STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345090	A. BUILDING _____ B. WING _____	C 08/29/2019

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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E 000	Initial Comments An unannounced Recertification survey was conducted 8/26/19 through 8/29/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JQ2U11.	E 000		
F 000	INITIAL COMMENTS A recertification with complaint investigation survey was conducted from 8/26/19-8/29/19. 2 of the 10 complaint allegations were substantiated resulting in deficiencies F 658 and F 686.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		9/26/19

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

Electronically Signed | 09/17/2019

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to indicate code status in the medical record for 1 of 23 residents (Resident #90) reviewed for advanced directives. The findings included: Resident #90 was admitted to the facility on 7/17/19 with diagnoses of, in part, Alzheimers, depression, hypertension and heart disease. A review of the comprehensive Minimum Data Set assessment dated 7/24/19 revealed Resident #90 had severely impaired cognition. A review of the electronic health record was conducted on 8/26/19. There was not a code status addressed for Resident #90. An interview was conducted on 8/27/19 at 3:37 PM with Nurse #2. She was asked where code	F 578	Tag Cited: F-578 Issue Cited: Request/Refuse/Discontinue Treatment-Formulate Advanced Directives 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: An order was written for resident #90 and entered into the EMR by the charge nurse at 3:38pm. The DNR was noted in the record already and was scanned in the EMR on 7/19/19.	

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F 578	Continued From page 2 status was found for residents. Nurse #2 stated code status is available in the electronic health record and on the report sheet. Surveyor asked Nurse #2 what Resident #90 ' s code status was, Nurse #2 went to the computer and pulled up Resident #90 ' s electronic health record. Nurse #2 stated she didn ' t see Resident #90 ' s code status addressed on the profile. Nurse #2 then looked at the physician orders in the electronic health record and could not locate a physician ' s order for code status. Nurse #2 then looked on her report sheet; no code status information for Resident #90 was observed on the report sheet. She stated the admission nurse would take the code status information from the discharge summary, but this did not get done for this resident. An interview was conducted on 8/29/19 at 4:56 PM with the Director of Nursing. She stated the admission nurse puts the order in for code status. She did not know why it did not get done for this resident.	F 578	2. Identification of other residents having the potential to be affected was accomplished by: An audit was completed on 8/27/19 at 4:00pm by the DON and 1st shift supervisor of all current resident records to ensure that an order was in place for each resident to match the current scanned directive for either Full code or DNR. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The admission order set that is used on each resident admission in the EMR library has been updated to not allow for order set to be completed/saved unless at least one advanced directive designation has been added for a resident. Staff provided education regarding the change. The admission review process includes review by nursing supervisor if advanced directive order is in place on admission and matches scanned document. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The nursing supervisor will audit each admission/re-admission on resident entry to ensure that order is in place and correct. The DON will complete twice weekly reviews of an admission/re-admission of resident to ensure that an order is in place X 8 weeks and then once weekly for an additional 8 weeks. All audit summaries will be	

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F 578	Continued From page 3	F 578	presented at the monthly QAPI meeting by the DON for review by the committee. Corrective action completion date: _____9/26/2019_____	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow a physician order for straws not to be used for 1 of 6 residents reviewed for nutrition (Resident #53). Findings included: Resident #53 was admitted to the facility on 4/3/18 with multiple diagnoses that included dysphagia. The quarterly Minimum Data Set (MDS) dated 7/3/19 revealed the resident had moderately impaired cognition, needed one to two-person extensive to total assistance for activities of daily living (ADLs), and required one-person supervision while eating meals. During an observation of Resident #53 on 8/26/19 12:40 PM Nurse #10 was setting up Resident	F 658	Tag Cited: F-658 Issue Cited: Services Provided Meet Professional Standards 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: Since notification of the use of a straw for resident #53 n 8/26/19 was not presented until 8/29/19 review was completed on that day by the DON to ensure that the	9/26/19

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F 658	Continued From page 4 #53's meal and this surveyor saw a straw in his drink cup. The resident took a sip from the straw. At the time of the observation, this surveyor had not reviewed his record and did not know that the resident had orders to not use straws. All other meal observations of the resident revealed no straws were used. Review of Resident #53's Care Plan revealed a plan in place last updated on 7/3/19 for risk for aspiration related to dysphagia with history of aspiration pneumonia. It stated that he required a soft textured diet with thin liquids with no use of straws. Resident #53's Physician Orders and diet slip were reviewed and revealed that he was receiving a mechanical soft textured diet for dysphagia management, and it specifically instructed that he did not use straws. Review of the Resident #53's Speech Therapy Discharge Summary dated for 10/31/18 revealed that the resident had an aspiration risk with straws due to overly large sip size and bolus propulsion to base of tongue at a quick rate. It stated that Resident #53 was not safe to use straws with thin liquids. During an interview with Nurse Assistant (NA) #10 on 8/29/19 at 12:03 PM she stated that Resident #53 did not get straws during meals because he was an aspiration risk. She stated that this information was located on his care plan and on the diet slip on his meal tray when it was delivered. During an interview with Nurse #10 on 8/29/19 1:47 PM she stated that she knew the resident was an aspiration risk, remembered setting his	F 658	diet ticket communicated “no straw” for resident. Order was added by the DON for charge nurse too sign each shift. PHI alert was added for resident #53 as well for no straws. 2. Identification of other residents having the potential to be affected was accomplished by: An audit of all residents with no straw orders was completed on 8/29/19 by the DON. A total of 7 seven residents was identified. Orders were entered into each resident record. PHI notice was added to EMR for each resident. Speech therapy was given a list of the resident to complete screens to ensure need for No Straw orders to continue. Care plans and CNA task assignments were also reviewed. The RD confirmed on 9/16/19 that all tickets for trays were UTD with information for each resident. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Speech therapy order change communication form was implemented to notify nursing of recommended changes. Including no straw orders as well as diet changes. Staff educated on use of form and will be given to charge nurse and DON with any changes for review. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON will complete audits of each resident following a change by Speech	

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F 658	Continued From page 5 meal tray up on 8/26/19, but that she could not remember if he had used a straw or not. During an interview with the speech therapist on 8/29/19 at 1:32 PM she stated that it was recommended that Resident #53 did not use straws due to his large sip size and that this increased his risk for aspiration pneumonia. During an interview with the Director of Nursing on 8/29/19 at 2:18 PM she stated that it was her expectation that staff follow physician orders and care plan interventions. She stated that she would expect that straws were not used by Resident #53 to ensure his safety and to prevent aspiration.	F 658	therapy or MD. Random observations of residents will be completed by the DON twice weekly X 8 weeks and then once weekly for an additional 8 weeks to ensure compliance with current orders for NO Straws. All audit summaries will be presented at the monthly QAPI meeting by the DON for review by the committee. Corrective action completion date: _____9/26/2019_____	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow a physician ordered intervention for pressure reduction for 1	F 686	Tag Cited: F-686 Issue Cited: Treatment/Services to Prevent/Heal Pressure Ulcers	9/26/19

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F 686	Continued From page 6 of 3 (Resident #168) reviewed for pressure ulcers. The findings included: Resident #168 was admitted to the facility on 8/21/19. Her diagnoses included pressure ulcer to left heel. The Minimum Data Set assessment had not been completed however, a review of the admission nursing assessment revealed Resident #168 required extensive assistance with bed mobility and transfers and was incontinent of bowel and bladder. The care plan dated 8/22/19 revealed a problem of presence of skin breakdown on left heel. The goal was for Resident #168 to not develop additional areas of skin breakdown through the next review and the wound would be free from signs and symptoms of infection. Interventions included treatments as ordered, monitor for signs and symptoms of infection and assess characteristics of wound daily and document findings weekly. A physician ' s order dated 8/22/19 read "float heels in bed". An observation on 8/28/19 at 8:23 AM revealed Resident #168 lying in bed without her heels floated. There was no device observed near Resident #168 ' s feet used to float heels. An observation on 8/29/19 at 8:24 AM revealed Resident #168 lying in bed on her back without her heels floated. There was no device observed near Resident #168 ' s feet used to float heels.	F 686	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: On 8/29/19 the ADON updated the CNA assignment worksheet for resident #168. The charge nurse on the 200 hallway noted that the resident was out of the facility at her dialysis appointment when she was notified by the surveyor of the residents heels not being floated. Pillow was noted in room for use to float heels. 2. Identification of other residents having the potential to be affected was accomplished by: An audit of all residents with float heels orders was completed on 9/16/19 by the DON. CNA assignment worksheets were reviewed by the ADON/DON to ensure that information was communicated on worksheet. CNA tasks in the EMR were also reviewed at this time to ensure that float heels was noted for each resident with an order. Care plan reviewed and updated as needed. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 686	Continued From page 7 An interview was conducted on 8/29/19 at 2:29 PM with NA #1. She stated she gets the information for what each resident needs from the report sheet which is kept at the desk in a binder. She stated she was not aware Resident #168 required her heels to be floated. She stated the assistant director of nursing fills out the sheets. An interview was conducted on 8/29/19 at 2:31 PM with Nurse #1. She revealed she didn ' t recall their being an order to float Resident #168 ' s heels. She stated she does go around and make sure interventions are put into place when she does her medication pass. An interview was conducted on 8/29/19 at 2:36 PM with the assistant director of nursing. She stated she does update the report sheets for the residents. She stated she gets the information from the nurses ' , the physician orders and from meetings. She couldn ' t say why the order to float Resident #168 ' s heels did not get put onto the report sheet. An observation of Resident #168 ' s wound was completed on 8/29/19 at 2:45 PM. Resident #168 had a darkened area to her left heel that was unopened. An interview was conducted on 8/29/19 at approximately 3:15 PM with the director of nursing revealed Resident #168 should have her heels floated per the physician ' s orders.	F 686	The EMR library order for floating of heels was added to the facility list on 9/16/19 by the DON. The ADON will monitor residents for new float heels orders with her daily order changes review and update the CNA assignment worksheets when new orders are noted. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The wound nurse will complete a random weekly audit of each resident with a “float heels” order to ensure compliance with orders once a week for 12 weeks and then bi-weekly for an additional 12 weeks. The wound nurse will report finding to the DON for review. All audit summaries will be presented at the monthly QAPI meeting by the DON for review by the committee. Corrective action completion date: _____9/26/2019_____	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		9/26/19

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F 812	Continued From page 8 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to use a method to maintain cold food temperatures of protein-based sandwiches prepared with mayonnaise for bagged lunches provided to residents on dialysis. This was evident for 1 of 1 resident (Resident #168) reviewed for dialysis. The findings included: Resident #168 was admitted to the facility on 8/21/19 with diagnoses of, in part, end stage renal disease and dependence on renal dialysis. The Minimum Data Set assessment had not yet been completed. A review of the care plan dated 8/22/19 revealed a problem of dialysis. The goal was to maintain	F 812	Tag Cited: F-812 Issue Cited: Food Procurement, Store/Prepare/Serve-Sanitary 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: Resident #168 was provided a cooler bag from the central storage room by clerk on 8/29/19.	

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F 812	Continued From page 9 stability within constraints of disease process through next review. Interventions included sending scheduled meal with resident to dialysis using a cooler bag with ice pack. An observation on 8/27/19 at 10:02 AM revealed Resident #168 sitting in her wheelchair at the front door of the facility. Resident #168 was observed with a lunch meat sandwich, applesauce, drink and graham crackers in a zip lock bag. There was no cooler bag observed for the lunch. An observation on 8/29/19 at 9:36 AM revealed Resident #168 being wheeled by transportation driver to the van for transport to dialysis. Nurse #1 brought Resident #168's lunch to her in a zip lock bag. The lunch consisted of a chicken salad sandwich, juice, applesauce and graham crackers. An observation on 8/29/19 of Resident #168's room revealed she did not have a cooler bag in her room. An interview on 8/29/19 at 2:43 PM with the dietary manager revealed the dietary staff prepare the bagged lunches for the residents on dialysis and leave them in the refrigerator. The nursing staff is responsible for picking up the bagged lunch before the resident leaves for dialysis and putting the lunch into the cooler bag. She stated the cooler bags are kept in the resident's room. An interview on 8/29/19 at 3:03 PM with Nurse #1 revealed she didn't put the lunch in the cooler bag because the trip from dialysis to facility is so short. She stated central supply keeps the cooler	F 812	2. Identification of other residents having the potential to be affected was accomplished by: Resident #168 is the only current resident in the facility that attends dialysis. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Additional cooler bags are available when needed in the central supply room. The central supply clerk provides a welcome kit to every resident on admission. Any resident admitting on dialysis services will have the cooler placed in their welcome kit prior to arrival and delivered to the room. Order added for resident #168 on 9/16/19 for nurse to sign lunch was placed in a cooler bag prior to leaving for dialysis. Education provided to dietary and nursing departments regarding need for use of the cooler bag. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON will complete audits of each resident that admits to the facility with dialysis orders to ensure that a cooler bag is in the room on admission. Random observations of resident going out of the facility for dialysis will be completed by the DON and/or designee once weekly X 6 months to ensure cooler bag is in use. All audit summaries will be presented at the monthly QAPI meeting by the DON for review by the committee.	

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F 812	Continued From page 10 bags. An interview on 8/29/19 at 3:06 PM with the supply clerk revealed when a resident is admitted that requires dialysis, she puts a cooler bag in their room. She stated she was unaware that this resident didn't have one.	F 812	Corrective action completion date: _____9/26/2019_____	