

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 10/20/2016
NAME OF PROVIDER OR SUPPLIER WINDSOR POINT CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 BROAD STREET FUQUAY VARINA, NC 27526	
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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain dignity for 5 of 6 residents who needed assistance with feeding by standing over the residents while feeding them. (Residents #12, #18, #22, #24, #38).</p> <p>Findings included:</p> <p>1. Review of the medical record of Resident #24 indicated she was admitted into the facility on 11/08/2015.</p> <p>Records also indicated the resident had a current diagnoses of Dementia.</p> <p>Review of the resident's most recent Minimum Data Set (MDS) dated 08/30/2016 indicated the resident had severe cognitive impairment and required extensive assistance of one person for eating.</p> <p>During an observation on 10/18/2016 at 10:10 AM, Resident #24 was observed seated in a wheelchair in the hallway directly in front of the nursing station. At 10:15 AM, Nursing Assistant (NA) #1 was observed spoon feeding the resident a snack from a container. During the entire feeding which lasted 4 minutes, the NA stood</p>	F 241	<p>F 241 It is the policy of Windsor Point Continuing Care Retirement Community to promote the care of residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Corrective actions for affected residents: 1. An in-service was conducted by the Director of Nursing on 10/20/16 and 10/21/16 that educated all staff on dignity and respect of individuality when providing a snack to residents. Chairs will now be provided for nursing staff to sit in while assisting with feeding a snack to residents #12, #18, #22, #24, #38, and all other residents requiring assistance with their snack. The in-service also focused on nursing staff engaging the resident at eye level when feeding residents their snack.</p> <p>2. The Administrator reviewed the requirements of 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY with the Director of Nursing on 10/20/16.</p> <p>Procedure for Identifying Potentially</p>	11/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/03/2016

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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F 241	<p>Continued From page 1</p> <p>directly over the resident. During the feeding, the NA was chatting with other staff members and not engaged with the resident.</p> <p>During an observation on 10/19/2016 from 10:15 AM to 10:22 AM, Resident #24 was observed seated in a wheelchair in the resident lounge directly across from the nursing station. At 10:15 AM, NA #2 was observed spoon feeding the resident a snack while standing directly over the resident. During the feeding, the NA was chatting with other staff members and not engaged with the resident.</p> <p>2. Review of the medical record of Resident #22 indicated the resident was admitted into the facility on 02/05/2015.</p> <p>Records also indicated the resident had a current diagnoses of Dementia.</p> <p>Review of the resident's most recent Minimum Data Set (MDS) dated 08/22/2016 indicated the resident had severe cognitive impairment and required extensive assistance of one person for eating.</p> <p>During an observation on 10/18/2016 at 10:10 AM, Resident #22 was observed seated in a reclining chair in the lounge directly across from the nursing station. At 10:15 AM, the facility Director of Nursing (DON) was observed spoon feeding the resident a snack while standing directly in front of the resident.</p> <p>During an observation on 10/19/2016, Resident #22 was observed seated in a reclining chair in the lounge directly across from the nursing</p>	F 241	<p>Affected Residents:</p> <p>1. All residents in the facility were evaluated on 10/21/16 by the Director of Nursing for potential for residents to be affected by the same deficient practice. The Director of Nursing has determined that four additional residents were identified to have the potential to be affected by the deficient practice.</p> <p>2. The Nursing Assistants are required to report to the charge nurse any change in resident's ability to feed themselves so assistance with eating a snack can be provided in a respectful and dignified manner.</p> <p>Measures Adopted for Systemic Change:</p> <p>1. Chairs were placed in the storage room behind the nurses station on 10/20/16 for nursing staff to sit in when feeding resident's their snack. The chairs are placed in close proximity to the nursing station so they are readily available for nursing staff to use when feeding resident's their snack.</p> <p>Monitoring of Corrective Action and Quality Assurance:</p> <p>On 10/20/16, the Director of Nursing began monitoring the feeding of snacks to ensure nursing staff was engaging residents and sitting in chairs at eye level to promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. The charge nurse on first and second shift will continue to monitor for</p>		

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F 241	<p>Continued From page 2</p> <p>station. At 10:30 AM, NA #2 was observed feeding the resident a nourishment/snack. The NA stood directly in front of and over the resident during the feeding. During the feeding, the NA was chatting with other staff members and not engaged with the resident.</p> <p>3. Review of the medical record of Resident #12 indicated the resident was admitted into the facility on 04/07/2008.</p> <p>Records also indicated the resident had a current diagnoses of Dementia.</p> <p>Review of the resident's most recent Minimum Data Set (MDS) dated 05/30/2016 indicated the resident had severe cognitive impairment and required extensive assistance of one person for eating.</p> <p>During an observation on 10/18/2016 at 10:30 AM, Resident #12 was observed seated in a wheelchair in the hallway directly across from the nursing station. At 10:30 AM, the facility DON was observed spoon feeding the resident a snack. During the feeding, the DON stood directly over the resident.</p> <p>During an observation on 10/19/2016 at 10:30 AM, Resident #12 was observed seated in a wheelchair in the hallway directly across from the nursing station. At 10:38 AM, the facility DON was observed spoon feeding the resident a snack. During the feeding, the DON stood directly over the resident.</p> <p>4. Review of the medical record of Resident #18</p>	F 241	<p>compliance with 483.15(a) three times daily for four weeks. All monitoring will continue to be ongoing.</p> <p>A monitoring sheet has been created to ensure daily compliance to be reviewed by the Director of Nursing weekly.</p> <p>All monitoring sheets will be reviewed during the next QA meeting to ensure substantial compliance has been achieved and is no longer a problem.</p>		

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F 241	<p>Continued From page 3 indicated the resident was admitted into the facility on 12/29/2009.</p> <p>Records also indicated the resident had a current diagnoses of Dementia.</p> <p>Review of the resident's most recent Minimum Data Set (MDS) dated 07/29/2016 indicated the resident had severe cognitive impairment and required extensive assistance of one person for eating.</p> <p>During an observation on 10/19/2016, Resident #18 was observed seated in a reclining chair in the lounge directly across from the nursing station. At 10:35 AM, NA #2 stood over Resident #18 in the lounge and spoon fed the resident a snack standing directly in front of and over the resident's chair.</p> <p>5. Review of the medical record of Resident #38 indicated the resident was admitted into the facility on 09/02/2015.</p> <p>Records also indicated the resident had a current diagnoses of Dementia.</p> <p>Review of the resident's most recent Minimum Data Set (MDS) dated 06/14/2016 indicated the resident had severe cognitive impairment and required extensive assistance of one person for eating.</p> <p>During an observation on 10/18/2016, Resident #38 was observed seated in a reclining chair in the lounge directly across from the nursing station. At 10:20 AM, NA #2 stood over Resident #38 in the lounge and spoon fed the resident a</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>snack standing directly in front of and over the resident's chair.</p> <p>During an interview with NA #1 on 10/20/2016 at 11:55M, the NA stated she received training on feeding residents when hired. The NA also stated she should be at eye level when feeding a resident. The NA also stated it might intimidate a resident if you stand over them while feeding them. The NA further stated she should have sat beside the resident's chair when feeding them the snack.</p> <p>During an interview with NA #2 on 10/20/2016 at 12:02 PM, the NA stated she received training on feeding residents when hired. The NA also stated she should be at eye level when feeding a resident. The NA further stated she should have sat beside the resident's chair when feeding them the snack.</p> <p>The facility Director of Nursing (DON) was interviewed on 10/20/2016 at 12:08 PM and stated all staff should sit or be at eye level and engaged with the resident during feeding. The DON further stated the facility focused on being seated beside a resident while feeding them in the dining room during meals and not on feeding them in other places in the facility. The DON also stated feeding the residents while standing over them and not engaging with them was not dignified.</p>	F 241			