PRINTED: 12/07/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345500	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to use a mechanical lift during a transfer which resulted in an injury for 1 of 4 (Resident #11) sampled residents reviewed for accidents. Findings include: Resident #11 was admitted to the facility on 10/24/12 with cumulative diagnoses of spinal cord disease and osteoarthritis. Resident #11's admission Minimum Data Set (MDS) dated 11/6/12 indicated that Resident #11 was totally dependent on staff for transfers. Resident #11 was severely impaired in cognition. Review of the Resident Care Guide (a form which dictates the type of specialized care each resident needs) dated 10/24/12 showed a mechanical lift under additional infomation for Resident #11. Review of the Admission Nursing Assessment dated 10/24/12 showed a non-weight bearing status for Resident #11. Review of the Weekly Nursing Summaries dated	F 323	Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable release provisions of residents. The Plan of Correction is submitted as a written allegation of compliance. Windsor Point's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Windsor Point reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal process, and/or, any other administrative or legal proceeding **F 323** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #11 found to have been affected by the deficient practice as follows: 1. On 11/28/12 the Director of Nursing checked all resident care cards for accuracy and also checked all resident's rooms to ensure Hoyer Lift signs were in place. II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 12/14/12

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.

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	345500	A. BUILDING ______ B. WING ______	11/29/2012

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F 323	Continued From page 1 10/31/12, 11/2/12, and 11/7/12 indicated that Resident #11 needed to be transferred using a specialized mechanical lift and not physically lifted by the staff. Review of the Nurses Notes dated 11/3/12 at 5:30 PM showed Nursing Assistant (NA) #1 had approached Nurse #1 to report that Resident #11 had received a large skin tear to the right leg during a transfer from the bed to a wheelchair. Bright red blood was noted dripping onto the floor and pressure was applied to the wound by Nurse #1. Emergency Medical Services (EMS) was called. Review of the Nurses Notes dated 11/3/12 at 5:40 PM indicated the arrival of EMS and the removal of pressure from the wound. On assessment a 3 inch by 3 inch "V" shaped laceration (cut) was noted to Resident #11's right calf by Nurse #1. The wound was bandaged and Resident #11 was transported by EMS to the Emergency Department (ED). Review of the Nurses Notes dated 11/3/12 at 7:45 PM showed that Nurse #1 received information from the ED staff that Resident #11 had received stitches (10) to the right calf to close the wound. Review of the Nurses Notes dated 11/3/12 at 9:30 PM showed Resident #11 was returned to the facility. Review of the Nurses Notes dated 11/3/12 at 10:00 PM indicated that NA #1 had not used a mechanical lift to transfer Resident #11 as required but had transferred Resident #11 by	F 323	follows: 1.. On 11/28/12 the Director of Nursing checked all resident care cards for accuracy and also checked all resident's rooms to make sure Hoyer Lift signs were in place. 2. On 11/30/2012 the Director of Nursing counseled NA #1 on the following: Where to locate a resident's activity level and "Accidents, Care Cards, Signage and Resident Activity Levels." NA #1 was also counseled to check at the beginning of her shift each resident's activity transfer status. **(EXHIBIT 1)** 3. In-service for staff was held on 12/5/12 focusing on "Accidents, Care Cards, Signage and Resident Activity Levels." **(EXHIBIT 2)** 3. Directed in-service training for staff will be held from December 2012 to January 31, 2013. The in-service training will focus on and address supervision to prevent accidents (F323). The training DVD has been approved by The Division of Health Service Regulation and involves transfer, ambulation and accidents or falls involving mobility problems. The approved DVD is titled "Mobility and Safe Movement of the Elderly: Improving Skills to Reduce Falls." III. The systemic changes put into place so that deficient practices will not recur will be: 1. The following systems checks will be implemented: a. "Hoyer Lift Signs and Resident Care Card" **(EXHIBIT 3)**	

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F 323	Continued From page 2 herself from the bed to a wheelchair. According to the note, NA #1 did not use the mechanical lift because there was no mechanical lift sign over Resident #11's bed. In an interview on 11/28/12 at 2:26 PM NA #2 stated that Resident #11 had needed a mechanical lift for transfer since admission on 10/24/12. She indicated there was a card (Resident Care Guide) in the Activities of Daily Living (ADL) book to show what assistance each resident needed. NA #2 stated she had been at the facility when Resident #11 had been admitted and had been informed at that time that a mechanical lift would be needed for transfers. In an interview on 11/29/12 at 9:27 AM Nurse #1 stated that Resident #11 was non-weight bearing and needed a mechanical lift for transfers. Nurse #1 indicated that this was NA #1's first time working with Resident #11. Nurse #1 stated that the transfer information was available hanging in the resident's closet, on the Resident Care Guide and also in the assignment book. She indicated that NA #1 should have looked for the information in the areas provided or asked the nurse prior to providing care to Resident #11 if she was not familiar with the resident. In an interview on 11/29/12 at 11:22 AM NA #3 stated she would look in the closet and on the Resident Care Guide to see if a resident needed one or two people to assist with transfers or needed a mechanical lift for transfers. She indicated the Resident Care Guide should be checked by the aide at the beginning of the shift to see if any changes to care had been made. NA #3 indicated that Resident #11 had needed a	F 323	IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. The systems check "Hoyer Lift Signs and Resident Care Cards" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, monthly x 3 and randomly thereafter. **(EXHIBIT 3)** b. All findings will be reported to QA. V. **January 31, 2013**	1/31/2013

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F 323	Continued From page 3 mechanical lift for transfers since admission. In an interview on 11/29/12 at 11:42 AM NA #4 indicated she would look in the assignment book which was kept at the nursing station or on the Resident Care Guide to see if special equipment was needed for transfers. She stated Resident #11 had been a mechanical lift transfer since admission. In an interview on 11/29/12 at 1:18 PM the Rehabilitation Manager stated Resident #11 had been a mechanical lift transfer since admission. He indicated Resident #11 was weak and could not bear weight on her legs. In an interview on 11/29/12 at 1:49 PM Nurse #2 indicated that Resident #11's stitches had been removed. The wound was still being bandaged and monitored by the nursing staff. In an interview on 11/29/12 at 2:10 PM the Director of Nursing (DON) stated it was her expectation that aides check the Resident Care Guide, look in the assignment book at the list of residents requiring mechanical lifts, or to ask the nurse for direction prior to transferring a resident. Multiple attempts over three days were made to contact NA #1. She was unavailable for interview.	F 323		

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	345500	A. BUILDING 01 - MAIN BUILDING 01 B. WING	JAN 2 3 12/20/2012

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable release provisions of residents. The Plan of Correction is submitted as a written allegation of compliance. Windsor Point's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Windsor Point reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal process, and/or, any other administrative or legal proceeding.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations and staff interview at	K 018	**K 018** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished by Windsor Point to correct the deficient practice as follows: 1. An audit on all facility doors was completed on 12/20/12. Four doors were found to have door props: Dietary Manager's office, dry storage (Dietary), Director of Nursing's Office, MDS/Medical Records office. **(EXHIBIT 1)** 2. All door props were removed on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	01-15-2013

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.

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K 018	Continued From page 1 approximately 8:30 am onward, the following items were noncompliant, specific findings include: managers and dry storage room doors were held open with a wooden wedge at time of survey(kitchen). 42 CFR 483.70(a)	K 018	12/20/12. II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows: 1. An audit on all facility doors was completed on 12/20/12. Four doors were found to have door props: Dietary Manager's office, dry storage (Dietary), Director of Nursing's Office, MDS/Medical Records office. **(EXHIBIT 1)** 2. All door props were removed on 12/20/12. III. The measures/systemic changes put into place so that deficient practices will not recur will be: 1. Facility managers and employees were in-serviced not to prop open any doors at any time. **(EXHIBIT 2)** IV. Performance correcting these deficiencies will be monitored through the following methods: 1. The systems check "Propping Mechanism Audit" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, and randomly thereafter. **(EXHIBIT 1)** **V. January 31, 2013**	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: smoke detector's and pull station did not transmit a visual/audible signal with loss of normal power. 42 CFR 483.70(a)	K 052		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to	K 056		

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K 056	Continued From page 2 provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: bedrooms 31,32 and 54 closets has storage within 18 inches of sprinkler head. 42 CFR 483.70(a)	K 056	**K 052** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished by Windsor Point to correct the deficient practice as follows: 1. Fire alarm company was contacted and arrived on 12/20/12 to ensure facility had working audio/visual signal with activation for loss of power. 2. Audio/visual signal with activation for loss of power was restored on 12/20/12. **(EXHIBIT 3)** II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows:	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey no spare heads were in sprinkler box in riser room.	K 062	1. Fire alarm company was contacted and arrived on 12/20/12 to ensure facility had working audio/visual signal with activation for loss of power. 2. Audio/visual signal with activation for loss of power was restored on 12/20/12. **(EXHIBIT 3)** III. The measures/systemic changes put into place so that deficient practices will not recur will be: 1. During routine/random fire alarm testing and drills, working audio/visual signal with activation for loss of power will be	

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K 062	Continued From page 3 42 CFR 483.70(a)	K 062	checked to ensure compliance. IV. Performance correcting these deficiencies will be monitored through the following methods: 1. The systems check "Fire Alarm Testing" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, and routinely/randomly thereafter. **(EXHIBIT 5)** **V. January 31, 2013** **K 056** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished by Windsor Point to correct the deficient practice as follows: 1. Resident rooms were checked and remedied on 12/20/12 to ensure all storage was 18 inches below sprinkler heads. **(EXHIBIT 6)** 2. A facility walkthrough was completed on 12/21/12 to ensure all storage was 18 inches below sprinkler heads. **(EXHIBIT 6)** II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows:	

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K 056	1. Resident rooms were checked and remedied on 12/20/12 to ensure all storage was 18 inches below sprinkler heads. **(EXHIBIT 6)** 2. A facility walkthrough was completed on 12/21/12 to ensure all storage was 18 inches below sprinkler heads. **(EXHIBIT 6)** III. The measures/systemic changes put into place so that deficient practices will not recur will be: 1. Facility managers and employees were in-serviced on proper storage throughout facility (ensure all storage was 18 inches below sprinkler heads). **(EXHIBIT 2)** IV. Performance correcting these deficiencies will be monitored through the following methods: 1. The systems check "Proper Facility Storage Audit" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, and randomly thereafter. **(EXHIBIT 7)** **V. January 31, 2013**	K 056	practice as follows: 1. Sprinkler company was contacted on 12/20/12 to replace missing sprinkler heads in sprinkler box located in wet sprinkler room. 2. Sprinkler company was contacted on 12/20/12 to complete sprinkler obstruction test. II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows: 1. Sprinkler company was contacted on 12/20/12 to replace missing sprinkler heads in sprinkler box located in wet sprinkler room. 2. Sprinkler company was contacted on 12/20/12 to complete sprinkler obstruction test.	
K 062 SS=E	**K 062** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished by Windsor Point to correct the deficient	K 062	III. The measures/systemic changes put into place so that deficient practices will not recur will be: 1. The systems check "Spare Sprinkler Head Audit" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, and randomly thereafter. **(EXHIBIT 8)** 2. A sprinkler obstruction test will be completed at least every 5 years from next scheduled test.	

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K 062		K 062	IV. Performance correcting these deficiencies will be monitored through the following methods: 1. The systems check "Spare Sprinkler Head Audit" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, and randomly thereafter. **(EXHIBIT 8)** 2. A sprinkler obstruction test will be completed at least every 5 years from next scheduled test. V. **January 31, 2013**	

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