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 _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #9JYY11.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain dignity of residents requiring assistance with meals by staff calling residents "feeders" during 3 out of 6 dining observations. Findings Included: During an observation of the dining area on Hall 600 on 07/25/16 at 12:24pm, Nurse #3 referred to 2 residents needing assistance with meals as "feeders" with other residents and a family member sitting at the table. An interview was conducted on 07/25/16 at 12:24pm with Nurse #3 Hall 600. When asked why 2 residents have not been served lunch, Nurse #3 referred to them as "feeders" in the presence of staff, a family member and other residents. During an observation of dining area on Hall 400 on 07/25/16 at 12:34pm, nursing assistant (NA) #5 was observed referring to 1 resident needing	F 241	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_____ F241 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: No individual resident was found to have been affected by the deficient practice. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	8/25/16

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

Electronically Signed | 08/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 assistance with meals as a "feeder". Several residents were in the dining area. An interview was conducted on 07/25/16 at 12:34pm with NA #5 Hall 400. When asked why the resident was waiting to be served lunch, NA #5 explained they needed assistance, they were "feeders" in the presence of staff and other residents. During an observation of dining area on Hall 500 on 07/25/16 at 12:45pm, Nurse #4 referred to residents needing assistance with meals as "feeders" with several residents at the same table. An interview was conducted on 07/25/16 at 12:45pm with Nurse #4 Hall 500. When asked why residents were not sitting in the main dining room Nurse #4 explained they chose to eat here and some were "feeders" in the presence of staff and other residents. During an interview on 07/28/16 at 11:45pm with the Director of Nursing (DON), she indicated a mix of residents and family members access the dining areas. The DON stated that staff were expected not to refer to residents who needed assistance with meals as "feeders".	F 241	Facility staff will maintain the dignity of residents requiring assistance with meals by not referring to them as feeders or any other term that may label the residents. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Director of Nursing or Assistant Director of Nursing on 7/28/16 - 8/25/16 educated all staff on the proper terminology for referring to residents needing assistance with meals in order to preserve their dignity. The Director or Nursing or designee will conduct daily interviews of staff over all shifts 7 times per week for 30 days, 5 times per week for 2 months, then 3 times per month for 3 months to ensure staff are maintaining resident dignity. Any corrections will be made as necessary. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 6 months.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		8/25/16

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F 282	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to follow the care plan to provide medpass (nutritional supplement) as ordered by the Physician for 1 of 3 residents reviewed for weight loss. Resident #47. Findings included: Resident #47 was admitted to the facility on 01/03/16 with diagnoses which included: congestive heart failure, hyperlipidemia, congenital mitral insufficiency, dementia, and psychosis. Review of the physician's order dated 01/03/16 revealed Resident #47 was to receive 120 ml (milliliters) of medpass (nutritional supplement) every day at 9:00am and 5:00pm. The quarterly MDS (minimum data set) dated 05/13/16 indicated Resident #47 had moderately impaired cognition; required supervision with eating; had no swallowing problems, no weight loss or no weight gain; and received a therapeutic diet. The updated Care Plan dated 06/28/16 revealed Resident #47 was at risk for weight loss related to her diagnosis of congestive heart failure and her diuretic use; and significant weight loss during the month of June 2016. Interventions included: med pass to be given by nursing per physician's order. Review of the medication administration records from 01/03/16 to 07/27/16 indicated the 120 ml medpass was not administered to the Resident	F 282	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_____ F282 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 7/27/16 resident #47□'s physician was notified of the order for supplements. Physician decided to continue current order and re-evaluate as needed. Order for supplement for resident #47 was clarified and transferred to medication administration record. Resident #47□'s care plan was evaluated and updated as necessary. On 8/3/16 resident #47□'s physician informed that resident #47 was refusing to drink supplement, order for supplement was discontinued. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Director of Nursing and Certified Dietary Manager conducted an audit, 8/12/16 - 8/15/16 of all resident□s	

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F 282	Continued From page 3 #47 as ordered. During an interview on 07/26/16 at 11:55am, SN#1 (staff nurse) revealed Resident #47 did not receive a nutritional supplement. During an interview on 07/27/16 at 11:10am, the DON (Director of Nursing) acknowledged there was no documentation available indicating the Resident #47 received the medpass supplement as ordered by the physician. The DON revealed that when the resident was re-admitted to the facility on 01/3/16 the nurse failed to assign the order for the 120 ml medpass to a destination administration in the computer program used by the facility; therefore, the nurses were unable to view the order during the medication administration round.	F 282	nutrition care plans to ensure that orders for nutritional supplements were present on the resident□s medication administration record. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Director of Nursing or Assistant Director of Nursing on 7/28/16 - 8/25/16 educated nursing staff on utilization of resident care plans and following as directed as well as updating of resident care plans when necessary. The Director of Nursing or designee will review random care plans 5 times per week for 30 days, 3 times per week for 2 months, then 10 per month for 3 months. Any corrections will be made as necessary. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 6 months.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		8/25/16

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F 323	Continued From page 4 by: Based on observations and staff interviews, the facility failed to secure oxygen cylinder bottles in 1 of 2 storage areas (2nd floor clean utility room). The findings included: A review of the State Operational Manual (SOM) revealed, if oxygen is in use, precautions must be observed for (e.g., proper storage and handling of oxygen cylinders - secured.) On 07/27/16 at 10:30 AM, an interview and observation of the 2nd floor clean utility room was conducted with the facility's Director of Nursing (DON). The observation revealed 6 free standing oxygen cylinder bottles standing up unsecured in the room, without any support to keep them from falling (chained to wall, dolly, stand, or rack, etc.) and could be easily tipped over by anyone entering the clean utility room. The DON indicated the oxygen bottles were not being supported by any means as they should have been, in a dolly or stand. The DON then placed the 6 oxygen cylinders into an oxygen tank rack located in the same clean utility room. The DON indicated that it was her expectation that all staff secured facility ' s oxygen cylinder bottles to prevent accidents. On 07/28/16 at 9:45 AM, a second observation of the 2nd floor clean utility room was conducted with the facility's Assistant Director of Nursing (ADON). One oxygen cylinder tank was observed to be standing unsecured on the floor without any support (chain to wall, dolly, stand, or rack, etc.). The ADON indicated that it was her expectation that all oxygen cylinder bottles needed to be secured in order to prevent accidents.	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_____ F 323 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: The oxygen cylinders located in the clean utility room on the second floor which were not properly chained or supported in a proper cylinder stand or cart were secured on 7/28/16. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Director of Nursing on 7/29/16 completed an audit of all rooms where oxygen cylinders are stored to ensure the cylinders are properly secured and segregated. Any oxygen cylinders found not secured were properly secured. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Director of Nursing or Assistant	

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F 323	Continued From page 5 During an interview with the facility Administrator on 07/28/16 at 10:40 AM., the Administrator indicated that it was his expectation that all oxygen cylinder tanks be secure at all times, and his expectation was not being met.	F 323	Director of Nursing on 7/27/16 - 8/25/16 educated all nursing staff on the proper manner for storing oxygen cylinders. Proper chaining or supporting of oxygen cylinders in a proper cylinder stand or cart was stressed. The Director or Nursing or designee will conduct daily audits for 30 days, weekly audits for 2 months then monthly audit of the rooms where oxygen cylinders are stored to ensure proper storage. Any corrections to storage will be made as necessary. 4. Indicate how the facility will monitor its performance: Results will be presented to Quality Assurance team for recommendations and follow up for 6 months.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to provide a	F 325	Preparation and/or execution of this Plan of Correction does not constitute an	8/25/16

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F 325	Continued From page 6 nutritional supplement as recommended by the Registered Dietician and ordered by the Physician for 1 of 3 residents reviewed for weight loss. Resident #47. Findings included: Resident #47 was admitted to the facility on 01/03/16 with diagnoses which included: congestive heart failure, hyperlipidemia, congenital mitral insufficiency, dementia, and psychosis. Review of the physician's order dated 01/03/16 revealed Resident #47 was to receive 120 ml (milliliters) of medpass (nutritional supplement) every day at 9:00am and 5:00pm. The quarterly MDS (minimum data set) dated 05/13/16 indicated Resident #47 had moderately impaired cognition; required supervision with eating; had no swallowing problems, no weight loss or no weight gain; and received a therapeutic diet. The updated Care Plan dated 06/28/16 revealed Resident #47 was at risk for weight loss related to her diagnosis of congestive heart failure and her diuretic use; and significant weight loss during the month of June 2016. Interventions included: med pass to be given by nursing per physician's order. Review of the RD's (Registered Dietician) Note dated 06/28/16 indicated Resident #47 had a 7.75% significant weight loss from 05/01/16 (214.2 pounds) to 06/01/16 (197.6 pounds), no weight changes in three months, and a loss of 9.2% in six months. Routine diuretic therapy in place; weight changes expected due to changes	F 325	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_____ F325 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 7/27/16 resident #47'□s physician was notified of the order for supplements. Physician decided to continue current order and re-evaluate as needed. Order for supplement for resident #47 was clarified and transferred to medication administration record. Resident #47'□s care plan was evaluated and updated as necessary. On 8/3/16 resident #47'□s physician informed that resident #47 was refusing to drink supplement, order for supplement was discontinued. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Director of Nursing and Registered Dietician conducted an audit, 7/29/16 - 7/30/16 of all resident□s with orders for nutritional supplements to ensure that orders for nutritional supplements were present on the resident□s medication administration record.	

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F 325	Continued From page 7 in fluid status. Therapeutic NAS (no added salt) diet. The resident consumed 50-100% of meals per meal intake documentation records. Medpass 120 ml every day in place for nutrition support. On 06/15/16, NP's (Nurse Practitioner) Notes indicated the resident's congestive heart failure was improving, weight loss since May with goal of weight 200+/- 5 pounds. Weight loss related to decreased fluid retention and congestive heart failure. Continued weight changes expected. Current diet and supplement order remain appropriate. Review of the medication administration records from 01/03/16 to 07/27/16 indicated the 120 ml medpass was not administered to the Resident #47 as ordered. During an interview on 07/26/16 at 11:55am, SN#1 (staff nurse) revealed Resident #47 did not receive a nutritional supplement. During an interview on 07/27/16 at 11:10am, the DON (Directed of Nursing) acknowledged there was no documentation available indicating the Resident #47 received the medpass supplement as ordered by the physician. The DON revealed that when the resident was re-admitted to the facility on 01/03/16 the nurse failed to assign the order for the 120 ml medpass to a destination administration in the computer program used by the facility; therefore, the nurses were unable to view the order during the medication administration round. During an observation on 07/27/16 at 12:55pm, Resident #47 observed ambulating from bathroom towards her bed where her completed/finished meal noted on the over-bed	F 325	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Director of Nursing or Assistant Director of Nursing on 8/4/16 - 8/25/16 educated nursing staff on providing of nutritional supplements as recommended by the Registered Dietician and ordered by the physician. Staff were instructed on nutritional supplement order entry and ensuring order is on resident medication administration record. The Director of Nursing or designee will conduct daily order reviews for 30 days, then weekly order reviews for 2 months, then monthly order reviews for 3 months. Any corrections will be made as necessary. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 6 months.	

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F 325	Continued From page 8 table. The resident had consumed approximately 95% of her meal. During an interview on 07/27/16 at 4:30pm and after reviewing the previous RD's (Registered Dietician) notes, the interim RD indicated Resident #47 was discharged to the hospital on 12/29/15 and the facility discontinued the medpass (nutritional supplement) on 12/30/15. When the res was re-admitted to the facility on 01/03/16, the medpass supplement was re-started. The RD stated that although the resident's meal intakes were good, due to the resident receiving large amounts of a diuretic, the resident was at risk for weight changes; therefore, a supplement would have provided additional calories to support the resident ' s nutritional needs. She revealed the 120 ml (milliliter) of medpass provided 240 calories and 10gms (grams) protein. The RD also revealed that the absence of the ordered daily supplement over the six month period may or may not have contributed to the resident's significant weight loss from 05/01/16 to 06/01/16 due to the resident's food consumption/intake of 50-100% since August 2015, and related to the resident's diuretic use.	F 325		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		8/25/16

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F 356	Continued From page 9 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post up to date staffing information for two of four days of the recertification survey, and failed to keep past staff postings for 18 months. The findings included: During the initial tour on Monday, 07/25/16 at 10:00 AM, the staff posting on the wall by the main entrance was dated for Sunday, 07/24/16. During a tour on Tuesday, 07/26/16 at 3:00 PM, the staff posting on the wall by the main entrance	F 356	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_____ F356	

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F 356	Continued From page 10 was dated for Sunday, 07/24/16. During a tour on Wednesday, 07/27/16 at 9:00 AM, the staff posting on the wall by the main entrance was dated for Wednesday, 07/27/16. On 04/28/16 at 10:02 AM. an interview was conducted with the Schedule Coordinator who was responsible for posting the daily staffing. She stated that she put up the Monday staff posting, but did not put up Tuesday's staff posting because she was out of town at a conference. When asked, the Schedule Coordinator was not able to produce Monday, Tuesdays, or any past staff postings. She said she always threw the staff postings away after she posted a new one. She stated she was not aware that she was required to keep the postings for 18 months. During an interview with the facility Administrator and the Director of Nursing (DON) on 07/28/16 at 10:20 AM., the Administrator indicated that it was his expectation that the staff posting be current, posted daily, kept for 18 months, and his expectation was not being met.	F 356	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Up to date and correctly dated staffing information was posted on 7/27/16. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: A filing system was established to maintain copies of posted daily staffing data for a minimum of 18 months. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Education provided 7/28/16 - 8/25/16 to the scheduling coordinator and nursing supervisors as to what the daily staff posting must contain and where it will be located. Director of Nursing or designee will monitor daily staff posting daily for 30 days, then weekly for 8 weeks then monthly to confirm it contains up to date information and that a copy is maintained for a minimum of 18 months. 4. Indicate how the facility will monitor its performance: Results will be presented to the QA&A team for recommendations and follow up for 6 months.	