STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345090	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER MANOR AT PROVIDENCE PLACE	1795 WESTCHESTER DRIVE HIGH POINT, NC 27262

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F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		9/7/17

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

Electronically Signed | 09/01/2017

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F 225	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to submit a 24 hour working report and 5 day working report for 1 of 4 residents, Resident #83 who stated she was grabbed by a staff member and her arm was twisted. Findings included: Resident #83 was admitted to the facility on 6/2/17 with a diagnosis that included hypertension, hyperlipidemia, anxiety disorder, psychosis and depression. She was treated for a Urinary Tract Infection and the antibiotic treatment began on 7/31/17 and ended on 8/6/17.	F 225	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F225	

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F 225	Continued From page 2 Review of Resident #83's Minimum Data Set (MDS) assessment dated 7/20/17 indicated Resident #83 required extensive assistance of one staff person in the areas of bed mobility, transfers, and toileting. The MDS further revealed Resident #83 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9. Resident #83 was interviewed on 8/7/17 at 3:46 pm. Resident #83 stated a girl that works nights slams you against the wall and said "you lay down in that bed and don't get up". Resident #83 turned her left arm over to reveal a bruise. Resident Observation on 8/7/17 at 3:46 pm revealed a large, dark blue bruise with slight yellowing at edges to her left wrist and lower forearm. The bruise was rectangular in shape with no circular bruising noted, and did not show signs of shearing or circular bruising associated with twisting or squeezing of Resident #83's left arm. Review of the 24 hour report dated 8/6/17 for Resident #83 indicated the allegation type as Resident Abuse. The allegation description stated, "Bruise to left wrist, resident stated, she grabbed my wrist and twisted it." Then said, "I don't like you and was mocking me." The form was faxed to DHHS on 8/6/17 at 3:06 pm. Review of Resident #83's Care Plan dated 6/3/17 revealed Resident #83 was care planned for psychotropic drug use related to anxiety, depression, and psychotic/delusional thoughts. The goal for Resident #83 was to have no side effects related to psychoactive medications. Interventions for this care plan included	F 225	"The plan of correcting the specific deficiency cited: An investigation of resident #83□s allegation of abuse was begun on 8/6/17. A 24 hour working report was submitted at 3:06 pm on 8/6/17. An investigation into the allegation was conducted by the Director of Nursing from 8/6/17 □ 8/11/17. The Director of Nursing submitted the 5 day working report on 8/11/17 at 6:26 pm. All staff were educated as to the policy for the timely submission and investigation of allegations of abuse. On 8/8/17 resident #83 was observed with left arm resting on WC wheel with left wrist and forearm hitting the wheels. The wheelchair was changed to avoid arms hitting the wheels. "The procedure for implementing the plan of correction for the specific deficiency cited: Education provided to nursing staff from 8/6/17 - 8/9/17 on Abuse and Neglect policy. All current facility staff were educated on the updated policy concerning the timely reporting and investigating of abuse and neglect 8/25/17 □ 9/1/17. The updated policy is included in new hire orientation for all new staff members and will be reviewed with all staff on an annual basis. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The Director of Nursing or Assistant	

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F 225	Continued From page 3 monitoring for restless behaviors and providing diversion. Review of Mental Health Visit Note dated 7/21/17 revealed Resident #83 stated that she has a secret she could not tell but did involve someone hurting her. The Mental Health Visit Note further revealed that the resident had symptoms of worry, psychosis, paranoid delusions, and not sleeping well. Review of Mental Health Note dated 8/2/17 revealed Resident #83 had increased anxiety and paranoia. The note further revealed that an order for Xanax was given to help her anxiety. Review of Social Work note dated 7/26/17 Resident #83 reported to the Social Worker she was scared and "that girl raised her fist at me". The Social Work note dated 7/26/127 also stated that the resident was confused and unable to say when the accident happened or describe the person involved. The note further revealed that Resident #83 had increased confusion, was awake a lot of the night, and hallucinated about a man in a yellow suit in her room. Review of Occupational Therapy Daily Treatment Note dated 7/26/17 revealed Resident #83 reported a staff person upset her by being mean and threatening to hit her. The note also stated the resident was confused and unclear. The note further revealed the Occupational Therapist Assistant notified the Social Worker of Resident #83's statement. Review of nursing note dated 8/6/17 at 12:07 pm by Nurse #3 revealed a 3 inch dark purple bruise with faint yellow borders was noted to the	F 225	Director of Nursing will conduct random audits of facility staff to ensure understanding of the updated facility policy concerning the timely reporting of resident abuse and neglect daily for 30 days, then weekly for 8 weeks, then monthly for 3 months. Re-education of staff will be conducted as necessary. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months or longer as necessary. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing or Assistant Director of Nursing is responsible for ensuring that all staff are educated as to the facility policy concerning timely reporting of resident abuse and neglect on an ongoing basis and that the policy is being followed appropriately. Assistant Director of Nursing will conduct random audits and present findings to the Director of Nursing. The Director of Nursing will prepare the Quality Assurance report for 6 months or longer.	

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residents left wrist. The note also revealed Nurse #3 asked resident #83 how she got the bruise and Resident #83 stated "someone grabbed my wrist and twisted and said I don't like you and was mocking her". The note revealed the Director of Nursing and Resident #83"s family member were notified of the bruise.

Review of nursing note dated 8/6/17 at 2:24 pm revealed Nurse #3 spoke with Resident #83's family member regarding the possible allegations and concerns of the resident. The note further revealed a room change was offered to the family member but she refused. The family member was afraid that the room change would increase Resident #83's confusion.

Interview with Family Member on 8/7/17 at 5:27 pm revealed a family friend had visited Resident #83 on Thursday (8/3/17) and communicated to the Family Member Resident #83 had a bruise on her left wrist during the visit. The Family Member stated she visited the resident on Saturday (8/5/17) and saw the bruise to Resident #83's left lower arm. She stated the bruise was solid and about 4 inches long to the underside of Resident #83's left wrist and forearm. The Family Member indicated Resident #83 was afraid to stay in the facility at night. Resident #83 told the Family Member she was afraid of the "mean lady" at night. The Family Member stated that Resident #83 was not able to describe the person. The Family Member further revealed Resident #83's confusion was worse since she had a urinary tract infection and that she had a history of "sundowner's at night". The Family Member stated she had never found a bruise on Resident #83 before and that the bruise did not look like someone had grabbed Resident #83's arm.

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Follow up interview on 8/9/17 at 3:27 pm with Family Member revealed the family member told Nurse #1 that Resident #83 was afraid of a staff member and that she had a large bruise to her left wrist and forearm on Saturday (8/5/17).

Interview on 8/7/17 at 4:47 pm with Nurse #3 revealed she saw the bruise to the underside of the resident's left wrist and that it was dark in color when she was notified by Nurse #1 between 11:45am and 12:00 pm on 8/6/17. Nurse #3 also stated that Resident #83 reported someone grabbed her by the arm and twisted.

Interview with the Director of Nursing on 8/7/17 at 4:53 pm revealed that she was notified of the bruise to Resident #83's left wrist on Sunday (8/6/17) and arrived at the facility at 1:15 pm. She stated she had not interviewed any of the staff that had worked with Resident #83.

Interview with Social Worker on 8/7/17 at 5:55 pm revealed the Social Worker had not reported to the Director of Nursing when Resident #83 reported to her that she was scared and "that girl raised her fist at me", which the Social Work documented in her note on 7/26/17. The Social Worker stated Resident #83 was more confused for the past week and that she had a history of delusions. She indicated Resident #83 would speak of a man in a yellow suit in her room signing autographs. The Social Worker also stated that the Director of Nursing had called her Sunday (8/6/17) to tell her that Resident #83 had a bruise and she told staff that someone hurt her, but could not identify the person that hurt her and her stories were inconsistent.

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Interview with the Occupational Therapy Assistant on 8/8/17 at 10:56 am revealed Resident #83 reported to her on Monday of last week (7/31/17) that "a young girl talked nasty to her and hit her". The Occupational Therapy Assistant further revealed she reported the incident to the Social Worker that day.

Interview with NA #2 on 8/8/17 at 9:30 am revealed NA #2 told her charge nurse, Nurse #4, that resident #83 reported someone had been rough with her and she had small bruises on her wrist on Thursday 8/3/17.
Interview with Nurse #4 on 8/8/17 at 9:40 am revealed she was told by NA #2 that Resident #83 communicated someone was rough with her on Thursday, 8/3/17. Nurse #4 reported she told the Social Worker about the allegation on 8/3/17 and the Social Worker came and spoke with the resident. Nurse #4 stated she told the Director of Nursing and Supervisor about Resident #83's allegation before she left work (3:15 pm) on Friday 8/4/17.

Interview with Nurse #2 on 8/8/17 at 11:30 am revealed the bruise to Resident's left lower arm and wrist had not been measured. During the interview Nurse #2 measured Resident #83's bruise to her left lower forearm and wrist with a flexible wound measuring tape. Nurse #2 stated the bruise was 15 centimeters long and 12 centimeters wide.

Interview with NA# 3 on 8/9/17 at 9:00 am revealed she had observed the bruise to Resident #83's left arm on Saturday (8/5/17).
Interview with NA # 7 on 8/9/17 at 11:00am revealed Resident #83 had communicated to her that someone was rough with her sometime last

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week. NA#7 revealed Resident #83 said they didn't like her and grabbed her wrist and twisted it. NA #7 stated Resident #83 had a small bruise at that time. She indicated that she was going to tell the nurse but got distracted with another patient needs and forgot to communicate the concern. She stated she noticed the bruise on Resident #83 left hand on Friday (8/4/17) while showering Resident #83's upper body. She stated by Friday (8/4/17) Resident #83's bruise had gotten worse and was longer. NA#7 indicated she was not interviewed about Resident #83's allegation or bruise until Monday (8/7/17).

Interview with Nurse #1 on 8/10/17 at 10:10 am revealed the Family Member reported to Nurse #1 on Saturday (8/5/17) Resident #83 was crying and stated she was afraid of a staff member. Nurse #1 stated she did not recall the Family Member telling her the resident had a bruise. Nurse #1 stated she did not report Resident #83's allegation because "the resident is always confused and always stating that people are mean to her".

Interview with the Director of Nursing 8/9/17 at 2:45pm revealed she was unaware of the Mental Health Visit Note dated 7/21/17; Occupational Therapist Note dated 7/26/17; and the Social Work Note dated 7/26/17 that indicated Resident #83 had communicated allegations of abuse. The Director of Nursing further revealed that the only protection put into place was a room change that was offered to Resident #83 and her Family Member which was declined. She further revealed she had not interviewed any staff in regards to the Resident #83's complaint of staff mistreatment on 8/8/17. It was her expectation that all allegations of abuse be reported to her,

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F 225	Continued From page 8 the Assistant Director of Nursing, or the Administrator. She indicated she was unaware of the changes implemented for reporting abuse F232 that identified reporting allegations of abuse within 2 hours.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 226		9/7/17

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F 226	Continued From page 9 (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and review of facility policy the facility failed to follow their abuse policy for investigating and reporting to the state Health Care Personnel Registry (HCPR) for 1 of 4 residents with allegations of abuse (Resident #83). The findings: Review of Facility policy titled, "Resident Abuse-Staff Responsibilities" revealed it did not have an implementation date or date of revision. It was obtained on 8/7/17 at 4:30 pm from the Director of Nursing. The policy stated: "Any alleged violations involving mistreatment, neglect, or abuse including injuries of an unknown source and misappropriation of resident property, must be immediately reported to the Administrator and to other officials in accordance with State law (including State survey and certification agency." "A completed copy of the Resident Abuse Report Form and written statements from witness, if any, must be provided to the administrator within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be provided to the Administrator or designated representative and to other officials in accordance with State law (including the State survey and certification agency) within five working days of the occurrence of such incident." "The investigation shall consist of an interview	F 226	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F226 "The plan of correcting the specific deficiency cited: On 8/10/17 the facility updated the policy concerning the timely reporting of abuse and neglect to include the following: It is the policy of this facility that all residents have the right to be free from abuse that includes but is not limited to verbal, physical, sexual and mental abuse, corporal punishment and involuntary seclusion or exploitation by facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Abuse also includes those practices and omissions, neglect and misappropriation of resident property that left unchecked, lead to abuse. It is the policy of this facility to ensure that	

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F 226	Continued From page 10 with staff members (on all shifts) having contact with the resident during the period of the alleged incident". "The facility shall take all measures necessary to prevent further potential abuse during an investigation of an alleged violation." Resident #83 was admitted to the facility on 6/2/17 with diagnosis that included hypertension, anxiety disorder, psychosis and depression. Review of Resident #83's Minimum Data Set (MDS) assessment dated 7/20/17 indicated Resident #83 required extensive assistance of one staff person in the areas of bed mobility, transfers, and toileting. The MDS further revealed Resident #83 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9. Review of the 24 hour report for Resident #83 dated 8/6/17 indicated allegation type as Resident Abuse. The allegation description stated, "Bruise to left wrist, resident stated, "she grabbed my wrist and twisted it. Then said, I don't like you and was mocking me." The form indicated it was faxed to DHHS on 8/6/17 at 3:06 pm. Review of Mental Health Visit Note dated 7/21/17 revealed that Resident #83 states that she has a secret she could not tell but did involve someone hurting her. The Mental Health Visit Note further revealed Resident #83 had symptoms of worry, psychosis, paranoid delusions, and not sleeping well. The Social Work note dated 7/26/17 also stated Resident #83 was confused and unable to say when the incident happened or describe the person involved. The note further revealed	F 226	all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. An investigation of resident #83□s allegation of abuse was begun on 8/6/17. A 24 hour working report was submitted at 3:06 pm on 8/6/17. An investigation into the allegation was conducted by the Director of Nursing from 8/6/17 □ 8/11/17. The Director of Nursing submitted the 5 day working report on 8/11/17 at 6:26 pm. All staff were educated as to the policy for the timely submission and investigation of allegations of abuse. "The procedure for implementing the plan of correction for the specific deficiency cited: All current facility staff were educated on the updated policy concerning the timely reporting and investigating of abuse and neglect 8/25/17 □ 9/1/17. The updated policy is included in new hire orientation	

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F 226	Continued From page 11 Resident #83 had increased confusion, was awake a lot of the night, and hallucinated about a man in a yellow suit in her room. Review of Mental Health Visit Note dated 8/2/17 revealed Resident #83 had increased anxiety and paranoia. The note further revealed that an order for Xanax was given to help her anxiety. Review of the Occupational Therapy Assistant note dated 7/26/17 revealed Resident #83 reported to the Occupational Therapy Assistant a staff member had upset her by being mean and threatening to hit her. The note further revealed the Occupational Therapy Assistant had notified the Social Worker. Review of the Social Work note dated 7/26/17 revealed the Social Worker had visited Resident #83. Resident #83 told the Social Worker she "was scared and that girl raised her fist at me". The note stated Resident #83 was unable to say when the incident happened or describe the person(s) involved. The Social Work note further revealed that Resident #83 had increased confusion, was awake a lot of the night, and hallucinated about a man in a yellow suit in her room. Resident #83 was interviewed on 8/7/17 at 3:46 pm. Resident #83 stated, "a girl that works nights slams you against the wall and says, you lay down in that bed and don't get up". Resident #83 turned her left arm over and revealed a large, linear, dark blue bruise with slight yellowing at edges to her left wrist and lower forearm. She stated the Director of Nursing was looking into the incident.	F 226	for all new staff members and will be reviewed with all staff on an annual basis. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The Director of Nursing or Assistant Director of Nursing will conduct random audits of facility staff to ensure understanding of the updated facility policy concerning the timely reporting of resident abuse and neglect weekly for daily for 30 days, then weekly for 8 weeks, then monthly for 3 months. Re-education of staff will be conducted as necessary. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months or longer as necessary. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing or Assistant Director of Nursing is responsible for ensuring that all staff are educated as to the facility policy concerning timely reporting of resident abuse and neglect on an ongoing basis and that the policy is being followed appropriately.	

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Interview with Nurse #3 on 8/7/17 at 4:47 pm revealed she worked 8/6/17. Nurse #3 stated that Nurse #1 reported the resident's bruise to her and she had observed the bruise and notified the Director of Nursing between 11:45 am and 12:00 pm. Nurse #3 stated Nurse #1 reported Resident #83 stated "it happened on night shift". Nurse #3 further revealed she did not interview any staff regarding the allegation or injury of unknown origin on 8/6/17.

Interview with the Social Worker on 8/7/17 at 5:55 pm revealed she did not report to the Director of Nursing Resident #83's allegation she recorded in her Social Work noted dated 7/26/17. She stated Resident #83 was confused and had a history of delusional behavior. The Social Worker indicated Resident #83 would speak of a man in a yellow suit in her room signing autographs. The Social Worker also stated she was notified by the Director of Nursing on Sunday (8/6/17) by phone that Resident #83 had a bruise and had told staff that someone had hurt her. The Social Worker stated she had not interviewed any of the staff regarding the allegation or injury of unknown origin on 8/7/17.

Interview with NA #2 on 8/8/17 at 9:30 am revealed NA #2 told her charge nurse, Nurse #4, that Resident #83 reported someone had been rough with her and she had a small bruise on her wrist on Thursday (8/3/17). NA #2 also stated that she had not been interviewed by facility staff regarding what the resident told her nor had she been asked to provide a written statement.

Interview with Nurse #4 on 8/8/17 at 9:40 am revealed she was told by NA #2 Resident #83

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communicated someone was rough with her on Thursday (8/3/17). Nurse #4 reported she told the Social Worker about the allegation on 8/3/17 and the Social Worker came and spoke with the resident. Nurse #4 stated she told the Director of Nursing and Supervisor about Resident #83's allegation before she left work (3:15pm) on Friday (8/4/17). Nurse #4 stated she was not interviewed or asked to write a statement regarding the allegation or the injury of unknown origin.

Interview with the Occupational Therapy Assistant on 8/8/17 at 10:56 am revealed Resident #83 reported to her on Monday of last week (7/31/17) that "a young girl talked nasty to her and hit her". The Occupational Therapy Assistant further revealed she reported the incident to the Social Worker that day. The Occupational Therapy Assistant stated she was not asked to write a statement regarding the resident's allegation.

Interview with the Assistant Director of Nursing on 8/9/17 at 4:08 pm revealed she was not aware of the allegation of abuse and injury of unknown origin until Monday (8/7/17) morning. She stated the staff were not interviewed about Resident #83's allegation of abuse or injury of unknown origin on Monday (8/7/17).

Interview with the Director of Nursing on 8/9/17 at 2:45 pm revealed she had not interviewed any staff regarding Resident #83 allegation of abuse or injury of unknown origin before 8/9/17. The Director of Nursing stated that Resident #83 and her Family Member were offered a room change but no other protection was put into place for Resident #83 because she wasn't able to identify a staff member. The Director of Nursing stated

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F 226	Continued From page 14 she had Therapy look at how the resident propelled herself in the wheelchair on 8/8/17 and they assumed the injury was caused by the wheelchair. The Director of Nursing stated that her expectation is that allegations of abuse and injuries of unknown origin should be reported immediately.	F 226		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to label and properly store personal care items in semi-private rooms occupied with 2 residents on 1 of 6 units of the facility (Unit # 100). Findings included: 1a. On 8/08/2017 9:42 am, observation revealed in Resident # 82's semiprivate bathroom, there were two stacked unlabeled washbasins stored in one plastic bag. b. On 8/08/2017 11:31 am, observation revealed in Resident # 107's semiprivate bathroom there were two unlabeled stacked washbasins in one plastic bag and one unlabeled washbasin in a plastic bag and one unlabeled urine hat (measuring device) in plastic bag and one unlabeled bedpan in a plastic bag. c. On 8/08/2017 9:52 am, observation revealed in Resident # 6's semiprivate bathroom, there was one unlabeled washbasin in plastic bag.	F 253	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F253 "The plan of correcting the specific deficiency cited: On 8/25/17 personal care items for residents # 82,107, 6, 13 and 48 were labeled and bagged to ensure the maintenance of a sanitary, orderly and comfortable interior. An inspection of all resident rooms on 100 hall was completed	9/7/17

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F 253	Continued From page 15 d. On 8/08/2017 11:30 am, observation revealed in Resident # 13's semiprivate bathroom there were two unlabeled stacked washbasins in one plastic bag and one unlabeled washbasin in a plastic bag and one unlabeled urine hat in plastic bag and one unlabeled bedpan in a plastic bag. e. On 8/08/2017 11:04 am, observation revealed in Resident # 48's semiprivate bathroom there were two of three stacked washbasins and one of one bedpan without resident names. On 8/9/17 at 10:00 am, an interview with the Maintenance Supervisor confirmed that the nursing staff are responsible for taking care of the resident personal care equipment stored in the bathroom. f. On 8/10/2017 at 1:25 pm, observation revealed in Resident # 6's semiprivate bathroom there was one wash basin in the shower unlabeled. g. On 8/10/2017 at 1:30 pm, observation revealed Resident # 82's semiprivate bathroom there was an unlabeled bed pan and wash basin in one bag. h. On 8/10/2017 at 1:36 pm, observation revealed Resident # 107's semiprivate bathroom there was one bed pan bagged, not labeled and one wash basin and urine hat bagged, not labeled. On 8/10/17 at 2:15 pm interview ADON (Assistant Director of Nursing) confirmed that nursing assistants (NAs) are responsible for labeling all items with the residents' names. Items such as bed pans and basins should be labeled and stored in a bag in the resident's bathroom or where they prefer for it to be stored.	F 253	to ensure the proper labeling and bagging of resident personal single use items. Any improperly stored personal care items were corrected to ensure the maintenance of a sanitary, orderly and comfortable interior. "The procedure for implementing the plan of correction for the specific deficiency cited: All nursing staff which includes nurses and certified nursing assistants were educated 8/25/17 - 9/1/17 as to the expectation of labeling and bagging all personal care items such as bedpans, urine hats and wash basins. On 8/25/17 an inspection of all resident rooms was conducted to ensure wash basins, urine hats, and bedpans were labeled and were in a separate plastic bag. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: Audits of resident rooms to ensure the proper labeling and bagging of resident personal care items to ensure the maintenance of a sanitary, orderly and comfortable interior will be initiated on 9/8/17 by the Assistant Director of Nursing. For 30 days 2 separate resident rooms will be monitored daily for the labeling and bagging of bedpans, washbasins and urine hats. Afterwards 4 separate resident rooms will be monitored weekly for 8 weeks. Finally, 6 rooms will be monitored monthly for 3 months for the	

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F 253	Continued From page 16 On 8/10/17 at 2:20 pm interview with DON (Director of Nursing) confirmed that the NAs are responsible to tag and bag personal care equipment in clear trash bags. On 8/10/17 at 2:30 pm interview with NA # 5 on 100 hall confirmed that resident personal care equipment is supposed to be stored in a bag, it should be labeled with the resident name, they should be dry and on opposite sides of the bathroom. On 8/10/17 at 2:35 pm interview with NA # 6 on 100 hall confirmed that resident personal care equipment should be stored in the bathroom, placed in clear bags and have the resident last name and an A or B labeled clearly.	F 253	labeling and bagging of bedpans, washbasins and urine hats. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months or longer as necessary. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing and/or Assistant Director of Nursing are responsible for ensuring the completion of all staff education and proper storage and labeling of resident personal care items. Audits and reporting to the Quality Assurance Committee.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes	F 279		9/7/17

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F 279	Continued From page 17	F 279		

to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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F 279	Continued From page 18 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to initiate a care plan for incontinence for 1 (Resident 134) of 4 residents reviewed for urinary incontinence. Findings included: Resident was admitted to the facility on 3/2/17 with diagnosis of: Chronic Obstructive Pulmonary Disease, Hypertension, Macular Degeneration, Weakness, Vitamin D Deficiency, Anemia, Anxiety, Bipolar Disorder and Insomnia. Most recent quarterly Minimum Data Set (MDS) dated 6/8/17 revealed a decline in bladder continence (occasionally incontinent) from Admission MDS dated 3/10/17 (always continent). Care plans reviewed for Activities of Daily Living (ADL) Self-care deficits, Falls, Sensory deficit, Impaired vision, Fall risk, Risk for dehydration, Risk for skin breakdown, Respiratory Disorders, Psychotropic drug use, Oxygen use, Activities and Mood state. 08/9/17 11:35 Record review revealed no care plans for incontinence. 08/9/17 Record review for look back period 6/2/17-6/8/17 for quarterly MDS revealed resident had 2 episodes of bladder incontinence and 2 episodes of bowel incontinence on the night shift. Further record review revealed resident had one episode of bowel and bladder incontinence during	F 279	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F279 "The plan of correcting the specific deficiency cited: On 8/9/17 resident #134□s care plan was updated with new problem of Risk for Incontinent Accidents added to current comprehensive care plan. Plan included interventions for prompted toileting and staff assistance as needed. On 8/9/17 the prompted toileting schedule was added to the direct care staff instructions for care. On 8/9/17 direct care staff were informed of the addition of toileting plan to instructions for care already in place. "The procedure for implementing the plan of correction for the specific deficiency cited: Determine the need for new/additional care plan based on MDS data and other clinical evaluations by the Interdisciplinary	

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F 279	Continued From page 19 the past week 8/3/17-8/9/17. 08/09/2017 11:50:38 AM Interview with Minimum Data Set (MDS) nurse revealed care plan for incontinence should have been added after incontinence was identified on Quarterly MDS. 08/10/2017 10:55:06 AM Interview with Director of Nursing (DON) revealed she would expect problems that trigger on MDS to be care planned.	F 279	Care Team, no less than quarterly. Initiate new/additional care plan when clinically indicated. Inform direct care staff of updated care plan to include direct care interventions and goals. The MDS Coordinator to provide education training to all Interdisciplinary Care Team members involved in reviewing and updating care plans by 9/1/17. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The MDS Coordinator or Assistant MDS Coordinator will conduct random care plan audits daily for 30 days, then 3 per week for 60 days then 10 per month for 3 months. Make corrections to care plans as needed. Audit findings will be presented during the Quality Assurance meetings for recommendations and updates for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The MDS Coordinator and members of the Interdisciplinary Care Team are responsible for ensuring all clinical evaluations including MDS data are completed in a timely and appropriate manner.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10	F 280		9/7/17

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F 280	Continued From page 20 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21	F 280		

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F 280	Continued From page 21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff	F 280	Preparation and/or execution of this Plan	

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F 280	Continued From page 22 interviews, the facility failed to update the Care Plan for 1 of 1 sampled resident (Resident #48) with a dialysis access device. Findings included: Resident #48 was admitted to the facility on 2/1/17 with diagnoses which included end-stage renal disease. The annual MDS (minimum data set) dated 5/23/17 indicated Resident #48 was moderately, cognitively impaired and received dialysis treatments. Review of the Care Plan revealed Resident #48 received hemodialysis three times each week due to ESRD (end-stage renal disease). Interventions effective since 9/3/14, included: monitor fistula site for signs and symptoms of infection: (redness, odorous drainage, new or worse confusion, elevated white blood cells); and, maintain aseptic field as needed when checking fistula site. During an observation on 8/9/17 at 10:01 am, Resident was asleep in bed, partially covered with bed linen. The resident was wearing a nightgown with short sleeves and low neckline. A dialysis access site covered with a clear dressing was noted to the resident's right upper chest. There was no fistula site observed in either of the resident's arms. During an interview on 8/9/17 at 10:19 am, NA#4 (nursing assistant) stated that she had worked with Resident #48 often for over a year and the resident received dialysis treatment three times	F 280	of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F280 "The plan of correcting the specific deficiency cited: On 8/10/17 resident #48□s care plan was corrected by MDS Coordinator with intervention for dialysis access site monitor. On 8/10/17 nursing staff were informed of change in plan of care intervention. "The procedure for implementing the plan of correction for the specific deficiency cited: Determine the need for changes/updates to current care plan based on MDS data and other clinical evaluations by the Interdisciplinary Care Team, no less than quarterly. Initiate changes/updates to care plan when clinically indicated. Inform direct care staff of updated care plan to include direct care interventions and goals. The MDS Coordinator to provide education training to all Interdisciplinary Care Team members involved in reviewing and updating care plans by	

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WESTCHESTER MANOR AT PROVIDENCE PLACE	1795 WESTCHESTER DRIVE HIGH POINT, NC 27262

(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 280	Continued From page 23 each week. NA#4 revealed the resident's dialysis site was located in her right upper chest area and was covered with a clear bandage. During an interview on 8/9/17 at 10:56 am, SN#5 (staff nurse) revealed Resident #48 went to the dialysis center on Tuesdays, Thursdays, and Saturdays. SN#5 indicated the resident's dialysis access site was a porta-catheter located in her right upper chest. During an interview on 8/10/17 at 9:56 am, the MDS Coordinator revealed Resident #48's fistula was replaced with the current dialysis access device in April 2016 and the Care Plan should have been updated at that time to reflect the correct device in use. She indicated dialysis access device care, not fistula care should have been documented on the resident's Care Plan. She stated that the resident's Care Plan would immediately be corrected to reflect the appropriate dialysis access device.	F 280	9/1/17. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: The MDS Coordinator or Assistant MDS Coordinator will conduct random care plan audits daily for 30 days, then 3 times per week for 60 days then 10 per month for 3 months. Make corrections to care plans as needed. Audit findings will be presented during the Quality Assurance meetings for recommendations and updates for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The MDS Coordinator and members of the Interdisciplinary Care Team are responsible for ensuring all clinical evaluations including MDS data are completed in a timely and appropriate manner.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/7/17

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F 323	Continued From page 24 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to maintain functioning bed rails for (#83) 1 of 2 residents. Findings included: Resident #83 was admitted to the facility on 6/2/17 with a diagnosis that included hypertension, hyperlipidemia, anxiety disorder, psychosis and depression. She was treated for a Urinary Tract Infection and the antibiotic treatment ended on 8/6/17. Review of Minimum Data Set (MDS) assessment date 7/20/17 indicated Resident #83 required extensive assistance of one staff person in the areas of bed mobility, transfers and toileting. The MDS further revealed Resident #83 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9.	F 323	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F323 "The plan of correcting the specific deficiency cited: On 8/8/17 resident #83□s bed rail was repaired by the maintenance department. A review of the facility maintenance work order system revealed that no staff	

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F 323	Continued From page 25 Review of Resident #83's Care Plan dated 6/3/17 revealed Resident #83 was care planned as at risk of falls due to impaired balance, muscle weakness, medication use, and history of falls. The goal for Resident #83 was to have no injury related to falls. Resident #83's care plan also identified upper side rails for bed mobility as an intervention. Observation of Resident #83 on 8/7/17 at 3:46 pm revealed a large linear bruise to her left wrist and lower forearm. The bruise was rectangular in shape and did not have circular areas or areas that appeared to be the shape of fingerprints. During an interview with Nurse #2 on 8/8/17 at 11:30 am she measured the Resident #83's left lower forearm/wrist bruise. She used a flexible wound measuring tape and stated that the measurement of the bruise was 15 centimeters long and 12 centimeters wide. Interview with NA #1 on 8/9/17 at 11:50 am revealed Resident #83's left side rail was not functioning properly. She stated she recalled Resident #83's left side rail dropping last weekend (August 5, 2017 and August 6, 2017). She indicated she believed Resident #83's side rail was missing a screw and was bent. The left side rail would drop down when the resident attempted to use the rail to assist staff with positioning. She further indicated the rail would drop after staff put the rail up when providing care. NA #1 stated Nurse #1 had assisted her during the weekend of August 5, 2017 and August 6, 2017 due to Resident #83 not being able to use the left side rail to assist one staff in transferring and bed mobility.	F 323	member had submitted a request for maintenance in regards to resident #83□s bed rail prior to 8/8/17. All staff are instructed to submit maintenance requests into the facilities work order system as soon as they become aware of a maintenance issue. "The procedure for implementing the plan of correction for the specific deficiency cited: All facility staff were educated as to the expectation of submitting maintenance requests into the work order system as soon as they are aware of maintenance issues. Reviews of the facility maintenance work order system are conducted multiple times per day as maintenance requests are submitted. Maintenance staff are alerted by electronic means when a new maintenance request has been submitted. The alert system allows for the prioritization of maintenance requests so that maintenance staff can address the most critical issues first. The timely submission of maintenance requests will allow for the maintenance department to repair any malfunctioning bed rails to ensure resident safety. An inspection of facility bed rails was conducted by the Maintenance Director or Maintenance Technician 8/28/17 □ 9/1/17. Any bed rails found to be malfunctioning were repaired/replaced as necessary. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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Continued From page 26

Interview with NA #2 on 8/9/17 at 1:50pm revealed that the left side rail to Resident #83's bed was broken for at least a week and had not functioned properly for the past two weekends. She stated that she had told Nurse #1 about the left side rail not functioning properly. She stated, "you had to pull real hard for it to stay up".

Interview with NA #2 on 8/9/17 at 1:50pm revealed that the left side rail to Resident #83's bed was broken for at least a week and had not functioned properly for the past two weekends. She stated that she had told Nurse #1 about the left side rail not functioning properly. She stated, "you had to pull real hard for it to stay up".

Interview with NA #2 on 8/9/17 at 1:50pm revealed that the left side rail to Resident #83's bed was broken for at least a week and had not functioned properly for the past two weekends. She stated that she had told Nurse #1 about the left side rail not functioning properly. She stated, "you had to pull real hard for it to stay up".

In an interview with the Maintenance Director on 8/10/17 at 10:50am revealed he received work orders electronically. The Maintenance director stated he received a work order in regards to Resident #83's bed rail on 8/8/17 and made the repairs on 8/8/17. He indicated he had no work order prior to 8/8/17 for needed repairs to Resident #83's bed rails. The Maintenance Director stated it was his expectation that staff complete an electronic work order as soon as broken equipment was identified.

Interview with Director of Nursing on 8/9/17 at 2:45 pm revealed she wasn't aware of the broken side rail until 8/9/17 and she revealed a work

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and/or in compliance with regulatory guidelines:
Maintenance staff will continue to review facility work order system daily to ensure work orders are completed in a timely manner. Priority will be placed on completing any work order that effects resident safety. Re-prioritization of work orders will be made as needed to ensure any resident safety issues are addressed in the appropriate time frame. The Director of Nursing, Assistant Director of Nursing or Maintenance Director will conduct audits beginning 9/8/17 to ensure broken equipment issues are being addressed timely and appropriately. At initiation 2 different rooms will be monitored daily for 30 days for broken equipment. Then 4 rooms will be monitored weekly for 8 weeks for broken equipment. Finally, 6 rooms will be monitored monthly for 3 months.
Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months.

"The title of the person responsible for implementing the acceptable plan of correction:
The Maintenance Director or Maintenance Technician is responsible for ensuring all submitted work requests are completed in a timely and appropriate manner. The Director of Nursing and Assistant Director of Nursing are responsible for ensuring facility staff are submitting maintenance requests in a timely and appropriate manner.

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F 323	Continued From page 27 order was done 8/8/17. The Director of Nursing also revealed therapy evaluated Resident #83 on 8/9/17 in her wheelchair and they observed that when the resident self-propelled her left arm hit the wheel of the wheelchair. She stated therapy concluded the bruise came from the wheelchair wheel. She stated her expectation was a work order should be completed immediately if there is a danger to the resident.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		9/7/17

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F 431	Continued From page 28 (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to date an open vial of Tuberculin PPD (purified protein derivative) injectable in 1 of 2 medication room refrigerators. Findings included: Review of Medication Ordering, Receiving and Storage Policy provided by the Assistant Director of Nursing (ADON) on 8/10/17 at 2:11 PM revealed that the facility "Shall store all medications and biologicals in a safe, secure, and orderly manner". Per the policy guidelines, in	F 431	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F431	

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F 431	Continued From page 29 part, #3, "If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items", and #4, "If the facility has discontinued, outdated or deteriorated medications or biologicals, contact the dispensing pharmacy for instructions regarding returning or destroying these items". 8/10/17 1:44:03 PM Observation of medication room refrigerator on second floor revealed 1 bottle of opened, undated vial of Tuberculin PPD injectable (used at skin test in the diagnosis of Tuberculosis). 8/10/17 2:14:45 PM Interview with ADON revealed that her expectation was that if medications were opened, they should be dated.	F 431	"The plan of correcting the specific deficiency cited: On 8/10/17, the open but undated vial of tuberculin PPD (purified protein derivative) injectable was destroyed. "The procedure for implementing the plan of correction for the specific deficiency cited: Audit of all medication carts and medications rooms was completed by the consultant Pharmacy on 8/25/17 to ensure that all medications were properly labeled and dated. All nurses were educated by the Assistant Director of Nursing on the proper procedure for labeling medications when opened, 8/25/217 - 9/01/17. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: Audits of facility mediation carts and/or medication rooms will be initiated on 9/8/17 by the Assistant Director of Nursing. One medication cart and/or medication room will be audited daily for expired or improperly dated medications for 30 days. Afterwards, two medication carts and/or medication rooms will be audited for expired or improperly dated medications weekly for 8 weeks. Finally, four medication carts and/or medication room will be audited for expired or improperly dated medications monthly for	

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F 431	Continued From page 30	F 431	3 months. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing or Assistant Director of Nursing is responsible for ensuring that the nurses have properly labeled and dated all medications.	
F 461 SS=D	Various sections in 483.10,483.25,483.90 BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET 483.10 (i)(4) Private closet space in each resident room, as specified in §483.90(e)(2)(iv); 483.25 (n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. 483.90 (c)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. (e)(1)(vi) - Resident Rooms Bedrooms must --	F 461		9/7/17

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F 461	Continued From page 31 (vi) - Have at least one window to the outside; and (vii) Have a floor at or above grade level. (e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to provide maintenance to side rails for 1 of 2 residents (Resident #83). Resident #83's bed rail would not stay locked in the up position during activities of daily living. Findings included: Resident #83 was admitted to the facility on 6/2/17 with a diagnosis that included hypertension, hyperlipidemia, anxiety disorder, psychosis and depression. Review of Minimum Data Set (MDS) assessment date 7/20/17 indicated Resident #83 required extensive assistance of one staff person in the areas of bed mobility, transfers and toileting. The MDS further revealed Resident #83 was moderately cognitively impaired as evidenced by	F 461	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F461 "The plan of correcting the specific deficiency cited: On 8/8/17 resident #83□s bed rail was	

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F 461	Continued From page 32 a Brief Interview for Mental Status (BIMS) score of 9. Review of Resident #83's Care Plan dated 6/3/17 revealed Resident #83 was care planned as at risk of falls due to impaired balance, muscle weakness, medication use, and history of falls. The goal for Resident #83 was to have no injury related to falls. Resident #83's care plan also identified upper side rails for bed mobility as an intervention. Review of Work Order Report dated 8/8/17 revealed, "Bed rail in room 608 (rail on hallway side of bed, not window side of room) can fall unexpectedly. Rail framework is bent and can easily open up enough to release restraining pin that holds rail in up position." The Work Order dated 8/8/17 was closed on 8/8/17. Observation of Resident #83 on 8/7/17 at 3:46 pm revealed a large linear bruise to her left wrist and lower forearm. The bruise was rectangular in shape. Interview with NA #1 on 8/9/17 at 11:50 am revealed Resident #83's left side rail was not functioning properly. She stated she recalled Resident #83's left side rail dropping last weekend (August 5, 2017 and August 6, 2017). She indicated she believed Resident #83's side rail was missing a screw and was bent. The left side rail would drop down when the resident attempted to use the rail to assist staff with positioning. She further indicated the rail would drop after staff put the rail up when providing care. NA #1 stated Nurse #1 had assisted her during the weekend of August 5, 2017 and August 6, 2017 due to Resident #83 not being able to use	F 461	repaired by the maintenance department. A review of the facility maintenance work order system revealed that no staff member had submitted a request for maintenance in regards to resident #83□s bed rail prior to 8/8/17. All staff are instructed to submit maintenance requests into the facilities work order system as soon as they become aware of a maintenance issue. "The procedure for implementing the plan of correction for the specific deficiency cited: All facility staff were educated as to the expectation of submitting maintenance requests into the work order system as soon as they are aware of maintenance issues. Reviews of the facility maintenance work order system are conducted multiple times per day as maintenance requests are submitted. Maintenance staff are alerted by electronic means when a new maintenance request has been submitted. The alert system allows for the prioritization of maintenance requests so that maintenance staff can address the most critical issues first. The timely submission of maintenance requests will allow for the maintenance department to repair any malfunctioning bed rails to ensure resident safety. An inspection of facility bed rails was conducted by the Maintenance Director or Maintenance Technician 8/28/17 □ 9/1/17. Any bed rails found to be malfunctioning were repaired/replaced as necessary. The Maintenance Director on 8/28/17 included	

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F 461	Continued From page 33 the left side rail to assist one staff in transferring and bed mobility. Interview with NA #2 on 8/9/17 at 1:50pm revealed that the left side rail to Resident #83's bed was broken for at least a week and had not functioned properly for the past two weekends. She stated that she had told Nurse #1 about the left side rail not functioning properly. She stated, "you had to pull real hard for it to stay up". In an interview with the Maintenance Director on 8/10/17 at 10:50am revealed he received work orders electronically. The Maintenance director stated he received a work order in regards to Resident #83's bed rail on 8/8/17 and made the repairs on 8/8/17. He indicated he had no work order prior to 8/8/17 for needed repairs to Resident #83's bed rails. The Maintenance Director stated it was his expectation that staff complete an electronic work order as soon as broken equipment was identified. Interview with Director of Nursing on 8/9/17 at 2:45 pm revealed she wasn't aware of the broken side rail until 8/9/17 and she revealed a work order was done 8/8/17. The Director of Nursing also revealed that she had therapy evaluate the resident in her wheelchair and they observed that when the resident self-propelled her left arm hit the wheel of the wheelchair. She stated therapy concluded the bruise came from the wheelchair wheel. The Director of Nursing stated her expectation was a work order should be completed immediately in the electronic system.	F 461	the task of monthly checks of bed rails to ensure proper functioning. The electronic work order system will alert maintenance of the task for inspecting bed rails beginning 9/1/17. Any broken or malfunctioning bed rails will be repaired or replaced as necessary. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: Maintenance staff will continue to review facility work order system daily to ensure work orders are completed in a timely manner. Re-prioritization of work orders will be made as needed to ensure any resident safety issues are addressed in the appropriate time frame. Priority will be placed on completing any work order that effects resident safety. The Maintenance Director or Maintenance Technician will inspect bed rails weekly for 4 weeks, then twice a month for 3 months, then monthly going forward to ensure the monthly task of inspecting bed rails is completed. Inspection findings will be presented during Quality Assurance meetings for recommendations for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The Maintenance Director or Maintenance Technician is responsible for ensuring all submitted work requests are completed in a timely and appropriate manner. The Director of Nursing and Assistant Director	

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F 461	Continued From page 34	F 461	of Nursing are responsible for ensuring facility staff are submitting maintenance requests in a timely and appropriate manner.	
F 490 SS=B	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to update their policies concerning the timely reporting of abuse and neglect. Findings included: Review of the Facility policy titled, "Resident Abuse-Staff Responsibilities" revealed it did not have an implementation date or date of revision. It was obtained on 8/7/17 at 4:30 pm from the Director of Nursing. The policy stated: "A completed copy of the Resident Abuse Report Form and written statements from witnesses, if any, must be provided to the administrator within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be investigation will be provided to certification agency within five working days of the occurrence of such incident." Interview with the Director of Nursing on 8/9/17 at 2:45 pm revealed the facilities abuse policy and	F 490	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F490 "The plan of correcting the specific deficiency cited: On 8/10/17 the facility updated the policy concerning the timely reporting of abuse and neglect to include the following: It is the policy of this facility that all residents have the right to be free from abuse that includes but is not limited to verbal,	9/7/17

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F 490	Continued From page 35 procedure had not been updated to include reporting within two hours after forming the suspicion if the events that caused the suspicion result in serious bodily injury, or not later than 24 hours if the events that caused the suspicion do not result in serious bodily injury. The Director of Nursing stated she was not aware of the changes to the abuse reporting regulation beginning February 2017. Interview with the Assistant Director of Nursing on 8/9/17 at 4:08 pm revealed she was not aware of the changes to the abuse reporting regulation beginning February 2017. Interview with the Administrator on 8/9/17 at 4:46 pm revealed he was not aware of the change to the abuse reporting regulation beginning February 2017.	F 490	physical, sexual and mental abuse, corporal punishment and involuntary seclusion or exploitation by facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Abuse also includes those practices and omissions, neglect and misappropriation of resident property that left unchecked, lead to abuse. It is the policy of this facility to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. "The procedure for implementing the plan of correction for the specific deficiency cited: All current facility staff were educated on the updated policy concerning the timely reporting and investigating of abuse and neglect 8/25/17 □ 9/1/17. The updated policy is included in new hire orientation	

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F 490	Continued From page 36	F 490	for all new staff members and will be reviewed with all staff on an annual basis. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: Director of Nursing or Assistant Director of Nursing will audit facility personnel files to ensure all facility staff have documentation of training on the updated facility policy concerning timely reporting of resident abuse and neglect. The Director of Nursing or Assistant Director of Nursing will conduct random audits of facility staff to ensure understanding of the updated facility policy concerning the timely reporting of resident abuse and neglect weekly for 4 weeks, then twice a month for 3 months, then monthly for 6 months. Re-education of staff will be conducted as necessary. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing or Assistant Director of Nursing is responsible for ensuring that all staff are educated as to the facility policy concerning timely reporting of resident abuse and neglect on an ongoing basis.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET	F 520		9/7/17

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F 520	Continued From page 37 QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		

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F 520	Continued From page 38 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility's Quality Assessment and Assurance Committee (AQQ) failed to maintain implemented procedures and monitor interventions the committee put in place following the 7/28/16 certification survey. The facility received a recited deficiency in the area of accidents F323 again on recertification survey/complaint investigation 8/7/17. The continued failure of the facility during two surveys of record in the same area of deficiency showed a pattern of inability to maintain an effective QAA program. Findings include: This tag is cross referenced to: F323 - Accidents/hazards: Based on staff interviews and record review the facility failed to maintain functioning bed rails for 1 of 2 residents. The facility must ensure correct maintenance of bedrails to prevent accident hazards. During the recertification survey 7/28/16 the facility failed to secure oxygen cylinder bottles in 1 of 2 storage areas. On the current recertification survey of 8/7/17, the facility failed to maintain functioning bed rails for 1 or 2 residents. Interview of Director of Nursing on 8/10/17 at 2:20 pm revealed the facilities Quality Assurance meetings were held every quarter on the third Wednesday of the month. The Director of Nursing stated the Administrator, Medical Director, Social Worker, Infection Control Nurse, Activity Director and the Director of Nursing attended the QAA committee meetings. The	F 520	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F520 "The plan of correcting the specific deficiency cited: On 8/8/17 resident #83□s bed rail was repaired by the maintenance department. An inspection of facility bed rails was conducted by the Maintenance Director or designee 8/28/17□9/1/17. Any bed rails found to be malfunctioning were repaired/replaced as necessary. The Maintenance Director on 8/28/17 included the task of monthly checks of bed rails to ensure proper functioning into the electronic work order system. The electronic work order system will alert maintenance of the task for inspecting bed rails beginning 9/1/17. Any broken or malfunctioning bed rails will be repaired or replaced as necessary. On 9/7/17 the facility Quality Assurance Committee began reviewing plan of correction items and any newly discovered quality	

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F 520	Continued From page 39 Director of Nursing further revealed the facilities QAA Committee monitored a Plan of Correction for the failure to secure oxygen cylinder bottles which ended in February 2017. The Director of Nursing stated her expectation is that employees will report hazards immediately in the facilities computer generated reporting system.	F 520	concerns on a weekly basis for 4 weeks then monthly for 6 months or longer as deemed necessary. Afterwards the Quality Assurance Committee will meet on a quarterly basis going forward. "The procedure for implementing the plan of correction for the specific deficiency cited: All facility staff were educated as to the expectation of submitting maintenance requests into the work order system as soon as they are aware of maintenance issues. Reviews of the facility maintenance work order system are conducted multiple times per day as maintenance requests are submitted. Maintenance staff are alerted by electronic means when a new maintenance request has been submitted. The alert system allows for the prioritization of maintenance requests so that maintenance staff can address the most critical issues first. The timely submission of maintenance requests will allow for the maintenance department to repair any malfunctioning bed rails to ensure resident safety. The Maintenance Director on 8/28 /17 included the task of monthly checks of bed rails to ensure proper functioning. The electronic work order system will alert maintenance of the task for inspecting bed rails beginning 9/1/17. Any broken or malfunctioning bed rails will be repaired or replaced as necessary. The increased Quality Assurance Committee meetings and reviews will assist in ensuring continued quality assurance and process	

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F 520	Continued From page 40	F 520	improvement. "The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory guidelines: Maintenance staff will continue to review facility work order system daily to ensure work orders are completed in a timely manner. Priority will be placed on completing any work order that effects resident safety. The Director of Nursing or designee will conduct daily audits for 30 days, weekly audits for 2 months then monthly to ensure . Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months. The Quality Assurance Committee will meet weekly for 4 weeks, then monthly for 6 months or longer as deemed necessary and finally on a quarterly basis moving forward. Resident safety concern areas will be reviewed during Quality Assurance meetings. "The title of the person responsible for implementing the acceptable plan of correction: The Quality Assurance Committee leader is responsible for ensuring an effective QAA program and that the facility appropriately addresses areas of concern identified through the routine QAA process. All monitoring information will be taken to the Quality Assurance Committee weekly focusing on Ftags 225, 226, 253, 279, 280, 323, 431, 461 and 490 on a weekly for 4 weeks then monthly for 6	

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F 520	Continued From page 41	F 520	months or longer as deemed necessary.	