STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to obtain an order for [REDACTED].#52). Findings included: Resident #52's emergency room history and physical dated 07/06/20 revealed she required continuous oxygen at 6 liters per minute via nasal canula (O2 6L/NC) for chronic [MEDICAL CONDITION] with [MEDICAL CONDITION] and the oxygen should be continued. Resident #52 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #52's respiratory care plan dated 07/07/20 indicated she had potential for ineffective breathing pattern with interventions that included oxygen therapy and monitoring for signs and symptoms of insufficient breathing pattern, shortness of breath, and blueness of the lips. A progress notes written by the nurse practitioner dated 07/08/20, 07/09/20, 07/13/20, and 07/14/20 revealed Resident #52 was oxygen dependent. A 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #52 was cognitively intact. It further noted Resident #52 had received oxygen therapy and experienced no shortness of breath. A nurses' discharge progress note written on 07/18/20 at 09:48 AM revealed Resident #52 had been discharged on oxygen via NC. A review of the monthly physician orders [REDACTED]. A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated July 2020 revealed there were no orders for oxygen or nurse signatures of usage. An interview was conducted with Nurse Aide (NA) #3 on 08/05/20 at 3:46 PM. The NA indicated she had been aware of Resident #52's oxygen dependence. She stated she had transported Resident #52 via wheelchair outside to the family member's car for discharge and had not placed her on oxygen during the transport. She stated Resident #52 had developed shortness of breath and had been brought back into the lobby. The NA reported she left Resident #52 in the lobby while she ran back to Resident #52's room to look for her personal O2 tank. When she returned to Resident #52 two or three minutes later, her lips were pale, and the color improved after the oxygen was put on. She stated she had forgotten to report this to the nurse. An interview was conducted with Nurse #7 on 08/04/20 at 12:31 PM. The nurse revealed that she had discharged Resident #52. She recalled Resident #52 had been oxygen dependent and required continuous oxygen. Nurse #7 stated it had been after the discharge that she had been made aware of Resident #52's symptoms and that she had not been placed on oxygen during transport. Nurse #7 also explained a physician order [REDACTED]. An interview was conducted with the day shift supervisor (Nurse # 8) on 08/04/20 at 5:10 PM. Nurse #8 stated she recalled Resident #52 being oxygen dependent. Nurse #8 also revealed staff were to place an oxygen dependent resident on portable oxygen anytime they were being transported. Nurse #8 further elaborated that all residents requiring oxygen should have a physician's orders [REDACTED]. An interview with the Director of Nursing (DON) was conducted on 08/05/20 at 1:51 PM. The DON stated she was aware Resident #52 had been oxygen dependent and had required continuous oxygen but she had been unaware of any concerns at the time of discharge. The DON explained that a physician order [REDACTED]. An interview with the Administrator was conducted on 08/13/20 at 4:07 PM. The Administrator explained the discharging nurse should have ensured Resident #52's oxygen was in place, the NA should not have transported the resident without oxygen, and she should have brought the resident back to the nurse for assessment. The Administrator further explained that physician orders [REDACTED].
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observations, record review, staff interviews, review of the signage labeled Droplet Precautions and review of the facilities infection control policies, the facility staff failed to don and doff PPE (Personal Protective Equipment) per CDC guidelines for residents under transmission based precautions, failed to display Enhanced Droplet Contact Precautions signage for confirmed and possible COVID-19 exposure resident rooms, and failed to perform hand hygiene before entering or after contact with a resident or objects in a residents room who were under isolation precautions. The facility failed to develop and implement a policy for Enhanced Droplet Contact Precautions for suspected and quarantined residents. These failures in infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents in the facility through the transmission of COVID-19. A total of 37 residents were confirmed as positive for COVID-19 as of 08/03/20. Immediate Jeopardy began on 07/28/20, when the facility failed to identify residents with potential exposure of COVID-19 by not placing them on Enhanced Droplet Contact Precautions, failed to implement basic infection control practices, and failed to prevent cross over of staff from the quarantine hall to the general population. Immediate Jeopardy was removed on 08/11/20 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. The findings included: According to the facility policy titled Standard and Transmission-Based Precautions dated 03/10/20 indicated in part: Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in healthcare facilities and standard precautions are used for the care of all residents. Handwashing should be performed after touching contaminated items whether gloves are worn or not, immediately after gloves are removed, between residents, and when otherwise necessary to avoid transfer of microorganisms to other residents or the environment. Good hygiene is essential and in the absence of an outbreak either soap and water or alcohol-based sanitizer may be utilized. Gloves are to be worn when touching contaminated items. Remove gloves promptly before touching non-contaminated items and environmental surfaces and before going to another resident. It further indicated in part under the heading titled sharps that care is to be taken to prevent injuries when using needles, scalpels, and other sharp objects or devices, when handling sharp instruments after procedures, when cleaning instruments, and when disposing of needles. The policy details contact, droplet and airborne precautions, but does not address the CDC's recommended isolation precaution of Enhanced Droplet Contact Precautions for the COVID-19 pandemic. During the entrance conference on 07/28/20 at 10:45 AM, the Director of Nursing (DON) identified the 600 hall was designated as the New Admission/ Observation quarantine hall. Observations on the 600 hall on 07/28/20 began at 10:52 AM and ended at 2:20 PM and revealed Nurse #1, Nurse #2, Nurse Aide (NA) #1, NA #3, NA#6, and Housekeeper #1 were working on the facility's quarantine unit. The following observations were made: A review of the Droplet Precaution signage displayed in the 600 hall revealed a visual illustration that indicated staff were to wear a mask, perform hand hygiene before and after entering the room, and dietary was not permitted in these care areas. A review of the Contact Precaution signage displayed in the 600 hall revealed a visual illustration that indicated staff were to wear a gown and gloves, perform hand hygiene before and after entering the room, and to use single use equipment or sanitize multi-use equipment between patients. a. An observation on 07/28/20 at 10:56 AM revealed Housekeeper #1 wore a gown as she exited Resident #1's room and carried a mop, a soiled cloth, and a bottle of sanitizing spray. Signage on Resident #1's door indicated Droplet Precautions. Housekeeper #1, with her gloved hands, opened the lid of her cart using a key located on a lanyard around her neck. She placed the spray bottle in the cart, disposed of the used rag, and removed the soiled mop pad from the mop handle. Housekeeper #1 placed the mop pad in a plastic bag attached to the cart and disposed of her gloves. Housekeeper #1 then pushed her cart to Resident #2's room and did not perform hand hygiene. Resident #2's door revealed signage that indicated Droplet Precautions. When she approached

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) Resident #2's room, she donned clean gloves, picked up the bottle of disinfectant and other items from the cart and locked the cart with the key around her neck. She then entered Resident #2's room and closed the door. An interview with Housekeeper #1 on 07/28/20 at 11:38 AM revealed Housekeeper #1 had worn a gown, mask, face shield, and gloves in Resident #1's room to clean. Housekeeper #1 indicated she should have performed hand hygiene when she removed her gloves. Housekeeper #1 acknowledged she touched items on the cart with both dirty gloves and clean hands and that the cart and items should have been sanitized to prevent cross contamination and she should have performed hand hygiene, and donned clean gloves before she entered Resident #2's room. Housekeeper #1 revealed she was educated to don PPE in the front lobby and she wore her gown for the duration of her shift and was not educated to change gowns when she left the 600 hall New Admission/observation quarantine unit and went to other areas in the facility. An interview with the Housekeeping Supervisor on 08/04/20 at 1:51 PM revealed she was the Supervisor for Housekeeper #1. She stated Housekeeper #1 should have placed the items on the outside of the cart while she removed her gloves, performed hand hygiene, and donned clean gloves and wiped off the bottle of sanitizer used in Resident #1's room who was on Droplet Precautions. She stated after she sanitized the bottle, Housekeeper #1 should have removed her gloves and performed hand hygiene again before she proceeded to Resident #2's room. b. An observation on 07/28/20 at 12:23 PM revealed Nurse Aide (NA) #3 entered Resident #8's room which had signage on the door that indicated Droplet Precautions. NA #3 picked up a knife from the room and exited the room with the knife in her bare hand. NA #3 carried the knife to the 600 hall nourishment room and closed the door. NA #3 exited the nourishment room carrying the knife soiled with visual residue in her hand and walked down the hall and she entered a room labeled employees only located behind the nurses' station. NA #3 was not observed to wear gloves when she entered Resident #8's room nor while she held a contaminated knife from inside of Resident #8's room. An interview with NA #3 on 7/31/20 at 10:14 AM revealed she routinely worked the 600 New Admission/observation quarantine hall on day shift. She stated she was required to wear full PPE on that unit which included a gown, mask, and face shield, and gloves and she did not change her gown during her shift. She stated she was unaware that a resident on her unit had signage that indicated Contact Precautions and she would be required to change her PPE when she cared for that resident. She stated she changed gloves between residents but did not think she needed to don gloves when she entered to retrieve an object in Resident #8's room. She acknowledged Resident #8 was on Droplet Precautions and she should have worn gloves when in the room and performed hand hygiene when she exited Resident #8's room. She stated she should not have entered the nourishment room, or the room labeled employees only behind the nurses' station while she held the potentially contaminated knife from Resident #8's room. NA #3 acknowledged those areas should have been sanitized after she touched them because she potentially spread infection to other surfaces. NA #3 indicated she was required to assist on the adjacent 400 hall (general population) and did not change her PPE when she exited the 600 hall. She acknowledged there were no signs on the 400 hall that indicated any resident was on isolation precautions. c. An observation on 07/28/20 at 12:25 PM revealed Nurse #2 entered the room of Resident #9 and she held a medication cup in her bare hand. Resident #9's door indicated Contact Precautions. Nurse #2 administered the cup of medications then exited the room and returned to the medication cart in the hallway. Nurse #2 was not observed to don clean PPE to include a gown, gloves, mask, and face shield when she entered Resident #9's room nor doff her gown and gloves or perform hand hygiene before she returned to the medication cart. Nurse #2 spoke to Nurse #1 at the medication cart, Nurse #1 handed Nurse #2 a cup of medications and Nurse #2 left the medication cart and entered the room of Resident #10 and #11 and did not don clean PPE that included a gown, gloves, mask, and face shield. Signage on Resident #10 and #11's door indicated Droplet Precautions. Nurse #2 administered the cup of medications and exited the room and was not observed to perform hand hygiene when she exited Resident #10 and #11's room. An interview with Nurse #2 on 07/28/20 at 1:15 PM revealed she worked on the 600 hall New Admission/observation quarantine unit. Nurse #2 revealed she was required to wear full PPE when she worked on this unit that included a gown, mask, face shield, and gloves. Nurse #2 stated she thought all residents on that unit were under Droplet Precautions and she had not noticed the Contact Precaution sign before she entered Resident #9's room to administer her medications and failed to perform hand hygiene when she exited. She further revealed because she had not realized Resident #9 was on a different isolation precaution than the other residents on the unit, she had not changed her PPE after she exited Resident #9's room. d. An observation on 07/28/20 at 12:28 PM revealed Nurse #1 entered the room of Resident #12. As she entered the room, she pushed Resident #12's wheelchair out of the way with her bare hands as she approached the bed and answered the call light. Signage on Resident #12's door indicated Droplet Precautions. Nurse #1 was not observed to perform hand hygiene before she left Resident #12's room. An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed Nurse #1 admitted she had not worn gloves in Resident #12's room when she entered and moved the wheelchair out of the way while she approached the bed to see what Resident #12 needed. She stated she went in the room to answer the call light and did not think about Resident #12's Droplet Precautions. Nurse #1 revealed she entered the room and did not don gloves nor wash her hands when she left the room. e. An observation on 07/28/20 at 12:30 PM revealed Nurse Aide #6 enter the room of Resident #9 and carried a lunch meal tray with her bare hands. Signage on Resident #9's room indicated Contact Precautions. NA #6 sat the meal tray down on the overbed table and set the tray up then exited the room. NA #6 was not observed to wear gloves nor perform hand hygiene before she returned to the meal tray cart located in the hallway. At 12:33 PM, NA #6 entered the room of Resident #13 and Resident #14. Signage on the door indicated Droplet Precautions. NA #6 placed the tray on the bedside table of Resident #13 and exited the room. NA #6 was not observed to don gloves nor perform hand hygiene while she delivered a lunch meal tray to Resident #13. An interview with NA #6 on 07/31/20 at 6:54 PM revealed NA #6 worked the 600 hall New Admission/observation quarantine unit on day shift. NA #6 stated she was required to wear full PPE that included a gown, mask, and face shield always and wore gloves when she provided incontinence care. NA #6 indicated she had not change PPE during her shift and was required to wear the same gown for the duration of her shift unless it became visibly soiled. NA #6 stated she was unaware that Resident # 9's door contained signage that indicated Contact Precautions and she had not changed her PPE or perform hand hygiene when she exited the room of Resident #9 after she delivered the meal tray. NA #6 revealed she did not don gloves when she retrieved Resident #13's tray from the meal tray cart and delivered it to Resident #13. NA #6 stated she should have worn gloves and performed hand hygiene when in Resident #13's room that indicated Droplet Precautions. NA #6 indicated she was required to help on the 400 hall, but she was not educated that PPE must be changed between units. She stated she did not recall any signage on the 400 hall to indicate any resident was on isolation precautions. f. An observation on 07/28/20 at 12:35 PM revealed Nurse #2 entered the room of Resident #3 and carried a cup of medications in her bare hand. Signage on the door indicated Droplet Precautions. Nurse #2 was not observed to wear gloves or to perform hand hygiene after contact with Resident #3 during medication administration. Nurse #2 exited the room and approached Nurse #1 at the medication cart, then she obtained a box of tissues from the top of the nurses' station, and re-entered Resident #3's room as she carried the box of tissues and handed the box to Resident #3. Nurse #2 was not observed to perform hand hygiene after she exited Resident #3's room the second time. Resident #3's lab results dated 07/28/20 indicated a positive COVID-19 detected test. An interview with Nurse #2 on 07/28/20 at 1:15 PM revealed Nurse #2 stated she acknowledged Resident #3 was on Droplet Precautions, but she failed to don gloves before she entered the room or perform hand hygiene after she exited the room. She stated she should have performed hand hygiene before she touched items at the nurses' station and donned clean gloves before she returned to Resident #3's room to give her the tissues. g. An observation on 07/28/20 at 12:40 PM revealed Nurse #1 entered the room of Resident #12 and carried a glucometer, test strip, and an alcohol prep pad in her bare hands. Signage on the door indicated Droplet Precautions. She donned gloves and obtained Resident #12's blood sugar. Nurse #1 then exited the room and wore gloves on both hands, placed the glucometer on a tissue on the top of the cart. Nurse #1 then opened the drawer of the cart and obtained a pouch that held a wipe and placed the wipe over the glucometer. She then turned to the laptop on the medication cart and entered the medical record of Resident #12 as she used her right gloved hand. Nurse #1 then opened the drawer of the medication cart and retrieved a bottle of insulin and a syringe and drew the insulin in the syringe and laid the syringe on the top of the cart. She opened the drawer on the right side of the medication cart and dispensed a medication into a cup and placed the cup on top of the cart. Nurse #1 picked up the medication cup and the insulin syringe and re-entered Resident #12's room. She administered the medication and the insulin, removed and discarded her gloves, and exited the room and held the used syringe in her bare hand. She placed the insulin syringe in the sharps box on the medication cart and was observed to continue to type on the laptop. Nurse #1 was not observed to perform hand hygiene before or after contact with Resident #12. An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed she wore gloves while she obtained the blood sugar for Resident #12, but she should have removed the test strip from the glucometer, removed her gloves, and performed hand hygiene before she touched items on the medication cart. Nurse #1 stated she should have pulled the oral medications from the medication cart first, drew up the insulin into the syringe,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) then applied clean gloves before she re-entered Resident #12's room to administer the medications. She should have removed the glove from one hand, carried the syringe in the gloved hand and discarded it in the sharps container on the cart, then removed her other glove and performed hand hygiene before she touched items on the medication cart such as the laptop. Nurse #1 acknowledged Resident #12 was on Droplet Precautions. h. An observation on 07/28/20 at 12:46 PM revealed Nurse Aide #2 worked the 200 hall carried a meal tray to the 600 hall New Admission/observation quarantine unit with her bare hands. NA #2 wore a gown, a mask, and a face shield when she entered the unit. She carried the meal tray to Resident #3's room, setup the tray, and exited the room. She was not observed to doff the PPE worn in the quarantine unit, perform hand hygiene, and don clean PPE after she left Resident #3's room or before she exited the unit. An interview with NA #2 on 08/05/20 at 4:55 PM revealed NA #2 worked the 200 hall where residents who had been exposed to COVID-19 from a previous roommate resided. NA #2 stated she was instructed to wear full PPE that included a gown, mask, and face shield for the duration of her shift unless they became visibly soiled and gloves were to be worn in all resident rooms. She further elaborated she had not worn gloves to deliver meal trays on her unit and therefore, had not thought she needed to apply gloves when she delivered Resident #3's tray to the 600 hall which was designated as a New Admission/ observation quarantine unit and she had not noticed the signage on Resident #3's door which indicated she was on Droplet Precautions. She stated she setup the meal tray and exited the room to return to her unit. She stated she had not changed her PPE between units when she delivered the meal tray. i. An observation on 07/28/20 at 12:50 PM revealed Nurse #1 entered the room of Resident #8 on the 600 hall New Admission/observation quarantine unit and she held a glucometer, alcohol prep pad, and a test strip in her bare hand. Signage on the door indicated Droplet Precautions. Nurse #1 donned gloves and obtained Resident #8's blood sugar. At 12:52 PM, Nurse #1 then exited the room with her gloved hands and carried the glucometer with the test strip attached and sat it on a tissue on the top of the medication cart. Nurse #1 then opened the drawer of the medication cart and obtained a bottle of insulin and a syringe and drew the insulin into the syringe. She then re-entered Resident #8's room. She carried the syringe and administered the insulin. Nurse #1 removed and discarded her gloves and exited the room and she carried a used syringe in her bare hand. She placed the syringe in the sharps box on the medication cart and began to type on the laptop located on the medication cart. An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed she wore gloves and carried supplies to obtain Resident #8's blood sugar. Nurse #1 stated after she obtained Resident #8's blood sugar, she should have discarded the test strip, removed her gloves, and performed hand hygiene before she touched items on the medication cart. Nurse #1 stated she should have pulled the oral medications first, drew up the insulin into the syringe, then applied clean gloves before she re-entered Resident #8's room to administer the medications. Then she should have removed the glove from one hand, carried the syringe in the gloved hand and discarded it in the sharps container on the cart, then she should have removed her other glove and performed hand hygiene before she touched the items on the medication cart such as the laptop. Nurse #1 acknowledged Resident #8 was on Droplet Precautions. j. An observation on 07/28/20 at 12:56 PM revealed Nurse #1 exited the room of Resident #13 and #14 she carried a glucometer with her gloved hands. Signage on the door indicated Droplet Precautions. She placed the glucometer on a tissue on top of the medication cart, obtained a bottle of alcohol spray from the side of the medication cart, sprayed the glucometer, removed her gloves and discarded them. Nurse #1 then wiped the glucometer with a tissue and her ungloved hands. Nurse #1 was not observed to perform hand hygiene after she exited Resident #13 and #14's room or after she cleaned the glucometer with the alcohol spray. An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed she had removed her gloves before she cleaned the glucometer after she had exited the room of Resident #13 and #14 with signage that indicated Droplet Precautions but she should have worn gloves to clean the glucometer and then performed hand hygiene. She stated she worked on the New admission/observation quarantine unit and full PPE that included a mask, gown, face shield and gloves are always required when in rooms with residents on isolation precautions. She also stated gloves should be changed between residents to include meal delivery. k. An observation on 07/28/20 at 2:20 PM revealed Nurse #1 was on the lower end of 400 hall adjacent to the 600 hall. She had pulled medications for medication administration and she wore a mask, face shield, and a gown in the hallway. An interview with Nurse #1 on 08/04/20 at 3:30 PM revealed when she worked the 600 hall New Admission/observation quarantine unit she was also responsible for medication administration for residents in rooms 406-410 on the adjacent unit. She acknowledged there were no residents on the 400 hall under any form of isolation precautions. Nurse #1 stated she had been instructed to wear the same gown during her entire shift and did not change it unless it was soiled until the date of the survey but did change gloves between patients on the 400 hall. An interview with Nurse #1 on 08/04/20 at 3:30 PM revealed when she worked the 600 hall New Admission/observation quarantine unit she was also responsible for medication administration for residents in rooms 406-410 on the adjacent unit. She acknowledged there were no residents on the 400 hall under any form of transmission based precautions. Nurse #1 stated she had been instructed to wear the same gown during her entire shift and did not change it unless it was soiled until the date of the survey but did change gloves between patients on the 400 hall. An interview with Nurse #4 on 07/31/20 at 1:48 PM revealed Nurse #4 was the nurse on the 600 hall New Admission/observation quarantine unit on the evening shift. Nurse #4 stated he was required to wear full PPE which included a gown, gloves, mask, and a face shield when on duty and he donned the PPE in the front lobby of the facility. Nurse #4 reported he was educated to wear the same gown for the duration of the shift unless it became visibly contaminated. Nurse #4 indicated he thought all the residents on the 600 hall unit were on Droplet Precautions and had not noticed the signage on Resident #9's door that indicated Contact Precautions and had not changed PPE when he cared for Resident #9. Nurse #4 stated the 600 hall nurse was also responsible for medication administration on a portion of the rooms on the end of 400 hall which he recalled were rooms 406-410. Nurse #4 revealed there was no signage on the doors of any residents on the 400 hall that indicated they were on any form of transmission based precautions. He stated he was not educated to change PPE between units when he cared for the residents on the 600 hall quarantine unit and residents on the 400 hall where there had been no known COVID-19 exposures. An interview with the IC Nurse and DON on 07/28/20 at 3:30 PM revealed neither had thought about the potential for cross contamination when staff wore the same PPE between the 600 hall and the 400 hall units. l. An observation on 07/28/20 at 10:59 AM in the 500 hall secured memory care unit revealed 9 residents sitting in the day room and Resident #20 had ambulated and stood in the hallway outside the room. Nurse Aide #1 was observed to wear a gown, mask, and face shield while she pushed the soiled linen/trash receptacles through the double doors to leave the unit. She had not worn gloves as she pushed the cart through the double doors on the memory care secured unit. An interview with Nurse Aide #1 on 08/05/20 at 3:39 PM revealed NA #1 worked the secured memory care unit. She stated she was required to wear full PPE to include gown, mask, and face shield during her entire shift and she did not change gowns unless it becomes soiled. She stated she left the unit for break when she was observed to push the soiled linen/trash receptacle out the double doors of the unit. She further elaborated she should have worn a glove to push the contaminated cart to the laundry room . An interview with Nurse #3 on 07/28/20 at 11:05 AM revealed NA #1 should have worn a glove to push the cart to the laundry room. The following observations were made on the 100/200 halls which were identified by the Director of Nursing and the Infection Control Nurse as potential exposure halls during the entrance conference on 07/28/20. m. Observations of the 100/ 200 hall on 07/28/20 between 11:08 AM and 11:19AM revealed no signage which indicated any form of transmission based precautions to include Enhanced Droplet Contact Precautions on the doors of residents who had potentially been exposed to COVID-19 by their former roommates. An interview with NA #2 on 08/05/20 at 4:55 PM revealed NA #2 worked the 200 hall where residents who had potential exposure to COVID-19 from a previous roommate resided. She stated she was instructed to wear full PPE which included a gown, mask, and face shield for the duration of her shift unless they became visibly soiled and gloves were to be worn in all resident rooms She stated there was no visible signage to indicate Enhanced Droplet Contact Precautions on the doors of the rooms where residents with potential exposures resided to alert her that her PPE should be changed when she exited that room and therefore she did not know which residents were considered exposed and/or potentially contagious. An interview with NA #8 on 8/4/20 at 9:48 AM revealed she works the 200 hall on day shift. NA #8 explained she was required to wear full PPE to include a gown, mask, and face shield always when in the facility. She stated she was educated that gloves are to be worn with resident care and hand hygiene is to be performed before and after gloves are used. She reported she has recently worked both 100 and 200 hall unit on the same shift and she had not been educated to change gowns between the units. She was instructed to wear the same gown the entire shift unless it tore or was soiled. She stated there was no signage on either the 100 or 200 hall units that indicated any residents were on isolation precautions and no signage to indicate any resident on either unit had Enhanced Droplet Contact Precaution signage to alert staff PPE should be changed when they cared for that resident. An interview with NA #4 on 07/31/20 at 12:23 PM revealed NA #4 worked the 100 and 700 hall units in the facility on day shift. NA #4 stated she was required to wear full PPE to include a gown, mask, and face shield the duration of her shift and she wore gloves when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) performed incontinence care, and she performed hand hygiene between residents. She indicated she was educated to wear the same gown for the duration of her shift and only change gowns if it became visibly soiled. She revealed there were no signage on the doors on her unit that indicated any resident was on isolation precautions and no signage that indicated Enhanced Droplet Contact Precautions that required her to change PPE when she cared for that resident. She stated she was unaware if any residents on her hall may have been potentially exposed to COVID-19. NA #4 explained she had not worn gloves when she delivered meal trays on her unit. An interview with NA #5 on 07/31/20 at 6:33 PM revealed NA #5 worked 12 hours shifts on the 100 and 700 hall units in the facility on day shift. NA #5 stated she was unaware of any resident on her unit that had signage that indicated any form of isolation precautions and there was no signage that indicated Enhanced Droplet Contact Precautions that would alert her that her PPE should be changed when she cared for a resident on her unit. NA #4 indicated she had been educated to wear her PPE to include gown, mask, and face shield for the duration of her shift unless it became visibly soiled and she donned all PPE in the front lobby of the facility at the start of her shift. She stated she cleans her face shield when she goes on break and at the end of the shift and occasionally must change her gown when it becomes wet with sweat. She stated she had not been educated that she needed to wear gloves when she delivered meal trays on her unit or that she needed to change gowns if she went to other areas of the facility. An interview with NA #9 on 08/04/20 at 10:19 AM revealed NA #9 worked the 100 hall unit on day shift. NA #9 reported she was unaware of any resident on the 100 hall who was on any form of transmission-based precautions and had not seen any signage posted that indicated Enhanced Droplet Contact Precautions on resident doors to indicate PPE should be changed when she cared for the resident on her unit. NA #9 indicated she had been educated to wear full PPE which included a gown, mask, and face shield for the duration of her shift unless it becomes soiled. NA #9 explained she had not been educated to change gowns when she left the unit or went to other areas within the facility. NA #9 further indicated she had not worn gloves when she delivered meal trays on her unit. n. An observation on 07/28/20 at 11:15 AM revealed Housekeeper #2 was mopping the room of Resident #4 and #5 had not worn gloves. Housekeeper #2 wore a gown and a mask. Housekeeper #2 exited the room and removed the mop pad from the mop with her bare hands and placed it in a bag attached to the cart. She then picked up a bottle of cleaner and re-entered the room and began to clean the sink. An interview on 07/28/20 at 11:18 AM revealed Housekeeper #2 was in Resident #3 and #4's room. She was mopping the floor and wore a gown and mask. Housekeeper #2 stated she had not replaced her face shield yet and had not been educated that she needed to wear gloves when she mopped the floor or when she removed the soiled mop pad from the handle. Housekeeper #2 stated she was unaware if any residents on the 200 hall had a potential exposure to COVID-19 but there was no signage on any resident door on the unit that indicated Enhanced Droplet Contact Precautions to show her she needed to take extra precautions in that room or that she should change her PPE when she exited the room. An interview with the Housekeeping Supervisor on 08/04/20 at 1:51 PM revealed she was the Supervisor for Housekeeper #2. She stated Housekeeper #2 had not been educated to wear gloves when she mopped in a resident's room; however, she acknowledged gloves should have been worn to remove the mop pad from the handle. The Housekeeping Supervisor stated Housekeeper #2 may not have known which rooms had potentially exposed residents because there was no signage that indicated any residents on the 200 hall were on isolation precautions and Housekeeper #2 had not been educated to change PPE when in rooms of the potentially exposed residents. An interview with Nurse #8 on 08/04/20 at 5:10 PM revealed Nurse #8 was the day shift supervisor and was responsible to oversee all the halls in the facility. Nurse #8 stated she was aware the first cases of COVID-19 in the facility were residents who had resided on the 100/200 hall units and the roommates of those residents had been relocated to other rooms on these units. Nurse #8 explained she had not recalled any signage on the doors of any resident rooms on 100/200 hall that indicated a resident was on isolation precautions and there were no signs that indicated Enhanced Droplet Contact Precautions that would alert staff that PPE should be changed when they cared for the residents in those rooms. Nurse #8 indicated she wore full PPE which included a gown, mask, and face shield always. Nurse #8 voiced she had been educated to wear her gown for the entire shift unless it was soiled, and she said all PPE is donned in the front lobby of the facility after staff was screened at the start of the shift. Nurse #8 expressed staff had recently been educated to wear gloves to pass out trays and to change gowns if they went on an