DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____ NOV 15 2011	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to maintain the dignity of 1 of 3 sampled residents whose personal hygiene was observed. Findings include: 1. Resident # 18 was admitted on 07/20/10 with cumulative diagnoses of debility, depression, blindness, anxiety, and dementia. Resident # 18's care plan, dated 03/25/11, identified an inability to perform activities of daily living independently related to cognitive loss. The goal to have her needs met and to keep Resident # 18 clean, neat and well groomed daily would be achieved by routine nail care, morning and evening care and routine oral care. The approaches included to anticipate the resident's needs for activity of daily living assistance. The Annual Minimum Data Set (MDS), dated 07/20/11, indicated Resident # 18 was severely cognitively impaired. She was identified as totally dependent on staff for toilet use and personal hygiene. Rejection of care was not exhibited during the assessment period. Resident # 18 was coded as always incontinent of bowel and bladder.	F 241	Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable release provisions of residents. The Plan of Correction is submitted as a written allegation of compliance. Windsor Point's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Windsor Point reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal process, and/or, any other administrative or legal proceeding. **F 241** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #18 found to have been affected by the deficient practice as follows: 1. On 10/18/11 the Director of Nursing asked NA #2 to complete proper personal hygiene care. Director of Nursing monitored care until resident #18 had received proper nail and oral care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: WILL BATOT

TITLE: ADMINISTRATOR

(X6) DATE: 11/9/11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 241	Continued From page 1 An observation was made of Nurse # 3 during medication pass at 3:45 PM on 10/18/11. Nurse # 3 entered Resident # 18's room. The nurse stated the resident had been playing in her brief again. Black matter was noted on 4 fingers of the resident's right hand. Nurse # 3 was observed giving the resident her medications and a liquid supplement. As the nurse was giving the medication which was mixed in pudding, she commented she had stool in her mouth. Nurse #3 continued to place the straw into her mouth and encouraged her to drink the chocolate supplement. Once she had given both the medication and the supplement she exited the room. Nurse # 3 did not offer mouth care before offering the supplement or completing medication pass. The nurse then exited the room and reported to the Nursing Assistant (NA) that Resident # 18 had "been down south again". The NA commented it was not any fun if it was not down south, went in another resident's room, stayed approximately 5 minutes and then went down the hall to another resident's room and shut the door. Resident # 18 remained soiled. The nurse stated the NA had to complete care on the resident he was assisting and then he would take care of Resident # 18. The nurse continued her medication pass. Resident # 18 remained soiled. An observation was made on 10/18/11 at 4:15 PM of Nursing Assistant (NA) # 2 providing incontinent care to Resident # 18. The NA cleaned the resident's perineum from front to back. The folded sheet used in moving the resident was on the bed. Brown stains were seen on the left side of the turn sheet and pencil eraser sized brown balls were seen on the right side of	F 241	II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows: 1. In-service for staff was held on 11/4/11 focusing on "Dignity and Respect" of residents. (EXHIBIT 1) III. The systemic changes put into place so that deficient practices will not recur will be: 1. The following systems checks will be implemented: a. "Systems Check for Finger Nail Care" (EXHIBIT 2) b. "Systems Check for Denture/Mouth Care" (EXHIBIT 2) IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. The "Systems Check for Finger Nail Care" and "Systems Check for Denture/Mouth Care" will be completed and audited as follows: a. Daily until 100% compliance is reached, weekly x 4, monthly x 3 and randomly thereafter. (EXHIBIT 2) b. All findings will be reported to QA. V. December 5, 2011	12/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 241	Continued From page 2 the turn sheet. NA # 2 identified the stains and balls as feces. Resident # 18's hand was laying in the brown smear on the left. Brown stains were seen under Resident # 18's fingernails and around the nail beds. The NA did not clean the resident's nails, nor did he provide oral care. The resident was dressed and placed in her wheelchair and taken to the lounge area. An interview was held with NA # 2 on 10/18/11 at 4:29 PM. NA # 2 stated he did not provide oral care and had cleaned Resident # 18's nails the best he could. The NA stated Nurse # 3 had informed him Resident # 18 had feces around her mouth. He added that was why he wiped her face. NA # 2 stated he did not provide oral care or clean under the resident's nails because Resident # 18 had no orange sticks or oral swabs in her room. He added these items were available in the facility. NA # 2 stated he could have gotten someone to retrieve those items in order to provide nail care and oral care for Resident # 18, but, he was not thinking. Nurse # 3 was interviewed at 5:00 PM on 10/18//. The nurse stated Resident # 18 had a habit of putting her hands in her brief and playing in her feces adding that Resident # 18 also put the feces in her mouth. Nurse # 3 stated that was what Resident # 18 had done that afternoon. She stated interventions provided by the facility included a consultant psychiatric assessment. Nurse # 3 stated she had seen what looked like feces on Resident # 18's chin but thought it was chocolate supplement. The nurse added when she touched the spot on Resident # 18's chin, the area was dried and did not move, so she figured it was feces. The nurse stated she continued to	F 241	**F 279** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #45 and #18 to have been affected by the deficient practice as follows: 1. Resident #45's care plan (behavior) was developed and evaluated on 10/12/11. (EXHIBIT 3) 2. Resident #18's care plan (nutrition) was developed and evaluated on 11/4/11. (EXHIBIT 4) II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows: 1. A facility audit of all resident care plans was completed for accuracy on 11/11/11. (EXHIBIT 5) III. The systemic changes put into place so that deficient practices will not recur will be: 1. Care plans will be updated by utilizing daily review of physicians, 24 hour report and incidents and accidents. IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 241	Continued From page 3 give the resident medications and the supplement. Nurse # 3 stated she reported the incident to NA # 2 adding that he should have moved quicker in cleaning Resident # 18. The nurse added that since Resident # 18 smeared feces on her face and her chest, the NA should have washed the resident's hands and provided oral care. The nurse could offer no explanation as to why she did not offer to assist the resident with personal care, but after discussion stated she should have cleaned the resident. The Director of Nursing (DON) was interviewed at 5:10 PM on 10/18/11. Her expectations for this situation included the nurse stopping medication pass and assisting the resident by washing her hands and providing oral care prior to giving medication and supplements. The DON stated she expected the NA to provide oral care and clean the resident's nails to remove the feces. The DON added she thought the entire incident was disgusting. An observation was made of Resident # 18's hands at 5:34 PM on 10/18/11. Resident # 18 was sitting in the resident lounge. The resident's left hand had spots of brown matter with brown matter observed under the nails and around the nail beds. The right hand had brown specks of matter with brown matter under the nail and around the nail bed. The DON stated the nails should have been cleaned and oral care provided.	F 241	1. "Systems Checks" will be completed as follows: a. Daily until 100% compliance is reached, weekly x 4, monthly x 3 and randomly thereafter. (EXHIBIT 2) b. All findings will be reported to QA. V. December 5, 2011 12/5/11 **F 312** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #18 and #46 to have been affected by the deficient practice as follows: 1. On 10/18/11 resident #18 was immediately provided general grooming, as well as, oral and nail care. 2. On 10/20/11 resident #46 was immediately shaved. II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows:	
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	1. Between 10/20/11 and 10/21/11 all residents were checked for improper grooming (nail, oral, shaving and general grooming). Any resident found with improper grooming was corrected.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 4 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a care plan to address the care area trigger of Nutritional Status for 1 of 6 sampled residents (Resident #45) reviewed for nutrition concerns and failed to care plan behaviors for 1 of 4 sampled residents (Resident # 18) that exhibited behaviors. Findings include: 1. Resident #45 was admitted to the facility on 08/31/10 and readmitted on 10/07/10. The resident's documented diagnoses included Alzheimer's dementia and glaucoma. The resident's Monthly/Weekly Weight Record documented she weighed 106.8 pounds on 01/03/11, 104.8 pounds in February 2011, and	F 279	(EXHIBIT 2) III. The systemic changes put into place so that deficient practices will not recur will be: 1. In-service for staff was held on 11/7/11 focusing on "Providing ADL Care" and also "Grooming" of residents. (EXHIBIT 6) a. "Competency Evaluations" will be completed on CNAs by 12/5/11. (EXHIBIT 7) IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. The following systems checks will be implemented: a. "Systems Check for Finger Nail Care" b. "Systems Check for Oral Care" c. "Systems Check for Incontinence Care" d. "Systems Check for Showers" The above "Systems Checks" will be completed as follows: Daily until 100% compliance is reached, weekly x 4, monthly x 3 and randomly thereafter. (EXHIBIT 2) b. All findings will be reported to QA. V. December 5, 2011	12/5/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 5 100 pounds on 03/03/11. A 03/24/11 physician's order for Resident #45 initiated the provision of ice cream with her lunch and supper trays. The resident's April 2011 through October 2011 Medication Administration Records (MARs) documented the FYI (for your information), "Add ice cream to lunch and supper tray." The Care Area Assessment (CAA) Summary generated by Resident #45's 09/30/11 Significant Change Minimum Data Set (MDS) documented the care area Nutritional Status triggered, and was to be addressed in the resident's care plan. The resident's Nutritional Status CAA documented, "Resident is at risk for weight loss. Complicating factors include impaired cognition, refusal of care, bilateral hand ROM (range of motion), sleep pattern disturbance, confusion, possible sedative effects of xanax, percocet, atrial fib (fibrillation), dementia, disorientation, and multiple medical comorbidities. Will care plan with resident receiving assistance for eating, weights as ordered, labs as ordered, PO intake (intake by mouth) monitored and MD (doctor of medicine) notification for decreased intake, Hospice services as ordered, dietary evaluation and recommendations, supplements as ordered with snacks offered on hydration rounds, diet mechanical soft with chopped meats." Review of Resident #45's care plan revealed the resident being at risk for weight loss was not identified as a problem with interventions developed to address the problem.	F 279	**F 315** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #46 and #32 to have been affected by the deficient practice as follows: 1. Resident #46's Foley Catheter was discontinued on 10/18/11. 2. NA #3 was retrained on proper perineal care on 10/19/11. (EXHIBIT 8) II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows: 1. A Foley Catheter Audit was completed on all residents with Foley Catheter usage on 10/19/11. (EXHIBIT 9 2. Between 10/20/11 and 10/21/11 all residents were checked for improper grooming (nail, oral, shaving and general grooming). Any resident found with improper grooming was corrected. (EXHIBIT 2) III. The systemic changes put into place so that deficient practices will not recur will be: 1. The following systems checks will be implemented: a. "Systems Check for Foley Catheter" (EXHIBIT 2)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 6 At 11:07 AM on 10/19/11 the Director of Nursing (DON) stated, after reviewing Resident #45's Significant Change MDS assessment, the resident's care plan was supposed to address the resident being at risk for weight loss. She reported the care plan did not address this problem, but she could not explain why the MDS Nurse had not followed through since the Nutritional Status care area triggered, and it was documented on the CAA Summary that the care area would be addressed in the resident's care plan. At 11:34 AM on 10/19/11 the MDS Nurse stated she just started work in the facility this week, but after reviewing Resident #45's 09/30/11 Significant Change MDS and current care plan, she reported the care plan did not address the resident being at risk for weight loss like it should have. She explained all care areas which triggered, and were documented as being addressed in the care plan on the CAA Summary, should be identified as problems in the care plan with interventions developed to address the problems. 2. Resident # 18 was admitted on 07/20/10 with cumulative diagnoses of debility, depression, hypothyroidism, hypertension, blindness, anxiety, osteoporosis and dementia. The Annual Minimum Data Set (MDS), dated 07/20/11, indicated Resident # 18 was severely cognitively impaired. She was identified as	F 279	b. A review of physicians' orders for usage of Foley Catheters will also be completed. 2. In-service for staff was held on 11/7/11 focusing on "Providing ADL Care" and also "Grooming" of residents. (EXHIBIT 6) a. "Competency Evaluations" will be completed on CNAs by 12/5/11. (EXHIBIT 7) IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. The following systems checks will be implemented: a. "Systems Check for Foley Catheter" (EXHIBIT 2) 2. The following systems checks will be implemented: a. "Systems Check for Finger Nail Care" (EXHIBIT 2) b. "Systems Check for Oral Care" (EXHIBIT 2) c. "Systems Check for Incontinence Care" (EXHIBIT 2) d. "Systems Check for Showers" (EXHIBIT 2) The above "Systems Checks" will be completed as follows: Daily until 100% compliance is reached,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 7 requiring extensive assistance with bed mobility and total dependence on staff for toilet use and personal hygiene. Rejection of care was not exhibited during the assessment period. Resident # 18 was coded as always incontinent of bowel and bladder. Resident # 18 was coded as having behaviors that did not affect others, including smearing of feces on a daily basis. Resident # 18's care plan, with an onset date of 07/29/11, did not identify any behaviors for Resident # 18. The care plan did identify Resident # 18 was incontinent of bowel. The plan did not identify any behavioral issues associated with bowel incontinence. Resident # 18's care plan also identified she had difficulty making decisions and the inability to complete activities of daily living independently. There were no entries that addressed behavioral issues associated with these identified problems. The Nursing Weekly Summary, dated 09/30/11, indicated the resident had repetitive health complaints and repetitively calling out for help. On 09/30/11, a physician's order was received for Haldol (an antipsychotic medication) 0.5 milligrams twice daily. There was no care plan developed for the medication or the behaviors associated with receiving the medication. The September 2011 Documentation of Behavior Sheet, indicated behaviors on an almost daily basis on the 7 to 3 and 3 to 11 shift. The care plan for Resident # 18 did not identify behaviors. The Physician's progress note, dated 10/06/11, indicated the physician issued an order for a psychiatric consult. Behaviors were not	F 279	weekly x 4, monthly x 3 and randomly thereafter. (EXHIBIT 2) b. All findings will be reported to QA. V. December 5, 2011 **F 325** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #45 #36 and #23 to have been affected by the deficient practice as follows: 1. Resident #45's ice cream was discontinued on 10/19/11. a. Following the exit interview on 10/20/11, Resident #45's ice cream was monitored to be on her tray at lunch and dinner. As follow-up on 10/27/11 Resident #45's ice cream was discontinued due to weight stability. 2. Resident #36's ice cream was discontinued on 10/19/11. a. Pudding was added as a nutritional supplement in place of the ice cream for lunch and dinner. 3. Resident #23's double meat and eggs was discontinued on 10/27/11. a. Following the exit interview on	12/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 8 addressed on Resident # 18's care plan. On 10/14/11, an order was received to increase the Haldol to 1 milligrams at bedtime and 0.5 milligrams every morning. There was no problem identifying behaviors added to Resident # 18's care plan. An observation was made of Nurse # 3 during medication pass at 3:45 PM on 10/18/11. Nurse # 3 entered Resident # 18's room. The nurse stated the resident had been playing in her brief again. Black matter was noted on 4 fingers of the resident's right hand. After the nurse had given the supplement and medications, she turned and stated the resident had feces in her mouth. The nurse then exited the room and reported to the Nursing Assistant (NA) that Resident # 18 had "been down south again". Nurse # 3 was interviewed at 5:00 PM on 10/18//. The nurse stated Resident # 18 had a habit of putting her hands in her brief and playing in her feces adding that Resident # 18 also put the feces in her mouth. Nurse # 3 stated that was what Resident # 18 had done that afternoon. She stated interventions provided by the facility included a consultant psychiatric assessment. The Director of Nursing (DON) was interviewed at 5:10 PM on 10/18/11. Her expectations for this situation included the nurse stopping medication pass and assisting the resident by washing her hands and providing oral care prior to giving medication and supplements. The DON stated she expected the NA to provide oral care and clean the resident's nails to remove the feces. The DON added she thought the entire incident	F 279	10/20/11, Resident #23's double meat and eggs were provided on meal trays for each meal. As follow-up, the double meat and eggs was monitored to be on her tray at lunch and dinner. As follow-up on 10/27/11 Resident #23's order for double meat and eggs was discontinued. II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows: 1. An audit was completed on 10/22/11 by the Executive Director on tray cards "versus" physicians' orders. a. Dietician performed a tray card "versus" physicians' orders audit on 11/9/11 to reach 100% compliance. III. The systemic changes put into place so that deficient practices will not recur will be: 1. Dietary Manager, or designee will randomly monitor tray card accuracy to ensure proper diets are followed using the "System Check for Diet Order Accuracy." (EXHIBIT 2) a. An in-service will be given to dietary staff from 11/9/11 through 11/11/11 regarding "tray cards." b. Dietician will complete a tray card "versus" physicians' orders audit for a random selection of residents each month. IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 9 was disgusting. Nurse # 4 was interviewed on 10/20/11 at 10:12 AM. The nurse reported Resident # 18 required extensive/total assistance for activities of daily living. Nurse # 4 stated Resident # 18's behaviors included playing in her brief/feces. An interview was held with NA # 5 on 10/20/11 at 10:32 AM. The NA reported Resident # 18 played in her brief and smeared feces. A telephone interview was held with the MDS Coordinator on 10/26/11 at 3:05 PM. She stated she was new to the facility and not aware of all resident behaviors. The MDS Coordinator stated behaviors and psychoactive medications should be addressed on a resident's care plan. She added if a resident played with feces, that surely should be added to that individual resident's care plan.	F 279	has been put in place to assure the following systems are in place. 1. Dietician performed a tray card "versus" physicians' orders audit on 11/9/11 to reach 100% compliance. b. Dietician, or designee, will complete a tray card "versus" physicians' orders audit for a random selection of residents each month. V. December 5, 2011 **F 371** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Residents to have been affected by the deficient practice as follows: 1. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) 2. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10)	12/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 279	Continued From page 10	F 279	3. Dietary Manager and Dietary Assistant Manager audited all kitchen utensils/devices on 10/19/11. Any device found to not be sanitary for use was immediately discarded or properly sanitized. a. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10)	
F 312 SS=G	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 by: Based on observations, staff interviews and record review, the facility failed to provide proper personal hygiene for 2 of 3 sampled residents (Resident # 18 and Resident # 46) whose care was observed. Findings include: 1. Resident # 18 was admitted on 07/20/10 with cumulative diagnoses of debility, depression, hypothyroidism, hypertension, blindness, anxiety, osteoporosis and dementia. Resident # 18's care plan, dated 03/25/11, identified an inability to perform activities of daily living independently related to cogntive loss. The goal to have her needs met and to keep Resident # 18 clean, neat and well groomed daily would be acheived by routine nail care, morning and evening care and routine oral care. The approaches included to anticipate the resident's	F 312	4. Dietary Manager and Dietary Assistant Manager audited all kitchen food items on 10/19/11. Any food item found to not be labeled/dated was immediately labeled/dated or discarded. a. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) 5. Medical Records Clerk audited all nourishment refrigerator food items on 10/20/11. Any food item found to not be labeled/dated was immediately labeled/dated or discarded. a. A thermometer was placed in nourishment freezer on 10/21/11. b. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 312	Continued From page 11 needs for activity of daily living assistance. The Annual Minimum Data Set (MDS), dated 07/20/11, indicated Resident # 18 was severely cognitively impaired. She was identified as requiring extensive assistance with bed mobility and total dependence on staff for toilet use and personal hygiene. Rejection of care was not exhibited during the assessment period. Resident # 18 was coded as always incontinent of bowel and bladder. An observation was made of Nurse # 3 during medication pass at 3:45 PM on 10/18/11. Nurse # 3 entered Resident # 18's room. The nurse stated the resident had been playing in her brief again. Black matter was noted on 4 fingers of the resident's right hand. Nurse # 3 was observed giving the resident her medications and a liquid supplement. After the nurse had given the supplement and medications, she turned and stated the resident had feces in her mouth. Nurse # 3 did not offer mouth care before offering the supplement or completing medication pass. The nurse then exited the room and reported to the Nursing Assistant (NA) that Resident # 18 had "been down south again". The NA commented it was not any fun if it was not down south, went in another resident's room, stayed approximately 5 minutes and then went down the hall to another resident's room and shut the door. Resident # 18 remained soiled. The nurse stated the NA had to complete care on the resident he was assisting and then he would take care of Resident # 18. The nurse continued her medication pass. Resident # 18 remained soiled. An observation was made on 10/18/11 at 4:15	F 312	II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows: 1. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) 2. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) 3. Dietary Manager and Dietary Assistant Manager audited all kitchen utensils/devices on 10/19/11. Any device found to not be sanitary for use was immediately discarded or properly sanitized. a. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) 4. Dietary Manager and Dietary Assistant Manager audited all kitchen food items on 10/19/11. Any food item found to not be labeled/dated was immediately labeled/dated or discarded. a. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 312	Continued From page 12 PM of Nursing Assistant (NA) # 2 providing incontinent care to Resident # 18. The NA cleaned the resident's perineum from front to back. The folded sheet used in moving the resident was on the bed. Brown stains were seen on the left side of the turn sheet and pencil eraser sized brown balls were seen on the right side of the turn sheet. NA # 2 identified the stains and balls as feces. Resident # 18's hand was laying in the brown smear on the left. Brown stains were seen under Resident # 18's fingernails and around the nail beds. The NA did not clean the resident's nails, nor did he provide oral care. The resident was dressed and placed in her wheelchair and taken to the lounge area. An interview was held with NA # 2 on 10/18/11 at 4:29 PM. NA # 2 stated he did not provide oral care and had cleaned Resident # 18's nails the best he could. The NA stated Nurse # 3 had informed him Resident # 18 had feces around her mouth. He added that was why he wiped her face. NA # 2 stated he did not provide oral care or clean under the resident's nails because Resident # 18 had no orange sticks or oral swabs in her room. He added these items were available in the facility. NA # 2 stated he could have gotten someone to retrieve those items in order to provide nail care and oral care for Resident # 18, but, he was not thinking. Nurse # 3 was interviewed at 5:00 PM on 10/18//. The nurse stated Resident # 18 had a habit of putting her hands in her brief and playing in her feces adding that Resident # 18 also put the feces in her mouth. Nurse # 3 stated that was what Resident # 18 had done that afternoon. She stated interventions provided by the facility	F 312	sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) 5. Medical Records Clerk audited all nourishment refrigerator food items on 10/20/11. Any food item found to not be labeled/dated was immediately labeled/dated or discarded. a. A thermometer was placed in nourishment freezer on 10/21/11. b. Dietary Manager held an in-service on 10/20/11 and 10/21/11 on the following: correct hot and cold food temperatures, sanitization procedures, disposal/sanitization of utensils/devices, labeling and dating. (EXHIBIT 10) III. The systemic changes put into place so that deficient practices will not recur will be: 1. Dietary Manager, or designee, will complete "Dietary System Check." (EXHIBIT 11) a. New coffee mugs will be purchased by December 1, 2011. IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. The "Dietary System Check" will be completed as follows: a. Daily until 100% compliance is reached, weekly x 4, monthly x 3 and randomly	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 312	Continued From page 13 included a consultant psychiatric assessment. Nurse # 3 stated she had seen what looked like feces on Resident # 18's chin but thought it was chocolate supplement. The nurse added when she touched the spot on Resident # 18's chin, the area was dried and did not move, so she figured it was feces. The nurse stated she continued to give the resident medications and the supplement. Nurse # 3 stated she reported the incident to NA # 2 adding that he should have moved quicker in cleaning Resident # 18. The nurse added that since Resident # 18 smeared feces on her face and her chest, the NA should have washed the resident's hands and provided oral care. The nurse could offer no explanation as to why she did not offer to assist the resident with personal care, but after discussion stated she should have cleaned the resident. The Director of Nursing (DON) was interviewed at 5:10 PM on 10/18/11. Her expectations for this situation included the nurse stopping medication pass and assisting the resident by washing her hands and providing oral care prior to giving medication and supplements. The DON stated she expected the NA to provide oral care and clean the resident's nails to remove the feces. The DON added she thought the entire incident was disgusting. An observation was made of Resident # 18's hands at 5:34 PM on 10/18/11. Resident # 18 was sitting in the resident lounge. The resident's left hand had spots of brown matter with brown matter observed under the nails and around the nail beds. The right hand had brown specks of matter with brown matter under the nail and around the nail bed. The DON stated the nails	F 312	thereafter. (EXHIBIT 11) **V. December 5, 2011** **F 441** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Residents to have been affected by the deficient practice as follows: 1. On 10/19/11 the Director of Nursing provided antimicrobial wipes (CaviWipesXL) for all medication carts throughout facility. a. In-service on proper sanitization of glucometers was held on 10/19/11. (EXHIBIT 12) b. "Blood Sugar Monitoring Policy" was updated on 10/19/11. (EXHIBIT 12) 2. The Director of Nursing held an in-service on infection control on 10/17/11. (EXHIBIT 13) a. QA Action Plan was initiated on 10/17/11. (EXHIBIT 13) II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as follows: 1. On 10/19/11 the Director of Nursing	12/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 312	Continued From page 14 should have been cleaned and oral care provided. 2. Resident #46 was re-admitted to the facility on 06/03/11. Cumulative diagnoses included thyroid disorder, anemia, Parkinson's Disease, hypertension, osteoporosis, gout, gastroesophageal reflux disease and history of a healed stage 2 pressure ulcer. According to the most recent Quarterly MDS (Minimum Data Set) assessment of 08/21/11, Resident #46 required total assistance with toilet use, bathing and hygiene. There were no behaviors noted. Resident #46 was observed on 10/18/11 at 8:30 AM in her wheelchair out in the front of the facility. She was noted to have long white chin hairs and light brownish hair on her upper lip. Resident #46 was observed again on 10/18/11 at 4:00 PM with long white chin hairs as well as light brownish hair on her upper lip. Resident #46 was observed being pushed in her wheelchair by staff on 10/19/11 at 10:55 AM. She remained unshaven. During an interview with Nurse #5 on 10/20/11 at 10:00 AM, she stated Resident #46 was usually cooperative with care. She added that female residents were usually shaved on an as needed basis.	F 312	provided antimicrobial wipes (CaviWipesXL) for all medication carts throughout facility. a. In-service on proper sanitization of glucometers was held on 10/19/11. (EXHIBIT 12) b. "Blood Sugar Monitoring Policy" was updated on 10/19/11. (EXHIBIT 12) 2. The Director of Nursing held an in-service on infection control on 10/17/11. (EXHIBIT 13) a. QA Action Plan was initiated on 10/17/11. (EXHIBIT 13) III. The systemic changes put into place so that deficient practices will not recur will be: 1. Antimicrobial wipes (CaviWipesXL) will continue to be used to ensure proper sanitization of glucometers. 2. Proper infection control practices, including handling of linen, will be observed and monitored during weekly infection control rounds by the Director of Nursing, or designee. (EXHIBIT 14) IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. Medication pass observations will be completed by Director of Nursing, or designee, to ensure proper sanitization of glucometers. (EXHIBIT 13)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 312	Continued From page 15 Resident #46 was observed being pushed by staff in her wheelchair on 10/20/11 at 11:30 AM. She had long white chin hairs and light brownish hair on her upper lip. During an interview with Nurse Aide#4 (NA#4) on 10/20/11 at 1:30 PM, she stated residents were scheduled for showers every other day and partial bed baths on the other week days. She commented that resident's hair was washed on shower days. NA#4 also commented that men were shaved daily and females were shaved as needed. When questioned about Resident #46, she reported she had not noticed any facial hair. She stated she was not aware of any females in the facility who were being shaved on a regular basis. During an interview with the Director of Nurses (DON) on 10/20/11 at 1:45 PM, she stated her expectation was for female residents to be well groomed. She stated she expected direct care staff to shave the ladies on an as needed basis during morning care. On 10/20/11 at 3:00 PM, Resident #46 was noted in the activity room reading a magazine. She remained unshaven.	F 312	2. Director of Nursing, or designee, will monitor proper infection control practices by completing infection control rounds as follows: a. Weekly x 4, monthly x 3 and randomly thereafter. (EXHIBIT 14) b. All findings will be reported to QA. V. December 5, 2011	12/5/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 16 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to have medical justification for the use of an indwelling urinary catheter for 1 of 3 sampled residents (Resident #46) who had an indwelling urinary catheter. The facility also failed to provide adequate incontinent care for 1 of 3 sampled residents (Resident #32) whose care was observed. Findings include: 1. Resident #46 was re-admitted to the facility on 06/03/11. Cumulative diagnoses included thyroid disorder, anemia, Parkinson's Disease, hypertension, osteoporosis, gout, gastroesophageal reflux disease and history of a healed stage 2 pressure ulcer. Admission physician orders of 06/03/11 indicated to change Resident #46's indwelling urinary catheter every 2 weeks. There was no specification as to the size of the catheter. An admission nursing assessment of 06/03/11 indicated Resident #46 was admitted with a 22 fr (French) indwelling urinary catheter. According to a 60 day Minimum Data Set (MDS) assessment, Resident #46 had a stage 2 pressure ulcer upon admission that was red granulation tissue. According to the most recent Quarterly MDS	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 17 (Minimum Data Set) assessment of 08/21/11, Resident #46 scored 8 out of 15. She required total assistance with toilet use, bathing and hygiene. It was noted she had an indwelling urinary catheter. According to the standing physician's orders found in Resident #46's record, the indwelling urinary catheter was to be discontinued upon admission to the facility if there was no supporting diagnosis or bladder retrain orders. A telephone physician's order of 07/13/11 indicated Resident #46 was to have the indwelling urinary catheter changed monthly and PRN (as needed). A nurse's note of 08/04/11 at 1:00 AM indicated that Resident #46's indwelling urinary catheter had been changed and a new 16 fr catheter had been inserted. A nurse's note of 08/09/11 at 1:00 AM indicated Resident #46 was screaming for help at 11:00 PM. The nurse documented there was a strong urine smell in the room and very minimal urine in the drainage bag. The nurse attempted to irrigate the catheter tubing but was unable to do so and the tubing was totally blocked. The nurse indicated she had inserted a new 18 fr indwelling urinary catheter. Resident #46's care plan, last reviewed 08/21/11, identified a potential for urinary tract infections related to "foley" catheter (indwelling urinary catheter). Included in the approaches section was to change the catheter monthly and flush with 30 cc (cubic centimeters) normal saline as	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 18 needed for thick sediment, leakage or blockage. A Bowel/Bladder assessment of 08/24/11 in Resident #46's record indicated the rationale for the indwelling urinary catheter was multiple skin issues and recurrent decubitus ulcers with MRSA (methicillin resistant staphylococcus aureus). During an interview with the Director of Nurses (DON) on 10/17/11 at 11:39 AM, she stated Resident #46 had the indwelling urinary catheter originally for a pressure area but it had long since healed. She stated Resident #46 had been out to the urologist who had given the order to leave it in due to her recurrent urinary tract infections and skin issues. She stated her urine was thick with sediment as well. Resident #46 was observed on 10/17/11 at 11:50 AM to have an indwelling urinary catheter connected to straight drain with the drainage bag in a privacy bag. A physician's telephone order of 10/18/11 at 2:10 PM was to discontinue the indwelling urinary catheter. During an interview with the hall nurse (Nurse #1), on 10/19/11 at 11:00 AM, she stated Resident #46 no longer had her catheter. She stated it had been inserted due to a wound and was removed yesterday since the wound was healed. During an interview with the DON on 10/20/11 at 11:05 AM, she stated Resident #46 was prone to breakdown. She stated she had talked with Resident #46's physician last week about the	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 19 indwelling urinary catheter as well as the skin creams but as yet he had not evaluated her. The DON stated one of the nurses had telephoned him earlier this week and obtained the order to remove the catheter. She added that she was on every 2 hour toileting. The DON commented that she had been confused as to what was included in the justification for the indwelling urinary catheters and thought a stage 2 was justification. She also stated Resident #46 had a history of urinary tract infections. 2. The undated facility policy, titled Incontinence - Basic Care, indicated the perineal area should be cleansed from front to back. Resident # 32 was readmitted on 03/15/10 with cumulative diagnoses of dementia, urinary tract infection and acute renal failure. The resident's care plan with an onset date of 03/25/11, indicated Resident # 32 had a potential for urinary tract infections (UTI) related to urinary incontinence. The goal of being free of signs and symptoms of a UTI included approaches of monitoring for signs and symptoms of a UTI, obtain urinalysis and culture and sensitivities as ordered by the physician, toilet increase fluid consumption during the day and limiting fluid at night, changing soiled clothes after each incontinent episode and giving medications as ordered. The Quarterly Minimum Data Set (MDS),dated	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 20	F 315		

06/23/11, indicated Resident # 32 was severely cognitively impaired. She was coded as needing extensive assistance with transfer, dressing, and eating and was dependent for toilet use, personal hygiene and bathing. The MDS identified Resident # 32 as always incontinent of bowel and bladder with no toileting program in place. She was not identified as having a UTI in the past 30 days.

Urine was obtained for a urinalysis (UA), culture and sensitivity on 08/24/11. The urine color was cloudy (normal is clear), with large blood (normal is no blood), positive nitrite (normal is negative), 4 to 8 white blood cells (WBC's), 2 + bacteria (normal is no bacteria). The culture was returned on 08/26/11 with a result of greater than 100,000 colonies per milliliter of urine of gram negative rods.

On 08/25/11, the physician completed a History and Physical (H & P). The H & P indicated a recent UA showed positive nitrites, large blood and 4 to 8 WBC's. The physician determined the resident had a UTI and indicated Cipro would be used for treatment.

A Physician's Fax, dated 08/30/11, indicated Resident # 32 had received Cipro, but when the culture and sensitivity returned, the organism was resistant. The physician ordered Macrobid.

The care plan was revised on 08/30/11 to reflect an actual UTI.

A Pharmacy Review note to the physician, dated 09/15/11 identified the previous UTI as caused by Escherichia coli (a bacteria found in feces).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 21 The Quarterly MDS, dated 09/22/11, indicated the resident had impairment of short and long term memory and severely impaired cognitive skills for daily decision making. Resident # 32 was coded as being dependent on staff for all activities of daily living and was identified as being totally incontinent of bowel and bladder. Resident # 32 was identified as having a UTI in the last 30 days. On 09/24/11, urine was obtained for a UA. Results were negative. The urine culture was returned on 09/28/11 indicating greater than 100,000 colonies per milliliter of urine of gram negative rods that was sensitive to Macrobid. The physician ordered this medication for Resident # 32. October 2011 physician orders indicated Resident # 32 received cranberry capsule 475 mg daily. A 10/03/11 physician's order indicated Resident # 32 received Macrobid 100 milligrams twice daily for 10 days for a UTI. The care plan was revised to reflect an actual UTI.. An observation was made Nursing Assistant (NA) # 3 completing incontinent care on Resident # 32 on 10/19/11 at 2:26 PM. NA # 3 washed her hands, donned gloves and checked Resident # 32 for incontinence. NA # 3 cleansed the resident's perineum from back to front using the same part of the disposable wipe multiple times. Resident # 3 had a bowel movement. A brown stain, resembling stool was present on the disposable wipe as the NA cleansed the resident from bottom to top. NA # 3 confirmed she had	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 315	Continued From page 22 cleansed Resident # 32 from bottom to top. The NA affirmed she normally provided incontinent care on female residents from bottom to top. NA # 3 disposed of the soiled brief, removed her gloves, washed her hands and donned cleaned gloves. The NA then cleansed Resident # 32 again removing stool using a bottom to top action. An interview was held with NA # 3 on 10/19/11 at 2:59 PM. The NA stated she was taught to wipe a female from bottom to top. She added she had not seen the stool on the cloth until after she had cleansed Resident # 32. NA # 3 stated that cleansing the resident with a cloth that contained stool could cause an infection. An interview was held with the Director of Nursing (DON) on 10/19/11 at 3:47 PM. The DON stated the expectation was for the female residents to be cleansed using a top to bottom motion with a clean part of a cloth with each swipe. She stated if a resident was cleansed from the bottom of the perineum to the top, there was a risk of contamination with bacteria that could cause a UTI.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 23	F 325		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and record review the facility failed to implement nutrition interventions ordered to help prevent weight loss or to help promote wound healing for 3 of 6 sampled residents (Resident #23, #36, and #45) who were reviewed for nutritional concerns. Findings include:

1. Resident #45 was admitted to the facility on 08/31/10 and readmitted on 10/07/10. The resident's documented diagnoses included Alzheimer's dementia and glaucoma.

The resident's Monthly/Weekly Weight Record documented she weighed 106.8 pounds on 01/03/11, 104.8 pounds in February 2011, and 100 pounds on 03/03/11.

A 03/24/11 physician's order for Resident #45 initiated the provision of ice cream with her lunch and supper trays.

A Diet Order and Communication form dated 03/24/11, present in the resident's active medical record, documented to add an ice cream cup to the resident's lunch and supper trays.

The resident's Monthly/Weekly Weight Record documented she weighed 102.4 pounds on 07/01/11.

The registered dietitian's (RD's) 08/15/11 nutrition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 24 progress note for Resident #45 documented ice cream on the resident's lunch and supper trays was still being utilized as an intervention to prevent further weight loss. The resident's Monthly/Weekly Weight Record documented she weighed 103 pounds in September 2011. The RD's 09/12/11 nutrition progress note for Resident #45 documented ice cream on the resident's lunch and supper trays was still being utilized as an intervention to prevent further weight loss. The resident's Monthly/Weekly Weight Record documented she weighed 104.6 pounds on 10/05/11. Resident #45's October 2011 Treatment Administration Record (TAR) documented she was receiving treatments to a blister on the left great toe which had opened and to skin tears on her right lower extremity and her left thumb. The resident's care plan identified "Has stage 2 pressure ulcer left foot great toe" as a problem on 10/12/11. Interventions to this problem included "Offer supplemental nutritional support to resident as ordered." On 10/17/11 from 12:21 PM until 12:43 PM (when the resident was taken back to her room) Resident #45 was observed in a dining room where staff were feeding residents. There was no ice cream on the resident's meal tray, and no staff obtained ice cream from the kitchen to feed the resident. The provision of ice cream with	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 25 meals was not documented on the resident's tray slip. On 10/18/11 from 12:02 PM until 12:39 PM (when the resident was taken back to her room) Resident #45 was observed in a dining room where staff were feeding residents. There was no ice cream on the resident's meal tray, and no staff obtained ice cream from the kitchen to feed the resident. The provision of ice cream with meals was not documented on the resident's tray slip. On 10/18/11 from 5:50 PM until 6:27 PM (when the resident was taken back to her room) Resident #45 was observed in a dining room where staff were feeding residents. There was no ice cream on the resident's meal tray, and no staff obtained ice cream from the kitchen to feed the resident. The provision of ice cream with meals was not documented on the resident's tray slip. At 10:12 AM on 10/19/11 the Director of Nursing (DON) stated the nurse who took a physician order for supplements completed a Diet Order and Communication form. She reported the yellow copy of this form was given to the dietary department. According to the DON, someone in the dietary department put the information from the form into the computer system so that it would print out on resident tray slips. She commented if the order involved adding foods such as ice cream, yogurt, or soup on the meal trays this would be captured on the tray slips, and the dietary employees preparing resident trays would add the ordered foods right at the trayline.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 26 At 10:18 AM on 10/19/11, after reviewing Resident #45's chart, the Dietary Manager (DM) stated the resident was supposed to be receiving ice cream at lunch and supper. The DM commented he was not sure the dietary department ever got a copy of the Diet Order and Communication form which documented the initiation of supplementing the resident's lunch and supper meals with ice cream. At 10:43 AM on 10/19/11 Nurse #1 stated it was the responsibility of the dietary department to place supplemental foods, ordered to help prevent weight loss or promote wound healing, on resident trays. At 10:50 AM on 10/19/11 Nurse #2 stated it was the responsibility of the dietary department to place supplemental foods, ordered to help prevent weight loss or promote wound healing, on resident trays. At 2:12 PM on 10/19/11 the DM stated he or his Assistant Dietary Manager (ADM) entered the information from Diet Order and Communication forms into the computer system so it would print out on resident tray slips. He reported the resident tray slips were the only way dietary staff would know to place supplemental foods on resident trays during the operation of the trayline. According to the DM, ice cream was added to Resident #45's meal trays to increase her caloric intake. (In addition, the protein in the ice cream would be beneficial in wound healing. The resident had a stage II pressure ulcer to her left great toe and multiple skin tears).	F 325		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 27 2. Resident #36 was admitted to the facility on 10/1/10 with cumulative diagnoses of dementia, anemia, and esophagitis. Resident #36's quarterly Minimum Data Set (MDS) dated 7/19/11 indicated that Resident #36 had short and long term memory problems and was severely impaired in daily decision making. Resident #36 was totally dependent on one person for eating. Review of the Physician Orders dated October 2011 showed that Resident #36 was to receive a mechanical soft with finger foods and chopped meats diet. Liquids were to be nectar thick. Ice cream was to be included on the lunch and dinner trays. Review of the Progress Notes (Dietary) dated 4/14/11 indicated that Resident #36 was receiving the diet as ordered including the ice cream. Review of a Diet Order and Communication sheet dated 4/30/11 indicated a clarification of Resident #36's diet. The diet was to be mechanical soft with finger foods, chopped meat, nectar thick liquid and ice cream with lunch and dinner. Review of the Progress Notes (Dietary) dated 7/16/11 indicated that Resident #36 was receiving the diet as ordered including the ice cream. Review of Resident #36's Care Plan (CP) last updated 7/19/11 indicated a potential for weight loss related to leaving 25% or more of food uneaten at most meals. Approaches included provide diet as ordered: mechanical soft diet with	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 28 chopped meat and finger foods, nectar thick liquids and ice cream at lunch and dinner. Review of the Progress Notes (Dietary) dated 10/12/11 indicated that Resident #36 was receiving the diet as ordered including the ice cream. In an observation on 10/18/11 at 12:04 PM, Resident #36 was sitting in a reclining chair in the small dining room. She was being fed by Speech Therapist (ST) #1. There was no ice cream on Resident #36's tray. Resident #36 received chopped up fish, steak fries, cole slaw and a slice of cake with pudding and fruit cocktail on top. Resident #36 did not feed herself any portion of the meal. The dietary meal card did not state to add ice cream to Resident #36's trays. Review of the Medication Administration Record (MAR) showed the nurses initials that Resident #36 had received ice cream for lunch on 10/18/11. In an observation on 10/18/11 at 6:05 PM, Resident #36 was sitting in a reclining chair being fed by the administrator. There was no ice cream on the dinner tray. The dietary meal card did not state to add ice cream to Resident #36's trays. In an interview on 10/19/11 at 11:00 AM with the Dietary Manager (DM), he indicated that when there was a diet change a communication slip was provided to the dietary department. When told that the ice cream was not on the meal card he stated he would check his paperwork to see if a communication was received.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 29 In an observation on 10/19/11 at 12:10 PM, Resident #36 was sitting in a reclining chair being fed lunch. There was no ice cream on the lunch tray. The dietary meal card did not state to add ice cream to Resident #36's trays. In an interview on 10/19/11 at 2:00 PM with ST #1, she stated that she had changed Resident #36's diet yesterday. Resident #36 would no longer be receiving ice cream. Pudding would be provided instead. In an interview on 10/19/11 at 3:10 PM with the DM, he stated that the ice cream ordered for Resident #36 had been overlooked and ice cream had not been served to her as ordered. In an interview on 10/20/11 at 8:52 AM with the Registered Dietician (RD), she indicated that her assessment process was to look at resident weights and to go through their charts. She stated she did not watch tray preparation, check meal cards, or watch meals. She indicated she looked at the orders in the chart and looked in the MAR's to see what the nurses were signing for. She did not visualize Resident #36 eating a meal to see if the ordered ice cream was given or consumed. In an interview on 10/20/11 at 3:10 PM with the Director of Nursing (DON), she stated that it was her expectation that residents were given the diets that were ordered for them. If the nurses were supposed to initial something on the MAR, she expected them to either give it themselves or ask the appropriate person for the information. She would not expect the nurse to just initial the box because it was there.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 30 3. Resident # 23 was admitted to the facility on 3/2/98 and re-admitted on 12/2/09 with cumulative diagnoses of Parkinson's disease, glaucoma and peripheral vascular disease. Resident #23's quarterly Minimum Data Set (MDS) dated 9/25/11 indicated that Resident #23 was moderately impaired in cognition. Resident #23 was independent with eating after set-up. Review of the Medical Record did not show any dietary likes or dislikes. Review of the Physician's Orders dated October 2011 showed an order for a regular diet with double meat and eggs. Review of the Progress Notes (Dietary) dated 6/8/11 indicated that Resident #23 received a regular diet. Review of the Progress Notes (Dietary) dated 7/12/11 indicated that Resident #23 received a regular diet with double meat and eggs. Review of the Diet Order and Communication sheet dated 7/19/11 indicated a change in diet to regular with double meat and eggs. Review of the Progress Notes (Dietary) dated 8/15/11 indicated that Resident #23 received a regular diet with double meat and eggs. Review of the Progress Notes (Dietary) dated 9/12/11 indicated that Resident #23 received a regular diet with double meat and eggs. Review of Resident #23's Care Plan (CP)	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 31 updated 9/26/11 listed a stage 2 sacral ulcer and bilateral ankle stasis ulcers as a problem. Approaches listed a diet high in protein. In an observation on 10/18/11 at 12:40 PM, Resident #23 was sitting up at the bedside with the meal tray on the over bed table. The meal card read double meat portions. There were 4 fish nuggets provided to Resident #23. In an observation on 10/19/11 at 8:40 AM, an aide was observed setting up Resident #23's breakfast. Resident #23 received 2 strips of bacon, 1 slice of toast, ½ banana, orange juice, milk, and coffee. There were no eggs provided. The diet slip read double eggs. Also listed was that Resident #23 did not like eggs. In an interview on 10/19/11 at 11:00 with the Dietary Manager (DM), he stated that he did not put resident likes or dislikes in the chart but put them directly into the dietary system. He indicated that Resident #23 did like eggs but did not want them everyday. He indicated that a normal portion of breakfast protein would have been 2 slices of bacon and that Resident #23 should have received 4 slices of bacon. He indicated that a normal portion of fish nuggets would have been 3-4 nuggets and that Resident #23 should have received 6-8 nuggets for a double portion. He indicated that when there was a diet change a communication slip was provided to the dietary department. He stated that Resident #23 should have received double meat and egg portions and that the kitchen staff needed to be more careful when they were preparing the trays. In an observation on 10/19/11 at 12:15 PM,	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 325	Continued From page 32 Resident #23 received 2 chicken thighs for lunch which was a double portion. In an interview on 10/20/11 at 8:52 AM with the Registered Dietician (RD), she indicated that her assessment process was to look at resident weights and to go through their charts. She stated she did not watch tray preparation, check meal cards, or watch meals. She indicated she looked at the orders in the chart and looked in the MAR ' s to see what the nurses were signing for. She did not visualize Resident #23's meals to see that she was getting double portions. In an interview on 10/20/11 at 3:10 PM with the Director of Nursing (DON), she indicated that the Nursing Assistants would not necessarily know what a double portion consisted of. She indicated that she expected the kitchen staff to provide the diet that was ordered.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a cold salad made with	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 33	F 371		

mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline, failed to sanitize a sink used for preparing raw chicken, failed to replace or discard compromised kitchenware, and failed to label and date opened food items in the kitchen and the nourishment room refrigerator. Findings include:

1. At 11:40 AM on 10/18/11, when checked with a calibrated thermometer, the tray pan of chicken salad at the trayline registered 53.6 degrees Fahrenheit. The tray pan was sitting above a steam well which was filled with ice. A new pan of chicken salad, removed from the reach-in freezer, registered 45.9 degrees Fahrenheit.

At 11:42 AM on 10/18/11 a review of the log of trayline temperatures revealed no temperatures were taken on any hot or cold foods before or as the 10/18/11 lunch trayline began operation. At this time the cook stated he was supposed to take hot and cold food temperatures just before the trayline began operation at each meal. The Dietary Manager (DM) reported the cook was behind in his food preparation tasks so that may have been the reason he forgot to obtain temperatures before the trayline began operation. The DM commented that the resident trays for one hall had already left the kitchen. He stated he would pull the chicken salad at the trayline, place it in the walk-in freezer, and lower the temperature before continuing to serve it to residents.

At 12:10 PM on 10/18/11 a tray pan of chicken salad was back on the trayline. The DM reported he was able to lower the temperature to 45 degrees Fahrenheit so it was safe to continue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 34 serving it to the residents. When checked with a calibrated thermometer, the chicken salad registered 45.3 degrees Fahrenheit. At 12:12 PM on 10/18/11 two chicken salad croissants were assembled and placed on resident trays. After surveyor intervention, the croissants were pulled from resident trays, and the chicken salad was once again removed from the trayline. The DM stated all cold foods should remain at or below 45 degrees Fahrenheit during operation of the trayline per ServSafe guidelines. At 2:12 PM on 10/19/11 the DM reported the chicken salad was made using chicken, mayonnaise, mustard, boiled eggs, pickle relish, garlic powder, and onion powder. According to the DM, the chicken salad was prepared the day it was served, rather than being prepared the day before serving as recommended. He stated he expected temperature of all food items to be recorded in the trayline temperature log just before the trayline began operation at each meal. The DM commented staff were trained that cold foods should remain at or below 40 degrees Fahrenheit during the entire operation of the trayline. At 2:24 PM on 10/19/11 the PM cook stated all cold foods were supposed to be prepared the day before they were served and stored in the walk-in refrigerator after preparation. She reported she preferred to place ice in a large cart and set tray pans of cold salads down into the ice, rather than trying to place the salads on the steam table over ice. The cook commented she thought keeping cold foods away from hot foods on the steam table was more effective for temperature control.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 35 She reported she was trained that all cold foods should be kept at 40 degrees Fahrenheit or below during the entire operation of the trayline. 2. At 8:34 AM on 10/18/11 the cook poured raw chicken directly into the poultry sink. The chicken was rinsed under running water and placed on a cutting board to be trimmed. At 9:00 AM on 10/18/11 the cook obtained a dishwashing detergent solution from the three-compartment sink dispensing system, and washed down the ledge, sides, and bottom of the poultry sink. No sanitizing solution was applied to the sink afterwards. At 9:30 AM on 10/18/11 the cook stated he had only washed down the poultry sink, and did not realize he was supposed to sanitize the sink. At 2:12 PM on 10/19/11 the Dietary Manager (DM) stated dietary staff were trained to wash, rinse, and sanitize meat and poultry sinks after finishing preparation tasks in them. He reported staff were supposed to obtain quaternary sanitizing solution from the three-compartment sink dispensing system to be used when sanitizing food preparation sinks. The DM commented it was important to kill bacteria in the sinks so it would not multiply between preparation tasks, especially when meat and poultry were placed directly in the sinks. At 2:48 PM on 10/19/11 the PM cook stated she was trained to use a spray bottle of sanitizer on sinks immediately after completion of poultry or meat preparation tasks.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 36 3. During the initial tour of the kitchen on 10/17/11, beginning at 9:42 AM, a saute/frying pan which was hanging in storage had a coating which was scratched. At 9:54 AM, during a follow-up inspection of kitchenware on 10/18/11, a saute/frying pan hanging in storage had a coating which was scratched. At 10:08 AM on 10/18/11 32 of 35 green coffee mugs were stained dark brown inside. At 2:12 PM on 10/18/11 the Dietary Manager (DM) stated when kitchenware became compromised or damaged, the dietary staff was trained to bring it to him so he could replace it. He commented kitchenware with scratched surfaces could increase the chance that bacteria could grow on it, and coating which was peeling off kitchenware could possibly make residents sick. According to the DM, using metal utensils on the non-stick coating of the saute/frying pan probably caused the scratches. He commented the facility was eventually going to replace the current coffee mugs, and was in the process of making a decision about which cups to purchase. The DM explained the dietary staff was supposed to put stained kitchenware in a bleach de-staining solution weekly. However, he reported he could say for sure when the staff last submerged the mugs in a bleach solution. The DM commented he thought the coffee mugs were so badly stained that a bleach solution would no longer remove the dark brown staining inside the mugs. At 2:48 PM on 10/19/11 the PM cook stated she was trained to take damaged kitchenware to the	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 37 DM so he could dispose of it and reorder new kitchenware to replace it. She reported scratched, cracked, and chipped kitchenware increased the chance that bacteria could make residents sick. The cook commented the dietary staff was supposed to soak stained kitchenware weekly to remove the discoloring. However, she explained this was not her responsibility so she could not say for sure if the weekly de-staining was occurring. 4. During initial tour of the kitchen on 10/17/11, beginning at 9:42 AM, three bags of opened frozen biscuits and one bag of opened frozen cinnamon roll dough did not have labels or dates on them. These items were found in the reach-in freezer. In the dry storage room a 5.7 ounce packet of onion soup mix, a 16 ounce bag of marshmallows, a 24 ounce bag of lemon gelatin mix, and a 24 ounce bag of strawberry gelatin mix were opened and resealed, but did not have labels or dates on them. In the walk-in freezer an opened bag of steaks, which had been resealed, had a label on it, but the date was unreadable. Bags of French fries, hamburger patties, tortelini, and sausage which were opened and resealed in the walk-in freezer, did not have labels and dates reflecting when they were opened. During a follow-up tour of the kitchen on 10/19/11 at 10:03 AM a bag of bacon crumbles in the walk-in refrigerator was opened and resealed, but did not have a label or date on it. In addition, in the bottom of a crate in the walk-in freezer two bags containing two different types of sausages were opened and resealed, but did not have a label or date on them.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 38 At 2:07 PM on 10/19/11 a boxed whipped cream layer cake, which was opened and stored in the reach-in freezer, did not have a label and date on it. At 2:12 PM on 10/19/11 the DM stated he, the Assistant Dietary Manager (ADM), and the cooks monitored the storage areas daily to make sure food items which were opened were resealed using plastic wrap, labeled, and dated. In addition, the DM reported leftovers and foot items removed from their original packaging/containers should have labels and dates on them. At 2:48 PM on 10/19/11 the PM cook stated the DM, ADM, and cooks monitored storage areas daily. In addition, she commented the stock person also monitored storage areas when placing newly delivered foods into storage. The cook reported all storage areas were monitored daily to make sure food items which were opened, leftovers, and food items which were removed from their original packaging had labels and dates on them. 5. On 10/20/11 at 8:50 AM the nourishment refrigerator that contained resident's food was observed. Nursing Assistant (NA) # 1 was in attendance during the observation. In the refrigerator there was an opened container of jelly, mustard, mayonnaise with no name or opened date. Also observed was an uncovered pitcher of a red fluid with no date and a pitcher with a golden colored fluid covered with tin foil with no date. Another pitcher dated 10/19/11	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 39 contained a dried yellow substance on the bottom of the pitcher. There was no thermometer in the freezer section. The freezer contained a plastic container half filled with a brown substance. There was a name on the container, but no date. NA # 1 stated she did not know why the container would even be in the freezer since the resident did not live in the unit. There was no date on the container. There were 2 - 1.5 quarts of vanilla ice cream opened. One container had ice cream frozen to the outside of the container. There were no dates or names on the containers. A plastic container that was full of a brown substance had no date or name. In the freezer was seen a styrofoam cup loosely covered by tin foil. In the 1/2 filled cup was ice cream with a spoon in the ice cream. There was no name or date on the cup. NA # 1 stated she thought the 3rd shift was responsible for keeping the refrigerator clean. She stated without names and dates on the food items, she was unable to determine how long the items had been in the refrigerator or to whom the items belonged. An interview was held with the Director of Nursing (DON) on 10/20/11 at 9:28 AM. She stated prior to NA # 1 speaking with her, she thought housekeeping was responsible for cleaning the refrigerator. The DON stated she was unclear of the facility system for dating/labeling and cleaning the nourishment refrigerator. The DON stated the 3rd shift nurse was responsible for recording temperatures. She stated she was unsure how this was done without a thermometer in the freezer. The DON stated the Administrator had decided housekeeping would be responsible for	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 371	Continued From page 40 cleaning the refrigerator and the dietary department would be responsible for making sure food items were dated and labeled.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 441	Continued From page 41 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to disinfect a blood glucose meter after a random fingerstick blood glucose was performed while being observed during medication pass. The facility also failed to ensure staff were practicing adequate handwashing hygiene and handling soiled linens properly to prevent the spread of infection. Findings include: 1. According to the infection control section of the manufacturer's recommendations for the Assure 4 glucose monitor (meter) (revised 6/07), the glucose monitor was to be cleaned and disinfected. The use of a lint free cloth dampened with soapy water or 70-80% alcohol was to be used to clean the outside of the blood glucose meter. For disinfecting the glucose meter it indicated to dilute 1ml (milliliter) of household bleach (5%-9% sodium hypochlorite solution) in 9ml of water for a 1:10 solution. In the maintenance section of the manufacturer's guide it indicated to clean between patients. There was no frequency noted for disinfection. During medication pass observation, on 10/18/11 at 4:00 PM, Nurse #3 was observed performing a random fingerstick blood glucose on Resident #6. Once she finished, she used an alcohol prep pad to clean the machine and placed it back into the medication cart. When questioned as to the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 441	Continued From page 42 procedure for disinfecting and cleaning blood glucose meters she stated she had been told to use alcohol wipes. On 10/19/11 at 9:30 AM, Nurse #1 stated she always cleaned blood glucose meters after each use. She stated she cleaned them using an alcohol prep pad from the medication cart. During an interview with the Director of Nurses (DON), on 10/19/11 at 11:40 AM, she stated she kept a disinfectant solution in her office for disinfecting the blood glucose meters. She also stated the same solution was in the medication room. The DON reported staff were expected to go to the medication room to clean/disinfect the meters in between residents. She added that her office was always open. The DON stated using alcohol wipes was not sufficient for disinfecting blood glucose meters. She added that the revised guidance information for disinfecting blood glucose meters was in the Administrator's office as she had just obtained it from him. The DON also reported that the medical records staff had the manufacturer's recommendations available in her office for staff if they had questions in regards to disinfecting the meters. On 10/20/11 at 11:20 AM, the DON stated antimicrobial wipes had been provided for all of the medication carts as of today and an inservice had been provided on the proper way to disinfect the blood glucose meters.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 441	Continued From page 43	F 441		

2. Resident # 18 was admitted on 07/20/10 with cumulative diagnoses of debility, depression, blindness, anxiety, and dementia.

An observation was made on 10/18/11 at 4:15 PM of Nursing Assistant (NA) # 2 providing incontinent care to Resident # 18. On entering the room, the resident's personal blankets (2) were lying on the floor at the end of the bed along with the top sheet from the bed. After completing incontinent care, the NA rolled the soiled brief with the feces inside the quilted incontinent pad and threw both over the resident where it landed on the floor on the left side of the bed. The turn sheet was left on the bed. Smeared feces was observed on the left side of the turn sheet and eraser sized balls of feces were left on the right side of the turn sheet. Without changing his dirty gloves ,the NA placed the clean brief over the balls of feces and fastened the brief on Resident # 18. The NA then used the soiled gloves to pick up clean pants dressed the resident. The resident's shirt was removed and a clean shirt applied using the same gloves. NA # 2 used the soiled gloves and opened the resident's dresser to find socks and shoes. At this point, the NA changed his gloves. After dressing Resident # 18, NA # 2 picked up the soiled clothing items and sheets/pad and without bagging the items, took them across the hall to the dirty linen room. Coming back to the room, he used the soiled gloves and transferred the resident to the wheelchair. NA # 2 went back to the soiled linen room. Upon leaving the soiled linen room, he assisted another NA to push a shower gurney to the other resident's room. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 441	Continued From page 44 NA had not changed the soiled gloves. NA # 2 then went to the clean linen room and retrieved clean linen using the soiled gloves. The resident's bed was made, her personal blankets picked up off the floor and placed on the clean bed. After completion of making the bed, the NA disposed of the soiled gloves and washed his hands. An interview was held with NA # 2 on 10/18/11 at 4:29 PM. He stated he had been taught to handle dirty linen by putting linens in the dirty linen bin adding he was taught not to place soiled linen on the floor. NA # 2 stated he did not know why he put the linen on the floor. The NA stated he had not been taught to change gloves between dirty and clean. He acknowledged he put the clean diaper on top of the draw sheet with the visible feces. NA # 2 stated he had not been thinking. The NA stated the danger could be cross contamination. The NA stated he would not commonly put items that had been on the floor back on the bed, but did that today because he was not thinking. An interview was held with the Director of Nursing (DON), who had previously served as the Staff Development Coordinator at 5:10 PM on 10/1811. The DON stated the expectation was for staff to wash their hands before and after any care. She added staff had been taught not to wear gloves in the hall. An in-service had recently been presented on infection control addressing blood borne pathogens, etc. The DON stated if linens soiled with stool were on the floor, staff could possibly transport stool on their shoes causing cross contamination. If the staff member handled dirty linens then gloves should be changed. The	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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 441	Continued From page 45 DON stated NA # 2 had been taught to bag linens and clothes when soiled.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0580	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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) COMPLETE DATE
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide portable oxygen for 1 of 1 (Resident #58) sampled residents reviewed for respiratory needs. Findings include: Resident #58 was admitted into the Adult Care Home at the facility on 7/27/11 and re-admitted on 8/4/11 with cumulative diagnoses of dementia and coronary artery disease with a cardiac pacemaker. Review of the Physician Orders for October 2011 showed an order for oxygen at 3 liters per minute via nasal cannula to run continuously. Review of an In-Service Summary and Attendance packet showed an in-service on oxygen had been done on 8/24/11. The in-service provided the following information: "When a resident is on oxygen before taking them off of their concentrator make sure that they have a portable tank to use and that it has oxygen in it Do not remove the concentrator oxygen until portable tank is in place on wheelchair, turned on, and set at the correct liters. Med-Techs are responsible for changing portable oxygen tanks	D 358	Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable release provisions of residents. The Plan of Correction is submitted as a written allegation of compliance. Windsor Point's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Windsor Point reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal process, and/or, any other administrative or legal proceeding. **D 358** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished for Resident #58 found to have been affected by the deficient practice as follows: 1. On 10/19/11 Resident #58's portable oxygen was turned on to 3 liters as ordered by MD. II. Corrective action will be accomplished for all residents having potential to be affected by the same deficient practice as	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE W.B. TITLE WILL ADMINISTRATOR (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0580	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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) COMPLETE DATE
D 358	Continued From page 1 and making sure that residents do not run out of oxygen. If you find a resident without oxygen in their portable tank, immediately take them back to their room and put them on their concentrator until another portable tank can be used. Then notify the Med-Tech or supervisor on duty immediately. If you cannot find the Med-Tech for your hall a supervisor or a nurse can help you change out portable tanks." Review of the Adult Care Home Personal Care Physician Authorization and Care Plan dated 9/7/11 showed Resident #58 used oxygen at 3 liters per minute continuously. Review of the Licensed Health Professional Support Initial Evaluation and Quarterly Review of Residents dated 9/14/11 showed that oxygen administration and monitoring was being done for Resident #58 and that competency of the staff working with Resident #58 had been validated. In an observation on 10/18/11 at 12:10 PM, Resident #58 was sitting up in a wheelchair in the main dining room. Portable oxygen at 3 liters per minute was provided via nasal cannula. The portable tank was approximately 25% full. In an observation on 10/18/11 at 5:45 PM, Resident #58 was sitting up in a wheelchair in the main dining room. Portable oxygen was attached to a nasal cannula but the oxygen gauge needle was in the red and pointing to zero. Resident #58 was not experiencing any shortness of breath and was able to speak in complete sentences without pausing. No respiratory issues were observed. In an interview on 10/18/11 at 5 50 PM with Med-Tech #1, she stated her responsibilities included passing medications, helping residents	D 358	follows: 1. Staff were in-serviced on oxygen usage from 10/19/11 – 10/21/11. (EXHIBIT 1) 2. All other residents receiving oxygen were checked for proper liters and oxygen distribution. III. The systemic changes put into place so that deficient practices will not recur will be: 1. "System Check for Oxygen" will be implemented. (EXHIBIT 2) IV. Performance correcting these deficiencies will be monitored through the following methods. A QA monitoring tool has been put in place to assure the following systems are in place. 1. "System Check for Oxygen" will be completed as follows: daily until 100% compliance is reached, weekly x 4, monthly x 3, and then randomly thereafter. (EXHIBIT 2) 2. Findings and documents will be reviewed in monthly QA meetings. V. October 26, 2011	10/26/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0580	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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) COMPLETE DATE
D 358	Continued From page 2 get up and changing oxygen tanks when needed. She indicated that portable oxygen tanks were checked daily. She stated that she did not know Resident #58's portable oxygen was empty and that the aide who got Resident #58 up should have checked the tank and told her it was low. In an interview on 10/18/11 at 5:55 PM with Personal Care Assistant (PCA) #1, she indicated that her responsibilities included getting residents up and making sure they were dry. She stated that she looked at Resident #58's portable oxygen tank and saw that it was registering in the red. She indicated that she "hoped" it would last through dinner and took resident #58 to the dining room. She stated she did not notify the Med-Tech that the portable oxygen tank was low. In an observation on 10/19/11 at 8:15 AM, Resident #58 was sitting up in a wheelchair in the main dining room. The oxygen cannula was in place and connected to the portable oxygen tank. The portable oxygen gauge needle was in the red and on zero. Nursing Assistant (NA) #1 approached Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 was not experiencing any shortness of breath and was able to speak in complete sentences without pausing. No respiratory issues were observed. In an interview on 10/19/11 at 8:20 AM with PCA #2 she stated she got Resident #58 up and connected the portable oxygen tank. She indicated she took Resident #58 to the main dining room at approximately 7 35 AM She stated she was unable to turn the portable oxygen on as she did not have access to the key used to turn the tank on She indicated that she told Med-Tech #2 that Resident #58's oxygen needed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0580	A. BUILDING _____ B. WING _____	C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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) COMPLETE DATE
D 358	Continued From page 3 to be turned on. In an interview on 10/19/11 at 8:50 AM with NA #1, she indicated that Resident #58's oxygen was supplied by a different vendor than the one the facility provided. If a tank was not available from Resident #58's supply the facility oxygen could be used. She stated that when an aide gets a resident up the portable oxygen tank should be checked. If the tank reading was low or empty the Med-Tech should be notified. The aide should not remove the resident from the room with an empty tank. In an interview on 10/19/11 at 9:26 AM with Med-Tech #2, she stated that she had not been told by anyone that Resident #58 needed the portable oxygen tank turned on. She indicated that PCA #2 should not have taken Resident #58 to the dining room without the oxygen being turned on. She stated she was always available and that Resident #58 had never run out of oxygen before this. In an observation on 10/19/11 at 9:45 AM, Resident #58's portable oxygen tank was approximately 25% full. In an interview on 10/19/11 at 10:45 AM with the Adult Care Home Supervisor, she indicated it was the responsibility of the Med-Techs to check the portable oxygen tanks each time the residents left their rooms. She stated that the PCA's needed to get the Med-Techs prior to taking a resident with portable oxygen out of their rooms so the tanks could be checked. She indicated that it was her expectation that a PCA would not remove a resident from their room with an empty portable oxygen tank.	D 358		

PF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED DEC 28

PRINTED: 12/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345600	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: By observation on 12/8/11 at approximately noon there was not a visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone line connection, nor at the panel at the side entrance near the manned nursing station.	K 051	Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable release provisions of residents. The Plan of Correction is submitted as a written allegation of compliance. Windsor Point's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Windsor Point reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal process, and/or any other administrative or legal proceeding. **K 051** Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished by Windsor Point to correct the deficient practice as follows: 1. A visual/audible trouble signal will be installed at the Fire Alarm Control Panel (FACP) located at the front entrance of the facility. This area is likely to be seen or heard by Windsor Point staff.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Will Batot — TITLE: Administrator — (X6) DATE: 12/21/11

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.

DRW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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
K 144	Continued From page 1 accordance with NFPA 99. 3.4.4.1.	K 144	II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows: 1. A visual/audible trouble signal will be installed at the Fire Alarm Control Panel (FACP) located at the front entrance of the facility. This area is likely to be seen or heard by Windsor Point staff. III. The measures/systemic changes put into place so that deficient practices will not recur will be: 1. A visual/audible trouble signal will be installed at the Fire Alarm Control Panel (FACP) located at the front entrance of the facility. This area is likely to be seen or heard by Windsor Point staff. IV. Performance correcting these deficiencies will be monitored through the following methods: 1. Audits of the visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone connection will be completed using the "Telephone Connection Loss Audit" by Administrator or designee as follows: weekly for 4 weeks and at least annually thereafter. [redacted] V. February 6, 2012 2/6/12 K 144 Windsor Point will ensure the services provided or arranged by the facility will meet	

This STANDARD is not met as evidenced by:
42 CFR 483.70(a)
By observation at approximately noon the facility did not meet NFPA 99 3-4.1.1.15 Alarm Annunciator which states: A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. (see NFPA 70, National Electrical Code, Section 700-12). The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:
(a) Individual visual signals shall indicate the following:
1. When the emergency or auxiliary power source is operating to supply power to load
2. When the battery charger is malfunctioning
(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:
1. Low lubricating oil pressure
2. Low water temperature (below those required in 3-4.1.1.9)
3. Excessive water temperature
4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply
5. Overcrank (failed to start)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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
K 144	Continued From page 2 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15 (a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2] Specific findings include the annunciator panel was located in an area that is not a regular work station or likely to be readily observed.	K 144	professional standards of quality. I. Corrective action will be accomplished by Windsor Point to correct the deficient practice as follows: 1. A remote annunciator, storage battery powered, will be provided to operate outside of the generating room. The remote annunciator will be moved to the facility's nurses' station. This area is a regular work station and is likely to be seen or heard by Windsor Point staff. 2. An audible/visual derangement signal, appropriately labeled, will be established at the facility's nurses' station. II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows: 1. A remote annunciator, storage battery powered, will be provided to operate outside of the generating room. The remote annunciator will be moved to the facility's nurses' station. This area is a regular work station and is likely to be seen or heard by Windsor Point staff. 2. An audible/visual derangement signal, appropriately labeled, will be established at the facility's nurses' station. III. The measures/systemic changes put into place so that deficient practices will not recur will be: 1. A remote annunciator, storage battery	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346500	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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
K 144	Continued From page	K 144	powered, will be provided to operate outside of the generating room. The remote annunciator will be moved to the facility's nurses' station. This area is a regular work station and is likely to be seen or heard by Windsor Point staff. 2. An audible/visual derangement signal, appropriately labeled, will be established at the facility's nurses' station. 3. Staff will be in-serviced on the generator annunciator panel to identify and monitor the following individual audible/visual signals: a. Individual visual signals shall indicate the following: • When the emergency or auxiliary power source is operating to supply power to load. • When the battery charger is malfunctioning. b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: • Low lubricating oil pressure • Low water temperature • Excessive water temperature • Low fuel – when the main fuel storage tank contains less than a 3-hour operating supply • Overcrank (failed to start) • Overspeed IV. Performance correcting these deficiencies will be monitored through the following methods:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346500	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(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
K 144	Continued From page	K 144	1. A remote annunciator, storage battery powered, will be provided to operate outside of the generating room. The remote annunciator will be moved to the facility's nurses' station. This area is a regular work station and is likely to be seen or heard by Windsor Point staff. 2. An audible/visual derangement signal, appropriately labeled, will be established at the facility's nurses' station. 3. Staff will be in-serviced on the generator annunciator panel to identify and monitor the following individual audible/visual signals: a. Individual visual signals shall indicate the following: • When the emergency or auxiliary power source is operating to supply power to load. • When the battery charger is malfunctioning. b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: • Low lubricating oil pressure • Low water temperature • Excessive water temperature • Low fuel – when the main fuel storage tank contains less than a 3-hour operating supply • Overcrank (failed to start) • Overspeed V. March 9, 2012	3/9/12