STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Hills Nursing and Rehabilitation Center	1016 Fletcher Street Wilkesboro, NC 28697

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review and staff interviews the facility failed to ensure a residents (Resident #92) code status election was accurate throughout the medical record for 1 of 1 residents reviewed for advance directives. The findings included: Resident #92 was admitted to the facility on [DATE]. A significant change Minimum Data Set (MDS) dated [DATE] revealed that Resident #92 was severely cognitively impaired. A care plan last revised on 07/16/24 read: End of Life/Advance Directive and contained the following interventions Cardio-pulmonary resuscitation/Full Code. A physician order dated 08/12/24 read: Do Not Resuscitate (DNR). Nurse #1 was interviewed on 08/21/24 at 9:17 AM. She stated that code status election was done upon admission with the resident and family and then discussed at each care plan meeting. If the resident or family wished to change the advance directive then she would get help from the Unit Manager (UM) at getting the new forms completed, obtaining the physician order, and updating the care plan. She stated that when she completed the quarterly care plan review, she always made sure the care plan matched what the residents/family wishes were. Nurse #1 stated that if a resident changed their code status and once the order was signed off and paperwork completed then the care plan would be updated. UM was interviewed on 08/21/24 at 3:33 PM. The UM stated that she had taken the order for Resident #92 to be a DNR on 08/12/24 and forgot to update the care plan. She stated that she must have gotten busy because normally she would update the care plan when she took the order from the provider. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 08/21/24 at 4:14 PM. She stated that Resident #92 recently changed his code status and there was several nurses that updated care plans. Generally, when the UM put the order in the system, she would update the care plan or let Nurse #1 know that the care plan needed to be updated but Resident #92 fell through the crack. The DON added that they also reviewed all new orders in the daily morning meeting but again Resident #92 fell through the crack.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review, family, staff, and Nurse Practitioner interviews the facility failed to prescribe an antibiotic that would effectively treat a urinary tract infection (Resident #29) for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #29 was admitted to the facility on [DATE] with diagnoses that included vascular dementia. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #29 was severely cognitively impaired and was frequently incontinent of bowel and bladder. A urinalysis laboratory report dated 08/17/24 indicated that Resident #29 was positive for greater than 100, 000 bacteria and the culture report attached indicated that it was resistant to Ciprofloxacin (Cipro is an antibiotic). The report was signed by the Nurse Practitioner. Resident #29's family member was interviewed on 08/18/24 at 11:55 AM. The family member stated that Resident #29 had recently had 2 falls and the staff thought she may have a urinary tract infection and the medical provider over the weekend was going to order a test to determine if she did or did not have a urinary tract infection. A physician order dated 08/19/24 read, Cipro 500 milligrams (mg) by mouth twice a day for urinary tract infection proteus for five days. Review of the Medication Administration Record (MAR) dated August 2024 revealed that Resident #29 had received the Cipro one time on 08/19/24 and twice on 08/20/24. The Unit Manager (UM) was interviewed on 08/21/24 at 8:42 AM. The UM stated that generally lab reports were automatically uploaded into the system from the lab company and the medical providers would go in and review them and then write any orders that were needed. The UM stated if she saw a lab report that had not been addressed, she would say something to the provider and have them review and address it. The UM stated that if the providers were in the facility she generally did not review the lab reports because she assumed the providers would take care of them. However, if she was aware the provider was off or not going to be in the facility then she would review them and call anything urgent to the on-call provider. The Nurse Practitioner (NP) was interviewed on 08/21/24 at 8:50 AM. The NP stated she had reviewed Resident #29's urinalysis and started her on antibiotic because the urinalysis revealed she did have a urinary tract infection, and she was symptomatic. The NP was asked to review the culture again and draw her attention to the Cipro that indicated it was resistant to the bacteria that Resident #29 had, the NP stated, that was faux pas (error or mistake) on me and I will have to change it right now because the Cipro will not help her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 08/21/24 at 4:17 PM. The DON stated that the NP had reported to her that she had prescribed the wrong antibiotic. She stated the NP had already switched Resident #29 to the correct antibiotic. The DON stated that infection preventionist checked the urinalysis reports to ensure that the correct antibiotic had been ordered and she was very meticulous and would have probably caught the error in another day or two.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record reviews, facility policy, Center for Disease Control guidance, Statewide Program for Infection Control and Epidemiology (SPICE) representative, local health department, and staff interviews the facility failed to identify the need for and implement broad based testing during a Covid-19 outbreak when the interventions implemented failed to halt transmission of Covid-19 which spread to 2 of 5 hallways (100 and 200) and affected 11 residents on the 100 hall and 1 resident on the 200 hall (Resident #97). The findings included: Guidance from the Center for Disease Control (CDC) website updated 03/18/24 read in part, Responding to a newly identified SARS-CoV-2 infected health care personnel or resident: the approach to an outbreak investigation could involve either contract tracing or a broad-based approach; however a broad based (e.g., unit, floor, or other specific area (s) of the facility) approach is preferred if all potential contracts cannot be identified or managed with contract tracing or if contact tracing fails to halt transmission. If no additional cases are identified during contract tracing or the broad-based testing, no further testing is indicated. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit (s) or facility wide every 3-7 days until there are no new cases for 14 days. Review of a facility policy titled, Infection Control Manual Appendix A: Covid 19 Infection Prevention & Control Program Guidelines last revised on 09/25/23 read in part, facilities have the option to perform outbreak testing through two approaches, contract tracing or broad-based testing. Contract tracing is the recommended method as it more definitively identifies the source and provides best quality of life; although the Administrator, Director of Nursing, and Medical Director reserve the right to utilize broad based approach. If no additional cases are identified after completion of initial serial contact tracing or the broad-based testing, no further testing is indicated. If additional cases continue to be identified and facility assesses ongoing uncontrolled transmission, strong consideration should be given to shifting to the broad-based approach if not already being performed and implement additional precautions as indicated for residents in affected areas of the facility. As a part of the broad-based approach, testing should continue on affected unit(s) or facility wide every 3-7 days until there are no new cases for 14 days. Review of a list of residents that resided on the 100 hall of the facility revealed that Resident #11, #14, #20, #39, #54, #60, #64, #65, #75, 80, and #104 all actively had COVID-19 or had recently recovered from COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's COVID-19 Outbreak testing log revealed that on 07/31/24 a newly hired Activity Employee #1 tested positive for COVID-19. The log listed the residents and staff that Activity employee #1 had close contact with which included Activity Employee #2 and #3 and Resident #22, 95, and 102. The log revealed that through frequent testing Activity Employee #1, #2, and #3 all tested positive for COVID-19. Resident #22, #95, and #102 through testing tested negative for COVID-19. Further review of the Outbreak testing log revealed that through contact tracing testing Resident #11 and #65 tested positive for COVID-19 on 08/07/24, Resident #14, and #80 tested positive on 08/09/24, Resident #64 and #104 tested positive on 08/10/24, Resident #26 and #54 tested positive on 08/12/24, Resident #60 and #75 tested positive on 08/14/24, and Resident #39 tested positive on 08/15/24. Review of a list of residents that resided on the 200-hall revealed none of the residents had or recently had Covid-19 including Resident #97. Resident #97 was readmitted to the facility on [DATE] and was sent to the emergency room (ER) on 08/19/24. He resided on the 200-hall in the facility. Review of Resident #97's ER record dated 08/19/24 read in part, SARS-CoV-2 Nucleic Acid Test was performed on 08/19/24 at 10:34 AM and was detected (positive Covid-19 test). The report further read; patient states he feels fine and people at his care facility are sick with COVID and he had some mild nasal congestion and cough with some clear sputum however that resolved. Initial blood pressure was 93/59, he was given IV fluids and increase his blood pressure to low normal and slightly tachycardic with no hypoxia on room air and a fever of 101.2 however that was prior to his blood transfusion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Infection Preventionist (IP) and the Director of Nursing (DON) were interviewed on 08/20/24 at 1:55 PM. The DON explained that the facility's recent Covid-19 outbreak started on 07/31/24 when Activity Employee #1 tested positive for Covid-19. She explained that they obtained a list of residents and staff that were in close contact with Activity Employee #1 and began testing those individuals every other day for 3 tests. The DON stated that during that time they began to get calls from family members reporting that the family member had Covid-19 and had recently visited a resident in the facility. With each call that they received they added that resident to the list of residents to be tested . So, all the residents that were added to the contact tracing list were tested every other day for a series of 3 tests. While those test were being performed, they continued to have residents and staff that were testing positive for Covid-19. The IP stated that on 07/31/24 when Activity Employee #1 tested positive for Covid-19 the facility initiated and required all staff to wear a surgical mask at all times when in the facility except when caring for a Covid-19 positive resident then the staff were instructed to wear a N95 respirator. She stated that they placed surgical masks at the reception desk if visitors wanted to wear a mask as well while visiting. The IP stated that the Covid-19 positive residents and staff resided and worked on the 100 hall and the 700 hall which was the assisted living hall within the facility so because it was contained to one hall, they did not perform broad based testing or test all residents and staff in the facility. The IP stated she had reported the outbreak to the local health department Nurse on 07/31/24 and again on 08/02/24 and she had no additional recommendations for the facility. The DON explained that the same staff that worked on the 100 hall also worked on the assisted living hall within in the facility. In addition, Resident #11 and #65 who resided on 100 hall would go and visit some of their friends that resided on the assisted living hall, so they were unsure if the Covid-19 was being spread by staff or residents, but they continued to test their growing list of contract trace residents and continued to require the staff to wear mask while working in the facility. The DON stated that they also added any symptomatic residents or staff to the list for testing as well. A phone interview was conducted with the representative from SPICE on 08/21/24 at 11:49AM who stated that the CDC guidance regarding outbreak testing was pretty clear. It stated that if contract tracing testing could not identify all individuals who had potentially been exposed or if the contract trace testing and interventions failed to halt transmission of Covid-19 then the facility should strongly consider switching to broad-based testing. The local health department Nurse was interviewed via phone on 08/21/24 at 2:25 PM. She confirmed that she had been notified of the outbreak and she had opened the outbreak case paperwork on 08/02/24. She stated she had been made aware that the outbreak had been contained to one hall and one set of staff and she stated she had instructed them to ensure staff were wearing masks and washing their hands. The Nurse stated that if the Covid-19 outbreak spread to another unit then there may be additional recommendations and of course if a resident was symptomatic, they would recommend the facility test that resident. She added that if she saw the outbreak moving to another unit or other areas of the facility, she would recommend broad based testing. The local health department Nurse was not aware of Resident #97 who resided on the 200 hall and was transferred to the local ER and tested positive for Covid-19 the same day and was also not aware the outbreak affected the residents on the assisted living hall within the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A follow up interview was conducted with the local health department Nurse via phone on 08/21/24 at 3:55 PM. She stated that she had spoken to the DON and her health director at the local health department and because Resident #97 was still at the hospital there was nothing, that the staff could do about that, and they continued to support the facilities contract tracing testing at this time and had no additional or new recommendations. She again stated she had been kept informed of the outbreak and had no other recommendations at this time. A follow up interview was conducted with the DON and the Administrator on 08/21/24 at 4:21 PM. The DON stated that they had not considered broad based testing because the outbreak seems like it is fizzing out. If the local health department Nurse would have recommended it, we would have done it. The DON stated that Resident #97 has had no symptoms and that was why he was not tested in the facility. She stated that when they tested the residents' that remained on the contact tracing list on Sunday 08/18/24 everyone that was tested was negative. The Administrator stated that they could not mandate the visitors to wear a mask but did have them available to wear if they wanted to and stated that Resident #97 could have gotten Covid-19 in the ambulance ride on the way to the hospital and had also had an outside appointment on 08/02/24. The DON added that Resident #97 was in a private room and no staff had close contact for more than 15 minutes, so no residents or staff were added to the list for testing. The DON also added that the testing of the contact tracing was completed, and they would only be testing those residents that were symptomatic.