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 09/19/2018

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 the result of the complaint investigation on 9/19/18. Event# LWYV11.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		10/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/12/2018

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

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F 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services to two of three residents (Residents #25 and 96) reviewed for SNF Beneficiary Protection Notification Review. Findings included: 1. Resident #25 was admitted to the facility under part A Medicare services on 3/20/18. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #25 on 5/10/18. The notice indicated that Medicare	F 582	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F-582 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #25 was informed of payment status as of the resident's last covered day and signature of notification was obtained. Resident #96, has transitioned	

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F 582 Continued From page 2

coverage for skilled services were to end 5/12/18. The resident remained in the facility when Medicare coverage ended.

A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or resident representative.

An interview was completed with the Business Office Manager on 9/12/18 at 4:24 PM. He stated he did not issue an ABN because Resident #25's payor status was under Medicare part A and thought the ABN was only signed upon admission if a resident waived their Medicare benefit. The Business Office Manager further stated he was unaware the ABN was supposed to be completed when a resident remained in the facility after part A Medicare benefits ended.

A follow up interview was completed with the Business Office Manager on 9/13/18 at 2:51 PM. He said a utilization review meeting was held every Wednesday where the team discussed all residents on Medicare services. He stated typically he was notified either during the meeting or by the Case Mix Director when a resident was scheduled to be discharged from Medicare services. Once notified, he completed the beneficiary notice with the resident or resident representative.

An interview was completed with the Administrator on 9/18/18 at 1:07 PM. He stated he was unaware that the ABN form was to be completed after a part A Medicare stay and the resident remained in the facility. He said that going forward he would expect the ABN notice be issued when a resident remained in the facility following a part A Medicare stay.

F 582

to an ALF memory care unit; therefore, the resident’s representative was notified via telephone of the resident’s last covered day, and witness verification was documented.

2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit was conducted on residents who been admitted in the past 30 days, and ABN notification was provided and verified by either signature or phone call with a witness as appropriate.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
The Administrator educated the following personnel on the facility’s Advance Beneficiary Notices policy: Business Office Manager, Corporate Billing Manager, Social Services Director, MDS Coordinators, Director of Nursing, Rehabilitation Program Manager. Copies of the relevant forms were placed in slots in the forms rack located in the Central Business Office.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The Corporate Billing Manager will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks to verify that notices were issued timely and appropriately. Then continue to the five random audits monthly for 3

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F 582

Continued From page 3

2. Resident #96 was admitted to the facility on 8/24/17. Medicare part A skilled services began 2/9/18.

A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #96 on 4/24/18. The notice indicated that Medicare coverage for skilled services were to end 4/27/18. The resident remained in the facility when Medicare coverage ended.

A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or resident representative.

An interview was completed with the Business Office Manager on 9/12/18 at 4:24 PM. He stated he did not issue an ABN because Resident #96's payor status was under Medicare part A and thought the ABN was only signed upon admission if a resident waived their Medicare benefit. The Business Office Manager further stated he was unaware the ABN was supposed to be completed when a resident remained in the facility after part A Medicare benefits ended.

A follow up interview was completed with the Business Office Manager on 9/13/18 at 2:51 PM. He said a utilization review meeting was held every Wednesday where the team discussed all residents on Medicare services. He stated typically he was notified either during the meeting or by the Case Mix Director when a resident was scheduled to be discharged from Medicare services. Once notified, he completed the beneficiary notice with the resident or resident representative.

F 582

additional months to ensure maintained compliance.

A summary of the ABN audit findings will be presented to QAPI Committee monthly for their review and input on plan. Including but not limited to plan modifications or additional corrective actions if required.

Corrective action completion date: 10/17/2018

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F 582	Continued From page 4 An interview was completed with the Administrator on 9/18/18 at 1:07 PM. He stated he was unaware that the ABN form was to be completed after a part A Medicare stay and the resident remained in the facility. He said that going forward he would expect the ABN notice be issued when a resident remained in the facility following a part A Medicare stay.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		10/17/18

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F 584	Continued From page 5 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and resident interviews the facility failed to provide a non-institutional dining experience by not offering residents the option for their food to be removed from their tray for 3 of 4 dining areas (Hall 400, Hall 600 and second floor dining room). Findings included: 1a. An observation was made on 9-11-18 between 12:00pm and 12:30pm in the dining area of hall 400. There was noted to be 4 residents sitting at the dining room table and a nursing assistant placing a tray of food in front of each resident removing the cover on the plate. The nursing assistant was noted not to ask the residents if they would like their food taken off the tray. 1b. During an observation on 9-11-18 between 12:00pm and 12:30pm in the dining area of hall 600 it was noted that there were 3 residents siting at the dining room table and a nursing assistant was passing out the lunch trays. The nursing	F 584	F584 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The C.N.A□s Caring for residents #4 and #97 were provided one on one re-education regarding all residents being offered to have their meals removed from trays. 2. Identification of other residents having the potential to be affected was	

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F 584

Continued From page 6

assistant was noted to leave the residents food on the tray without giving the option for the resident to not eat their food on the tray.

During an observation on 9-11-18 at 6:15pm in the dining area of hall 600 there were 3 residents sitting at the dining room table receiving their dinner meal on trays and were not being given the option to have their meal taken off the tray.

1c. An observation was made on 9-11-18 at 5:25pm in the second-floor dining room. There were approximately 5 residents noted to be receiving their dinner on a tray without the option being given not to have their food on a tray.

An observation was made on 9-13-18 at 12:20pm in the second-floor dining room where lunch was being served on trays and the residents were not being given the option to not have their meal left on the tray.

During an interview with Resident #97, who was eating in the second-floor dining room on 9-13-18 at 12:22pm, he stated the nursing assistant had "never asked me if I didn't want to eat on my tray. We just always get our food like this." Resident also stated he would like to not have his food off the tray "so we have more room at the table."

An interview with the nursing assistant(NA) #3 occurred on 9-13-18 at 12:23pm. NA #1 stated she was the nursing assistant that served the meals in the dining room on the second floor and that she had never given the residents a choice to not eat on their trays "this is just how we have always done it."

During an interview with the Assistant Director of

F 584

accomplished by:
Observation of residents during meal times by the Director of Nursing and Assistant Director of Nursing from 10/8/18 through 10/11/18 indicated that all residents have the potential to be affected by the alleged deficient practice. However, no specific at-risk residents were identified; therefore, a new policy and procedure was developed to better ensure proper meal service to all residents. Furthermore, all nursing staff will be educated on the new policy and procedure finalized on 10/10/18. Multiple education sections will be conducted from 10/11/18 through 10/17/18.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
A policy governing meal service was developed and finalized on 10/10/18, and the facility nursing staff was educated at multiple education sections to be conducted between 10/11/18 and 10/17/2018 regarding the new policy then the policy was implemented.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
Nursing administrative staff will observe and record the resident meal service for

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F 584	Continued From page 7 Nursing (ADON) on 9-18-18 at 9:37am she stated she trains the nursing assistance in nutrition upon hire and that she was aware that the residents should be given an option not to have their plates left on the tray but that she did not teach this practice to the nursing assistance during new hire orientation. She also stated she expected the nursing assistant who was training the new hire assigned to them to teach the new nursing assistant the practice of giving the resident an option not to have their plates left on their tray. An interview with the Director of Nursing (DON) occurred on 9-19-18 at 10:16am. The DON stated she expected the nursing assistant to offer for the meal to be removed from the tray and if the resident was not cognitive enough to answer the question then the nursing assistant was expected to remove the meal from the tray.	F 584	compliance with the new policy, and compliance by staff with provision of beverages and food items being removed from trays. Additional corrective action will be taken as needed. Random audits will be conducted: three times pre-week for 8 consecutive weeks and then twice weekly for an additional 8 weeks. Audit records will be presented and reviewed at the monthly QAPI meetings for their review and input. Corrective action completion date: 10/17/2018	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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	F 656		10/17/18

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F 656	Continued From page 8 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop and implement a comprehensive person centered care plan on 1 out of 1 resident (Resident #33) reviewed for smoking at the facility. Findings include: Resident #33 was admitted to the facility on 7/26/01 with diagnoses that included stroke with hemiplegia and dementia. Resident #33's most recent MDS (Minimum Data Set) was dated 7/9/2018 and was coded as an annual assessment. Resident #33 was coded as cognitively impaired. Active diagnoses included	F 656	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. F656 1. Immediate action(s) taken for the resident(s) found to have been affected	

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 656	Continued From page 9 unspecified mood disorder, cerebrovascular accident, hemiplegia, dementia, and nicotine dependence. Resident #33's functional status was coded as limited one-person assistance with transferring and personal hygiene, and supervision with eating and locomotion on/off the unit. A review of Resident #33's care plan dated 7/9/18 revealed the resident was not care planned for smoking precautions at the facility or any previous care plans dating back to 2017. An observation was made on 9/11/18 at 12:45pm of Resident #33. Resident #33 asked Nurse #2 for a cigarette so she could go smoke. The nurse retrieved a cigarette from the medication cart and the resident rolled in her wheelchair out on the porch off the dining area of the 300 hall with Nurse #2. Nurse #2 lit the resident's cigarette then came back inside. Observed the resident smoking her cigarette unsupervised. An interview was conducted with Nurse #2 on 9/13/18 at 12:29pm. Nurse #2 reported when she first started working on the memory care unit, she was told Resident #33 didn't need supervision with smoking but just recently she was told that Resident #33 did need assistance with smoking. She reported she had never seen that a smoking assessment had been done on the resident and there was nothing in her care plan. An interview was conducted with the DON (Director of Nursing) on 9/18/18 at 10:11am. She reported it was her expectation that any resident who could smoke at the facility should be care planned for smoking precautions. She confirmed Resident #33's care plan did not include smoking precautions. An interview was conducted on 9/18/18 at 3:30pm with the MDS coordinator. She reported she only updated a care plan if told of a change	F 656	include: Care plan of the resident #33 was reviewed and updated as indicated on 9/12/18. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that no other residents have the potential to be affected due to above resident being the only smoker in the facility. The facility is non-smoking and resident #33 was grand fathered in when new policy was implemented. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A Comprehensive Care Plan policy was developed and finalized on 10/10/2018 then implemented. All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility□'s policy and procedure for developing Comprehensive Care Plans this education will be conducted on 10/17/2018. The care plan invitation letter was updated to encourage participation to assist with development of individualized resident center care plans. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated.	

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F 656	Continued From page 10 with the resident's condition.	F 656	The Director of Nursing Services (DNS), or designee, will complete random weekly audits of 4 care plans for six (6) consecutive weeks, followed by random monthly audits of 10 care plans for an additional 5 months. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: October 17, 2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 657		10/17/18

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 09/19/2018

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 657 Continued From page 11

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 observations, record reviews, and staff interviews, the facility failed to update the Care Plan of 1 of 1 sampled resident requiring treatment and services for a contracture of the right hand. Resident #60.

Findings included:

Resident #60 was admitted to the facility on 2/23/18 with diagnoses which included: Parkinson's disease, white matter disease, and dementia.

A review of the quarterly minimum data set dated 7/31/18 indicated Resident #60 was severely,cognitively impaired; required extensive assistance of two staff with bed mobility; was totally dependent of two staff with transfers; and had no range of motion impairments.

Review of the Care Plan dated 7/31/18 documented Resident #60's diagnosis of Parkinson's disease with the goal of remaining at the highest level of health possible within the disease limitations. Interventions included: referral to occupational, physical, and/or speech therapy, as necessary.

F 657

Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.
F-657
1. Immediate action(s) taken for the resident(s) found to have been affected include:
Care plan of the resident #60 was reviewed and updated as indicated on 9/13/18 and again on 9/18/18.

2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that all residents have the potential to be affected by the alleged deficient practice. A new protocol for monitoring of ROM was implemented and screens on all residents in the facility were completed.

3. Actions taken/systems put into place

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F 657

Continued From page 12

The Care Plan was not updated to include range of motion services and Resident #60 ' s hand contracture.

During an observation on 9/11/18 at 12:11 p.m., Resident #60 was awake, alert and verbal with some confusion. The resident's right hand was observed lying atop of the bed blanket in a fisted position. When asked if he could open his hand, the resident was unable to fully extend his fingers of his right hand. Upon further inspection of the resident's room, there was no splinting device observed in the room.

During an interview on 9/13/18 at 11:29 a.m., NA#5 (nursing assistant) indicated Resident #60 was alert and verbal but had some confusion. She stated that she had frequently worked with the resident since his admission. NA#5 stated that because the resident's right hand was contracted she would place a rolled cloth in the hand, but the resident continuously dropped it. NA#5 revealed the resident did not have a splinting device and was not currently receiving therapy.

During an interview on 9/13/18 at 2:00 p.m., the Rehabilitative Director revealed Resident #60 was not currently receiving therapy and the rehabilitative department had not received a therapy referral from the nursing department.

On 9/18/18 at 9:15 a.m., Resident #60 was observed sitting upright in bed, slowly feeding himself using a fork in his right, fisted hand.

During an interview on 9/18/18 at 1:46 p.m., the Rehabilitative Director stated if/when a functional change was noticed in a resident, the facility

F 657

to reduce the risk of future occurrence include:
A Care Plan Revision policy was developed and implemented. All interdisciplinary care plan team members responsible for writing/updating care plans were educated on the facility's policy and procedure for Care Plan revision. ROM evaluation will be completed on admission for new residents and on a quarterly basis for existing residents. Care plans will be updated with declines in ROM from baseline as noted.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
Updates will be completed when noted by the MDS Coordinators and/or nursing designee. All care plans will be reviewed at least on a quarterly basis.
The Director of Nursing Services (DNS), or designee, will complete random weekly audits of 4 care plans to assess updates of acute changes for six (6) consecutive weeks, followed by random monthly audits of 10 care plans for an additional 5 months.
Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Corrective action completion date:
October 17, 2018

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 657	Continued From page 13 nurses were to complete a Rehabilitative/Therapy Referral form. She indicated the Rehabilitative department had received several referrals of residents from the nurses, but had not received any referrals concerning Resident #60. The Rehabilitative Director revealed that as a result of the prior interview on 9/13/18, the resident was assessed and added to the therapy caseload on 9/17/18 by the OT (occupational therapist) for ROM (range of motion) of his right hand. She stated that the resident's right hand had a partial contracture; but the resident was at risk for contractures and the length of time the hand had been contracted could not be determined due to his diagnosis of Parkinson's disease. She revealed Resident #60 would also be fitted for a splinting device for his partially, contracted right hand. During an interview on 9/18/18 at 3:52 p.m., the MDS (minimum data set) Manager stated she was not aware Resident #60 had any ROM changes. She revealed the nurses were to inform the MDS staff when there was a change in a resident's functional ability via a direct message in the facility's software system or documenting the change in function on the 24-hour report. The MDS Manager stated that Resident #60's Care Plan would be immediately updated to include his contracted right hand.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		10/17/18

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	345090	A. BUILDING ______ B. WING ______	C 09/19/2018

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F 677	Continued From page 14 by: Based on observations, record review, and staff interviews, the facility failed to provide assistance with meals for 2 of 4 sampled residents (Resident # 69, Resident #63) who were dependent on staff for ADL care (Activities of Daily Living). Findings include: 1. Resident #69 was admitted to the facility on 10/5/14 with vascular dementia, pseudobulbar affect, and depression. A review of Resident #69's most recent MDS (Minimum Data Set) dated 8/2/18 was coded as a quarterly assessment. Resident #69 was coded as cognitively impaired and as needing extensive one-person assistance with eating. Active diagnoses included Non-Alzheimer's dementia, hypertension, and depression. A review of Resident #69's most recent care plan dated 8/2/18 revealed the resident was care planned to help as needed with meals, cue/redirect resident to finish meals, and monitor food consumption. Resident #69 was care planned to need extensive assistance with ADLs. An observation was made on 9/11/18 at 12:30pm of Resident #69 at lunch in the dining area on the memory care unit. Nurse #2 placed Resident #69's tray on the table in front of the resident. Observations of the meal tray revealed the tray had 4 covered bowls on it. Nurse #2 opened one of the bowls and handed it to the resident with a spoon. Resident #69 ate all the food in the bowl and kept scraping the sides. When Resident #69 had cleaned the bowl, she sat with the bowl in her hands. It was observed that no staff came over during the meal. At 12:55pm, the aides picked up Resident #69's tray after placing the empty bowl on it and the aides did not offer the resident any of the other unserved foods on her meal tray. The other 3 bowls of food on the resident's meal tray	F 677	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. F-677 1. Immediate action(s) taken for the resident(s) found to have been affected include: The nursing staff caring for resident□s #63 & #69 were re-educated regarding appropriate methods for assisting these resident□s #63 & #69 during meal times. 2. Identification of other residents having the potential to be affected was accomplished by: Observation of resident meal times by the Director of Nursing and Assistant Director of Nursing showed that all residents have the potential to be affected by the alleged deficient practice. The observations were conducted from 10/8/18 through 10/10/2018. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Serving a meal policy was developed and finalized on 10/10/2018. Observation of all residents on the 300 unit was completed	

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	345090	A. BUILDING _______ B. WING _______	C 09/19/2018

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F 677	Continued From page 15 remained unopened. An observation was made on 9/12/18 at 12:30pm of Resident #69 at lunch in the dining area on the memory care unit. It was observed that staff placed the resident's 4 covered bowls in front of her. Nurse #2 opened the pinto bean bowl and the rice bowl and combined the food and placed the mixed food on the table in front of Resident #69. Resident #69 was observed to eat one bite of food with the spoon then dropped the spoon on the table. Resident #69 then started picking up the food with her fingers. She kept moving the bowl closer to the edge of the table as she ate. Nurse #2 was observed to come over to the table Resident #69 was seated at and she assisted a couple other residents with their meal, but she did not provide any meal assistance to Resident #69. Resident #69 proceeded to spill bowl of food into lap/floor during meal while attempting to feed herself the meal. An interview was conducted with Nurse #2 on 9/12/18 at 12:59pm. She reported Resident #69 could not open her own bowls to eat so staff had to open them for her and hand them to her. An interview was conducted with NA #4 (Nursing Assistant) on 9/19/18 at 9:35am. He reported there were only 2 residents on the memory care unit that needed assistance with feeding and both usually were fed in their rooms. He reported the residents that ate in the dining room including Resident #69 could feed themselves once the tray was set up. 2. Resident #63 was admitted to the facility on 4/27/11 with diagnoses that included diabetes mellitus, mood disorder, and dementia. A review of Resident #63's most recent MDS dated 8/8/18 was coded as a quarterly assessment. The MDS coded the resident as cognitively impaired. Active diagnoses included	F 677	by the nursing supervisor from 10/8/2018 through 1/10/2018, and CNA instructions reviewed for appropriate assistance needed for the residents. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The dayshift nursing supervisors will monitor the resident meal times on 300 for compliance with the new policy and compliance by staff to provide assistances as assigned and needed by the residents. Monitoring will be randomly three times a week for 6 consecutive weeks and then twice weekly for an additional 6 weeks. Audit records will be presented and reviewed at the monthly QAPI meetings. Corrective action completion date: October 17, 2018	

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F 677	Continued From page 16 Non-Alzheimer's dementia, diabetes mellitus, and psychotic disorder. Resident #63's functional status was coded as resident needed extensive one-person assistance with eating. A review of Resident #63's care plan dated 8/8/18 revealed the resident was care planned for ADL self-care deficits which included assisting and encouraging resident throughout meals. An observation was made on 9/11/18 at 12:32pm of Resident #63 during a meal in the dining area of the memory care unit. Observed that Resident #63 had difficulty using her spoon to obtain food off her plate. Resident #63 would attempt to get food off plate but unable to perform the task, so she would eat her brownie that she picked up with her fingers. Throughout the meal, Resident #63 was observed attempting to unsuccessfully eat food off her plate. No staff were observed to assist the resident during the meal. Observations at 1:00pm revealed an aide picked up the resident's tray without asking the resident if she was finished with her meal or to provide encouragement to eat more. An observation was made on 9/12/18 at 12:55 pm of Resident #63 during a meal in the dining area of the memory care unit. Observed Resident #63 having difficulty with using fork for food. Nurse #2 came over and stood over the resident and assisted her with using her fork for a couple bites then left to take care of another resident. After Nurse #2 left Resident #63, she continued to struggle to eat her meal. An interview was conducted with Nurse #2 on 9/12/18 at 1:10pm. Nurse #2 reported Resident #63 needed to be encouraged to eat. Reported the resident sometimes did need some assistance with meals. An interview was conducted with NA #4 (Nursing Assistant) on 9/19/18 at 9:35am. He reported	F 677		

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	345090	A. BUILDING ______ B. WING ______	C 09/19/2018

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F 677	Continued From page 17 there were only 2 residents on the memory care unit that needed assistance with feeding and both usually were fed in their rooms. He reported the residents that ate in the dining room including Resident #63 could feed themselves once the tray was set up. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 2:00pm. She reported it was her expectation that all residents care planned as needing assistance with meals be aided throughout the meals. She reported it was the responsibility of the nurse and the aides on the memory care unit to assist and be present in the dining area during the meals.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff	F 688	Preparation and/or execution of this plan	10/17/18

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F 688	Continued From page 18 interviews, the facility failed to provide treatment and services to increase range of motion and prevent the right handed contracture of 1 of 1 sampled resident reviewed for limited range of motion. Resident #60. Findings included: Resident #60 was admitted to the facility on 2/23/18 with diagnoses which included: Parkinson's disease, white matter disease, and dementia. A review of the quarterly minimum data set dated 7/31/18 indicated Resident #60 was severely, cognitively impaired; required extensive assistance of two staff with bed mobility; was totally dependent of two staff with transfers; and had no range of motion impairments. Review of the Care Plan dated 7/31/18 documented Resident #60's diagnosis of Parkinson's disease with the goal of remaining at the highest level of health possible within the disease limitations. Interventions included: referral to occupational, physical, and/or speech therapy, as necessary. Review of the Progress Notes from Resident #60's admission date to 9/14/18 revealed no documentation of the resident's contracted right hand and/or range of motion issues. During an observation on 9/11/18 at 12:11 p.m., Resident #60 was awake, alert and verbal with some confusion. The resident's right hand was observed lying atop of the bed blanket in a fisted position. When asked if he could open his hand,	F 688	do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F-688 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 60 was screened on 9/17/18 by the therapy department. Occupational therapy services were initiated. A new splint was ordered for the resident and implemented on 10/5/18. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by the alleged deficient practice. Therefore, a ROM evaluation form has been initiated for all resident currently in the facility and screens completed. Therapy referrals will be completed for need, as indicated by the screens. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A ROM evaluation form initiated for all resident currently in the facility. Form will be completed on admission and reviewed quarterly. Education provided to nursing department staff regarding new evaluation process and referral to therapy if a decline	

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	345090	A. BUILDING ______ B. WING ______	C 09/19/2018

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F 688

Continued From page 19

the resident was unable to fully extend his fingers of his right hand. Upon further inspection of the resident's room, there was no splinting device observed in the room.

During an interview on 9/13/18 at 11:29 a.m., NA#5 (nursing assistant) indicated Resident #60 was alert and verbal but had some confusion. She stated that she had frequently worked with the resident since his admission. NA#5 stated that because the resident's right hand was contracted she would place a rolled cloth in the hand, but the resident continuously dropped it. NA#5 revealed the resident did not have a splinting device and was not currently receiving therapy.

During an interview on 9/13/18 at 2:00 p.m., the Rehabilitative Director revealed Resident #60 was not currently receiving therapy and the rehabilitative department had not received a therapy referral from the nursing department.

On 9/18/18 at 9:15 a.m., Resident #60 was observed sitting upright in bed, slowly feeding himself using a fork in his right, fisted hand.

During an interview on 9/18/18 at 1:46 p.m., the Rehabilitative Director stated if/when a functional change was noticed in a resident, the facility nurses were to complete a Rehabilitative/Therapy Referral form. She indicated the Rehabilitative department had received several referrals of residents from the nurses, but had not received any referrals concerning Resident #60. The Rehabilitative Director revealed that as a result of the prior interview on 9/13/18, the resident was assessed and added to the therapy caseload on 9/17/18 by the OT (occupational therapist) for

F 688 (Plan of Correction)

in ROM is noted.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The nursing supervisors will review new admissions for completion of ROM evaluation by charge nurse. Director of Nursing Services (DNS) will conduct random audits weekly, as follows, 2 new admissions and 1 long term resident for forms in medical record and completion of therapy evaluation if indicated for 6 weeks and then 1 each once weekly for 6 additional weeks. Audit records will be presented and reviewed at the monthly QAPI meetings.

Corrective action completion date:
October 17, 2018

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 688	Continued From page 20 ROM (range of motion) of his right hand. She stated that the resident's right hand had a partial contracture; but the resident was at risk for contractures and the length of time the hand had been contracted could not be determined due to his diagnosis of Parkinson's disease. She revealed Resident #60 would also be fitted for a splint for his partially, contracted right hand.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to supervise a resident during smoking and to have safety equipment accessible to prevent smoking accidents and fires for 1 out of 1 residents (Resident #33) reviewed for smoking at the facility. Findings include: A review of the facility's smoking policy dated August 2010 revealed "the staff will review the status of a resident smoking privileges periodically, and consult as needed with the Director of Nursing Services and the Attending Physician." Resident #33 was admitted to the facility on 7/26/01 with diagnoses that included stroke with hemiplegia and dementia.	F 689	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. F-689 1. Immediate action(s) taken for the resident(s) found to have been affected include: The care plan for resident #33 was updated on 9/12/18. A new smoking evaluation was completed for resident #33	10/17/18

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F 689

Continued From page 21

Resident #33's most recent MDS (Minimum Data Set) was dated 7/9/2018 and was coded as an annual assessment. Resident #33 was coded as cognitively impaired. Active diagnoses included unspecified mood disorder, cerebrovascular accident, hemiplegia, dementia, and nicotine dependence. Resident #33's functional status was coded as limited one-person assistance with transferring and personal hygiene, and supervision with eating and locomotion on/off the unit.

A review of Resident #33's current care plan dated 7/9/18 revealed the resident was not care planned for smoking precautions at the facility or any previous care plans dating back to 2017.

A review of Resident #33's medical record revealed no recent smoking assessments could be located in the medical record.

An observation was made on 9/11/18 at 12:45pm of Resident #33 who resided in the facility's memory care unit. Resident #33 was observed to ask Nurse #2 for a cigarette, so she could go smoke. The nurse retrieved a cigarette from the medication cart and the resident rolled in her wheelchair out of the facility onto the porch off the dining area of the 300-hall with Nurse #2. Further observations revealed Nurse #2 lit the resident's cigarette then came back inside the facility which left the resident unsupervised while smoking her cigarette. Observations of Resident #33 smoking her cigarette revealed some cigarette ashes fell from her cigarette onto the concrete ground below her while she was reaching for the ashtray. Observations revealed an ashtray located on the table next to the resident's wheelchair within the resident's reach. Resident #33 was observed to put out the cigarette in the ashtray on a glass table. The resident was observed to ring the doorbell to be let back in the facility. Nurse #2

F 689

on 9/7/18. The facility placed a fire extinguisher in the smoking area on 9/10/18. A smoking blanket was obtained on 10/02 /2018 and mounted on the wall just inside the designated smoking area door. A smoking apron was placed in the designated smoking area for resident on 9/10/2018. Signage was place on the designated smoking area door on 10/2/2108.

2. Identification of other residents having the potential to be affected was accomplished by:
Resident #33 is the only smoking resident left in the facility; therefore, she was determined to be the only resident with the potential to be affected by this all alleged deficient practice.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
The resident's safe smoking assessment will be completed quarterly for any resident in the facility that is smoking.
The smoking policy was reviewed and updated. The facility administrator will check the smoking area for protective equipment, signage, and staff resident supervision daily for 5 days then he will complete 3X week random checks for 30 days then weekly checks for an additional 60 days. Additionally, the 300 hall nursing staff was educated regarding the revised safe smoking protocol and updated policy.

4. How the corrective action(s) will be

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 09/19/2018

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 689	Continued From page 22 came to the door and let the resident back into the facility when she was finished smoking her cigarette. Red metal trashcan in corner of the porch. An interview was conducted on 9/12/18 at 10:40pm with NA #2. She reported that Resident #33 had certain times she was able to go outside to smoke. She reported the resident had to have supervision when she smoked so someone always had to stay outside with Resident #33 due to the resident having confusion and agitation at times. NA #2 reported there was no smoking apron, fire blanket, or fire extinguisher in the smoking area. NA #2 reported Resident #33 was the only resident in the facility allowed to smoke as she was grandfathered in when the facility became non-smoking. She reported Resident #33 was allowed to smoke only on the porch off the 300-hall dining area. An interview was conducted on 9/12/18 at 10:45pm with NA #1. She reported Resident #33 had to always have supervision with smoking because of confusion. NA #1 reported Resident #33 did not have anything to protect her clothes from ashes when she smoked. She reported she never saw Resident #33 dropping ashes or her cigarette while smoking. An interview was conducted on 9/13/18 at 12:27pm with Resident #33. She reported sometimes staff would go out with her while she smoked and sometimes they let her go on her own. An interview was conducted with Nurse #2 on 9/13/18 at 12:29pm. Nurse #2 reported when she first started working on the memory care unit, she was told Resident #33 didn't need supervision with smoking but just recently she was told that Resident #33 did need assistance with smoking. She reported she had never seen that a smoking	F 689	monitored to ensure the practice will not recur: The facility administrator will check the smoking area for protective equipment, signage, and staff resident supervision daily for 5 days then 3X week random checks for 30 days then weekly for an additional 60 days. Additional corrective action will be implemented as indicated. Timely completion of the resident's smoking assessments will be conducted quarterly by the MDS coordinator and she will take additional corrective action as indicated. Summaries of findings will be presented monthly to the facilities QAPI Committee for their review and input. Corrective action completion date: October 17, 2018	

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	345090	A. BUILDING ______ B. WING ______	C 09/19/2018

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

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F 689	Continued From page 23 assessment had been completed on the resident and there was nothing in her care plan about whether she needed supervision or not. She reported she never knew the resident to have any problems smoking and that usually she only took a few puffs of her cigarette and was done. An interview was conducted with the DON (Director of Nursing) on 9/18/18 at 10:11am. She reported the facility was a non-smoking facility. She reported Resident #33 was grandfathered in and allowed to continue to smoke as she had been a resident since 2001. She reported Resident #33 was the only resident allowed to smoke at the facility. The DON reported she could not find that a smoking assessment had been done on Resident #33 in at least 5 years. She reported it was her expectation that a smoking assessment would be done on the resident at least quarterly. She reported the nurses should have completed the smoking assessments. She reported it was her expectation that a smoking area be equipped with safety items in case of fire. The DON reported the smoking area should have signage, a smoking apron, metal trash can for disposal of ashes, and a fire blanket or fire extinguisher. She reported it was her expectation that any resident who needed supervision with smoking be supervised. She reported Resident #33 needed supervision with smoking cigarettes due to her cognitive impairment.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		10/17/18

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 09/19/2018

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F 755 — Continued From page 24 — F 755

§483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(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.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and staff and resident interviews, the facility allowed a nursing assistant instead of a licensed nurse to administer a prescription powder to 1 out of 3 residents (Resident #32) reviewed for ADL (Activities of Daily Living).
Findings include:
Resident #32 was admitted to the facility on 5/27/17 with diagnoses that included chronic respiratory disorder and hemiplegia following

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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 09/19/2018

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F 755

Continued From page 25

cerebral infarct.
Resident #32's most recent MDS (Minimum Data Set) was dated 7/9/18 and was coded as a quarterly assessment. The resident was coded as minimally impaired cognitively. Active diagnoses included cerebrovascular accident, hemiplegia, and diabetes. Resident #32's functional status was coded as needing 2-person total assistance with bathing, bed mobility, and Activities of Daily Living. Resident #32 was coded as always incontinent of bowel and bladder.
A review of Resident #32's medical record revealed a physician's order written 5/30/17 that read Mycostatin 100,000 unit/gram topical powder apply by topical route twice daily.
An observation was conducted on 9/12/18 at 10:20pm of Resident #32 receiving incontinence care by NA (Nursing Assistant) #1 and #2. During the observation, NA #1 retrieved a bottle in a prescription bag labeled "Mycostatin powder apply twice a day" off the windowsill. NA #1 applied the powder from the prescription bottle to Resident #32's groin and perineal area. When NA #1 finished using powder, she placed the bottle back in the bag and placed it back in the windowsill.
An interview was conducted on 9/12/18 at 10:30pm with NA #1 and NA #2. NA #1 reported she followed the resident's care plan and the nurse's report when providing care to the residents. She reported she applied the Mycostatin powder to Resident #32 with every incontinence episode. NA #2 reported that nursing assistants were not allowed to apply any prescription ointments or powders to residents, only nurses could apply prescription medications.
An interview was conducted on 9/12/18 at 11:39pm with Nurse #1. She reported all prescription medications including prescription

F 755

F-755
1. Immediate action(s) taken for the resident(s) found to have been affected include:
The medicated powder was removed from resident #32 s room by the charge nurse, and a sweep of all rooms was performed by the Nursing Supervisor. No additional unsecured medications were found.

2. Identification of other residents having the potential to be affected was accomplished by:
The facility recognizes that all residents have the potential to be affected by the alleged deficient practice; however, as no additional unsecured medications were found all nursing staff will be re-educated on the North Carolina scope of practice; as well as, the consequences of varying from these ordinances.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
All facility staff were reeducated regarding scope of CNA practice during multiple education sessions conducted between 10/11/2018 and 10/17/2018. ADON will re-educate and provide current CNA staff the task list for nurse aides provided by the North Carolina state registry. Newly hired nurse aides will be provided the task list on hire in orientation. The task list

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 09/19/2018

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F 755	Continued From page 26 ointments and powders are only to be administered by nurses, not nursing assistants. She reported if a resident had an order for a prescription ointment or powder to be applied with incontinence care, then the NA would let the nurse know when the care was being provided so the nurse could apply the ointment or powder. She reported any prescription ointment or powder is listed on the resident's MAR (Medication Record Administration). She reported all prescription medications including prescription powders should be locked in the medication cart. An interview was conducted with the DON (Director of Nursing) on 9/13/18 at 12:14am. She reported no nursing assistant is to apply any prescription ointments or powders. She reported it is her expectation that all prescription ointments or powders be administered by a licensed nurse.	F 755	was also posted at the CNA kiosks for charting at the facility. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The ADON will perform once weekly audits of each hall, 1-6 for proper storage of medications for 6 weeks, and then biweekly for 6 weeks. Additional corrective actions will be provided as needed. The Audit records will be presented and reviewed at the monthly QAPI meetings for their review and input. Corrective action completion date: October 17, 2018	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		10/17/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 27 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 6 residents (Resident #15) reviewed for unnecessary medications. Findings include:	F 758	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this	

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	345090	A. BUILDING ______ B. WING ______	C 09/19/2018

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 758

Continued From page 28

Resident #15 was admitted to the facility on 1/18/07 with diagnoses that included atrial fibrillation, cerebrovascular accident, and vascular dementia.
A review of Resident #15's medical record revealed a physician order initially written on 10/15/2015 that read: "Ativan 2 mg/ml (milligram per milliliter) injection solutions Inject 0.5ml (milliliter) by injection route as needed for 1 dose as needed in 30 minutes if initial dose administered at 12 noon is not effective every week (PRN) on Saturday 12:30pm-1:30pm."
A review of Resident #15's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and dated 6/19/18. The resident was coded as cognitively impaired. Active diagnoses included dementia, anxiety, depression, and psychotic disorder. Resident #15's 7 day look back on medications revealed he received antipsychotic medications 7 out of 7 days.
A review of Resident #15's medical record revealed documentation from the pharmacy consultant on 5/18/18 requesting a GDR (Gradual Dose Reduction) of Ativan 0.5ml injection prn. The facility physician responded on 6/25/18 to keep the medication the same due to the resident's behaviors.
A review of Resident #15's medical record's physician documentation since October 2017 revealed the first time a physician's documentation addressed the PRN Ativan was 7/27/18. The psychiatric nurse practitioner documented "This is a 14 day review of PRN psychiatric medications as required by CMS. It is well tolerated and should be continued as a PRN for an additional 14 days. Will reassess in 14 days." The medical record revealed the next documentation addressing the PRN Ativan was

F 758

response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance.
F-758
1. Immediate action(s) taken for the resident(s) found to have been affected include:
The Director of Nursing (DNS) completed a review of physician□s orders for resident #15. The Director of Nursing then provided a copy of her findings to the Physician who then determined that the identified medication could be discontinued. The medication was then discontinued on 9/21/18 at 9:28 am due to the resident□s non-use of medication.

2. Identification of other residents having the potential to be affected was accomplished by:
As all residents have the potential to be affected by the alleged deficient practice; the DNS completed a review of all current residents in the facility with orders for PRN antianxiety and antipsychotic medications for a 14 day stop order. This list was provided the medical providers who reviewed the medications and documented appropriate stop orders, or discontinued the medication as clinically appropriate.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
The protocol for ordering prn psychoactive medications was updated. The charge nurse will provide a copy of all PRN psychoactive medications prescriptions to

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 09/19/2018

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 758	Continued From page 29 on 8/15/18. There was no further documentation addressing of the PRN Ativan in Resident #15's medical record. An interview was conducted on 9/18/18 at 2:55pm with the facility's pharmacy consultant. She reported she was to request any medication changes to the facility physician, but all antipsychotic medications were to be addressed by the psychiatric provider. She reported the provider was to address the prn Ativan every 14 days. She reported she had requested GDR's on Resident #15's medications with the provider not wanting to change the medications. An interview was attempted with the psychiatric provider on 9/18/18 at 3:15pm with no response. An interview was conducted on 9/18/18 at 4:05pm with the DON (Director of Nursing). She reported Resident #15's Ativan prn order needed to be assessed every 14 days to determine if the resident needed to continue to have Ativan prn. She reported this assessment was not happening as it was the psychiatric provider's responsibility to address and he only visited monthly. She reported it was her expectation that any prn psychotropic medications be reassessed by the provider every 14 days. An interview was conducted on 9/18/18 at 4:15pm with the psychiatric nurse practitioner. He reported he began treating Resident #15 in July 2018. He reported he had addressed the prn Ativan but not every 14 days since he was not the one who originally wrote the order.	F 758	the DNS following faxing of orders to the pharmacy. Nurses will be provided education at multiple education sessions from 10/11/2108 through 10/17/2018; regarding the protocol governing the ordering of all PRN psychoactive medications including the need to review medications for continued need after the initial 14 day period, and the nurse caring for the resident will provided the medical provider any information required to assist them in making this decision. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS will maintain a log of all PRN psychoactive medications orders received from providers, and the DNS will review the list prior to the 14 day stop dates. To ensure compliance with the revised protocol: on a bi-weekly basis for 6 consecutive weeks, and then weekly for 6 additional weeks the DNS will compare the log to the chart to ensure stop date compliance or that new orders have been received An audit summary will be presented and reviewed at the monthly QAPI meetings for their review and input. Corrective action completion date: October 17,2018	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		10/17/18

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 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761

Continued From page 30

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.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(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.

§483.45(h)(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 and staff interviews, the facility failed to properly store a prescription bottle of Mycostatin powder for one of three residents (Resident #32) observed for incontinence care.

Findings include:

Resident #32 was admitted to the facility on 5/27/17 with diagnoses that included chronic respiratory disorder and hemiplegia following cerebral infarct.

Resident #32's most recent MDS (Minimum Data Set) was dated 7/9/18 and was coded as a quarterly assessment. The resident was coded as minimally impaired cognitively. Active diagnoses

F 761

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F-761

1. Immediate action(s) taken for the resident(s) found to have been affected

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	345090	A. BUILDING ______ B. WING ______	C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 31 included cerebrovascular accident, hemiplegia, and diabetes. Resident #32's functional status was coded as needing 2-person total assistance with bathing, bed mobility, and Activities of Daily Living. Resident #32 was coded as always incontinent of bowel and bladder. A review of Resident #32's medical record revealed a physician's order written 5/30/17 that read Mycostatin 100,000 unit/gram topical powder apply by topical route twice daily. An observation was conducted on 9/12/18 at 10:20pm of Resident #32 receiving incontinence care by NA (Nursing Assistant) #1 and #2. During the observation, NA #1 retrieved a bottle in a prescription bag labeled "Mycostatin powder apply twice a day" off the windowsill. NA #1 applied the powder from the prescription bottle to Resident #32's groin and perineal area. When NA #1 finished using powder, she placed the bottle back in the bag and placed it back in the windowsill. An interview was conducted on 9/12/18 at 11:39pm with Nurse #1. She reported all prescription medications are to be locked up in the medication cart and this included prescription ointments and powders. She reported she applied Mycostatin powder with each incontinence care performed on Resident #32. NA#1 reported the Mycostatin powder was always kept in the windowsill. An interview was conducted on 9/13/18 at 12:14am with the DON (Director of Nursing). She reported it was her expectation that all prescription powders or ointments be locked in the medication cart or the treatment cart. She reported it was her expectation that no prescription medications including prescription powders or ointments be left out in resident's rooms.	F 761	include: The medication for resident #32 was secured on 9/13/18 and returned to the medication cart. A sweep of facility performed by nursing staff on 9/13/18 of all rooms to assess for additional medications that were not secured including treatment or medication carts. Cart audit of all medication and treatment carts were conducted to ensure medications were labeled as per pharmacy. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by the alleged deficient practice. Therefore, a complete room sweep was conducted, and no additional residents were found to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All facility staff were re-educated regarding scope of CNA practice. ADON/DON have re-educated nursing staff the regarding proper storage of medications. The education occurred during multiple education in-services conducted between 10/11/18 and 10/17/2018. Additionally, ongoing monitoring of resident rooms and medication carts will be performed as noted.	

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 09/19/2018

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F 761	Continued From page 32	F 761	4. How the corrective action(s) will be monitored to ensure the practice will not recur: The ADON will perform once weekly audits of each hall, 1-6 for proper storage of medications for 6 weeks, and then biweekly for 6 weeks. A pharmacy designee will perform a monthly audit of each medication cart on an ongoing basis. Additional corrective action will be taken as needed. Audit records will be presented and reviewed at the monthly QAPI meetings. Corrective action completion date: October 17, 2018	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions the committee put in place following the 8/10/17 recertification and complaint survey. The facility again received recited deficiencies in the areas of: developing and revising care plans; accident	F 867	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan	10/17/18

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F 867

Continued From page 33

hazards; and drug storage during the recertification and complaint survey on 9/19/18. The continued failure of the facility during two surveys of record in the same areas of deficiency showed a pattern of the facility's inability to maintain an effective QAA program.

The tags were cross referenced to:

F656: Based on observations, record reviews, and staff interviews, the facility failed to develop and implement a comprehensive person centered care plan on 1 out of 1 resident (Resident #33) reviewed for smoking at the facility.

F657: Based on observations, record reviews, and staff interviews, the facility failed to update the Care Plan of 1 of 1 sampled resident requiring treatment and services for a contracture of the right hand. Resident #60.
Based on observations, record review, resident and staff interviews, the facility failed to supervise a resident during smoking and to have safety equipment accessible to prevent smoking accidents and fires for 1 out of 1 residents (Resident #33) reviewed for smoking at the facility.

F689: Based on observations, record review, resident and staff interviews, the facility failed to supervise a resident during smoking and to have safety equipment accessible to prevent smoking accidents and fires for 1 out of 1 residents (Resident #33) reviewed for smoking at the facility.

F761: Based on observations and staff interviews, the facility failed to properly store a

F 867

of correction is submitted as the facility's credible allegation of compliance.
F-867
1. Immediate action(s) taken for the resident(s) found to have been affected include:
The QAPI process for the facility was reviewed by the DON and administrator. A new policy was developed and implemented regarding facility QAPI processes.

2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that due to the alleged repeat of deficient practices in more than one area of concern that all residents have the potential to be affected.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
A new policy for the QAPI processed was developed, and the facility staff was educated regarding the new policy. Next, the new policy was implemented. A QAPI review box was obtained and placed in a center area for all staff to bring concerns or suggestions at any time for review by the IDT to determine if the item has a need for QAPI committee review.
Additionally, new facility policies were developed for the for tags F-656, F-657, and F689.

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F 867 Continued From page 34

prescription bottle of Mycostatin powder for one of three residents (Resident #32) observed for incontinence care.

During an interview on 9/19/18 at 12:03 p.m., the Director of Nursing (DON) revealed the facility's Quality Assurance meetings were held monthly with the committee members which included: the Administrator, the DON, the Medical Director, the Social Worker, the Infection Control Nurse, the Activity Director and the Maintenance Director. The Committee would meet and review the following areas as well as any additional areas that were identified: Safety Committee; Pharmacy Report; Care Plan completeness and accuracy; Infection Control; Sanitation; Wound Prevention; Nutrition and weight management; Resident Council concerns; and general resident concerns. The Director of Nursing indicated her expectation was for employees to report any concerns immediately in the facilities computer generated reporting system and/or to her or the Administrator.

F 867

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The DON and administrator will review concerns from other team members on a weekly basis to determine new areas might indicate a need for review, this will be an ongoing process for the facility. Monthly meeting by the QAPI team will continue on the current schedule. Status of the action plan related to repeat deficiencies for F-656, F-657, F-689, and F-761 will be reviewed at each QAPI meeting for 12 months. Written agendas and minutes will be reviewed and signed by the administrator. Audit records will be presented and reviewed at the monthly QAPI meetings. This will be a permanent on-going process that is subject to the same review and revision process as other policies and procedures.

Corrective action completion date: 10/17/2018.