident #	224's February 2018 TAR		#224 and #174. The nu		
		providing catheter care on		was updated to include		
		00 PM) only starting on		every shift catheter care	-	
	02/19/18.			with indwelling catheters		
				On 3/20 /18 The Directo		
		224's March 2018 TAR		Nurse Consultant develo		
	indicated staff were p	providing catheter care on		assure that each resider	nt with a catheter	

Facility ID: 923117

If continuation sheet Page 32 of 42

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345216	B. WING		03/22/2018	
NAME OF PF	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIEL	D REHABILITATION AN	D HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC	
F 690	Continued From page	e 32	F 690			
	first shift (7:00 AM-7:0 Observation of Residu insertion site was com PM with Nurse #4. H his right leg and found Observation of the bri site indicated a mode Nurse #4 provided ca appeared no catheter shift (7:00-3:00 PM) b (NA). She stated the and were to report an nurse. She stated blo site could indicate tra on the catheter. She s provide catheter on e the NA's worked eigh care should be done to In an interview on 03/ stated urinary cathete on every eight-hour s and changes in the ap insertion site should b nurse. In an interview on 03/ nurse stated the it ap #224's was readmitte	00 PM) only. ent #224's urinary catheter aducted on 03/20/18 at 3:40 is leg strap was attached to d down around the right calf. ief and his catheter insertion arate amount of dried blood. attheter care and stated it care was completed on first by the nursing assistant NA's provided catheter care by evidence of blood to the od at the catheter insertion uma from pulling or tension stated the NA's were to very shift. Nurse #4 stated t hours shift so his catheter		 will have catheter care and seculd ocumented every shift. A proceed documented every shift. A proceed developed to assure that any new admitted or re-admitted resident catheter will have the catheter of securement ordered and docume every shift. On 3/20/18 the Director of Nurse re-educated Nurse #4, and Nurse re-educated Nurse #4, and Nurse #4 on 3/21/18 on facility polition to catheter care with return demined for NA#4, Nurse #4 and Nurse #4 practice observed by the Director Nurses. The procedure for implementing acceptable plan of correction for specific deficiency cited: On 3/26 /2018, the Director of N began re-education, with observent return demonstration, of all full to time, per-diem nurses, and nurse assistants. Education will be for catheter care and securement. As of 4/19/18 all full time, part tiper diem nurses will be educated Director of Nurses and will incluing return demonstration of catheter securement. The monitoring procedure to entite plan of correction is effective specific deficiency cited remains 	A series was average and been ted ts with a care and hented es se #8, and cy related honstration 8⊡s for of g the r the Nursing vation by ime, part sing cused on me and d by the de a r care and sure that e and that	
	NA task for every shif	er care was indicated on the 't but it was entered as not as a task the NA's had to ted.		and/or in compliance with the re requirements: The Director of Nurses or desig randomly observe nurse and nu assistant practice for adherence	nee will rsing	

Facility ID: 923117

If continuation sheet Page 33 of 42

	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· /		COMPLETED	
		345216	B. WING		03/22/2018	
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIEL	D REHABILITATION AN	D HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 690	changed his brief yes there was no blood er removed the morning toward the end of her assisted Resident #22 stated she did not not brief or at the urinary time. She stated if bl be reported to the nur leg strap should be m knee to prevent tension In an interview on 03/ Director of Nursing (II expectation that a cat should be maintained tension, NA's should or trauma at the cathor catheter care should eight-hour shift. 2. Resident #174 was 3/6/18 with multiple d retention. The admiss (MDS) assessment d Resident #174 had m impairment and has in Resident #174's care reviewed. One of the have indwelling cathor remain free from cath next review". The ap securement of the cat On 3/20/18 at 11:20 A	bath on Resident #224 and terday morning. She stated vident on his old brief she of 03/20/18. NA #4 stated shift on 03/20/18, she 24 to the bathroom. She ticed any dried blood to his catheter insertion site at the ood was observed, it should rse. NA #4 stated the urinary naintained just above the on on the catheter. (22/18 at 11:30 AM the DON) stated it was her theter securement device 1 at the thigh to prevent report any evidence of blood eter insertion site and be completed on every a admitted to the facility on iagnoses including urinary sion Minimum Data Set ated 3/13/18 indicated that ioderate cognitive indwelling urinary catheter. plan dated 3/8/18 was a care plan problems was "I eter". The goal was "I will ieter related trauma through proaches did not include theter tubing.	F 69	Assurance audit tool for adherence facility policy and process weekly of monthly x 3. The Director of Nursin present reports to the Administrato weekly, that in turn will be shared of Quality Assurance Committee to e that corrective action for any identit trends or ongoing concerns are init and monitored as appropriate. The Director of Nursing, Minimum Data Coordinator, Support Nurse, Minim Data Set RN assistant, Therapy M Health Information Manager, Dieta Manager and Administrator attend Monthly Quality Assurance Meetim Deficiencies that are identified duri monitoring process will be address through the facility Quality Assuran process. The title of the person responsible implementing the acceptable plan correction: The Director of Nursing	a 4 then ag will r with the nsure fied tiated e Set num anager, ry the g. ng the ed ice for of	

If continuation sheet Page 34 of 42

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345216	B. WING		03/22/2018
	ROVIDER OR SUPPLIER	D HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZII 3100 TRAMWAY ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 690	catheter. On 3/20/18 at 5:10 Pl interviewed. She stat used to secure the cat was a doctor's order. Resident #174 was a order for a leg strap/le On 3/22/18 at 11:40 A (DON) was interviewed	M, Nurse # 5 was ted that a leg strap was only atheter tubing when there Nurse #5 added that new admit and he had no	F 69	90	
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1) §483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following catego unlicensed nursing st resident care per shif (A) Registered nurses (B) Licensed practica vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must per	-(4) affing Information. equirements. The facility ng information on a daily and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed a defined under State law). des. g requirements. post the nurse staffing data h (g)(1) of this section on a	F 7:	32	4/19/18

Facility ID: 923117

If continuation sheet Page 35 of 42

		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
		345216	B. WING		03/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 732	residents and visitors §483.35(g)(3) Public is staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis is greater. This REQUIREMENT by: Based on record revi interview, the facility f staffing information po 9, 12, 13, 14, 15, 16, weekdays reviewed. The daily staffing info observed on 3/20/18 revealed that there we (RN) working on 7-3 s on 7P-7A shift. The staffing assignments	acce readily accessible to access to posted nurse cility must, upon oral or a nurse staffing data c for review at a cost not to ty standard. active the tention cility must maintain the affing data for a minimum of uired by State law, whichever - is not met as evidenced iew, observation and staff failed to have an accurate osted for 11 (March 6, 7, 8, 19 and 20, 2018) of 11 Findings included: rmation posting was at 9:30 AM. The posting ere 3 Registered Nurses shift, 2 on 7A-7P shift and 3 ent was reviewed for 2 RNs on 7A-7P shift and 3	F 73		tion and have an ed for 11 c d to the and the es for the ne fing
	for completing the sta weekdays (Monday th supervisor was respo (Saturday and Sunda	M, Nurse #8 was ted that she was responsible affing information for the nru Friday) and the weekend insible for the weekends y). She stated that the 3 day thru Friday were the		acceptable plan of correction for t specific deficiency cited: On 3/26/2018, the Director of Nur completed a new staffing posting accordance with the guidelines fo staffing posting. The monitoring procedure to ensu	he sing sheet in r the

Facility ID: 923117

If continuation sheet Page 36 of 42

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 03/22/2018		
ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 345216		A. BUILDING				
		B. WING				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC	
F 732	Continued From page	e 36	F 732	2		
PREFIX TAG(EACH DEFICIEN REGULATORY OF 732Continued From pa Director of Nursing data Set (MDS) nur told to include the D the staff posting info The staff posting fo 15, 16, 19 &20 wer RNs listed under 7- On 3/22/18 at 11:40 interviewed. She s that the DON and the included on the staff DON further stated		ursing (DON) and the 2 Minimum S) nurses. She added that she was a the DON and the 2 MDS Nurse on ng information. ting for March 6, 7, 8, 9, 12, 13, 14, 0 were reviewed. There were 2-3 der 7-3 shift. t 11:40 AM, the DON was She stated that she was not aware and the MDS Nurses should not be ne staff posting information. The stated that she had corrected the oday (3/22/18) by not including the		the plan of correction is effective a specific deficiency cited remains of and/or in compliance with the regu- requirements: The Director of Nurses will review daily staffing posting for accuracy. will be done daily during the week, weekend sheets will be reviewed M The Administrator or designee will complete the Quality Assurance au for adherence to facility policy and process weekly x 4 then monthly x Director of Nursing will present rep the Administrator weekly, that in tu be shared with the Quality Assuran Committee to ensure that correctiv action for any identified trends or of concerns are initiated and monitor appropriate. The Director of Nursii Minimum Data Set Coordinator, Su Nurse, Minimum Data Set RN assi Therapy Manager, Health Informat Manager, Dietary Manager and Administrator attend the weekly Qu Assurance Meeting. Deficiencies th identified during the monitoring pro- will be addressed through the facili Quality Assurance process. The title of the person responsible implementing the acceptable plan correction: The Administrator and Director of N	brrected latory the This and the Nonday. dit tool 3. The oorts to rn will nee e ongoing ed as ng, upport stant, ion uality hat are pocess ity for of	
F 759 SS=D		rror Rts 5 Prcnt or More	F 759) 	4/19/18	
	§483.45(f) Medication					

If continuation sheet Page 37 of 42

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/19/20 RM APPROVE NO: 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345216	B. WING				03/22/2018
NAME OF PR	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WESTEIL	D REHABILITATION AN			3100	TRAMWAY ROAD		
WESTFIEL	D REHABILITATION AN		SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 759	Continued From page	a 37	F 7	50			
1755			F /:	59			
		tion error rates are not 5					
	percent or greater;	is not met as evidenced					
	by:	is not met as evidenced					
	•	iew, observation and staff			F759 Free of Medication Error Ra	ite 5	
	interview, the facility failed to maintain their			- F	percent or More		
	-	at 5% or below by not		Ē	Based on observation, record revi	ew, and	
	following doctor's ord			staff, responsible party, resident			
	(Residents #27 & #8)errors of 25 opportunities for				nterviews the facility failed to main		
	-	% error rate. Findings			medication error rate at 5% or bel		
	included:				The plan for correcting the specific		
	1 Decident #27 had	a doctor's order dated			deficiency and the process that lea alleged deficiency:	a to the	
		Bastrostomy (G) tube with 30			On 3/22/18 the Director of Nursing	1	
		before and after medication			educated Nurse #7 on proper proc		
	administration			0	of gastrostomy tube medication administering		
	On 3/21/18 at 10:00 /	AM, Resident #27 was			medications as ordered by physici	an or	
		medication pass. Nurse # 7			mid-level practitioner. On 3/22/18		
	was observed to prep	pare and to administer the		[Director of Nursing and Support N	urse	
		be without flushing the tube			audited all patients for transderma		
	with water prior to ad	ministering the medications.			orders and observed patches were	e on or	
	0-0/04/40 140 10				off as ordered by the physician.		
	On 3/21/18 at 10:10 /	AM, Nurse #7 was ted that she should have			The procedure for implementing the procedure of correction for the		
		th 30 ml of water prior to			acceptable plan of correction for th specific deficiency cited:		
		dication but she forgot.			On 3/22/2018, the Director of Nurs	sina	
					began re-education of all full time,		
	On 3/22/18 at 11:40 /	AM, the Director of Nursing			time, per-diem nurses. Education	•	
	(DON) was interviewe	ed. She stated that she		f	focused on medication administration	tion as	
		to flush the tube with 30 ml			ordered by physicians or mid-leve		
	water prior to adminis	stering the medication.			practitioners, including gastrostom	y tube	
					medication administration.		
	2 a Dasidant 40 b	a doctoria order dated			As of 4/19/18 all full time, part time		
		a doctor's order dated			per diem nurses and nursing assis		
	1/1/18 for Synthroid (nicrogram (mcg) daily by			will be educated by the Director of on medication administration as or		
	mouth before a meal				by physicians or mid-level practitic		
	Augmentin (an antibio				including gastrostomy tube medica		

Facility ID: 923117

If continuation sheet Page 38 of 42

			0/0) 1/1/1	PLE CONSTRUCTION	OMB NO.		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345216		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	. ,	(X3) DATE SURVEY COMPLETED		
		B. WING		03/22	2/2018		
NAME OF PROVIDER OR SUPPLIER WESTFIELD REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE		DE		
				3100 TRAMWAY ROAD SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 759	Continued From page	e 38	F 75	59			
	 Continued From page 38 milligrams(mgs) by mouth 1 tablet daily with food for 7 days for urinary tract infection (UTI). On 3/21/18 at 8:26 AM, Resident #8 was observed during the medication pass. Nurse #7 was observed to prepare and to administer the resident's medications including Synthroid and Augmentin. The breakfast tray was in front of the resident and she had not started eating yet. On 3/21/18 at 10:10 AM, Nurse #7 was interviewed. She stated that medication ordered with food should be given with food and medication ordered before meal should be given before meals. Nurse #7 acknowledged that Synthroid and Augmentin should not be administered at the same time but she did. She further stated that she would call the doctor and change the administration time for Synthroid to 6:30 AM. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to follow the doctor's orders to administer medications with food and before meals. 			The monitoring procedure to the plan of correction is effect specific deficiency cited rema and/or in compliance with the requirements: The Director of Nurses or del randomly observe medication adherence to orders by phys mid-level practitioners. This wo on all shifts including weeker Director of Nurses or delegat complete the Quality Assuran for adherence to facility polic process weekly x 4 then mor Director of Nursing will prese the Administrator weekly, that be shared with the Quality As Committee to ensure that con action for any identified trend concerns are initiated and me appropriate. The Director of Minimum Data Set Coordinat Nurse, Minimum Data Set RN Therapy Manager, Health Inf Manager, Dietary Manager, A and Medical Director attend to Quality Assurance Meeting. I	tive and that ains corrected a regulatory legate will n pass for icians or will be done nds. The te will nce audit tool y and othly x 3. The ent reports to at in turn will ssurance rrective ls or ongoing onitored as Nursing, tor, Support N assistant, formation Administrator the Monthly		
	1/3/18 for Nitroglycer hypertension) patch 3 transdermally once a 9 PM.	34 H 0.1 mgs/hr 1 patch day - on at 9 AM and off at		that are identified during the process will be addressed the facility Quality Assurance pro The title of the person respor implementing the acceptable correction:	rough the ocess. nsible for		
	was observed to prep Nitroglycerin 1 patch	medication pass. Nurse #7		The Director of Nursing			

Facility ID: 923117

If continuation sheet Page 39 of 42

				CONSTRUCTION	OMB NO. 0938-0
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345216		A. BUILDING	COMPLETED		
		B. WING		03/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIEI	LD REHABILITATION AN	D HEALTH CENTER		100 TRAMWAY ROAD SANFORD, NC 27330	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
F 759	Continued From page Nitroglycerin patch fro wall.	e 39 om the resident's left chest	F 759		
	patch applied on 3/20	AM, Nurse #7 was ted that the Nitroglycerin 0/18 at 9 AM should have M of 3/20/18 as ordered but			
F 865 SS=D	(DON) was interviewe she expected the nur order to remove the N	AM, the Director of Nursing ed. The DON stated that ses to follow the doctor's litroglycerin patch at 9 PM. closure/Good Faith Attmpt (h)(i)	F 865		4/19/18
	§483.75(a) Quality assurance and performance improvement (QAPI) program.				
	§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;				
		ary may not require rds of such committee ch disclosure is related to ch committee with the			
	and correct quality de a basis for sanctions.	by the committee to identify ficiencies will not be used as			
	Based on observatio	ns, resident, staff, Nurse ician interviews and record		F865 QAPI Program/Plan, Disclosure Good Faith Attempt.	e/

Event ID: XIKH11

Facility ID: 923117

If continuation sheet Page 40 of 42

		MEDICAID SERVICES			OMB NO. 0938-0
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345216		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED		
		B. WING	03/22/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI	PCODE
				3100 TRAMWAY ROAD SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE
F 865	Continued From page	e 40	F 86	5	
	failed to maintain imp monitor the interventi place following the re 02/23/17. This was fi during a recertificatio areas of Comprehens Plans at F656 (F279) areas included Qualit Quality of Care at F65 failure of the facility d record shows a patte sustain an effective G Assurance program. The findings include: This citation is cross F656 (F279) Based c observation, and staff to implement the com hydration/fluid restrict monitor and documen Resident #26. The fac care plan for new psy Resident #228 and R	on record review, f interview, the facility failed aprehensive care plan for tion and intervention to nt the intake and output for acility also failed to develop a vchotropic medications for tesident #224. This was for dents reviewed for care plan		The plan for correcting the deficiency and the process alleged deficiency: The procedure for implete program as an acceptable correction for the specific On 4/15/18, the Quality // in-serviced the Administry to facility policy, related the Assessment and Assuran consisting at a minimum must maintain a QAPI or consisting of at minimum of Nursing; (ii) The Med his/her designee, (iii) at le members of the facility so of whom must be the Ad Owner, a Board Member individual in a leadership Quality Assessment an A committee must: meet at and as needed to coordi activities such as identify respect to which quality a assurance activities are , (ii) develop and implement plans of action to correct deficiencies; (iii)disclosu (A State or the Secretary	ess that led to the menting the QAPI de plan of c deficiency cited: Assurance Nurse rator in reference to Quality nce committee, of (1). A facility ommittee n, (i) The Director ical Director or east three other taff, at least one ministrator, r or other o role .The Assurance t least quarterly nate and evaluate ying issues with assessment and necessary, and ent appropriate t identified quality re of information.
	interview, the facility the comprehensive c	on record review and staff failed to review and revise are plan for dehydration dication was discontinued for dents (Resident #31).		disclosure of the records committee except in so f disclosure is related to th such committee with the this section. (i).Sanctions attempt by the committee	far as such ne compliance of requirements of s. Good faith e to identify and
	staff, Nurse Practitior	on observations, resident, ner and Physician interviews e facility failed to provide		correct quality deficiencie used as a basis for sanc The Administrator or des for adherence to the QA	tions.) signee will monitor

Facility ID: 923117

If continuation sheet Page 41 of 42

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	OMB NO. 0938-03 (X3) DATE SURVEY		
		A. BUILDING	COMPLETED		
		345216	B. WING	03/22/2018	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO
F 865	timely assessment ar resident with a left hip #224) of 1 sampled re well-being. F690 (F315) Based o interviews and record assess a urinary cath and failed to provide o ordered for Resident to secure a urinary ca Resident #174. This w residents reviewed fo Interview on 03/22/18 Administrator stated s in the areas of care p had been no staff turr Set (MDS) department program changes. Th was unsure why there diagnostic testing for	ad interventions for a b dislocation for 1 (Resident esidents reviewed for n observations, staff review, the facility failed to eter insertion site for injury urinary catheter care as #224. The facility also failed atheter to prevent tension for was for 2 of 3 sampled r urinary catheters. 8 at 10:40 AM, the she did not know what failed lanning. She stated there n-over in the Minimum Data att and no new computer ue Administrator stated she	F 86	 completing the Quality Assurance tool weekly x 4 then monthly x 3 Director of Nursing will present r the Administrator and the Quality Assurance Committee. The comreview each item to ensure that action for any identified trends of concerns are initiated and monit appropriate and followed throug QAPI program which identifies the that requires improvement, dever plan to correct, implementing the auditing and reviewing outcome adjusting the plan as needed. The Director of Nursing, Minimum Da Coordinator, Support Nurse, The Manager, Health Information Ma Dietary Manager, and Administrattend the weekly and monthly Q Assurance Meeting. Deficiencies identified through monitoring, wi processed through facility Qualiti Assurance program. (Identify procease a plan, implement the plaresults, and adjust as necessary Previous survey tags identified, brought before the QAPI commi 4/19/and will be reviewed to ider area that requires improvement, developing a plan to correct, implementing the plan, auditing reviewing outcomes, and adjustiplan as needed. The title of the person responsible implementing the acceptable plan correction: The Administrator 	. The reports to y mittee will corrective r ongoing ored as h the he area eloping a e plan, s, and he ata Set erapy anager, ator will Quality s II be ty roblem, n, study /.) will be ttee on ntify the

Facility ID: 923117

If continuation sheet Page 42 of 42