	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED	
			A. BUILDING			С	
		345216	B. WING		0,	4/18/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE		
WESTFIEI	LD REHABILITATION A	ND HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments		E 00	0			
		3.73, Emergency					
F 623 SS=C		s Before Transfer/Discharge)-(6)(8)	F 62	3		5/15/19	
	resident, the facility (i) Notify the residen representative(s) of the reasons for the r language and mann facility must send a representative of the Long-Term Care Om (ii) Record the reason discharge in the resi accordance with par and	sfers or discharges a must- t and the resident's the transfer or discharge and nove in writing and in a er they understand. The copy of the notice to a e Office of the State abudsman. ons for the transfer or dent's medical record in agraph (c)(2) of this section; tice the items described in his section.					
	 (i) Except as specifie (c)(8) of this section discharge required u made by the facility resident is transferred (ii) Notice must be m before transfer or dis (A) The safety of ind be endangered under this section; 	ed in paragraphs (c)(4)(ii) and the notice of transfer or under this section must be at least 30 days before the ed or discharged. nade as soon as practicable					

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.

05/04/2019

		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 05/21/2019 FORM APPROVED B NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		B) DATE SURVEY COMPLETED
		345216	B. WING _				C 04/18/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP COL	DE	
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER) 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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 623	be endangered, under this section; (C) The resident's he allow a more immedia under paragraph (c)(' (D) An immediate trai required by the reside under paragraph (c)(' (E) A resident has no days. §483.15(c)(5) Conten- notice specified in pa- must include the follo (i) The reason for trai (ii) The effective date (iii) The location to wit transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omt (vi) For nursing facilit and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C.	er paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; insfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ats of the notice. The written ragraph (c)(3) of this section wing: insfer or discharge; of transfer or discharge; inch the resident is rged; e resident's appeal rights, address (mailing and email), er of the entity which its; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related ing and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402,	F	523			

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	05/21/2019 APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		345216	B. WING		-	8/2019
NAME OF PF	ROVIDER OR SUPPLIER	I	s	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • •	
WESTEIEI	D REHABILITATION AN		3	100 TRAMWAY ROAD		
WEGHTIEL		DHEAEIN OENTER	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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 623	email address and tel agency responsible for advocacy of individual established under the for Mentally III Individ §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification prit to the State Survey A State Long-Term Carr the facility, and the re- well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on record revif facility failed to notify writing of the reason to of 4 sampled resident	sabilities, the mailing and lephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act. es to the notice. he notice changes prior to or discharge, the facility bients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of esident representatives, as he transfer and adequate lents, as required at § - is not met as evidenced iew and staff interview, the the responsible party (RP) in for hospital discharge for 4	F 623	The statements made on this pl correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and state regulations the facility or will take the actions set forth i	to and do n the federal has taken n this	
	facility on 3/21/19.	originally admitted to the 46 nurse's note written by		plan of correction. The plan of co constitutes the facility s allegati compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F623	on of will be	

Facility ID: 923117

If continuation sheet Page 3 of 33

						IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	E SURVEY IPLETED
		345216	B. WING			C 4/18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		4/10/2019
				3100 TRAMWAY ROAD		
NESTFIE	LD REHABILITATION AN	D 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) COMPLETIC DATE
F 623	Continued From page	<u>a</u> 3	F 62	23		
	hospital on 3/30/19 di and labored breathing that the RP was notifi for the discharge. On 4/17/19 at 10:58 A interviewed. The Nur notified the RP by pho discharged to the hos been sending a copy not a written discharg On 4/17/19 at 2:50 Pl interviewed. The Nur not present during the her/him by phone and resident was discharg Nurse reported that s notice of discharge in On 4/17/19 at 3:15 Pl interviewed. The Nur she was not aware of had to notify the RP in hospital discharge On 4/18/19 at 8:34 Al (DON) was interviewed that she was not aware	rse stated that he normally one when a resident was spital. He added that he had of the bed hold policy but le summary to the RP. M, Nurse #3 was rse stated that if the RP was e discharge, she called d notify him/her that the ged to the hospital. The he had not sent the RP a		 The plan of correcting the spee deficiency. The plan should ad processes that lead to the deficited: The facility failed to notify the party in writing of the reason for discharge. 1. Corrective action for resident by the alleged deficient practice On 5/3/19 the responsible par residents #25, 46, 8 and 39 ww written notice of the reason for to the hospital by the Support 2. Corrective action for resident potential to be affected by the deficient practice. On 5/3/19 the Director of Nursall discharges for the last 7 da monitor that the responsible potential. 3. Measures /Systemic change reoccurrence of alleged deficient of Nurse Consultant began educt full time, part time and as need social worker, administrator, a business and office manager of policy on notifying the responsible writing of the reason for a resident of the reason for a resident of the hospital. 	ddress the iciency responsible for hospital t(s) affected ce: ties of ere mailed r discharge Nurse. ts with the alleged res audited ys to arty had reason for es to prevent ent practice: rses and ation of all ded nurses, dmissions, on facility sible party in dent □ s	
	that she expected the be followed.	arge. The DON reported e regulation for notification to originally admitted to the		 be completed by 5/15/19 at who of the above must be in-service working. 4. Monitoring Procedure to ensighan of correction is effective a specific deficiency cited remainand/or in compliance with regular requirements. 	ed prior to sure that the and that ns corrected	

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 4 of 33

	F DEFICIENCIES	MEDICAID SERVICES	(Y2) MUU TU	PLE CONSTRUCTION	(X3) DATE SURV	<u>38-039</u> /FY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	COMPLETE	
					С	
		345216	B. WING		04/18/2	019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
WESTFIEL	D REHABILITATION AN	D HEALTH CENTER		3100 TRAMWAY ROAD SANFORD, NC 27330		
					0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE CON THE APPROPRIATE	(X5) MPLETIOI DATE
F 623	Continued From page	24	F 62	23		
		s note written by Nurse #2		The Director of Nurses will	I monitor	
		nt #25 was discharged to the		compliance utilizing the W		
		e to confusion and abnormal		Notification of RP Hospital		
		he RP was present during		Quality Assurance Tool we		
	-	is notified. The note did not		then monthly x 3 months.		
		discharge summary/notice		Nursing will monitor all nur	e e e e e e e e e e e e e e e e e e e	
	was discharged to the	he RP when the resident		for compliance with the co annual Dementia training.	-	
		e nospital.		presented to the weekly Q		
	On 4/17/19 at 10:58 /	AM, Nurse #2 was		Assurance committee by t		
	interviewed. The Nur	rse stated that he normally		Nurses to ensure correctiv		
		one when a resident was		initiated as appropriate. Co	-	
		pital. He added that he had		be monitored and the ongo		
		of the bed hold policy but le summary to the RP.		program reviewed at the w Assurance Meeting. The w	veekly QA	
	On 4/17/19 at 2:50 Pl	M Nurse #3 was		Meeting is attended by the Director of Nursing, MDS (
		rse stated that if the RP was		Therapy Manager, Health	-	
		e discharge, she called d notify him/her that the		Manager, and the Dietary		
		ged to the hospital. The		Date of Compliance: 5/15/	19	
	Nurse reported that s notice of discharge in	he had not sent the RP a writing.				
	On 4/17/19 at 3:15 Pl	M, the Nurse Consultant was				
		se Consultant stated that				
		the regulation that facility				
	had to notify the RP in hospital discharge	n writing of the reason for				
		M, the Director of Nursing				
	· · ·	ed. The DON also stated				
		re of the regulation that ne RP in writing of the reason				
		arge. The DON reported				
	that she expected the	e regulation for notification to				
	be followed.					
	Resident #8 was o	riginally admitted to the				

If continuation sheet Page 5 of 33

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/21/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	
		345216	B. WING				C 18/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIEI	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	9 5	F	623	3		
	he was discharged to to vomiting brown em	8 nurse's note revealed that the hospital on 2/10/19 due esis. The note did not vas notified in writing of the rge.					
		ed that he had been sending d policy but not a written					
	interviewed. The Nur she was not aware of	M, the Nurse Consultant was rse Consultant stated that the regulation that facility n writing of the reason for					
	(DON) was interviewed that she was not away facility had to notify the for the hospital discharge	M, the Director of Nursing ed. The DON also stated re of the regulation that he RP in writing of the reason arge. The DON reported e regulation for notification to					
	4/26/17 with diagnose kidney disease and a The annual Minimum						
	#39 ' s cognition was A medical record revie	severely impaired. ew revealed Resident #39					

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345216	B. WING				_ 18/2019
	ROVIDER OR SUPPLIER	D HEALTH CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	was transferred to the was no documentatio hospital discharge was s Responsible Party (readmitted to the facil On 4/17/19 at 10:58 A interviewed. Nurse # notified the RP by pho discharged to the hos been sending a copy not a written discharg On 4/17/19 at 2:50 PP interviewed. Nurse # not present during the RP by phone and not was discharged to the reported that she had discharge in writing. On 4/17/19 at 3:15 PP interviewed. The Nur she was not aware of the facility had to notif reason for the hospital On 4/18/19 at 8:34 AP (DON) was interviewed that she was not aware indicated the facility ho of the reason for the h	 a hospital on 3/26/19. There in that a written notice of its provided to Resident #39 'RP). Resident #39 was ity on 3/28/19. AM, Nurse #2 was 2 stated that he normally one when a resident was pital. He added that he had of the bed hold policy, but e summary to the RP. M, Nurse #3 was 3 stated that if the RP was a discharge, she called the field them that the resident if the RP a notice of the regulation that indicated fy the RP in writing of the al discharge. M, the Director of Nursing ed. The DON also stated re of the regulation that ad to notify the RP in writing nospital discharge. The e expected the regulation 	F	623	3		
F 641 SS=D	Accuracy of Assessm		F	641			5/15/19
	§483.20(g) Accuracy	of Assessments.					

Facility ID: 923117

If continuation sheet Page 7 of 33

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 09	PROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SUR COMPLETI C	
		345216	B. WING		04/18/2	2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER	-	100 TRAMWAY ROAD ANFORD, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) DMPLETION DATE
F 641	resident's status. This REQUIREMENT by: Based on record revi facility failed to code to (MDS) assessment and discharge status (Residents rejection of care (Resist sampled residents revi Findings included: 1. Resident 66 was and 1/30/19. Review of the dischart (MDS) assessment da Resident #66 was dis 2/17/19.	t accurately reflect the is not met as evidenced ew and staff interview, the the Minimum Data Set ccurately in the area of sident #66), active #116 and #20) and ident #15) for 4 of 17	F 641	The statements made on this plan correction are not an admission to a not constitute an agreement with th alleged deficiencies. To remain in compliance with all fec and state regulations the facility has or will take the actions set forth in th plan of correction. The plan of correc constitutes the facility a allegation compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. F641 Accuracy of Assessments For resident #66, a corrective action obtained on 05/04/19. "The specific deficiency was correc 05/04/19 by modifying the Minimum Set assessment with an ARD of 02.	and do e deral s taken his ection of be n was ted on n Data	
	that the resident was 2/17/19. On 4/16/19 at 3:10 PI interviewed. The MD nurse's notes and ver discharged to the con hospital. The MDS N discharge MDS asses coded incorrectly und On 4/18/19 at 8:34 AI (DON) was interviewe	discharged to home on M, MDS Nurse #1 was		in order to correct resident State Set assessment with an ARD of 02. in order to correct resident s disch disposition in Section A to accurate reflect their discharge to home. Th completed by the Regional Minimur Set Consultant. Corrected Minimur Set assessment was re-submitted t State Database in Batch #1278 on 05/04/19. For resident #116, a corrective action obtained on 05/04/19. "The specific deficiency was correct 05/04/19 by modifying the Minimur Set assessment with an ARD of 01, in order to code the presence of action diagnosis of Peripheral Vascular Di	arge ly is was m Data m Data to on was ted on n Data /29/19 tive	

Event ID: M7MY11

Facility ID: 923117

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/21/ FORM APPRC OMB NO. 0938-(
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345216	B. WING		C 04/18/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD	E
WESTFIEI	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE
F 641	1/22/19 with multiple Peripheral Vascular E Resident #116's adm (MDS) assessment d The assessment did f #116 had a diagnose: Resident #116's care care plan problems d at risk for acute pain PVD". On 4/17/19 at 2:35 Pl interviewed. The MD resident's medical red Resident #116 had a MDS Nurse indicated assessment dated 1/2 under the active diag On 4/18/19 at 8:34 Al (DON) was interviewed she expected the MD accurately.	s admitted to the facility on diagnoses including Disease (PVD). ission Minimum Data Set ated 1/29/19 was reviewed. not indicate that Resident s of PVD. plan was reviewed. The ated 1/29/19 included "I am related to PVD" and "I have M, MDS Nurse #2 was S Nurse reviewed the cords and verified that diagnoses of PVD. The that the admission MDS 29/19 was coded incorrectly noses. M, the Director of Nursing ed. The DON stated that S assessments to be coded	F 64		t. Corrected nt was se in Batch action was corrected on himum Data of 02/01/19 ection E to care that ent as completed tant. assessment tabase in action was corrected on himum Data of 02/06/19 ection I to hutrition. hum Data Set to State
	11/6/15 with diagnose right eye and dry eye A review of nursing n	admitted to the facility on es that included visual loss in syndrome. otes dated 1/27/19 indicated htly refused medications and		Corrective action for residents potential to be affected by the deficient practice. All residents have the potentia affected by the alleged deficie In order to validate accurate of	alleged al to be ent practice.

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 9 of 33

						IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		. ,	TE SURVEY MPLETED
			A. BUILDING	G		
		345216	B. WING			С
		545216				4/18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIC DATE
F 641	Continued From page	e 9	F 64	11		
	A review of Resident			Active Diagnoses, and	Section F	
		ds (MARs) from 1/26/19		Behaviors, the following		
		ted she refused medications		completed.		
	and/or eye drops on 7					
				#1. 100% audit of Disch	narge assessments	
	The annual Minimum	Data Set (MDS)		completed during timefi		
		1/19 indicated Resident #15		05/01/19 was complete		
	's cognition was intac	ct, and she had no rejection		the discharge status in		
	-	or Section of the 2/1/19 MDS		accurately coded. This		
	for Resident #15 was	completed by the Social		completed by the Regio		
	Worker (SW).			Set Nurse Consultant o	on 05/07/19.	
				"Audit Results: 76 of	76 Discharge	
	A review of Resident	#15 ' s active care plan was		assessments reviewed	had A2100	
	conducted on 4/16/19	This care plan had not		(Discharge Status) code	ed accurately.	
	addressed Resident #	#15 ' s rejections of				
	medications and/or e	ye drops.		#2. 100% audit of Minin	num Data Set	
				assessments complete	d during timeframe	
	An interview was con	ducted with the SW on		of 02/01/19 05/01/19	•	
	4/17/19 at 2:30 PM.			ensure that any resider		
		ior Section of the MDS by		diagnoses of either Mal		
		tes. She reported there also		Peripheral Vascular Dis		
		electronic medical record		accurately coded in Sec		
		Nursing Assistant (NA)		was completed by the F	•	
		d to behaviors and/or		Data Set Consultant on		
	-	reported that she had not		" Audit Results:2 of 2 re		
		o when she completed the		diagnosis of malnutritio		
		he MDS assessments. The		coding of malnutrition in		
	-	1/27/19 and the MARs from		* Audit Results:7 of 7 re diagnosis of peripheral		
	-	9 (the 7-day look back MDS) for Resident #15 were		had accurate coding of		
		I. The 2/1/19 MDS that		vascular disease in Sec		
		15 had no rejection of care				
		e SW. She revealed that		#3.100% audit of Minim	um Data Set	
		d the 1/27/19 nursing notes		assessments complete		
		reviewed Resident #15 ' s		of 02/01/19 05/01/19	-	
		evealed she was unaware		order to ensure accurat	-	
	Resident #15 had free			presence of resident be		
		ye drops. The SW indicated		E. This audit was comp		
		esident #15 was coded		Regional Minimum Data		

Facility ID: 923117

		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/21/2019 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COMF	E SURVEY PLETED
		345216	B. WING				C / 18/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WEOTELEI				31	00 TRAMWAY ROAD		
WESTFIEL	D REHABILITATION AN	ID HEALTH CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From page	e 10	F 64	41			
	inaccurately for reject			••	on 05/07/19.		
		lion of care.			"Audit Results: 77 of 77 residents		
	An interview was con	ducted with the Director of			reviewed had accurate coding of Sect	tion	
		17/19 at 11:40 AM. She			E (behaviors).		
		had no care plan that			. ,		
	addressed rejection of	of care.			Systemic Changes		
	A follow up interview	was conducted with the			On 05/06/19, the Regional Minimum I	Data	
	DON on 4/18/19 at 8	:27 AM. She indicated she			Set Consultant completed an in service		
	expected the MDS to	be coded accurately.			training for the facility Social Services		
					Director and Minimum Data Set		
					Coordinators that included the following	-	
		admitted to the facility on ses that included atrial			the importance of thoroughly reviewing the medical record prior to completion		
	fibrillation and adult fa				Section E of the Minimum Data Set	1 01	
					assessment in order to ensure accura	ite	
	A review of the medic	cal record indicated Resident			coding of the presence of any behavior		
	#20 was admitted to	hospice services on 1/24/19			during the assessment reference		
	with a primary hospic	-			lookback window. The education also)	
	protein-calorie malnu	trition.			included the importance of and instru-	ction	
					on reviewing the resident s medical		
		ge Minimum Data Set (MDS)			record thoroughly prior to coding Sect	ion	
		6/19 indicated Resident #20			A (Discharge Status) for Discharge	rata	
		derately impaired, and she e services. Resident #20 ' s			Assessments in order to ensure accu coding of where resident was dischar		
	• •	I not included malnutrition.			to. The education also contained	yeu	
	U	s Section of the 2/6/19 MDS			information on how to and the importa	ance	
	-	completed by MDS Nurse			of reviewing the resident s medical		
	#1.				record thoroughly prior to coding Sect	ion I	
					(Active Diagnoses) in order to ensure		
		ducted with MDS Nurse #1			accurately coding this section.		
		M. She stated that she					
		S for Resident #20 in the			This information has been integrated		
	-	oses. The 2/6/19 MDS for			the standard orientation training for ne		
		luded no diagnosis of ewed with MDS Nurse #1.			Social Services Directors and Minimu Data Set Coordinators.	111	
	The hospice docume						
	-	mitted to hospice services			The monitoring procedure to ensure t	hat	
		mary hospice diagnosis of			the plan of correction is effective and		

Facility ID: 923117

If continuation sheet Page 11 of 33

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/21/2019 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	e survey IPleted
		345216	B. WING		04	C I/18/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
WESTEIE	LD REHABILITATION AN	ID HEALTH CENTER		3100 TRAMWAY ROAD		
				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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	MDS Nurse #1. MDS malnutrition was an a #20 at the time of he MDS was coded inac An interview was cor Nursing (DON) on 4/	utrition was reviewed with S Nurse #1 confirmed active diagnosis for Resident r 2/6/19 MDS and that this	F 64		regulatory lursing or ill begin sessments order to ccurately e Status); ction I dits will be ssurance e Diagnoses ccurate ection A □ and tion E ure that the and that ns corrected gulatory weeks and orts will be ty Director of action for initiated as lity d by the sing, or, Unit rapy, Health Manager	

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 12 of 33

	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		345216	B. WING			/18/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
			3	100 TRAMWAY ROAD		
WESTFIE	LD REHABILITATION AN	D 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	FIX (EACH CORRECTIVE ACTION SHOULD F		(X5) COMPLETIO DATE
F 641	Continued From page	e 12	F 641			
				Administrator and /or Director of I	Nursing.	
F 656	Dovolon/Imploment (Comprehensive Care Plan	F 656	Date of Compliance: 05/07/19		5/15/19
F 050 SS=D	CFR(s): 483.21(b)(1)	•	F 000			0/10/19
00-D						
	§483.21(b) Compreh					
	• • • • • • •	cility must develop and				
		nensive person-centered sident, consistent with the				
		th at §483.10(c)(2) and				
	§483.10(c)(3), that in					
		ames to meet a resident's				
	-	I mental and psychosocial				
		ied in the comprehensive				
		nprehensive care plan must				
	describe the following (i) The services that a	are to be furnished to attain				
		ent's highest practicable				
		psychosocial well-being as				
		24, §483.25 or §483.40; and				
		would otherwise be required				
	0 / 0	.25 or §483.40 but are not				
	-	esident's exercise of rights Jing the right to refuse				
	treatment under §483					
		ervices or specialized				
		the nursing facility will				
	provide as a result of					
		a facility disagrees with the				
	rationale in the PASA	RR, it must indicate its				
		h the resident and the				
	resident's representa					
	(A) The resident's go	als for admission and				
	desired outcomes.					
		eference and potential for				
	future discharge. Fac whether the resident	ilities must document				

Facility ID: 923117

If continuation sheet Page 13 of 33

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C 04/18/2019	
		345216	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	community was asse local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on observation interview, and staff in develop a compreher refusals of care (Resi implement care plans Living (ADL) assistant of a gait belt (Residen (Resident #25) for 4 of The findings included 1. Resident #15 was 11/6/15 with diagnose syndrome and respira The annual Minimum assessment dated 2/ #15's cognition was in A review of Resident Administration Recorr through 4/16/19 rever - Artificial Tears Solut on 28 of 49 administratio - DuoNeb Solution (in 64 administration opp	ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the h in paragraph (c) of this T is not met as evidenced on, record review, resident terview, the facility failed hsive care plan in the area of ident #15) and failed to s related to Activity of Daily nee (Resident #39), the use int #7), and the use of a splint of 17 sampled residents. It: admitted to the facility on es that included dry eye atory disease. Data Set (MDS) 1/19 indicated Resident intact. #15's Medication ds (MARs) from 3/16/19 aled the following refusals: tion (eye drop) was refused on opportunities (eye drop) was refused on on opportunities haler) was refused on 26 of	F 656	Plan of Correction The statements made on this pl correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of c constitutes the facility s allegat compliance such that all alleged deficiencies cited have been or corrected by the F 656 Develop/Implement Comprehent Plan Corrective Actions for Resident A corrective action was taken to the care plan for Resident #15 c 04/17/19. The Minimum Data S revised resident s care plan in it may accurately reflect episode refusal/rejection of care. This w completed on 04/17/19. Corrective Action for Resident # A corrective action was taken to the care plan for Resident # A corrective action for Resident # A corrective action for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken to the care plan for Resident # A corrective action was taken t	 a to and do a to and do b to and do c has taken in this correction tion of d will be nsive Care #15. b correct con Set nurse order that es of vas # 39. b correct con Set nurse of correct con Set nurse of correct on Set nurse of ining 	

Facility ID: 923117

If continuation sheet Page 14 of 33

		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVI 0. 0938-03
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345216	B. WING		04	C //18/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				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	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 656	Continued From pag	e 14	F 6	56		
	1 0			requires 2 staff member	rs for transfers.	
	A review of Resident	#15's Nursing Assistant (NA)		This was done to ensur		
		nentation from 3/16/19		communication of this in	•	
		cated she had refused a		so that this intervention		
		ath on 9 of 32 days (3/25/19,		implemented. This was	s completed on	
		/19, 4/7/19, 4/8/19, and		05/02/19.		
	4/12/19).			Corrective Action for Re		
	A review of Desident	#1E's active core plan was		A corrective action was		
		#15's active care plan was 9. This care plan had not		the care plan for Reside The Minimum Data Set		
		#15's refusals of care.		resident⊡s care plan by		
				CNA s stating that resi		
	An interview was cor	nducted with the Director of		of a gait belt for transfe	-	
	- · ·	17/19 at 11:40 AM. She		to ensure adequate cor		
		5 had no care plan in place		intervention to staff so t		
		tion of care. She stated that		intervention may be full		
		IDS Nurses' responsibility to		This was completed on		
		to address rejection of care. a resident rejected care once		Corrective Action for Re A corrective action was		
		not have expected a care		the care plan for Reside		
		address this issue. The		05/02/19. The Minimur		
		ince Resident #15 had a		revised resident s care		
	-	nedication refusals that she		tasks to the CNA⊡s to g		
	expected a care plan	n to be in place that		use of splint. This was		
	addressed these refu	usals.		adequate communication		
	A internet			intervention to staff so t		
		nducted with MDS Nurse #1		intervention may be full	• •	
		AM. She verified Resident that addressed rejection of		This was completed on	00/02/19.	
		it she had been unaware		Corrective action for res	sidents with the	
	Resident #15 had a p			potential to be affected		
	•	personal care. She reported		deficient practice.	,	
		o develop a care plan to		All residents have the p	otential to be	
	address Resident #1	5's refusals of care.		affected by the alleged A 100% audit of all curr		
				care plans was complet the Regional Minimum	-	
		admitted to the facility on		Consultant. This audit		
	4/26/17 with diagnos	es that included chronic		that each resident has a	a comprehensive	

Facility ID: 923117

If continuation sheet Page 15 of 33

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		ATE SURVEY
	OURICEONON	IDENTIFICATION NOMBER.	A. BUILDING	G		
		245240	B WINC			С
		345216	B. WING			04/18/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WESTFIEI	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 DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 15	F 65	56		
		sia, history of cerebral		care plan that addresses	his/her needs.	
		alling, and unspecified		risks, goals, and appropri		
	convulsions.			interventions.		
				" Audit results: 7 of 77		
	The quarterly Minimu	· · · · · · · · · · · · · · · · · · ·		identified with incomplete		
		2/18/18 indicated Resident		These 7 resident care pla	•	
		moderately impaired. She		to include all required iter		
	required the extensive	e assistance of 2 for		completed on 05/07/19 by	, 0	
	transfers.			Minimum Data Set Consu	iltant.	
	Booidont #20 ' a coro	plan included the feaus		Systemic Changes	Minimum Data	
		plan included the focus Daily Living (ADL) self-care		On 05/06/19 the Regiona Set Nurse Consultant pro		
	-	elated to activity intolerance		education to the facility M		
		The interventions included,		Nurses on Comprehensiv		
		assistance of 2 people for		This education included t		
	transfers (initiated on			ensuring that each reside		
		,		addressed actual problen		
	An incident report dat	ted 3/2/19 completed by		resident strengths and pro	eferences. The	
		esident #39 had a witnessed		education emphasized th	at the care plan	
		3/2/19 at 4:39 PM. Nursing		must communicate the re		
		tified Nurse #4 that Resident		condition, needs, and pre		
		NA #7 reported that she		staff. Therefore, the care		
	-	dent #39, her bed was		ongoing revisions and up		
		d rolled causing her to be		resident s condition char	-	
	lowered to the floor b	resident. Resident #39 was		educational material inclu importance of ensuring th		
		y Ν/ τ.		interventions are commun		
	A review of the fall in	vestigation dated 3/4/19		and other appropriate sta		
		ector of Nursing (DON)		order to ensure that these		
		reviewed and it was noted		are implemented timely a		
	that the bed was not	locked prior to transferring		Also on 05/03/19, educat		
		air to bed. Staff were to		Nurses, CNAs and Med.	Tech□s/Med.	
	ensure that the bed w	-		Aides was initiated in ord		
	transferring Resident	#39 with a 2 person assist.		understanding of how to a		
				importance of reviewing e		
	-	is attempted with NA #7 on		Kardex and Tasks prior to		
		nd on 4/17/19 at 8:32 AM.		It emphasized the importa	-	
	She was unable to be	e reached.		that the care plan is follow	veu anu mat	

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 16 of 33

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	· · ·	IO. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	IPLETED
		345216	B. WING			С
	ROVIDER OR SUPPLIER	545210		STREET ADDRESS, CITY, STATE, ZIP		4/18/2019
				3100 TRAMWAY ROAD	SODE	
WESTFIEL	D REHABILITATION AN	D 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 656	Continued From page	2 16	F 65			
1 000		is conducted with Nurse #4	FUC	prescribed. This educatio	n also included	
		A. The 3/2/19 incident report		instructions on how to view		
		reviewed with Nurse #4.		well as how to view Tasks		
		A #7 was in Resident #39 ' s		on tasks. This education		
	room without another	NA present on 3/2/19 when		the Director of Nursing and	• •	
	she was notified of th	e assisted fall that occurred		Managers and will be com		
	during a transfer.			Nurses, CNA s and Med.		
				Aides no later than 05/09/		
1		ducted with the DON on		This information has been	-	
		The 3/2/19 incident report		the standard orientation tra		
		the investigation dated with the DON. She stated		Minimum Data Set Nurses CNA s and Med. Tech s		
		to recall with certainty if it		Monitoring Procedure to e		
		uring the investigation that		plan of correction is effect		
		ng Resident #39 without		specific deficiency cited re		
		tance. She indicated that		and/or in compliance with		
		on she was so focused on		requirements.	0 ,	
	the resident 's bed be	eing unlocked during the		The Director of Nursing or	designated	
		have not realized that the		Nurse Manager will condu		
		rson assist for transfers was		ensure that resident care		
		ne DON stated that she		completed, updated/revise		
	expected the care pla			conditions change, and the		
	implemented at all tin			interventions are being im	•	
	3. Resident #7 was a	s of Rheumatoid Arthritis,		the appropriate staff mem the following Quality Assu		
	contractures and Kyp			Tools: Care Plan Audit Too		
	contractures and typ			Communication and Imple		
	Resident #7's annual	Minimum Data Set (MDS)		Interventions Audit Tool.		
		ed she was cognitively intact		be completed weekly for 4		
		aviors. She was coded for		monthly for 6 months or u		
		with transfers and toileting.		compliance has been achi	•	
	Resident #7 was code	ed as having no falls.		will be presented to the we		
				Assurance committee by t		
		7's fall care plan last revised		Nursing to ensure correcti		
		intervention of a gait belt		initiated as appropriate. C		
		transfers originally initiated		be monitored and ongoing		
	1/10/14.			program reviewed at the w		
	Review of Resident #			Assurance Meeting. The v		

Facility ID: 923117

If continuation sheet Page 17 of 33

STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED	
		345216	B. WING				
	ROVIDER OR SUPPLIER	545216		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	18/2019	
	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 SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE	
F 656	Kardex the nursing as indicated the required Review of a facility in at 7:30 PM, read NA #7 to the bathroom w out. The Interdisciplin 3/29/19 read the staff ambulation and trans During an interview o Resident #7 stated th belt during her fall on stated she was not in 3/26/19. During an interview o Director of Nursing (D aware that the gait be since 1/10/14. During an interview o stated she was assig of 3/26/19 and recalle was aware that Resid using a gait belt beca computerized Kardex During an interview o stated the gait be aides would know to with the use of a gait of a gait belt was initic computerized Kardex	ssistants (NA) utilized d a gait belt for transfers. cident report dated 3/26/19 #8 was transferring Resident then the resident's legs gave hary Team note dated f were to use a gait belt for ferring to the toilet. In 4/16/19 at 1:40 PM, the staff were not using a gait 3/26/19. Resident #7 jured during the fall on In 4/16/19 at 1:46 PM, the DON) stated she was not elt had been an intervention In 4/16/19 at 3:15 PM, NA #8 ned Resident #7 the evening ed her fall. She stated she dent #7 was to be transferred tuse it was on her to a from the care plan except It had to be initiated so the only transfer Resident #7 belt. She confirmed the use ated and it appeared on the to sible to the aides.	F 65	Administrator, Director of Nursir Minimum Data Set Coordinator, Health Information Manager, an Dietary Manager. The title of the person responsit implementing the plan of correct Nursing is responsible for imple and completion of the acceptabl correction. Completion date: 05/09/2019	Therapy, d the ole for tion. or of mentation		
	-	iew on 4/18/19 at 8:27 AM, s her expectation that the					

		ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 05/21/2019 ORM APPROVED INO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345216	B. WING				C 04/18/2019
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIEI	D REHABILITATION AN	D HEALTH CENTER					
				5/	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 18	F	356			
	aides follow the care	plan and Kardex intervention r Resident #7's transfers.					
	facility on 8/3/17 with hemiplegia and hemi infarction affecting the quarterly Minimum Di dated 2/24/19 indicat cognition was intact a range of motion on ou further indicated that rejection of care. Resident #25' care pl reviewed. One of the Resident #25 had act self - care deficit and assistance of 2 perso right hemiplegia. The wear right upper extra hand splint every mot (added on 3/8/19). T	e care plan problems was tivities of daily living (ADL) she required extensive ons for toileting related to e approaches included to emity (RUE) modified resting rning for up to 6-8 hours he care plan did not indicate					
Resident #2 2019 were r that Resider	Resident #25 nurse's 2019 were reviewed.	d refused to wear the splint. notes for March and April The notes did not indicate d refused to wear the splint. M Resident #25 was					
	observed up in wheel wrist was contracted splint. She had a han observed. On the wa	Ichair in her room. Her right and she was not wearing a id roll on her right hand when all, there was an instruction RUE resting hand splint.					
	#25 was again obser	AM and 1:44 PM, Resident ved up in wheelchair in her was contracted and she					

Facility ID: 923117

If continuation sheet Page 19 of 33

		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345216	B. WING		0	C 4/18/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	
WESTFIEI	LD REHABILITATION AN	ID 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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From page	e 19	F 656			
	was not wearing a sp have a hand roll on h	lint. She was observed to er right hand.				
	interviewed. NA #1 s working at the facility	M, Nurse Aide (NA) #1 was stated that she started as a NA in August 2018.				
	#25. NA #1 reported wear a splint on her r was discontinued and	e was assigned to Resident that Resident #25 used to right arm but she thought it d was replaced with a hand she didn't know as to when tinued.				
	supposed to have a s Nurse #1 reviewed th Resident #25 was su applied at 6 AM even removed after 6-8 ho tolerated it. Nurse #7 NA was supposed to nurse to check behin check the splint this r not. The Nurse did n	ed that Resident #25 was splint on her right hand. he MAR and verified that pposed to have a splint y morning and it should be urs or until the resident 1 further indicated that the apply the splint and the d. She stated that she didn't morning if it was applied or not indicate that Resident #25				
F 000	(DON) was interview she expected nursing intervention/approact splint as care planned	M, the Director of Nursing ed. The DON stated that g to follow the n for the application of the d.				
F 688 SS=D	Increase/Prevent Dec CFR(s): 483.25(c)(1)	crease in ROM/Mobility -(3)	F 688			5/15/19
	§483.25(c) Mobility. §483.25(c)(1) The fac resident who enters t	cility must ensure that a				

Facility ID: 923117

If continuation sheet Page 20 of 33

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/21/2019 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345216	B. WING _				/18/2019
NAME OF P	ROVIDER OR SUPPLIER		1	SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER			100 TRAMWAY ROAD ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 688	range of motion unless condition demonstrate of motion is unavoida §483.25(c)(2) A reside motion receives appro- services to increase r prevent further decrea §483.25(c)(3) A reside receives appropriate s assistance to maintain the maximum practica reduction in mobility is This REQUIREMENT by: Based on record revi- resident and staff inte apply the splint as ord residents reviewed fo motion (Resident #25 Findings included: Resident #25 was origon 8/3/17 with multiple hemiplegia and hemip infarction affecting the quarterly Minimum Da dated 2/24/19 indicate cognition was intact ar range of motion on or further indicated that rejection of care. The Occupational The reviewed. The OT no	not experience reduction in as the resident's clinical es that a reduction in range ble; and ent with limited range of opriate treatment and ange of motion and/or to ase in range of motion. ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable. is not met as evidenced ew, observation and rview, the facility failed to dered for 1 of 4 sampled r limitation in range of).	F	588	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correction compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to apply splints to residents with contractures as ordered 1. Corrective action for resident(s) affer by the alleged deficient practice:	al aken on ne	

Facility ID: 923117

If continuation sheet Page 21 of 33

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/21/2019 RM APPROVED O. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345216	B. WING		04	C 4/18/2019
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
				3100 TRAMWAY ROAD		
WESTFIEL	D REHABILITATION AN	D 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 688	Continued From page	a 91	F 68	00		
1 000			F OC	56		
		the right forearm and right		For regident # 25 servestive	action was	
		ndation upon discharge was /ear the right upper extremity		For resident # 25 corrective obtained on 4/18/19.	action was	
		plint to prevent further		On 4/18/19 the Director of N	Ureae	
		ontracture management.		directed nursing staff to follo		
				physician s order for the RL		
	Resident #25 had a p	physician's order dated		hand splint and audited that	•	
		E modified resting hand		been applied as ordered for		
	splint every morning	for up to 6-8 hours.		The MDS Coordinator review	ved the	
				resident⊡s Kardex on 5/1/1	9 and audited	
	Resident #25' care pl			to assure the application of t	he splint was	
		e care plan problems was		in place.		
		tivities of daily living (ADL)				
		she required extensive		2.Corrective action for reside		
	-	ons for toileting related to		potential to be affected by th	e alleged	
		e approaches included to		deficient practice:		
		emity (RUE) modified resting rning for up to 6-8 hours		On 5/3/19 the Director of Nu	rees audited	
		he care plan did not indicate		all current residents with ord		
		d refused to wear the splint.		to assure that all ordered sp		
				being applied as ordered. Th		
	Resident #25 Medica	tion Administration Records		Coordinator audited all curre		
	(MAR) for April, 2019	was reviewed. The MAR		with ordered splints to ensur	e that all	
	revealed that the RU	E resting hand splint had		splints were indicated on the	kardex.	
	been applied every d	ay at 6 AM.		One other resident was affect	cted and the	
				kardex was corrected to refle	ect splint	
		notes for March and April		application on 5/3/19.		
		The notes did not indicate				
		d refused to wear the splint.		3.Measures /Systemic chang reoccurrence of alleged defin		
	On 4/15/19 at 3:29 P					
	-	Ichair in her room. Her right		On 4/30/19, the Director of N	•	
		and she was not wearing a		education of all full time, par		
	observed.	d roll on her right hand when		needed nurses and certified assistants on splint application	•	
		is an instruction on how to		the kardex. The in-servicing		
	apply the RUE resting			completed by 5/15/19 at whi		
				nurses and certified nursing		
	On 4/16/19 at 10:05	AM and 1:44 PM, Resident		in-serviced prior to working.		

Facility ID: 923117

If continuation sheet Page 22 of 33

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/21/201 RM APPROVE IO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY IPLETED
		345216	B. WING		0,	C 4/18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
WEGTEIEI				3100 TRAMWAY ROAD		
WESTFIEL	D 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 688	room. Her right wrist was not wearing a sp have a hand roll on h On 4/16/19 at 1:45 Pl interviewed. NA#1 s working at the facility She indicated that sh #25. NA #1 reported f wear a splint on her r was discontinued and roll. She added that s was discontinued. On 4/16/19 at 4:58 Pl interviewed. She stat supposed to have a s Nurse #1 reviewed th Resident #25 was su applied at 6 AM every removed after 6-8 ho tolerated it. Nurse #1 NA was supposed to nurse to check behind check the splint this r not. The Nurse did n was refusing to wear On 4/17/19 at 8:50 Al observed up in wheel wearing a RUE restin She stated that the st the splint for a while u On 4/18/19 at 8:34 Al	ved up in wheelchair in her a was contracted and she blint. She was observed to her right hand. M, Nurse Aide (NA) #1 was stated that she started as a NA in August 2018. We was assigned to Resident that Resident #25 used to right arm but she thought it d was replaced with a hand she didn't know as to when it M, Nurse #1 was ed that Resident #25 was splint on her right hand. We MAR and verified that pposed to have a splint y morning and it should be urs or until the resident 1 further indicated that the apply the splint and the d. She stated that she didn't morning if it was applied or not indicate that Resident #25 the splint.	F 68		and that and that ains corrected gulatory nonitor at Application dy x 2 weeks e Director of ents with liance with entation of ses or a residents random days ends) to will be lity Director of action is upliance will g auditing ekly Quality ekly QA dministrator, ordinator, formation anager.	
	she expected nursing	g to apply the splint as nent if the resident was				

Facility ID: 923117

If continuation sheet Page 23 of 33

STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345216	B. WING			04	04/18/2019	
	ROVIDER OR SUPPLIER	D HEALTH CENTER	1	31	TREET ADDRESS, CITY, STATE, ZIP CODE 00 TRAMWAY ROAD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688 F 689 SS=D	Continued From page refusing to wear the s Free of Accident Haz CFR(s): 483.25(d)(1)	splint. ards/Supervision/Devices		688 689			5/15/19	
	as free of accident ha §483.25(d)(2)Each re- supervision and assis accidents. This REQUIREMENT by: Based on record rev staff interview, the fac- interventions for trans- injury (Residents #39) reviewed for accident The findings included 1. Resident #39 was 4/26/17 with diagnose kidney disease, apha infarction, history of fa- convulsions. The quarterly Minimu assessment dated 12 #39 's cognition was required the extensive transfers. Resident #39 's care area of an Activity of performance deficit re-	ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent ⁻ is not met as evidenced iew, resident interview, and cility failed to implement the sfers resulting in falls without and #7) for 2 of 3 residents ts. : admitted to the facility on es that included chronic sia, history of cerebral alling, and unspecified im Data Set (MDS) 2/18/18 indicated Resident moderately impaired. She			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tak or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to implement the interventions for transfers resulting in fawithout injury.	l ken n e		

Facility ID: 923117

					0(0) 5	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
						С
		345216	B. WING			04/18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WESTFIELD REHABILITATION AND HEALTH CENTER				3100 TRAMWAY ROAD SANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	> 24	F 689			
F 009	Continued From page 24 in part, the extensive assistance of 2 people for transfers (initiated on 1/10/19). An incident report dated 3/2/19 completed by Nurse #4 indicated Resident #39 had a witnessed fall with no injury on 3/2/19 at 4:39 PM. Nursing Assistant (NA) #7 notified Nurse #4 that Resident #39 was on the floor. NA #7 reported that she was transferring Resident #39, her bed was unlocked, and the bed rolled causing her to be unable to support the resident. Resident #39 was lowered to the floor by NA #7. A review of the fall investigation dated 3/4/19 completed by the Director of Nursing (DON) indicated this 3/2/19 fall was reviewed and it was noted that the resident's bed was not locked prior to transferring Resident #39 from chair to bed. Staff were to ensure that the bed was locked prior to transferring Resident #39 with a 2 person assist. A phone interview was attempted with NA #7 on 4/16/19 at 1:32 PM and on 4/17/19 at 8:32 AM. She was unable to be reached. A phone interview was conducted with Nurse #4 on 4/16/19 at 4:35 PM. The 3/2/19 incident report for Resident #39 was reviewed with Nurse #4. She indicated that NA #7 was in Resident #39 's room without another NA present on 3/2/19 when she was notified of the assisted fall that occurred during a transfer. An interview was conducted with the DON on 4/17/19 at 12:05 PM. The 3/2/19 incident report for Resident #39 and the investigation dated		F 685	For resident # 7 corrective ac obtained on 4/18/19. The Director of Nurses obtain individual gait belt for residen to be maintained at the reside for use with staff transfers on 4/18/19 Nursing Assistant #8 5 were educated regarding pl the gait belt at the resident use with the resident transfer 4/8/19 the DON observed at demonstration of a gait belt tr nursing assistant #8. The gait was done correctly with Resid For resident #39 corrective ac obtained on 4/18/19. Nursing Assistant # 7 was ed the Director of Nurses on utili resident kardex to assure tha appropriate resident transfer used and that beds are in loc prior to initiating a transfer. N	and an t # 7 that is ent⊡ bedside 4/18/19. On and Nurse # acement of bedside for ers. On return ansfer by t belt transfer dent #7 ction was ucated by zation of the t the technique is ked position	
				 assistant #7 was observed by of Nurses and performed a redemonstration for compliance adherence to the kardex ident technique and locking of the linitiating a transfer on 04/18/2 2.Corrective action for resider potential to be affected by the deficient practice: On 05/02/19 the MDS Coordiall current residents to ensure transfer techniques were accident techniques were accident techniques and techniques and techniques and techniques were accident techniques were acc	e the Director eturn e with tified transfer bed prior to 19. Ints with the e alleged Inator audited e that all	

Facility ID: 923117

If continuation sheet Page 25 of 33

		ND HUMAN SERVICES MEDICAID SERVICES			FORM AF OMB NO. 0	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	RVEY
		345216	B. WING		C 04/18/	2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				3100 TRAMWAY ROAD		
WESTFIEI	LD REHABILITATION AN	ND 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE C THE APPROPRIATE	(X5) OMPLETIC DATE
F 689	Continued From pag	ie 25	F 6	80		
1 000					an and Kardov	
		during the investigation that ng Resident #39 without		place on both the care pla and the remaining eight re		
		stance. She indicated that		corrected on the care plan		
		ion she was so focused on		5/2/19.		
		being unlocked during the		As of 5/3/19 each nursing	assistant began	
		y not have realized that the		receiving a gait belt from		
		erson assist for transfers was		nurse for use with resider	U U	
		The DON stated that she		their shift. The gait belt is		
		an interventions to be		to the nurse at the end of		
		mes to reduce the risk of		shift and documented on	the Gait Belt log	
	falls.			to assure gait belts are av	ailable for use	
	2. Resident #7 was a	admitted 1/16/14 with		and being utilized by staff	the end of the	
	cumulative diagnose	es of Rheumatoid Arthritis,		shift and assigneAll had the		
	contractures and Ky	phosis.		intervention in place on be	oth the care plan	
				and kardex.		
		I Minimum Data Set dated		On 5/1/19 the facility Mair		
		e was cognitively intact and		Director audited all facility		
		ors. She was coded for		that the locking mechanis		
		e with transfers and toileting.		wheels of each bed was f	U U	
	Resident #7 was cou	ded as having no falls.		properly. Results: One bra replaced and all others we		
	Review of Resident :	#7's fall care plan last revised		functioning.		
		e intervention of a gait belt		3.Measures /Systemic cha	anges to prevent	
	was to be utilized for	-		reoccurrence of alleged d		
				On 5/2/19, the Director of	-	
	Review of Resident	#7's undated computerized		education of all full time, p	-	
		assistants (NA) utilized		needed nurses and certifi		
		d a gait belt for transfers.		assistants on Safe Reside	•	
				The education is to includ	le: accessing the	
	-	ncident report dated 3/26/19		kardex for assessed trans		
		#8 was transferring Resident		performance of the asses		
		when the resident's legs gave		method, assuring bed is in		
		nary Team note dated		prior to initiating a transfe		
		ff were to use a gait belt for		belts with resident transfe		
	ambulation and trans	sterring to the toilet.		how/where to obtain a gai		
				during an assigned shift.		
	-	on 4/16/19 at 1:40 PM,		will be completed by 5/15		
		he staff were not using a gait		all nurses and certified nu	-	
	beit during her fall or	n 3/26/19. She stated earlier		must be in-serviced prior	to working.	

Facility ID: 923117

If continuation sheet Page 26 of 33

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/21/2 FORM APPRO OMB NO. 0938-0	VED
STATEMENT (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345216	B. WING		C 04/18/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WEATELE			:	3100 TRAMWAY ROAD		
WESTFIE	LD REHABILITATION AN	D HEALTH CENTER		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	TION
F 689	taking her to the bath been using one. Res injured during the fall During an interview o Director of Nursing (E aware that the gait be since 1/10/14. She s position of DON and o who required the use She stated she would a gait belt in their roo practice was to have medication cart for sta During an interview o stated she was assign of 3/26/19 and recalle was aware that Resid using a gait belt, but s belt and could not find or at the nursing stati was not aware that the to be keep on the nur During an interview o stated Resident #7 w bathroom with one-pe walker. She stated sh belt when transferring could not always loca medication cart or at stated the nurse's and gait belts were not alw During an interview o #5 stated she did not	did use the gait belt while room, but the staff had not ident #7 stated she was not on 3/26/19. In 4/16/19 at 1:46 PM, the DON) stated she was not elt had been an intervention tated she recently took the only knew of a few residents of a gait belt with transfers. I like those residents to have ms, but it was the facility a gait belt on the nurse aff to use as needed. In 4/16/19 at 3:15 PM, NA #8 ned Resident #7 the evening ed her fall. She stated she lent #7 was to be transferred she lost her personal gait d one in Resident #7's room on to use. She stated she use gait belts were supposed se medication cart. In 4/17/19 at 8:50 AM, NA #5 as able to ambulate to the erson assistance and her use did not always use a gait g Resident #7 because she the a gait belt on the nurse the nursing station. NA #5 d the DON were aware that ways readily available. In 4/17/19 at 8:50 AM, Nurse have a gait belt on her hey were to be left at the	F 689	The Maintenance Director will mon locks on a weekly basis and or as r basis. Information will be document TELS system. 4.Monitoring Procedure to ensure t plan of correction is effective and th specific deficiency cited remains co and or/in compliance with regulator requirements: The Director of Nurses will monitor compliance utilizing the Safe Trans Quality Assurance Tool weekly x 2 then monthly x 3 months. The Dire Nurses or Support Nurse will obser residents weekly on random shifts a random days of the week(to include weekends) to assure compliance. F will be presented to the weekly Qua Assurance committee by the Direct Nurses to ensure corrective action initiated as appropriate. Complianc be monitored and the ongoing audi program reviewed at the weekly Qu Assurance Meeting. The	heeded ted in hat the hat prrected y fer weeks ector of ve 3 and e Reports ality tor of is e will ting uality A trator, tor, on	

If continuation sheet Page 27 of 33

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MUUT				NO. 0938-039
IND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345216	B. WING				C 04/18/2019
NAME OF PROVIDER OR SUPPLIER				STREE	ET ADDRESS, CITY, STATE, ZIP COL	DE	
VESTFIEL	D REHABILITATION AN	D HEALTH CENTER		3100 1	FRAMWAY ROAD		
				SANF	ORD, 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) COMPLETION DATE
F 689	Continued From page	e 27	F6	89			
	9:00 AM did not revea gait belt. Observation bathroom in her prese	Irsing station on 4/17/19 at al any visible evidence of a of Resident #7's room and ence on 4/17/19 at 9:05 AM ible evidence of a gait belt.					
	Resident #7 confirme belt anywhere in her	d she did not have a gait room.					
	the DON stated it was Resident #7 be transf further stated she wo issued a gait belt on h should be replaced at employee. The DON not their policy and the	stated at present, this was the gait belt were supposed to					
F 727 SS=B	the nursing station. T	Full Time DON	F 7	27			5/15/19
	must use the services						
		f this section, the facility istered nurse to serve as the					
	as a charge nurse on	ector of nursing may serve ly when the facility has an ncy of 60 or fewer residents.					

Facility ID: 923117

If continuation sheet Page 28 of 33

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/21/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345216	B. WING		04/18/2019
	NAME OF PROVIDER OR SUPPLIER WESTFIELD REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP 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 ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 727	by: Based on staff interv facility failed to staff F coverage for 8 conse days reviewed for RN 4/5/19, 4/8/19, 4/10/1 The findings included Review of the daily st RN coverage on 4/1/7 (census of 71, 4/5/19 (census of 70) and 4/ During an interview o Director of Nursing (E the impression that sl (MDS) Nurse could si consecutive hour RN question. She stated that the DON could o resident census of 60 stated it was her expendence hours of consecutive	is not met as evidenced iews and record review, the Registered Nurse (RN) cutive hours daily for 7 of 15 I coverage (4/1/19, 4/3/19, 9, 4/12/19 and 4/15/19).	F 7	 The statements made on correction are not an adm not constitute an agreeme alleged deficiencies. To remain in compliance v and state regulations the f or will take the actions set plan of correction. The plat constitutes the facilities all compliance such that all a deficiencies cited have be corrected by the dates ind F727 The plan of correcting the deficiency. The plan shoul processes that lead to the cited: The plan of correcting the deficiency. The plan shoul processes that lead to the cited: The plan of correcting the deficiency. The plan shoul processes that lead to the cited: The facility failed to staff F Nurse coverage for 8 const daily. 1. Corrective action for rest affected by the alleged de At least eight consecutive registered nurse staffing with maintained daily by 5/16/1 Corrective action for rest potential to be affected by the alleged by the alleged the formation of the consecutive hours of regists at ffing was in place daily. 	A specific address the address the addres

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 29 of 33

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/21/2019 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
	345216 B. WING			04	C 4/18/2019		
	NAME OF PROVIDER OR SUPPLIER			310	REET ADDRESS, CITY, STATE, ZIP CODE 00 TRAMWAY ROAD ANFORD, NC 27330	1 •	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 727	Continued From page	≥ 29	F7	727	at least 8 consecutive hours of regist nurse hours in place. An on call proot to maintain At least eight consecutive hours of registered nurse staffing wil maintained daily by 5/16/19 and an op process to maintain eight consecutive hours of registered nurse staffing dat and use of a contracted agency for registered nurses will be developed at use by 5/16/19. 3. Measures/Systemic changes to pr reoccurrence of alleged deficient pration 0n 5/3/19, the Nurse Consultant edu the Administrator and DON on the requirement of the facility to staff RN coverage for at least 8 consecutive for daily. Coverage by a Registered Nur at least eight consecutive hours will 1 maintained by 5/16/19. 4. Monitoring Procedure to ensure the plan of correction is effective and that specific deficiency cited remains corr and/or in compliance with regulatory requirements. The DON will monitor compliance util the F272 Quality Assurance Tool weat for staffing of registered nurse hours x 2 weeks, then monthly x 3 months. DON will monitor staffing for complia with the requirement for at least 8 ho or registered nurse hours daily x 2 w then monthly x 3 months. The DON will monitor staffing for compliance with requirement for at least 8 ho or registered nurse hours daily x 2 w then monthly x 3 months. The DON to ensure corrective action is initiated at appropriate. Compliance will be mont	ess elbe on call ely and in event ctice: icated nours se for be at the trected lizing ekly daily The nce urs eeks, will he rts will	

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 30 of 33

		ND HUMAN SERVICES			PRINTED: 05/21/20 FORM APPROV OMB NO. 0938-03
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
345216		345216	B. WING		04/18/2019
AME OF P	ROVIDER OR SUPPLIER	1	S	IREET ADDRESS, CITY, STATE, ZIP CODE	
ESTFIE	LD REHABILITATION AN	ID HEALTH CENTER	-	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIC
F 727	Continued From page 30		F 727	and the ongoing auditing program reviewed at the weekly Quality Assura Meeting. The weekly QA meeting is attended by the Administrator, Directo Nursing, MDS Coordinator, Rehab Manager, Health Information Manager and the Dietary Manager.	r of
F 730 SS=C		eview-12 hr/yr In-Service	F 730	and the Dictory Manager.	5/15/19
	The facility must com of every nurse aide a months, and must pro- education based on t reviews. In-service to requirements of §483 This REQUIREMENT by: Based on staff and fa interviews and record provide Nursing Assis dementia training. The 4/27/17, NA #3 hire of 6/15/17 and NA #6 hi NA's reviewed for an findings included During an interview of facility Nurse Consult evidence of any dem who received the trai	ovide regular in-service the outcome of these raining must comply with the 3.95(g). Γ is not met as evidenced acility Nurse Consultant d review, the facility failed to stant (NA) required annual his was for 4 (NA #2 hire date late 10/4/16, NA #5 hire date ire date 6/3/14) of 5 sampled nual dementia training. The on 4/17/19 at 1:53 PM, the tant stated there was no entia training but for NA #4 ning January 2019. She		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correcti constitutes the facility a llegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F730 The plan of correcting the specific deficiency. The plan should address the facility and the state of the state	al aken on
	training for all staff in staff would have the than July 2019. She t	ently added dementia January 2019 and that all dementia training no later further stated it was her receive dementia training		deficiency. The plan should address th processes that lead to the deficiency cited: The facility failed to provide nursing assistant annual dementia training.	ne

Facility ID: 923117

If continuation sheet Page 31 of 33

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/21/2019 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216		B. WING		C 04/18/2019
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 730	during orientation and During an interview o	d annually. on 4/18/19 at 8:27 AM the tated it was her expectation	F 7		lent(s) affected ctice: and 6 ng as of dents with the he alleged urses audited nitor for entia training. were in nges to prevent ficient practice: lurses began time, part time istants. All blete Dementia time all in-serviced ensure that the e and that nains corrected egulatory monitor mentia Training ekly x 2 weeks he Director of

Event ID: M7MY11

Facility ID: 923117

If continuation sheet Page 32 of 33

		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/21/2019 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		345216	B. WING				C 04/18/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
WESTFIELD REHABILITATION AND HEALTH CENTER				3100 TR	AMWAY ROAD		
WESTFIE	LD REHADILITATION AN	ND HEALTH CENTER		SANFO	DRD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 730	Continued From pag	e 32	F	pre Ass Nur initi be pro Ass Me Dire The	nual Dementia training. Repo sented to the weekly Quality surance committee by the Dir rses to ensure corrective acti- iated as appropriate. Complia monitored and the ongoing a gram reviewed at the weekly surance Meeting. The weekly eting is attended by the Admi ector of Nursing, MDS Coord erapy Manager, Health Inforn nager, and the Dietary Mana	rector of on is ance will uditing v Quality v QA inistrator, linator, nation	

Facility ID: 923117

If continuation sheet Page 33 of 33